# List of Hospital-wide/Department Policies & Procedures
Submitted to JCC for Approval on March 14, 2017

## 1. **a. 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>LHHPP 21-17</td>
<td>Document Shredding</td>
<td>Created to provide guidance to Laguna Honda Hospital (LHH) staff regarding the proper disposal of documents that contain confidential information and/or protected health information (PHI) and to provide the procedure for retrieval of documents after an erroneous disposal of a document into a document shredding bin.</td>
</tr>
<tr>
<td>LHHPP 21-18</td>
<td>Breach Policy</td>
<td>Created to define the responsibility for LHH’s response to a potential/actual privacy breach of Protected Health Information (PHI).</td>
</tr>
<tr>
<td>LHHPP 80-13</td>
<td>Laguna Honda Wellness Program</td>
<td>Created to support a workplace environment where participants can thrive and enhance their well-being.</td>
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## b. New Department Policies and Procedures

**Department: Medicine**

<table>
<thead>
<tr>
<th>Policy Number</th>
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<tbody>
<tr>
<td>MSPP C03</td>
<td>Supplemental Credentialing Requirements to meet NCQA Requirements</td>
<td>Created to establish a process to assess and credential providers in order to meet NCQA guidelines.</td>
</tr>
<tr>
<td>MSPP D08-05</td>
<td>Psychiatry Documentation and Billing Guideline</td>
<td>Created to ensure that LHH Psychiatry clinical documentation and billing practices meet regulatory and compliance requirements.</td>
</tr>
<tr>
<td>MSPP D08-09</td>
<td>Mental Health Services</td>
<td>Created to define the approach and procedure for specialty and non-specialty mental health services provided by LHH Psychiatry, as part of the comprehensive behavioral health services, for LHH residents with mental health needs.</td>
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## 2. **a. Revised Hospital-wide Policies and Procedures**

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LHHPP 28-01 Community Outing Program
Revised the types of community outings, education/training of staff who attends the outings including instructions to volunteers and family members, methods of transportation, planning activities, activities on the day of the outing, outing cancellation, safety protocol and evaluation and QA.

LHHPP 28-01 Community Outing Program Safety Guidebook
Revised the attachment to LHHPP 28-01 Community Outing Program, which includes revisions to the different types of therapeutic outings, completion of the Outing Planning form, staffing considerations, resident preference, clinical considerations, and safety tips for the staff implementing the outing.

LHHPP 70-01 Emergency Preparedness Committee
Revised the membership of the Emergency Preparedness Committee and the responsibilities of committee members.

LHHPP 70-03 Appendix L Vehicles and Radios
Revised appendix L to update the radios and vehicles.

LHHPP 73-01 Injury and Illness Prevention Program IIPP
Revised how employees may also choose to report health and safety hazards directly to Workplace Safety and Emergency Management (WSEM) or through a hazard reporting form. All Laguna Honda employees will receive an introduction to WSEM and an overview of the IIPP during new employee orientation.

LHHPP 73-08 Hearing Conservation Program
Revised title name, and to implement procedures for the prevention of noise-induced hearing loss in Laguna Honda employees and to comply with the Cal/OSHA standards for the control of occupational noise exposure.

LHHPP 90-05 Catering Services
Revised to include required approvals and procedures for non-resident services.

b. Revised Department Policies and Procedures

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<tr>
<td>NPP G 5.0</td>
<td>Blood Glucose Monitoring</td>
<td>Clarified the policy statement, timing of blood glucose checks and timing of insulin administration.</td>
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<tr>
<td>NPP B 7.0</td>
<td>Nursing Care of the Resident with Seizures</td>
<td>Revised to include care planning on individualized seizure precautions, acute seizure management, and phases of seizure.</td>
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<tr>
<td>NPP F 6.0</td>
<td>Ostomy Management</td>
<td>Added the section on “Ostomy Maintenance for Aquatic Services”</td>
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**b. Department Policies and Procedures for Deletion**

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DOCUMENT SHREDDING

POLICY:

LHH maintains document shredding bins that serve as secure, temporary storage for documents that contain confidential information and/or protected health information (PHI) until the document shredding vendor collects the contents of the document shredding bins for final destruction processing. It is the intent of this policy to provide guidance to LHH staff as to the proper use of the document shredding bins and the proper retrieval of documents that have been deposited into the document shredding bins in error.

PURPOSE:

1. The Document Shredding Policy is to provide guidance to Laguna Honda Hospital (LHH) staff regarding the proper disposal of documents that contain confidential information and/or PHI.

2. The Document Shredding Policy shall also provide the procedure for retrieval of documents that contain confidential information and/or PHI after an erroneous disposal of a document into a document shredding bin.

DEFINITIONS:

1. “Protected health information” or “PHI” is individually identifiable health information, including demographic data that relates to an individual’s past, present, or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

2. “Confidential information” is any document or record containing sensitive information of a resident/patient, employee, supplier, and other sensitive facility information.

PROCEDURE:

1. Documents that contain confidential information and/or PHI shall be deposited immediately into a document shredding bin upon the final use of such document.

2. Documents that contain confidential information and/or PHI shall only be deposited into a document shredding bin and shall never be deposited into a garbage, compost, or recycling bin.

3. Health Information Services (HIS) shall hold all keys to all document shredding bins.

4. Documents deposited into a document shredding bin shall be considered shredded.
5. Documents deposited into a document shredding bin in error shall not be retrieved except in the following circumstance:
   a. The document cannot be reproduced and its absence will cause resident/patient harm or is necessary to evidence the proper billing of services.

6. If a document is retrievable pursuant to section 5(a) of this policy, the following procedure shall be followed:
   a. The staff member who erroneously deposited the document into the document shredding bin shall immediately notify his or her supervisor and LHH’s Privacy Officer of the type of document erroneously deposited, when it was deposited, into which document shredding bