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

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Policy &amp; Procedure Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>None.</td>
<td>None.</td>
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</table>

2. **New Department Policies and Procedures**

**Department: Outpatient Clinics**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comments/Reason(s) for Revision</th>
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<tbody>
<tr>
<td>OP C8</td>
<td>Stirling Freezer: Portable Ultra Low Temperature Freezer</td>
<td>Created to provide guidelines on the proper maintenance procedures of the ultra-low temperature freezer, and the safe removal of wound therapy products.</td>
</tr>
</tbody>
</table>

2. **Revised Hospital-wide Policies and Procedures**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
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</thead>
<tbody>
<tr>
<td>LHHPP 22-06</td>
<td>Residents’ Council</td>
<td>Attachment A has been replaced with the latest version of the LHH Residents’ Council Bylaws, approved on April 7, 2017 (President/Vice President has been replaced with Co-Leaders).</td>
</tr>
<tr>
<td>LHHPP 24-04</td>
<td>Resident Found Off-Grounds</td>
<td>Procedures have been re-sequenced, and contact number has been updated. Removed procedure for calling San Francisco Sheriff’s Department for residents who appear lost; removed option to escort resident via vehicle if resident is cooperative.</td>
</tr>
<tr>
<td>LHHPP 25-02</td>
<td>Safe Medication Orders</td>
<td>Revised to include duration of therapy and quantity to meet billing requirements; expanded the information under discontinued medications to include discharged or transfer to acute.</td>
</tr>
<tr>
<td>LHHPP 25-05</td>
<td>Hazardous Drugs Management</td>
<td>Policy statements have been added: management of IV cytotoxic/chemotherapy drugs via CADD shall be initiated elsewhere; exclude staff who are pregnant from handling hazardous drugs; and tablets or capsules shall not be crushed or cut if labeled as “hazardous” or “chemotherapy”. Procedures and definitions have been streamlined and revised for clarity. Procedures have been revised to explain the usage of new yellow Chemo carts and update the instructions for contaminated linens. Appendix B has been replaced with LHH Duration of Chemo.</td>
</tr>
</tbody>
</table>
Precautions by Drug; Appendix C has been added to describe the procedures for cleanup of hazardous drug spills.

<table>
<thead>
<tr>
<th>LHHPP</th>
<th>Management of Dysphagia and Aspiration Risk</th>
<th>Revised to add definitions for Line of Sight, Close Supervision, and 1:1.</th>
</tr>
</thead>
</table>

| LHHPP 26-02 | California End of Life Option Act: Implementation at Laguna Honda | Revised to clarify that verbal request #2 is made to attending physician at a minimum of 15 days after initial verbal request; added policy effective dates; added that pharmacy shall notify QM of receipt of Aid-In-Dying prescription; and added annual review procedure. Appendix C has been replaced with information by Compassion and Choices to provide physicians and pharmacists with guidance on improving care and expanding choice at the end of life. Appendix D has been added to include Attending Physician Forms Submission Instructions; links have been added to the Reference section on required forms for submission to CDPH. |

b. Revised Department Policies and Procedures

<table>
<thead>
<tr>
<th>Department: Nursing</th>
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<tbody>
<tr>
<td><strong>Policy Number</strong></td>
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<td>NPP D6 4.0</td>
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<tr>
<th>Department: Pharmacy</th>
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<tr>
<td><strong>Policy Number</strong></td>
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<tr>
<td>Pharm 01.02.02</td>
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<tr>
<td>Pharm 02.01.00a</td>
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<td>Pharm 02.01.00b</td>
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3. a. Hospital-wide Policies and Procedures for Deletion

<table>
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b. Department Policies and Procedures for Deletion

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</table>
STIRLING FREEZER: PORTABLE ULTRA LOW TEMPERATURE FREEZER

POLICY:

1. Outpatient Clinic staff shall receive annual training, by an Osiris representative, on the operation and ongoing maintenance of the freezer.

2. The ultra-low temperature freezer temperature shall be monitored and logged daily by Outpatient Clinic staff.

3. Loading and unloading of wound products require use of freezer gloves

PURPOSE:
Provide guidelines on how to safely remove the wound therapy products and maintain the Ultra-low temperature freezer.

DEFINITION/BACKGROUND:
The ultra-low temperature freezer maintains a cryopreserved wound therapy product derived from placental tissue by Osiris Therapeutics for use in outpatient clinic. The freezer keeps the Osiris Therapeutics wound therapy product to -80 degrees Celsius and as such be able to keep the wound product on hand for up to 3 years storage.

PROCEDURE:
Operation: Operating Manual which is reviewed by Outpatient clinic staff will be placed in binder next to freezer for reference

Freezer Monitor:
a. TempTrak monitor attached to freezer by LHH Facility Services – see Facility Services P&P EM-11
b. Freezer is plugged into red emergency outlet
c. Temperature log maintained daily in Outpatient Clinic and kept on site for a period of 3 years.

Maintenance:
a. Weekly check and remove accumulated ice crystals on inner freezer lid – staff will use freezer gloves on to wipe away ice crystals with cloth or paper towel. No other cleaning is necessary.
b. Osiris representative will be in every 2-4 weeks to check freezer function.
Loading the Freezer:
   a. Load freezer with only Osiris Therapeutics wound substitute products using freezer gloves.
   b. Packaging inspected to ensure that it is sealed prior to placing in the freezer
   c. Label each package with loading date and staff initials
   d. Items can be stacked and grouped without specific order

Unloading Wound Product from Freezer:
   a. LHH outpatient clinic staff- MD, RN and LVN’s will use freezer gloves to remove the product and place packet into a plastic bin provided by Osiris.

Failure of Freezer:
   a. Freezer is monitored by TempTrak. If the temperature rises to -79 Celsius and above the Outpatient Clinic Director or charge nurse will be notified by pager. Outpatient Clinic Director or charge nurse will then notify the Osiris representative of the freezer failure. No other actions are necessary.
   b. If the failure occurs during the weekday, an Osiris representative will come to remove freezer and products.
   c. If the failure occurs during a weeknight, the Osiris representative will come the next business day to remove the freezer and product.
   d. If the failure occurs any time after hours from Friday until Monday morning, the Osiris representative will come on the next Business day to remove the freezer and product.

REFERENCE:
Stirling Ultracold Operating Manual
LHH Facility Services P&P: Equipment Management Program: Refrigeration

New 02/2017
Approved: 04/2017
RESIDENTS’ COUNCIL

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) 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 LHH.

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:
Attachment A: Laguna Honda Hospital and Rehabilitation Center Residents’ Council Bylaws (Last approved May 17, 2017)

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, 17/07/11 (Year/Month/Day)
Original adoption: 07/12/18
Attachment A:

**Main Building Laguna Honda Hospital And Rehabilitation Center**

**Residents' 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, 2014  
April 7, 2017

Bylaws:

1. The President (or designee) of Co-Leaders 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. *(Amended 4/7/2017)*

2. Members of the Residents’ Council include all interested residents.

3. Expected guests include:
   a. Facilitator (Activity Therapy Supervisor)
   b. Executive Assistant representative (Representing to the Executive Administrator)
   c. Executive Administrator (Ad. Lib)
   d. Nursing representative
   e. Ombudsman *(Added: 2013)*

4. Other invited guests:
   - The Residents’ Council will refer the request for the presence of invited guests to the Executive Assistant representative who will invite the specified personnel.
   - 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. *(11/15/07)*: Guest speakers will be scheduled towards the end of meeting, after resident topics and issues are addressed. *(Added: 11/15/07)*
5. The Residents’ Council officers and their roles and responsibilities are (Amended April 2017):  

   a. PresidentCo-Leaders (2 Residents):  
      Rresponsible 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.

   b. c. Past PresidentCo-Leaders:  
      Aacts as an advisor to the Council. The Past president Co-Leaders is are not elected, but assumes the role at the end of his or her terms in office.

   c. d. 3 Representatives (3 Residents):  
      Support resident council efforts, attend scheduled meetings. (Amended on July 18, 2013: Representatives will represent the North, South and (including Pavilion Mezzanine residents) residents, and a Short-Term Resident Representative.) (Added 7/18/2013)

   DEFINITIONS:
   Co-Leaders: Residents must have a minimum of 2 years of residence at LHH.
   North and South Building Representatives: Residents must have a minimum of 1 year at LHH.
   Short-Term Resident Rep: Resident must have a minimum of 90 days residence at LHH. (Added 4/7/2017)

6. All officers are encouraged to attend scheduled meetings between Staff & Officers to address hospital business. (Added 3/19/09).

6.  

7. Elections for Residents’ Council officers are held each June or as needed. Amended on April 21, 2011: The timeline for Resident elections are as follows (amended 4/21/2011):  

   March: Resident Council officers will make general announcement about upcoming election, ensure council body is aware of the process.
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.

May: Nominations will be finalized, afterwards a poster of the Candidates will be generated and distributed throughout the hospital.

June: Entire Resident Council meeting will be dedicated to election.

1. 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.

2. 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.

3. With staff and volunteer support, resident will complete ballot.

4. Tallying votes: 2 residents and former President/Co-Leaders and support staff will count the votes. Winner will be announced on that day.

5. New officers will begin their terms in July.

Campaigning:

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

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

• 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 Co-Leader will ask the Executive Assistant to make the request for response to the appropriate department head (edited 4/7/2017).

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
representative is responsible for facilitating the additional communication between the council and hospital staff.

11. Neighborhood representatives (Added 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 meetings, neighborhood meeting minutes are forwarded to Residents’ Council officers.

12. Proxies (Added 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 (Added 2014): Residents who are interested in attending Residents’ 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 FOUND OFF-GROUNDS

POLICY:

Employees and volunteers are encouraged to assist residents who are found off Laguna Honda Hospital and Rehabilitation Center (Laguna Honda LHH) campus and who appear to be lost.

PURPOSE:

To provide appropriate guidelines for employees and volunteers in assisting Laguna Honda LHH residents who are found outside of the Hospital campus and who appear lost.

PROCEDURE:

1. Employees or volunteers shall attempt to return the resident to the Hospital if the resident:
   a. Confirms that he/she is lost,
   b. Is unable to respond to questions, appears to be frightened, confused, and/or inappropriately dressed,
   c. Has an orange ribbon pinned to his/her clothing, bag pack, wheelchair, etc.

2. Employees or volunteers shall not attempt to return the resident to LHH if the resident states that he/she is not lost and is out of the Hospital on a “pass.”

3. If the resident is cooperative, the resident may be escorted by foot, and the LHH Nursing office (415-682-1500) shall be called to notify them of the resident’s location.

4. If the resident is not cooperative, proceed to call or ask someone to call Laguna Honda LHH Nursing office (415-682-1500) (415759-2300) and stay with the resident, if possible, while providing them with sufficient identifying information to assist them with locating the resident and returning them to Laguna Honda LHH.

1. Employees or volunteers should not attempt to return the resident to the Hospital LHH if the resident indicates states that he/she is not lost but is out of the Hospital on a “pass.”

2. Employees or volunteers should attempt to return the resident to the Hospital if the resident:
a. Confirms that he/she is lost,

b. Is unable to respond to questions, appears to be frightened, confused, and/or inappropriately dressed.

c. Has an orange ribbon pinned to his/her clothing, bag pack, wheelchair, etc.

If the resident is cooperative, you may escort the resident may be escorted by foot or vehicle to the resident’s unit or call the LHH Nursing office (415–682-1500) of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall be called and to notify them of the resident’s location.

3. Employees or volunteers should attempt to return the resident to the Hospital if the resident:

   a. Confirms that he/she is lost,

   b. Is unable to respond to questions, appears to be frightened, confused, and/or inappropriately dressed.

   c. Has an orange ribbon pinned to his/her clothing, bag pack, wheelchair, etc.

4. If the resident is not cooperative, proceed to call or ask someone to call the Laguna Honda San Francisco Sheriff’s Department (415-759-2319) or the Nursing office (415-759-2311) and stay with the resident if possible while providing them with sufficient identifying information to assist them with locating the resident and returning them to Laguna Honda.

ATTACHMENT:
None

REFERENCES:
None

Revised: 92/05/20; 98/04/01; 00/12/14, 09/04/28, 17/07/11 (Year/Month/Day)
Original adoption: 92/05/20
SAFE MEDICATION ORDERS

PURPOSE:
To ensure resident safety by reducing the potential for error or misinterpretation when orders are communicated.

POLICY:
Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal communication of prescription or medication orders is limited to situations in which immediate written communication is not feasible. Medication orders from physicians, dentists, podiatrists, physician assistants, nurse practitioners, and pharmacists are accepted if they comply with the requirements listed below.

PERSONS AFFECTED:
Clinical Staff, including but not limited to Physicians, Nurses, and Pharmacists

PROCEDURE:
1. Medication Orders
   a. All prescription orders must be in writing or electronic and shall contain the following:
      i. Date and time order is written
      ii. Patient name and medical record number
      iii. Medication name (generic preferred)
      iv. Strength or concentration
      v. Dose
      vi. Frequency or time of administration of the medication
      vii. Route, e.g. PO, IM, SC, IV or rectal
      viii. All orders (PRN and scheduled) must include the indication for use of the medication. PRN orders must also include how often the medication may be given.
      ix. Duration of therapy or quantity, if applicable (e.g. antibiotics, outpatient prescriptions, pass medications)
      x. Prescribing practitioner signature
   b. Medication orders that have a Banned abbreviation (e.g. QD instead of daily), acronym or symbol may not be used in any hand-written, patient-specific communication. This includes medication and treatment orders, medication and treatment administration records, laboratory and radiology orders, progress notes, etc. Refer to the “Do Not Use Abbreviation List.”
   c. All verbal or telephone orders shall be immediately recorded in the resident’s
chart and signed by the prescriber within 48 hours for the acute units and within five days for Skilled Nursing Facility (SNF) units.

d. Orders that are incomplete, illegible or unclear will not be transcribed or processed by nursing or pharmacy. The prescribing practitioner will be contacted for clarification and a new order shall be written. Making corrections to an existing order (e.g. crossing over an order) is not permitted.

2. Requirements for Specific Categories of Medication Orders

a. "As needed" (PRN) orders: Must include dose, frequency, route and indication for use.

b. There shall be no standing orders for medications or treatments. Standing Orders are defined as orders that allow practitioners to automatically & globally implement patient care without a patient specific order.

c. Hold orders: A "hold order" is interpreted as "discontinue" unless it is specified with specific parameters (eg. Hold if HR < 60). A hold order with specific parameters is held until the next scheduled dose.

d. Automatic stop orders: Drugs not specifically prescribed as to time or number of doses must automatically be stopped as outlined in the Policy and Procedure (P&P) for Automatic Stop Orders (PHARM 01.02.02).

e. Resume, Renew, Continue orders: Blanket reinstatement of previous medication orders is not acceptable. Resume, renew or continue orders must be written as a new order with all specified elements for a medication order as defined by this policy & procedure.

f. Titration orders (orders that a medication is to either progressively be increased or decreased for a specific patient response): "Titration orders" must contain criteria for use and clear parameters as to when to increase or decrease the medication.

g. Taper orders: "Taper orders" refer to those in which the dose is decreased by a particular amount with each dosing interval. Each dose of a tapering regimen must be clearly written out.

h. Range Orders: There shall be no range orders for medications. "Range orders" are defined as those in which the dose or dosing interval varies over a prescribed range. (e.g. instead of Oxycodone 5-10mg PO Q4 hours prn pain prescribe Oxycodone 5mg PO Q4 hours PRN mild pain; Oxycodone 10mg PO Q4h PRN moderate pain).

i. Multiple PRN medications written for the same indication: The parameters for use of each medication must be clearly written to specify when it should be used
(e.g. Milk of Magnesia 30ml PO daily PRN constipation; Bisacodyl 10mg PR daily PRN constipation not relieved by MOM).

j. Medications written with multiple routes of administration: The parameters for use must be specified (e.g. Famotidine 20mg PO Q12h, give IV if resident unable to take PO).

k. Investigational medication orders: Refer to PHARM 02.05.00 on Investigational Drugs.

3. Verbal Orders
   a. Communication of prescription or medication orders is limited to situations in which immediate written communication is not feasible. Verbal orders, when indicated, will be immediately written down by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be written before it is read back. The resident's allergy status must be discussed. Refer to LHHPP 25-03 Verbal/Telephone Orders.

4. STAT Orders & Pharmacy Response Time
   a. Nursing service and pharmacy (when open) shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered. When the pharmacy is closed, drugs ordered STAT which are available in the emergency drug supply shall be administered immediately. The nursing supervisor will be notified when access to the supplemental medication room or the on call pharmacist is needed as outlined in the P&P for Emergency and Supplemental Medication Supplies (PHARM 02.03.00).

   b. Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

   c. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

   d. Refills shall be available when needed.

5. Discontinued Medication Orders
   a. By the end of shift during which the medication is discontinued, the nursing unit shall send or fax the order to Pharmacy, and print "DC" on the prescription label. Room temperature medications are to be placed in the drug pick-up box, and refrigerated medications are to be returned to the pharmacy immediately. This also applies to the medications of residents who expire, are discharged, or transferred to an acute hospital. The pharmacy will process discontinued orders within 4 hours of receiving.
ATTACHMENT:
None

REFERENCES:
Do Not Use Abbreviation List
LHHPP 25-03 Verbal/Telephone Orders
PHARM 01.02.02 Automatic Stop Order Policy
PHARM 02.03.00 Emergency and Supplemental Medication Supplies
PHARM 02.05.00 Investigational Drugs Policy

Revised: 08/02/12, 15/05/12, 17/057/xx11 (Year/Month/Day)
Original adoption: 07/10/20
HAZARDOUS DRUGS MANAGEMENT

POLICY:

1. Hazardous Drugs (HDs) shall be managed according to established safe procedures to mitigate the risk to resident, employee and environmental safety.

2. Intravenous cytotoxic/chemotherapy drugs shall not be initiated or administered at Laguna Honda Hospital and Rehabilitation Center (LHH).

3. The management of intravenous cytotoxic/chemotherapy drugs initiated elsewhere via an ambulatory computerized drug delivery (CADD) pump shall be restricted to the Pavilion Mezzanine Acute (PMA).

4. Staff who are trying to conceive (male or female), or are pregnant or breast-feeding, shall not administer cytotoxic/chemotherapy or Hazardous Drugs or handle excreta of residents on chemo precautions. Staff who fit into these categories should inform their immediate supervisor for work reassignment.

5. Nurses preparing medications shall never crush or cut tablets, or open capsules labeled as “hazardous” or “chemotherapy” by the Pharmacy.

6. Clinical staff responsible for the ordering, dispensing, administering and monitoring of hazardous drugs shall be provided with training on hazardous drugs.

PURPOSE:

To safely handle, administer, and dispose of Hazardous Drugs (HDs). This policy has procedures relating to three areas of care:

1. Prescribing and Transcribing Cytotoxic/Chemotherapy Drugs

2. Preparing, Administering and Disposing of Hazardous Drugs

3. Exposure and Spill Management of Hazardous Drugs

DEFINITIONS:

1. Hazardous Drug (HD): Any drug which poses significant risk to a healthcare worker by virtue of its teratogenic, mutagenic, carcinogenic, reproductive toxicity potential, or which can cause serious organ or other toxic manifestation at low doses. Drug classes listed as HD include: cytotoxic/chemotherapy agents, hormonal agents, immunosuppressants, some antiviral agents, some antibiotics and some biological response modifiers.
2. Cytotoxic/Chemotherapy Drug: A type of hazardous drug that destroys cells or inhibits or prevents their function. Cytotoxic drugs include drugs used for cancer and in some cases those drugs are used to treat other conditions (e.g., psoriasis, arthritis, transplant rejection).

3. Chemo Precautions: Precautions required when handling and disposing of excreta from residents who are currently receiving or have recently received cytotoxic/chemotherapy. See Appendix B for duration of precautions.

PROCEDURE:

1. Procedure for Prescribing and Transcribing Cytotoxic/Chemotherapy
   a. Prescribing Cytotoxic/Chemotherapy
      i. All orders for cytotoxic/chemotherapy, including changes in dose or frequency, shall be written on the LHH Antineoplastic/Cytotoxic Medication Order Form (See Appendix A).
      ii. Consulting medical specialists (oncologist, rheumatologist, and dermatologist) may prescribe Cytotoxic/Chemotherapy, when cosigned by a LHH physician responsible for the resident’s care.
      iii. A LHH physician may order Cytotoxic/Chemotherapy in consultation with and cosigned by the clinical pharmacist.
      iv. Cytotoxic/Chemotherapy IV infusions initiated at another healthcare facility and continued at LHH (for example, CADD pump continuous infusion of fluorouracil) shall be ordered by a LHH physician for a complete medication profile. The LHH Pharmacy shall not dispense these medications
   b. Transcribing Cytotoxic/Chemotherapy Orders
      i. A registered nurse and a second licensed staff member (MD, Pharmacist, RN, LVN) shall review the completed Antineoplastic/Cytotoxic Medication Order Form with a current drug reference prior to transcription to confirm the completeness and accuracy of the order.
      ii. Questions regarding the order shall be referred to the prescribing physician or the clinical pharmacist for clarification prior to administration.
      iii. Medications and related orders (e.g. hydration, antiemetic, Cytotoxic/Chemotherapy, etc.) shall be transcribed in the order of administration.

2. Preparing and Administering Hazardous Drugs (HDs)
a. General Principles for HD Medication Administration

i. Procedures for oral, enteral, subcutaneous and topical routes of administration shall comply with Nursing policies and procedures.

ii. Appropriate personal protective equipment (PPE) shall be used given the likelihood of particular exposure:

- Wear two pairs of gloves when handling HDs and medication administration equipment or supplies.
- Outer gloves shall be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated.
- Wear a splash-resistant chemo gown and eye protection if risk of spillage or splashing is possible. Yellow gowns used for contact precautions do not provide adequate protection.
- Before leaving the immediate area, remove PPE and dispose in a yellow cytotoxic waste container.

b. Oral/Enteral Hazardous Drugs (HDs): Handling and Administration

i. Never crush or cut tablets, or open capsules labeled as "hazardous" or "chemotherapy" by the Pharmacy.

ii. If a resident is unable to swallow intact tablets or capsules, contact Pharmacy to provide an alternative dosage form. Contact Pharmacy for liquid dosage form immediately if tablets/capsules are dispensed for an enteral feeding resident.

iii. If a HD is to be administered enterally via GT/JT, a liquid preparation must be obtained from pharmacy.

iv. After a hazardous drug has been administered, discard administration equipment such as medication cups, PPE, and enteral feeding syringes, into the yellow cytotoxic waste container.

c. Intravenous Administration of Hazardous Drugs (HDs)

i. Administration of intravenous hazardous drugs (HDs) shall not include HDs that are identified as cytotoxic/chemotherapy other than those that are administered via CADD pump as stated in policy statements 2 and 3.
ii. Handling and Administering Intravenous Hazardous Drugs (HDs)

- Prior to administration of intravenous HDs:
  - A chemo cart shall be obtained from Central Supply;
  - A yellow, cytotoxic waste container shall be obtained from EVS.

- Follow standard safe medication administration practices and obtain an infusion pump for the administration of any I.V. medications.

- Intravenous HDs shall be delivered with appropriate tubing that has already been primed by the pharmacy. Nursing shall not prime tubing for intravenous hazardous drugs.

- Wear a splash resistant chemotherapy gown and two pairs of gloves when starting or discontinuing intravenous HDs or changing I.V. tubing.

- Face shields or goggles shall be used when there is a splash hazard.

- Place an absorbent pad with impermeable plastic backing underneath the infusion site to contain any leakage of solution which may occur during handling of I.V.

- All PPE and equipment used for administration of intravenous HDs shall be disposed of in a yellow cytotoxic waste container

- The management of intravenous cytotoxic/chemotherapy drugs initiated elsewhere via an ambulatory computerized drug delivery (CADD) pump shall be restricted to the PMA.

d. Subcutaneous or intramuscular hazardous drugs including cytotoxic chemotherapy may be administered at LHH and shall be administered using the same processes described in Nursing Medication Administration Policy. The Pharmacy shall dispense the medication in a pre-filled syringe for administration.

e. Topical HDs including cytotoxic chemotherapy may be administered at LHH according to Nursing Medication Administration Policy using two pairs of gloves and a chemo gown. Chemo precautions are not required for residents receiving only topical HDs.

f. Disposal of Hazardous Drug Waste from Medication Administration

i. Unused, unopened or expired drugs shall be returned to the pharmacy for disposal.
ii. Any contaminated containers or materials used in the preparation or administration of HDs including cytotoxic/chemotherapy, shall be disposed of in a yellow, cytotoxic waste container.

iii. Do not pour hazardous drugs/solutions down drains or into toilets.

g. Chemo Precautions

i. Following administration of cytotoxic/chemotherapy medications, residents are expected to excrete active drug and/or hazardous metabolites of the drug for time periods that are listed in Appendix B. Whenever a resident is taking one of the medications listed in Appendix B, chemo precautions shall be implemented for the specified duration.

Note: Follow standard infection control precautions whenever contact with body fluids is possible (regardless of medication regimen).

ii. A chemo cart shall be ordered from Central Supply and a yellow, cytotoxic waste bin shall be ordered from EVS.

iii. Place yellow sign on resident room door to inform all staff that all waste generated in the room must be disposed of in the yellow, cytotoxic waste bin.

iv. Use double gloves and splash-resistant chemo gown available on the cart when handling blood or excreta. A face shield shall be worn if splashing is possible.

v. Linen that is contaminated with cytotoxic/chemotherapy drugs or excreta from patients who are on chemo precautions shall be separated from regular dirty linen and placed in a yellow laundry bag from the chemo cart.

vi. Linens used by patients who have received cytotoxic/chemotherapy drugs, which are not contaminated with body fluids shall be handled as other linen.

vii. Staff laundering Practices:

- Staff laundering residents’ potentially contaminated personal clothing while on chemo precautions shall wear double gloves and a splash-resistant chemo gown. If splashing is possible, face shield shall be used.

- Contaminated personal clothing shall be:
  - Washed separately from other residents’ clothing if resident is incontinent.
3. Hazardous Drug Spill Management

a. Spills of hazardous drugs or body fluids contaminated with cytotoxic/chemotherapy drugs shall be contained by the person who caused the spill with help from another staff person on the scene using a Chemo Spill Kit.

b. Chemo Spill Kits are available on PMA, and on Chemo carts that are provided to resident rooms where there are chemo precautions in effect.

c. Procedures for cleanup are provided in the Spill Kit and in Appendix C.
ATTACHMENT:
Appendix A: Antineoplastic/Cytotoxic Medication Order Form MR153 (11/02)
Appendix B: LHH Duration of Chemo Precautions by Drug
Appendix C: Procedures for Cleanup of Chemotherapy and Hazardous Drug Spills

REFERENCE:
CDC NIOSH (National Institute for Occupational Safety and Health). 2004-165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings
U.S. Department of Labor Occupational Safety & Health Administration. 2008. Controlling Occupational Exposure to Hazardous Drugs; Section VI: Chapter 2; www.osha.gov
NPP J 1.0 Medication Administration
NPP J 6.0 Intravenous Therapy Maintenance
PPP 07.02.00 Preparation, Handling, and Disposal of Hazardous Drugs
LHH 73-01 Injury and Illness Prevention Program
LHH 73-10 Medical Waste Management Program
LHH 73-14 Personal Protective Equipment

Revised: 13/11/21, 17/07/11 (Year/Month/Day)
Original Adoption: 08/09/30
Replaces LHHPP 70-02 Cytotoxic Agents (Chemotherapy) (rev. 03/05/08)
Replaces NPP J10.0 Antineoplastic/Cytotoxic Medications (rev. 00/08/03)
### Appendix A:

**Antineoplastic/Cytotoxic Medication Order Form**

- All oral and parenteral antineoplastic/cytotoxic medication MUST be ordered on this form, including all changes in dose or frequency.
- All information marked with an asterisk (*) must be completed before the medication is dispensed.
- Orders for antineoplastic/cytotoxic agents, whether used for chemotherapy or immunosuppression, must be written by the consulting specialist (oncologist, rheumatologist, dermatologist) and cosigned by the ward physician, or ward physician with consultation from the clinical pharmacist.
- Orders for dosages of methotrexate exceeding 15mg per week must be reviewed by a clinic pharmacist.

### Patient Clinical Information

**Diagnosis**: ___________________________________________________________________________________

**Allergy**: ______________________________________________________________________________________

**Height**: ___________ (ft/in) **Weight (Corrected weight if obese)***: ____________ (lb)

**Antineoplastic/Cytotoxic Start Date** and Time: _______________________________________________________

**Special Instructions** (If pre-hydration, post-hydration and premedication are needed, please specify):

_____________________________________________________________________________________________

_____________________________________________________________________________________________

### Drug Name* | Dose* | Route* | Frequency* | Duration*
---|---|---|---|---

(Solution, volume and infusion rate of parenteral antineoplastic/cytotoxic MUST be specified):

_____________________________________________________________________________________________

### Routine Laboratory monitoring (check all that apply)* | Frequency (check all that apply)*
---|---

**CBC w/ differential and platelet counts**

☐ Baseline (today)  ☐ Q

**Liver function tests (Albumin, TBIL (total bilirubin), DBIL (direct bilirubin), ALKP, AST, ALT**

☐ Baseline (today)  ☐ Q

**Metabolic Panel (Electrolyte, BUN/Scr, Glucose**

☐ Baseline (today)  ☐ Q

**Other test (specify):**

☐ Baseline (today)  ☐ Q

### SIGNATURES

**Ordering MD Names:** _______________________________  **MD Signature:** _______________________________

**Pager:** ________________  **Date/Time:** ___________

**Unit MD Signature:** _______________________________  **MD Pager:** ____________  **Date/Time:** ___________

(Unit MD Signature is required if order is written by a consulting MD)

**Clinical Pharmacist Signature:** _________________________  **Rx Pager:** _____________  **Date/Time:** ___________

(Clinical Pharmacist Signature is required if order needs to be reviewed as indicated above)

**Transcriber Signature:** ____________________________________________________  **Date/Time:** ____________

**RN Signature:** __________________________________________________________  **Date/Time:** ____________
Appendix B: Laguna Honda Hospital Duration of Chemo Precautions by Drug

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>ado-trastuzumab emtansine</td>
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</tr>
<tr>
<td>altretamine</td>
<td></td>
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<tr>
<td>amsacrine</td>
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</tr>
<tr>
<td>arsenic trioxide</td>
<td></td>
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<tr>
<td>azacitidine</td>
<td></td>
</tr>
<tr>
<td>bacillus calmette Guerin (BCG)</td>
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</tr>
<tr>
<td>bendamustine</td>
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</tr>
<tr>
<td>bexarotene</td>
<td></td>
</tr>
<tr>
<td>bortezomib</td>
<td></td>
</tr>
<tr>
<td>brentuximab vedotin</td>
<td></td>
</tr>
<tr>
<td>busulfan</td>
<td></td>
</tr>
<tr>
<td>cabazitaxel</td>
<td></td>
</tr>
<tr>
<td>capecitabine</td>
<td></td>
</tr>
<tr>
<td>carboplatin</td>
<td></td>
</tr>
<tr>
<td>chlorambucil</td>
<td></td>
</tr>
<tr>
<td>cladribine</td>
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<tr>
<td>clofarabine</td>
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<tr>
<td>Crizotinib</td>
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<td>eribulin</td>
<td></td>
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<tr>
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</tr>
<tr>
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<tr>
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<tr>
<td>ifosfamide</td>
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</tr>
<tr>
<td>idarubicin</td>
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</tr>
<tr>
<td>irinotecan</td>
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</tr>
<tr>
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</tr>
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<td>Vorinostat</td>
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### 7 days of Chemo Precautions

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<tr>
<td>Daunorubicin</td>
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<td>Vincristine</td>
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### 14 days of Chemo Precautions

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<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temsirolimus</td>
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</tbody>
</table>

---

**References**

- J Oncol Pharm Pract September 2007 13: 66-69
- NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2014
Appendix C: Procedures for Cleanup of Chemotherapy and Hazardous Drug Spills

Procedure for Cleanup of Chemotherapy and Hazardous Drug Spills
Laguna Honda Hospital and Rehabilitation Center
July 29, 2016

This procedure is designed to for the cleanup of hazardous drug spills, and spills of body fluids containing cytotoxic drugs, including collection and disposal of spilled materials, cleaning of surfaces, and decontamination to remove any residual contamination.

Cleanup Requires 2 Persons

- Respondent 1 (R1) – Performs Hands-on cleanup (generally the person involved in or closest to the spill).
- Respondent 2 (R2) – Controls access to the area. Provides “Situational Awareness” for R1. Prepares and passes supplies and equipment so R1 never needs to leave the area.

Note: Persons who have had skin, body or clothing contamination should not be assigned to cleanup unless they have thoroughly decontaminated and changed into clean clothing.

Personal Protection Needed

- Safety Glasses
- Shoe covers
- Inner gloves (long cuff)
- Outer gloves (shorter cuff)
- Chemo Gown
- Face shield
- Fitted N95 respirator

Procedures

1. Block off spill area using “Do Not Enter” signs in the spill kit (Use the tape provided in the box). Notify area supervisor of the spill.
   R2 will read off and use the checklist on the back of the “OK to Enter” sign to keep track of the cleanup progress, initialing steps as they are completed.

2. R1 dons all PPE in the following sequence
   - Safety Glasses
   - Chemo Gown
   - Shoe covers
   - Fitted N95 Respirator
- Face shield
- Long cuff inner gloves
- Short cuff outer gloves

R2 dons short cuff gloves (or any available) and readies supplies. R2 prevents people from entering the spill area and watches R1, warning them about dragging clothing or possible contact with contaminated surfaces, and passing materials and supplies to R1 so they never need to step away from the spill.

3. R1 uses scoop/scraper to collect broken glass and gently place them in a yellow chemo waste bag. DO NOT use your gloved hands. Place the waste bag in a rigid yellow chemotherapy contaminated waste container immediately.

For liquid spills:
Taking care not to step or come in contact with spilled materials, R1 uses sorbent supplies in the spill kit to soak up the spilled materials. Use:
- Spill pads if there are puddles
- "Green Z" sorbent powder if there is spattered liquid or lots of droplets

Use scoop/scrapers to collect used green-Z. Place used Green Z, scoops/scrappers, and/or spill pads into yellow chemo waste bags.

For dry material spills:
Avoiding contact with dry material, R1 uses the dampened sponge to push spilled material into the scoop.
- Avoid using scraper from orange scoop/scraper; use the sponge
- Do NOT over wet the sponge
- Do NOT use sponge to clean surfaces.

4. After all the spilled materials are collected, R1 removes outer pair of gloves and dons a fresh set.

5. R1 uses detergent solution in a wash bottle to gently wet down the area (try to go 1 foot beyond known spill area). Gently agitate/wipe detergent on surfaces with paper towels. Use spill pads or clean sponge if lots of detergent solution is left over. Repeat detergent wipe down a second time.

R2 adds water to detergent wash bottle (labelled Alconox 5 gm) up to the fill line and gently agitates it. Place the detergent back into the plastic bag before handing it to R1.

6. R1 removes outer pair of gloves and dons a fresh set.
7. When area has dried, R1 uses step 1 - (Blue Label) of Surface Safe Wipes to wipe the spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag. Wait for two minutes.

8. R1 removes outer pair of gloves and dons a fresh set.

9. R1 uses step 2 - (Red Label) of surface safe wipes to re-wipe the entire spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag.

10. R1 removes all PPE in following sequence:

   - Shoe Covers
   - Outer Gloves
   - Chemo gown
   - Face shields
   - Inner Gloves
   - Safety glasses

   Place the used PPE in a chemotherapy waste bag for disposal.

11. R2 places the chemotherapy waste bags in a chemotherapy waste bin, and removes and disposes off their gloves as conventional trash.

12. R1 and R2 immediately wash their hands and arms with soap and water.

13. Post green “OK TO Enter” sign showing cleanup has been completed.

14. Contact EVS and request a “disinfection” (i.e. wet-cleaning) of the area. Ask EVS to check the floor and spot wax as necessary.

Complete and submit the Unusual Occurrence (UO) report.
HAZARDOUS DRUGS MANAGEMENT

POLICIES:

1. Hazardous Drugs (HDs) shall be managed according to established safe procedures to mitigate the risk to resident, employee and environmental safety.
2. The administration of intravenous hazardous drugs (HDs) shall be restricted to the Pavilion Mezzanine Acute (PMA) and Positive Care Units.
3. Clinical staff responsible for the ordering, dispensing, administering and monitoring of intravenous hazardous drugs shall be provided with training and demonstrate competency in hazardous drug administration.

PURPOSE:

To safely handle, administer, and dispose of Hazardous Drugs (HDs). This Policy has procedures relating to four areas of care:

1. Prescribing and Transcribing Chemotherapy/Antineoplastic Drugs
2. Preparing, Administering and Disposing of Hazardous Drugs (HDs)
3. Exposure and Spill Management of Hazardous Drugs (HDs)
4. Special Exposure Concerns

DEFINITIONS:

1. Antineoplastic Drug: Any drug that prevents the development, growth, or proliferation of malignant cells (anti-tumor).
2. Chemotherapy Agent: A chemical agent used to treat cancer.
3. Cytotoxic Drug: Any drug that destroys cells or inhibits or prevents their function. Cytotoxic drugs include drugs used for cancer (antineoplastics) and in some cases those drugs are used to treat other conditions (e.g. psoriasis, arthritis, transplant rejection). However, not all antineoplastics are cytotoxic nor are all cytotoxics used exclusively in the treatment of cancer.
4. Exposure: Cutaneous or mucosal contact with a hazardous agent.
5. Hazardous Drug (HD): Any drug which poses significant risk to a healthcare worker by virtue of its teratogenic, mutagenic, carcinogenic, reproductive toxicity potential, or which can cause serious organ or other toxic manifestation at low doses. Drug classes listed as HD include: antineoplastic agents, hormonal agents, immunosuppressants, some antiviral agents, some antibiotics and some biological response modifiers.
6. Hazardous Drug Waste includes Hospital Pharmacy listed Hazardous Drugs which include all chemotherapy agents, as well as the vials, ampoules, I.V. bottles, tubing,
syringes, gloves, masks, absorbent pads, and other contaminated items used in the preparation, administration and handling of these materials. For contaminated gowns and linen see section D.

7. RCRA (Resource Conservation and Recovery Act) Hazardous Waste: EPA P-listed materials that are considered to be “acutely hazardous” if found in the waste stream (see Appendix B). Laguna Honda pharmacy identifies these items with “black dots”. Examples include nicotine and warfarin. These drugs require special waste disposal.

8. Vesicant: Any agent that has the potential of causing blistering or tissue necrosis if infiltrated/extravasated.

PROCEDURE:

1. Procedure for Prescribing and Transcribing Chemotherapy/Antineoplastic Drugs (* Not including Hormonal agents used in cancer treatment)
   
a. Procedure for Prescribing Chemotherapy/Antineoplastic Drugs
      
i. Consulting medical specialists (oncologist, rheumatologist, and dermatologist) may prescribe Chemotherapy/Antineoplastic Drugs, whether used for cancer chemotherapy or immunosuppression, when cosigned by the ward physician.

   ii. The attending physician may order these drugs in consultation with and cosigned by the clinical pharmacist.

   iii. All orders for chemotherapy/antineoplastic drugs, including changes in dose or frequency, will be written on the Laguna Honda Antineoplastic/Cytotoxic Medication Order Form.

   iv. Chemotherapy/antineoplastic IV infusions initiated at SFGHMC will be ordered by the attending physician without pharmacy dispensing. For example, CADD pump continuous infusion of fluorouracil.

b. Procedure for Transcribing Chemotherapy/Antineoplastic Drugs
   
i. A registered nurse and a second licensed staff member (MD, Pharmacist, RN, LVN) will review the completed Antineoplastic/Cytotoxic Medication Order Form with a standard drug reference book prior to transcription to confirm the completeness and accuracy of the order.

   ▶ Pay particular attention to drug, dose, frequency, route, duration and any change from previous dose(s).
ii. Refer questions regarding the order to the prescribing physician or the clinical pharmacist for clarification prior to administration.

iii. Medications and related orders (e.g. hydration, antiemetic, antineoplastic, etc.) will be transcribed in the order of administration.

2. Preparing and Administering Hazardous Drugs (HDs)

a. Oral/Enteral Hazardous Drugs (HDs): Handling and Administration

i. Confirm resident’s identity and follow other standard medication administration policies and procedures including handwashing.

ii. Apply appropriate personal protective equipment (PPE) given the likelihood of particular exposure

- Wear nitrile gloves when handling HDs and associated administration equipment.

- Gloves should be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated.

- Wear protective gown and eye protection if risk of spillage or splashing is possible.

- If there is any risk of inhalation of particles, wear an N95 respirator. Dispose of used masks in a cytotoxic waste container.

- Wear gown and gloves within immediate work area only.

- Remove protective clothing (if applicable) and gloves in a way so that the contaminated surface is inside and then dispose in a cytotoxic waste container.

iii. Never crush, cut or break medications labeled as “hazardous” or “chemotherapy” or if warning label on medication container advises same.

iv. Avoid direct contact with the powder contained in capsules or tablets and skin, mucous membranes, or the respiratory tract. Avoid inhaling powder from the drug. Particles may aerosolize and travel into the lungs or mucous membranes.

v. If a resident is unable to swallow intact tablets or capsules, contact Pharmacy to provide an alternative dosage form. Contact Pharmacy for liquid dosage form immediately if tablets/capsules are dispensed for an enteral feeding resident.
vi. If a HD is to be administered enterally via GT/JT, a liquid preparation must be obtained from pharmacy. Instill 30 mls of water should be instilled before and after medication administration.

vii. After a hazardous drug has been administered, discard administration equipment such as medication cups, PPE, and enteral feeding syringes, into the cytotoxic waste container (yellow container).

b. Intravenous Administration of Hazardous Drugs (HDs)

i. Equipment for units administering Intravenous Hazardous Drugs (HDs)
   - Cytotoxic Spill Kit (available from CSR).
   - Cytotoxic waste containers (YELLOW) must be ordered and maintained on the Unit during the entire course of therapy. The regular size container is available from Central Supply (CSR). Large (32 Gal) containers are available from Environmental Services.
   - Chemotherapy gown and gloves (nitrile) are required and are available from CSR.

ii. Handling and Administering Intravenous Hazardous Drugs (HDs)
   - Follow standard safe medication administration practices.
   - Before parenteral HD administration, a RN and second licensed staff member (MD, RPh, or RN) must double-check the order against drug reference book and check intravenous preparation against the order. Then, the RN and a second licensed staff member must initial in the designated box on the Medication Administration Record.
   - Use personal protective equipment (PPE) including:
     - Chemotherapy gown and nitrile gloves when starting or discontinuing intravenous (I.V.), changing I.V. tubing or adding I.V. piggy-backs.
     - Chemotherapy gowns are for one time use only; use a new gown for hanging medication and another new gown for taking down I.V. bag. Change gloves if punctured, torn or contaminated and every 30 minutes when working continuously with HDs.
     - Used syringes, gowns, gloves, I.V. bags and tubing are placed in red biohazardous bag and disposed of in cytotoxic waste containers only.
Wear gown and gloves within the immediate work area only. Remove and dispose of gloves when leaving resident’s bedside, even if returning shortly.

Face shields or goggles are not usually needed, but caution is advised to avoid accidental splashes (e.g., when handling I.V. tubing changes or adding piggybacks above eye level).

Start a new peripheral I.V. line for HD administration unless the resident has a central venous access device. If it is not possible to start a new I.V. line, the existing I.V. line may be used after determining patency by aspirating for blood return.

Place an absorbent pad with impermeable plastic backing underneath the infusion site to contain any leakage of solution which may occur during handling of I.V.

If tubing priming is necessary (because IV bag was not primed under laminar flow hood in pharmacy), keep below eye level and prime inside of plastic bag with gauze to avoid splash into eyes or mouth. Place used supplies into resealable (e.g., Ziploc) bag and dispose in the cytotoxic waste container.

All continuous infusions must be delivered via an infusion pump.

After a HD has been administered, all used syringes, tubing and other equipment including absorbent pad to prevent droplet contamination, are to be placed in red biohazard bag and disposed of in cytotoxic drum.

When resident returns with continuous ambulatory infusion of hazardous medication initiated and dispensed at another approved health care facility, the procedures will be modified accordingly to insure safety and appropriate monitoring.

e. Subcutaneous Hazardous Drugs (HDs): Handling and Administration

i. Confirm resident’s identity and follow other safe medication administration policies and procedures including handwashing.

ii. Apply appropriate personal protective equipment (PPE) given the likelihood of particular exposure

iii. Wear nitrile gloves when handling HDs and associated administration equipment.
Gloves should be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated.

Wear protective gown and eye protection if risk of spillage or splashing is possible.

Wear gown and gloves within immediate work area only.

Remove protective clothing (if applicable) and gloves in a way so that the contaminated surface is inside and then dispose in a cytotoxic waste container.

Obtain spill kit

Pharmacy will dispense the medication in the syringe for administration.

d. Disposal of Hazardous Drug Waste

i. All antineoplastic drugs and Hazardous Drugs (HDs) that have been given to residents and contain more than residue (i.e., greater than 3% of the original volume) shall be disposed of in a cytotoxic waste container (yellow container).

ii. Hazardous Drug Waste that only contain residue in the dispensing container shall be disposed of in a pharmaceutical waste container (white and blue container).

iii. Any contaminated materials used in the preparation and administration of HDs, such as gloves, gowns, syringes and vials should also be disposed in a cytotoxic waste container.

iv. Unused, unopened or expired drugs, including RCRA hazardous waste (“black dot”) should be returned to the pharmacy for disposal.

Do not pour hazardous drugs/solutions down drains or into toilets.

Bag all contaminated I.V. equipment and supplies in a red biohazardous bag and then place it in the yellow container marked “Cytotoxic Waste”.

Place leftover hazardous drugs/solutions in a large resealable plastic bag (e.g., Ziploc). Seal and dispose in cytotoxic waste container.

Obtain a new cytotoxic waste container from Environmental Services when the current container reaches ¾ full or 90 days from first use or if malodorous, whichever comes first. Contact Environmental Services for removal and replacement of cytotoxic waste container.
Environmental Services will label containers to note when they should be replaced and will pick up and replace the cytotoxic waste container on Pharmacy, Positive Care Units or any other Units upon notification.

Use uncontaminated gloves to handle cytotoxic waste containers.

If exposure involves a resident, provide immediate first aid as outlined below and immediately notify the physician and nursing supervisor. Complete a Confidential Report of Unusual Occurrence.

e. Handling and Disposal of Body Fluids From Residents Who Have Received Chemotherapy/Antineoplastic Drugs* Within the Previous 48 Hours (* Not including Hormonal agents used in cancer treatment)

Note: Follow standard infection control precautions whenever contact with body fluids is possible (regardless of medication regimen). For 48 hours post administration of antineoplastic medications following these specific guidelines:

i. Use nitrile gloves and gown when handling body fluids, particularly urine. A face shield shall be worn if splashing is possible.

ii. Discard disposable items contaminated with body fluids of patients who have received antineoplastic drugs in the previous 48 hours into a large red biohazard plastic bag and then dispose into the designated cytotoxic waste container.

These items include diapers, urinals, bedpans, measuring devices, Foley catheters, drainage bags, and body fluids and fecal waste themselves.

iii. Potentially contaminated linen shall not be sent to Laundry.

iv. Linen contaminated with chemotherapy/antineoplastic drugs or excreta from patients who have received chemotherapy/antineoplastic drugs in the past 48 hours is a potential source of exposure to employees.

Linen that is grossly contaminated with antineoplastic drugs or excreta from patients who have received chemotherapy/antineoplastic drugs in the past 48 hours shall be placed in a red biohazard bag and then disposed of in a large yellow cytotoxic waste container.

Linens used by patients who have received chemotherapy/antineoplastic drugs in the past 48 hours, which are not contaminated with body fluids shall be handled as other linen.
Laundry personnel shall wear latex gloves and gowns while handling linens.

f. Staff laundering Practices:

i. Staff laundering residents’ potentially contaminated personal clothing within 48 hrs of receiving chemotherapy/antineoplastic medications will wear gloves AND gowns (double gloving is not required unless prolonged contact with highly wet/moist contaminated clothing likely). If splashing is possible, face shield should be used.

ii. Contaminated personal clothing will be:

- Washed separately from other residents if resident is incontinent.
- Placed in an impervious bag or a yellow cytotoxic waste drum (reserved for this purpose) for transport to washing machine.
- Sent through 2 cycles of washing (once a pre-wash, and a 2nd wash)

iii. Non-contaminated personal clothing will be handled as standard laundry procedure.

3. Exposure and Spill Management of Hazardous Drugs (HDs)

a. Exposure Management

i. Immediately remove the contaminated PPE and dispose in the cytotoxic waste container.

ii. Skin or mucous membrane contact: wash contact area thoroughly with soap and water. Avoid iodine preparations or chlorhexidine.

iii. Eye exposure: immediately flood affected eye with a gentle stream of water for at least 15 minutes with tap water or a 500-1000 ml bag of 0.9% sodium chloride or commercially available eye wash. Make sure the eye is open and the individual blinks and rotates eye in all directions.

iv. Needle stick or sharp exposure: Immediately rinse any sharps injury with soap and water. Report the exposure to the Needle stick hotline for expert assessment and advice regarding immediate treatment.

v. Obtaining medical attention immediately.
vi. Complete a “Supervisors Report of Injury” for exposed staff. Complete a Confidential Report of Unusual Occurrence for residents or other exposed individuals.

b. Spill Management

i. Spills are contained by the first competent staff person on the scene using the Chemotherapy/Cytotoxic Drug Spill kit maintained on Pavilion Mezzanine Acute (PMA), Positive Care Unit, Pharmacy, Supplemental Drug Room and CSR.

ii. Small spills of 5 ml or less or dropped pills may be wiped up with absorbent gauze (4x4) using gloved hands. Place in a resealable plastic bag (e.g., Ziploek) and discard in the cytotoxic waste container.

iii. For spills greater than 5 ml, use the Spill Kit.

- Caution bystanders to avoid the spill area to not disburse area of exposure and immediately obtain the spill kit from the treatment room.

- Open the kit. Use chemo spill caution sign to mark spill area.

- Apply personal protective equipment from the kit. If risk of aerosolization of powder medication, put on N95 respirator mask.

- Place materials to absorb cytotoxic materials in a “V” position on the outer perimeter of spill to prevent spread.

- Lightly place absorbent towels over spill, being careful not to touch the spill.

- Pick up saturated towels and spill pillows and place in red hazardous bag from the kit. Use disposable scoop and brush as needed to pick up debris.

- Remove mask, goggles, gown and inner gloves and dispose of in a large chemo waste bag and dispose the bag in the cytotoxic waste container.

- Notify Environmental Services for a final mop-down according to EVS procedures.

- Report the spill to the Industrial Hygienist.

- Complete a Confidential Report of Unusual Occurrence.

iv. Special Reproductive Health Exposure Concerns
Reproductive Hazards - Some studies have shown increased risks of miscarriage or of giving birth to malformed infants for persons occupationally exposed to certain HDs. The degree of risk for employees who are pregnant, or who are actively trying to conceive a child (female or male personnel) is uncertain at the present time.

Personnel Breast-Feeding Infants - No data is available as to whether these persons are at increased risk.

Staff Medical Surveillance - Staff who are trying to conceive (male or female), or are pregnant or breast-feeding, should not administer cytotoxic or hormonal agents labeled/classified as Hazardous Drugs.

Staff who fit into the above categories shall inform their immediate supervisor for work reassignment.

ATTACHMENT:
Appendix A Antineoplastic/Cytotoxic Medication Order Form MR153 (11/02)
Appendix B RCRA Hazardous Waste (EPA P-listed materials or Laguna Honda “black dot”-drugs) (07/08)

REFERENCE:

Environmental Health and Safety Office: OUHSC Hazardous Drug Procedures;

CDC NIOSH (National Institute for Occupational Safety and Health). 2004–165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings

U.S. Department of Labor Occupational Safety & Health Administration. 2008. Controlling Occupational Exposure to Hazardous Drugs; Section VI: Chapter 2; www.osha.gov


CROSS REFERENCE TO NURSING POLICIES AND PROCEDURES:
NPP J 1.0 Medication Administration
NPP J-6.0 Intravenous Infusion

CROSS REFERENCE TO PHARMACY POLICIES AND PROCEDURES:
PPP 07.00 Preparation, Handling, and Disposal of Hazardous Drugs section of Sterile Compounding Policy

CROSS REFERENCE TO ENVIRONMENTAL SERVICES POLICIES AND PROCEDURES:
ESPP

CROSS REFERENCES TO LAGUNA HONDA HEALTH AND SAFETY PROGRAM:
CHN/Laguna Honda Medical Waste Management Plan
Respiratory Protections

Revised: 13/11/21 (Year/Month/Day)
Original Adoption: 08/09/30
Replaces LHHPP 70-02 Cytotoxic Agents (Chemotherapy) (rev. 03/05/08)
Replaces NPP J10.0 Antineoplastic/Cytotoxic Medications (rev. 00/08/03)
Appendix A:

Antineoplastic/Cytotoxic Medication
Order Form

- All oral and parenteral antineoplastic/cytotoxic medication MUST be ordered on this form, including all changes in dose or frequency.
- All information marked with an asterisk (*) must be completed before the medication is dispensed.
- Orders for antineoplastic/cytotoxic agents, whether used for chemotherapy or immunosuppression, must be written by the consulting specialist (oncologist, rheumatologist, dermatologist) and cosigned by the ward physician, or ward physician with consultation from the clinical pharmacist.
- Orders for dosages of methotrexate exceeding 15mg per week must be reviewed by a clinic pharmacist.

### Patient Clinical Information

| Diagnosis*: __________________________________________________________________________________ |
| Allergy*: ______________________________________________________________________________________ |
| Height: ___________ (ft/in) Weight (Corrected weight if obese)*: ____________ (lb) |

### Antineoplastic/Cytotoxic Start Date* and Time:

| Special Instructions (If pre-hydration, post-hydration and premedication are needed, please specify): |
| ______________________________________________________________________________________________ |

### Drug Name*

<table>
<thead>
<tr>
<th>Dose*</th>
<th>Route*</th>
<th>Frequency*</th>
<th>Duration*</th>
</tr>
</thead>
</table>

(Solution, volume and infusion rate of parenteral antineoplastic/cytotoxic MUST be specified):

### Routine Laboratory Monitoring (check all that apply)*

<table>
<thead>
<tr>
<th>Frequency (check all that apply)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC w/differential and platelet counts</td>
</tr>
<tr>
<td>Liver function tests (Albumin, TBIL, total bilirubin, DBIL (direct bilirubin), ALKP, AST, ALT)</td>
</tr>
<tr>
<td>Metabolic Panel (Electrolyte, BUN/Ser, Glucose)</td>
</tr>
<tr>
<td>Other test (specify)</td>
</tr>
</tbody>
</table>

#### SIGNATURES

Ordering MD Names: _______________________________ MD Signature: _______________________________  
Pager: ________________ Date/Time: ___________

Unit MD Signature: _______________________________ MD Pager: ____________ Date/Time: ___________
(Unit MD Signature is required if order is written by a consulting MD)

Clinical Pharmacist Signature: _________________________ Rx Pager: _____________ Date/Time: ___________
(Clinical Pharmacist Signature is required if order needs to be reviewed as indicated above)

Transcriber Signature: ____________________________________________________ Date/Time: ___________

RN Signature: __________________________________________________________ Date/Time: ___________
Appendix B:

RCRA (Resource Conservation and Recovery Act)
(P-LIST) HAZARDOUS WASTE

- Nicotine patches, gum, etc. (un-used)
- Warfarin/Coumadin (un-used)

Epinephrine syringes & vials, used nicotine patches and gum, and soufflé cups for warfarin that are not overly contaminated are NOT considered hazardous waste. Medicinal nitroglycerin is not explosive and is NOT considered hazardous waste. These items should be disposed as pharmaceutical waste or as sharps if they have needles.
MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

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

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

PURPOSE:

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

DEFINITIONS:

1. Line of Sight - resident is within view of staff while eating.

2. Close Supervision – one staff sitting with no more than 4 residents during mealtime. Staff shall ensure that recommended aspiration precautions (e.g., standard precautions or precautions recommended in the specialized feeding plan) are followed by actively cueing, assisting, and/or observing the resident during meal time.

3. 1:1 – resident needs direct assistance or supervision during oral intake (e.g., impulsive eating behaviors, cues needed, unable to feed self, level of risk for aspiration).

PROCEDURE:

1. Identification of At-Risk Residents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ii. As described under Procedure 1 b (ii).
iii. Those who have clinical signs of dysphagia or aspiration and are candidates for ongoing oral feeding. Indications for referral to Speech Pathology include, but are not limited to, the following: Coughing, choking, holding food in mouth, significant pocketing of food, significantly delayed swallow, significant leakage of food or liquid from mouth, food or liquid coming from tracheostomy, and/or recurrent pneumonias. If in doubt about whether or not a referral is indicated, contact the Speech Pathology Department.

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

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

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

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

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

3. Dysphagia Evaluation

a. Dysphagia evaluations shall be carried out by a Rehabilitation Center Policy and Procedure #90-05, Establishment of Treatment Programs and Documentation: Dysphagia.

b. Evaluation of Residents for Upgraded Food/Liquid Consistencies

When a dysphagia evaluation involves upgraded food or liquid consistencies not currently included in the resident’s diet order, the following Tray Precautions shall be taken:
i. The Speech Pathologist shall contact Nutrition Services and ask them to write “Hold for Speech Therapy” on the tray ticket.

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

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

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

4. Treatment

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

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

5. Referral to Occupational Therapy

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

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

6. Management of Residents Who Are at Risk for Aspiration

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

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

c. A sign directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident is located in the Pavilion Lobby and designated areas.
d. Nursing is responsible for ensuring that family members and regular visitors who
assist residents with their meals have been trained. If a family or volunteer needs
additional training regarding feeding techniques, nursing may recommend referral
to Speech Pathology. Staff shall document family or volunteer training in the
medical record and resident care plan, including the date of training.

e. Residents with pink wristbands or pink ribbons shall not be given or sold food/liquid
by anyone who is not aware of the residents’ feeding needs.

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

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

7. Specialized Feeding Plans

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

i. **Close** supervision when eating and drinking

ii. **Provide** cues/assist for unsafe eating behaviors

iii. **Thin** down thick food

iv. **Small** sips of liquid

v. **Alternate** liquids and solids

vi. **Do** not use straw

vii. **Cut** food into small pieces

viii. **Cue** resident to tuck chin
ix. **Cue** or remind resident to swallow twice

x. **Cue** to swallow food/liquid before taking the next bite/sip

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

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

d. The physician shall include “Specialized Feeding Plan” as part of the diet order. Nursing shall include this information when communicating the diet order to Nutrition Services.

e. For residents with SFPs, Nutrition Services shall print “SFP” and the list of special precautions on the meal ticket, providing an easy reference for caretakers.

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

8. **Follow-Up**

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

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

9. **Documentation on Informed Decision**

a. When the resident or surrogate decision maker chooses to accept the risks of a diet upgrade, or not to accept the recommendation/benefits of a therapeutic diet
and feeding interventions, documentation of discussion regarding informed
decision shall be reflected in the Resident Care Conference meeting notes,
advance directives, and the resident care plan.

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

10. Others

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

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

ATTACHMENT:
None

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

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18,
08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12,
17/07/11 (Year/Month/Day)
Original adoption: 98/04/01
CALIFORNIA END OF LIFE OPTION ACT: IMPLEMENTATION AT LAGUNA HONDA

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) supports the decision of qualified Skilled Nursing Facility (SNF) residents to exercise their right of self-ingestion of aid-in-dying medications on the South 3, Palliative Care Neighborhood.

2. Staff members or volunteers for reasons of morality, cultural or religious considerations, have the right to opt out of participating in the care and support of residents exercising this option.

3. Patients without a skilled nursing need will not be admitted to LHH solely for the purpose of exercising this right.

4. The California End Of Life Option Act (EOLOA) shall remain in effect only until January 1, 2026, unless a later enacted California statute deletes or extends that date.

PURPOSE:

Describe the process for terminally ill residents with decisional capacity to self-ingest aid-in-dying medications at LHH safely.

PROCEDURE:

1. Qualifications/Eligibility for End Of Life Option Act (EOLOA)
   a. LHH Attending Physician is notified that resident requests information about End of Life Option Act
   b. Attending Physician determines resident’s eligibility for EOLOA (See Appendix A for the San Francisco Department of Public Health (DPH) - California EOLOA Policy)
      i. Adult 18 years or older.
      ii. California resident.
      iii. Diagnosed with a terminal illness, defined as an incurable and irreversible disease that, within the reasonable medical judgment of the Attending physician and Consulting physician, will result in death within 6 months.
      iv. Has the capacity to request an aid-in-dying (AID) drug.
v. Has the physical and mental capacity to self-administer the aid-in-dying drug.

c. If there is unresolved disagreement among providers regarding the patient’s eligibility for participation, or if there is any concern regarding coercion or whether the patient’s motivation regarding anticipatory suffering is due to economic situations, refer to LHH Ethics Committee.

d. If the patient’s primary care physician is unwilling to act as the Attending Physician for the EOLOA he/she refers to Chief Medical Officer to identify a willing physician to serve in this role.

e. If the primary care physician is willing to serve as prescriber for aid-in-dying medication, he/she determines the resident’s qualifications (as per above), counsels the resident about the availability of palliative care, such as aggressive symptom management including palliative sedation, etc. If resident affirms request for AID, this is regarded as Verbal Request #1.

f. If there is any concern regarding the capacity of a patient to make an informed decision as defined by the Act or any concern for mental illness interfering with a patient’s medical decision-making capacity, then a Mental Health Specialist consultation is required. Under the Act, a Mental Health Specialist is defined as a psychiatrist or licensed psychologist. The professional judgment of the Mental Health Specialist will determine whether the request for an aid-in-dying drug can proceed.

g. For residents with limited English proficiency inquiring about the EOLOA, trained interpreters from Zuckerberg San Francisco General Hospital (ZSFG) will be prescheduled to come to LHH for an in-person counseling session with the resident and his/her Attending Physician.

h. Attending Physician refers resident to a Consulting Physician to confirm qualifications for EOLOA.

i. Resident makes second request to Attending Physician at a minimum of 15 days after the initial verbal request. If resident expresses intent to self-ingest aid-in-dying medications to consulting physician (considered Verbal Request #2) and submits written attestation requesting EOLOA to attending physician (form available from San Francisco Health Network (SFHN) Provider Guide in Appendix B).

h. Resident submits written attestation requesting EOLOA to attending physician (form available from San Francisco Health Network (SFHN) Provider Guide in Appendix B).

2. Planning
a. Resident will be relocated to South 3 Palliative Care Unit if currently receiving care on another LHH SNF unit.

b. Resident will be counseled that when intending to ingest AID medications, scheduling needs to occur during daytime and usual business hours (Monday – Friday) to provide maximal support and a minimum of 24-48 hours of usual business hours for pharmacy to secure/prepare AID medications.

c. South 3 Resident Care Team will meet with resident and support system to elicit in detail resident’s wishes for dignified and peaceful AID plan. Wishes will be documented in a Resident Care Conference note. Considerations include:

   i. Who the resident wishes to be present at time of his/her taking AID medications.

   ii. Any other environmental wishes, e.g. music, flowers, aromatherapy, etc.

   iii. Any cultural/spiritual practices to be honored before or after death.

   iv. Any special meal or beverages requested before taking AID.

   v. Encouraging resident to discuss their intent with family/friends.

3. At least 15 days after resident’s first verbal request, Attending Physician performs the second visit with the resident and, after confirming the resident’s desire and ability to proceed, writes prescriptions for AID on security RX form and hand delivers to pharmacy. Pharmacy shall notify Quality Management (QM) of receipt of prescription. (See Appendix C for Compassion and Choices Phone Consultation Services Contact Information for Physicians and Pharmacists)

   a. Pharmacy does not prepare or deliver medications until the prearranged day of ingestion.

   b. Pharmacy reports dispensing on CURES report.

4. Implementation/Self Ingestion

   a. Twenty four to 48 hours before scheduled day of ingestion, pharmacy is notified about need to prepare/deliver medications to bedside of resident.

   b. Arrangements for dignified and peaceful AID plan are completed.

   c. Resident with or without assistance of family or friends prepares medication as per written instructions provided by pharmacy.
1. Resident takes premedications one hour before AID medications.
   
2. Resident independently sips/swallows AID medication.
   
3. If during the process of self-ingestion the resident changes his/her mind, appropriate medical care will be provided.

5. After care

4. Family/friends notify nurse when resident has stopped breathing.

5. Nurse assesses resident for absence of pulse and respiration, provides usual support and notifies physician.

6. Physician pronounces death of the resident.

7. Nurse records progress note describing self-ingestion of AID and pre-med (name, dose and timing of self-ingestion), any complications, who was present at time and support provided afterward to family/friends.

8. Physician documents in medical record and completes and delivers legal paperwork to Quality Management (QM) as per EOLOA requirements (see SFHN Provider Guide in Appendix B).

6. Annual Review

a. Documents submitted to CDPH shall be reviewed and compliance data aggregated by QM staff. The forms shall be sent to CDPH at the following address, or faxed to (916) 440-5209.

   California Department of Public Health
   Public Health Policy and Research Branch
   Attention: End of Life Option Act
   MS 5205
   P.O. Box 997377
   Sacramento, CA 95899-7377

b. The Performance Improvement and Patient Safety (PIPS) Committee shall conduct a review of the data gathered on terminally ill patients who opted for the End of Life Option Act to identify opportunities for improvement.

c. Based on the review by the PIPS Committee, a report shall be submitted to the Joint Conference Committee annually.

ATTACHMENT:
Appendix A: DPH California End of Life Option Act Policy
Appendix B: SFHN End of Life Option Act Provider Guide
Appendix C: Compassion and Choices: Physician to Physician and Pharmacist to Pharmacist Contact Info
Appendix C: End of Life Washington Recommended Dosing Letter
Appendix D: EOLOA Attending Physician Forms Submission Instructions

REFERENCE:
None
Patient Form to Request for Aid-in-Dying Drug
Patient Form for Final Attestation for Aid-in-Dying Drug
Patient Form to Request for Aid-in-Dying Interpreter Declaration Form
Attending Physician Checklist and Compliance Form
Consulting Physician Compliance Form
Attending Physician Follow-up Form

Revised: 17/07/11 (Year/Month/Day)
Original adoption: 17/05/09 (Year/Month/Day)
Your relationship with patients is critical to ensure they receive care they truly want. Doc 2 Doc helps physicians provide unbiased information and up-to-date care to patients who ask about available end-of-life options.

It can be surprisingly difficult to discuss a patient’s terminal illness and inevitable death. It’s hard to know when to explore issues, and what specifics to discuss. Physician communication about end-of-life options can be part of ongoing conversation regarding each patient’s goals of care. The knowledge you share helps patients weigh the benefits and burdens of various treatment options, and align treatment decisions with what is most important to them. Ideally, these conversations should begin soon after an illness enters an advanced or terminal phase and continue throughout progression of that illness.

A resource tailored to practicing physicians, Doc 2 Doc offers you readily available, free, confidential telephone consultation with one of our seasoned medical directors, each with years of experience in end-of-life medical care.

**Our Doc 2 Doc physicians stand ready with information and guidance to manage complex end-of-life decisions.**

**Call us anytime:** 800.247.7421.
Your relationship with patients is critical to ensure they receive care they truly want. Pharmacist2Pharmacist helps pharmacy professionals provide accurate information and up-to-date care to patients with prescriptions for aid-in-dying medications.

It can be difficult to discuss a patient’s terminal illness and death — and crucial for pharmacists to knowledgeably consult directly with patients and caregivers about medications intended to bring about a peaceful death.

The knowledge you give to patients and caregivers will help patients understand the aid-in-dying medication protocols.

A resource tailored to pharmacists, Pharmacist2Pharmacist offers you important documents and a readily available, free and confidential telephone consultation with a pharmacist in Oregon or Washington experienced with medical aid in dying.

Pharmacist2Pharmacist is ready with information and guidance to answer questions about medical aid in dying.

Call us anytime: 503.943.6517
Attending Physician Forms Submission Instructions

What Forms Does the Attending Physician Have to Submit to CDPH?

Within 30 calendar days of writing a prescription for medication under this Act, the attending physician must submit the following completed, signed, and dated forms to CDPH:

- A copy of the qualifying individual’s written request;
- Attending Physician’s Checklist and Compliance form (PDF); and
- Consulting Physician’s Compliance form (PDF).

Within 30 calendar days of a qualified individuals’ ingestion of the aid-in-dying medication obtained under the terms of the Act, or death from any other cause, whichever comes first, the attending physician shall submit:

- Attending Physician Follow-Up form (PDF).

The forms can be sent to CDPH at the following address:

California Department of Public Health
Public Health Policy and Research Branch
Attention: End of Life Option Act
MS 5205
P.O. Box 997377
Sacramento, CA 95899-7377

The forms can also be faxed to (916) 440-5209.
POSITIONING AND ALIGNMENT IN BED AND CHAIR

POLICY:

1. The Registered Nurse (RN) assesses the resident’s ability to reposition and maintain correct body alignment and consults with physician for rehab referral when indicated.

2. All residents who are physically unable to reposition independently, will be repositioned according to care plan.

3. Procedure may be performed by Licensed Nurse, Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA).

PURPOSE:

1. To provide comfort for the resident.

2. To prevent contractures.

3. To promote circulation and skin integrity.

PROCEDURE:

1. “Postural support” means a method other than orthopedic braces used to assist residents to achieve proper body position and balance. Postural supports may only include soft ties, seat belts, spring release trays or cloth vests and shall only be used to improve a resident’s mobility and independent functioning, to prevent the resident from falling out of a bed or chair, or for positioning, rather than to restrict movement. These methods shall not be considered restraints.

2. The use of postural support and the method of application shall be initiated after a physician order and must be specified in the resident’s care plan.

3. Postural supports shall be applied:
   a. Under the supervision of a licensed nurse.
   b. In accordance with principles of good body alignment and with concern for circulation and allowance for change of position.

4. Nursing staff will reposition resident as per Resident Care Plan (RCP).

5. Intervention for postural support will be evaluated accordingly.

EXCLUSIONS:

Mechanical Support: Used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint.
Positioning/Securing Device: Used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.

REFERENCES:


CROSS – REFERENCES:

LHHPP 24-19 The C-625 Battery Operated Ceiling Lift

NPP D01 1.0 Restorative Nursing Program
NPP D6 1.1 Battery-Operated Lift Transfer
NPP D6 2.0 Transfer Techniques

Revised: 4/2000; 01/2008; 03/25/2014

Reviewed: 03/25/2014

Approved: 03/25/2014
POLICY AND PROCEDURE FOR AUTOMATIC STOP ORDERS

Policy:
Pharmacy and Therapeutics Committee will establish stop-orders on various classes of medications.

Purpose:
To limit the duration of medication therapy in the event the physician has not done so by specifying a number of days or number of doses.

A. The Stop Order Policy is applicable to all medication as specified below.

B. The attending physician will be notified of stop orders before the medication order expires so that the medications are renewed if necessary to assure continuity of treatment.

C. Such notification will be documented by the licensed nurse in compliance with the medical records policy.

D. The Stop Order Policy will be available electronically on the Pharmacy Policy and Procedure Page.

Procedures:
Medication Categories with a Specific Stop Order include the following:

1. Schedule II Medications - Stop order in seven (7) days unless the prescription specifies a number of days and refills. The medication is considered maintenance if it is written for 30 days with 11 refills.

   a. the prescription is written for 30 days or specified maintenance in the order.

   Examples include:
   - Codeine
   - Fentanyl patches (Duragesic)
   - Hydrocodone and acetaminophen (NorCo, Vicodin)
   - Hydromorphone (Dilaudid)
   - Methadone
   - Methylphenidate (Ritalin)
   - Morphine (Oramorph SR, MS Contin, Roxanol)
   - Oxycodone
   - Oxycodone & acetaminophen (Percocet)
   - Oxycodone & aspirin (Percodan)
   - Tincture of Opium

2. Anticoagulants:

   - Unfractionated Heparin - 48 hours
   - Low molecular weight Heparin - twenty (20) syringes per dispensing and a maximum of two (2) dispensings
   - Warfarin - 7 days
   - Direct oral anticoagulants – 7 days
Stop order in days listed above unless the prescription specifies a number of days and refills. The medication is considered maintenance if it is written for 30 days with 11 refills.

**NOTE:** If the prescriber does not renew a warfarin or low molecular weight heparin order, he/she will be contacted to renew or discontinue it. If the prescriber is not readily available, warfarin/low molecular weight heparin may continue for up to 14 days or until contacted (it shall not be discontinued without a specific “D/C” order from the physician).

3. All orders for antibiotics, including those administered by the parenteral, oral, topical, and ophthalmic routes, unless otherwise specified by the prescriber, will have a stop order in seven (7) days. The seven (7) day stop order **EXCLUDES** antiviral, antifungal and antituberculosis agents.

**NOTE:** Antibiotic orders should preferably specify the dates of administration rather than the number of days.

4. Antiemetics, anti-diarrhea, antihistamines and cough and cold preparations will have an automatic stop order after seven (7) days unless the physician has specified a definite dc order date, or has written the prescription for 30 days with refills or specified maintenance in the order.

5. All Non-steroidal anti inflammatory agents (NSAIDS) will have an automatic stop of 7 days unless a specific number of days, for 30 days with refills or specified maintenance in the order. **NOTE:** This policy does not apply to single daily doses of aspirin.

6. Genito-urinary antispasmodics (flavoxate (Urispas), hyoscyamine (Levsin), oxybutynin (Ditropan), propantheline (Pro-Banthine), tolterodine tartrate (Detrol) will have an automatic stop of 14 days unless the physician has specified a definite dc order date, for 30 days with refills or specified maintenance in the order.

7. All other medication classifications will be in effect for 45 days.

New: 4/93
Revised: 1/94; 4/98, 6/98, 11/99, 6/00, 11/00, 04/03, 04/04, 08/05, 05/06, 01/08, 4/11, 2/15, 6/15, 4/17
Reviewed: 04/09, 02/10, 4/12, 8/13, 4/14
POLICY AND PROCEDURE FOR ACUTE CARE HOSPITAL ORDER PROCESSING AND MEDICATION DISTRIBUTION

Policy:

The Pharmacy at Laguna Honda Hospital will have sole responsibility for distributing medications in the acute care hospital and for establishing procedures for processing of medication orders. All compounding, packaging, distribution, and dispensing of drugs shall be consistent with federal and state laws, rules, and regulations and applicable law or regulation governing professional licensure and operation of pharmacies and professional standards of pharmacy practice.

Purpose:

To ensure proper supplies of medications are dispensed to acute care patients.

Procedures:

A. Persons who may Prepare, Dispense, Transfer Drugs, and make Labeling Changes
   1. Drug preparation and dispensing is restricted to a licensed pharmacist or to a designee under the direct supervision of a pharmacist. A licensed pharmacist must monitor all drug preparation and dispensing by non-pharmacist personnel.
   2. Only a pharmacist, or authorized pharmacy personnel under the direction and direct supervision of a pharmacist, shall fill and label containers from which drugs are to be distributed or dispensed, make labeling changes, or transfer drugs to different containers.
   3. Supportive personnel (non-pharmacists) shall work under the direct supervision of a licensed pharmacist. The supervising pharmacist must be fully aware of all drug-preparation and drug-dispensing activities. Supportive personnel shall comply with facility and pharmacy policies and procedures.

B. Requirement for an Original or Direct Copy of a Drug Order
   1. Drugs may be dispensed only from the original or a direct copy of the prescriber's drug order.
   2. Orders for drugs shall be transmitted to the pharmacy either by written prescription of the prescriber, by an order form which produces a direct copy of the order or by an electronically reproduced facsimile. (Also see Hospital wide Policy on Verbal Orders, LHPP 25-03)
   3. Orders that are incomplete, illegible, or otherwise unclear shall not be filled and shall be verified or clarified prior to dispensing.
   4. "Continue SNF meds" or "Resume previous orders" are not legitimate orders. Incomplete orders shall be clarified on admission to the acute care hospital.
   5. If there is any question regarding a drug prescribed, dose, or strength (e.g., very high or very low), administration frequency, or dosage interval, a nurse or pharmacist shall contact the prescriber. Questionable orders shall be clarified prior to dispensing the drugs.
C. Reviews of Order by a Pharmacist
   1. All medication orders must be reviewed by a pharmacist before administering to the patient unless a licensed independent practitioner (L.I.P.) controls the ordering, preparation, and administration of the medication or in urgent situations when the resulting delay would harm the patient.
   2. If the order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, it should be reviewed by a pharmacist as soon thereafter as possible, preferably within 24 hours, following preparation and dispensing.

D. Patient Profiles: The pharmacy shall maintain a patient profile (drug therapy profile) for each patient.
   1. Contents of Profiles shall include:
      a) Name and location of the patient.
      b) Sex and age (or birth date) of the patient.
      c) Pertinent problems or diagnosis(es)
      d) Drug allergies or sensitivities (or NKA).
      e) Potential significant drug-food interactions:
      f) Other information relating to the patient's drug regimen.
      g) Current drug therapy including:
         1) Prescription and nonprescription drugs.
         2) Date ordered/reordered and stop date.
         3) Drug name, strength, and dose form.
         4) Quantity dispensed.
   2. A pharmacist shall verify the correct entry of all orders.
   3. Patient profiles (or the information in patient profiles) shall be available for review by staff responsible for the patient's care. Access to the information through telephone calls to an on duty or on-call pharmacist is acceptable.

E. Order Processing Procedure
   1. The pharmacy shall process drug orders as follows:
      a) Ensure that the patient's name, other identification (e.g., patient number and location), time and date are on the order form.
      b) Review the order for effective, appropriate including allergies, and safe drug therapy.
      c) Enter the order into the pharmacy computer system.
   2. Amounts to Dispense
      a) Medications are stored in the Automated Dispensing Cabinet (ADC).
      b) If a medication is not stored in the ADC:
         1) The pharmacy shall dispense enough doses to last until the next scheduled delivery of drugs to patients (up to a 7-day supply, but not to exceed the amount prescribed).
         2) For short-term medications written for a specific length of time only that amount which is required will be dispensed.
         3) For "PRN" medications the amount dispensed will be estimated by the pharmacist, taking into account the rate of usage by the patient in the past; the condition written for e.g., pain, sleep, etc; and the fact that "PRN" orders may be refilled by the nurse when more medication is needed.
3. Dispensing in Ready-To-Administer Forms
   a) Drugs shall be dispensed in ready-to-administer forms to the extent practical to minimize opportunities for error.

4. Unit Dose
   a) Unit of Use packaging, which permits identification of the drug up to the point of administration, shall be used to the extent practicable.

5. Labels
   a) The medication label will include at least:
      - Patient's name.
      - Name of medication (generic or brand).
      - Drug strength
      - Dosage form
      - Shape and color of drug if applicable
      - Quantity of medication
      - Expiration date
      - Initials of technician or pharmacist filling prescription
      - Appropriate accessory and cautionary statements or supplemental labels that address storage requirements, administration procedures, safety precautions, etc.

6. Verifying Order Filling Accuracy
   a) A pharmacist shall perform a final check after the order has been filled or refilled. This check shall verify that the order was filled and labeled correctly.

7. Drug Availability to Patient Care Areas
   a) The pharmacy shall ensure that drugs arrive to patient care areas and are available for administration at the scheduled times. If the pharmacy is unable to provide a drug prior to the scheduled administration time, the pharmacy shall inform the nurse responsible for the area and/or the nurse responsible for the patient.

8. STAT Orders & Pharmacy Response Time:
   a) Nursing service and pharmacy shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered. Drugs ordered “STAT” which are available in the emergency drug supply shall be administered immediately.
   b) Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.
   c) Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.
   d) Refills shall be available when needed.

9. Discontinued Medication Orders
   a) By the end of shift during which the medication is discontinued, the nursing unit will send or fax the order to Pharmacy, print "DC" on the prescription label and place the medication in the drug pick-up box. This also applies to the medications of residents who expire. The pharmacy will process discontinued orders within 4 hours of receiving.

10. Floor Stock
    a) Orders for certain medications will not be filled, but will be available as floor stock items. (See Section A, Floor Stock System).

11. Storage of Patient’s Drugs in Patient Care Areas
    a) Each patient's medication is placed in an individual cassette-held drawer which is labeled and designated for that patient.

12. Comparison with Medication Administration Records
    a) Nurses shall compare drugs supplied with the Medication Administration Record (MAR) or prescriber’s order and report irregularities to the pharmacy.

13. Return of Drugs from Patient Care Areas to the Pharmacy
a) Discontinued drugs, drugs remaining after a patient is discharged; excessive drugs, and unusable drugs shall be returned to the pharmacy.

14. Disposition of Drugs Returned to the Pharmacy
   a) Drugs returned to the pharmacy shall not be placed in active stock or dispensed unless they can be absolutely identified and there is no evidence (or suspicion) of contamination or potential contamination.

F. Patient Transfers
1. When a patient is discharged / admitted to or from an acute unit, the patient's medications must be returned to pharmacy by the sending unit. New medications will be obtained by the receiving unit. If the pharmacy is closed at time of discharge / admission to or from the acute care unit, the nurse will send the medications to the receiving unit and these medications may be used temporarily until the pharmacy re-opens. Once the pharmacy re-opens new medications must be obtained.
2. When a patient is temporarily moved within LHH from a SNF unit to a bed within the acute hospital for a “come & go” visit (e.g. “boarders” for blood transfusion):
   a) New orders are not needed since this is not an acute care admission
   b) The nurse will send the patient's medication to & from the receiving SNF unit.
   c) The Chart, MAR and other pertinent care records from the SNF unit are used to chart information about medication use, vital signs, etc.

G. All medications of a deceased patient will be returned to the pharmacy for disposal.

H. Controlled Substances: All scheduled medications must be initiated with a written order.

I. Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room. (See Policy 02.03.00 for Supplemental Drug Room procedure.)

See HWP 25-02 Safe Medication Orders
POLICY AND PROCEDURE FOR SKILLED NURSING DISTRIBUTION OF MEDICATIONS AND MEDICATION ORDER PROCESSING

Policy:

The Pharmacy at Laguna Honda Hospital will have sole responsibility for distributing medications in the hospital and for establishing procedures for processing of medication orders.

Purpose:

To ensure proper supplies of medications to residents.

Procedures:

I. The Individual Resident Prescription System:

A. The physician writes or electronically prescribes new orders for residents. Monthly renewals for medications is accomplished thru the medication reconciliation process in the electronic health record or via a physician order form if the medication cannot be entered into the electronic health record.

B. New orders are either transmitted electronically via eRx, electronically reproduced facsimile or brought to the Pharmacy. These orders are maintained electronically in the pharmacy information system.

C. The pharmacy will check each order against the resident's medication profile for incompatibilities, allergies, unusual dosages, and errors. The pharmacist shall require physician clarification of orders prescribed for unusual uses, as well as any other medication irregularities.

D. Each order is filled with the appropriate amount of medication.

1. For Skilled Nursing Facility residents, a 7–day supply of medication is issued.

2. For short-term medications written for a specific length of time only that amount which is required will be dispensed.

3. For "PRN" medications the amount dispensed will be estimated by the pharmacist, taking into account the rate of usage by the resident in the past; the condition written for e.g., pain, sleep, etc; and the fact that "PRN" orders may be refilled by the nurse when more medication is needed.
E. Resident Transfers
   1. When a resident is transferred within LHH from a SNF unit to another SNF unit, the nurse will send the resident's medication to the receiving unit.
   2. When a resident is discharged / admitted to or from an acute unit, the resident's medications must be returned to pharmacy by the sending unit. New medications will be obtained by the receiving unit. If the pharmacy is closed at time of discharge / admission to or from the acute care unit, the nurse will send the medications to the receiving unit and these medications may be used temporarily until the pharmacy re-opens. Once the pharmacy re-opens new medications must be obtained.

F. A record of medications dispensed should be made in the resident's medication file to include: quantity of medication, prescription number, date and initials of pharmacist filling or checking the meds filled by a technician.

G. The prescription label for each resident will include:
   - Resident's name.
   - Amount of medication.
   - Prescription number.
   - Prescribing physician's name.
   - Date filled.
   - Resident's medical record number.
   - Manufacturer's name (if generic).
   - Directions including rate of administration for IV medications.
   - Expiration date.
   - Name of medication (generic or brand).
   - Initials of technician or pharmacist filling prescription.

H. Discharges:
   1. Cassette medications may be sent with the resident upon discharge unless one of the following situations exists:
      a) Physician specifies otherwise.
      b) Resident leaves without physician approval.
      c) Resident discharged to acute hospital or health care facility other than LHH.
      d) Medication discontinued prior to discharge.
      e) Labeled directions substantially differ from current orders.
   2. Discharge meds will be dispensed in child-proof containers. Labels will be typed in lay-language
   3. A record of the medications sent with the resident should be made in the resident's file to include: name of medication, prescription number, quantity of medication, date, and initials of pharmacist filling or checking the meds filled by a technician.

I. Passmeds: Medication Orders will be filled for resident's use on short-term passes, provided the physician has given orders for such medication use. (See Policy and Procedure 02.01.04, Pass Medication)
J. Orders for certain medications will not be filled, but will be available as floor stock items. These items include laxatives, vitamins, A & D ointment, petrolatum, antacids, acetaminophen, aspirin, or other approved medications. (See Section A, Floor Stock System)

K. Each resident's medication is placed in an individual cassette-held drawer which is labeled and designated for that resident.

L. The medications in the cassette-held patient drawers are delivered to the appropriate Unit on a cyclical basis and, in the case of refills, are exchanged for the previous cassettes.

M. The duplicate cassettes are returned to the pharmacy.

N. New physician's orders that are written during the interim period are accommodated in the following manner:
   1. Orders that add medication to a resident's drug regimen are sent to the pharmacy to be filled and delivered to the Unit.
   2. Orders that discontinue medication from a resident's drug regimen are sent to the Pharmacy, along with the discontinued med from the resident's drawer.

O. If a resident is transferred to a different Unit, the Unit nurse will include all of the resident's medications in the transfer to the new Unit.

P. All medications of a deceased resident will be returned to the pharmacy for disposal.

Q. All orders received will constitute a prescription and will be kept as required by State and Federal law.

R. Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room. (See Policy 02.03.00 for Supplemental Drug Room procedure.)

NOTE: Normal pharmacy hours are Monday through Friday, 8 a.m. to 5:30 p.m. and 9 a.m. to 4 p.m. on Sunday. On legal holidays the Pharmacy will be open from 8 a.m. to 4:30 p.m. The pharmacy will be closed on Thanksgiving and Christmas.

Reviewed 06/03dw, 02/06, 01/08, 04/09, 4/12, 8/13
Revised 06/07, 02/08, 05/08, 2/10, 5/11, 4/14, 2/15, 5/17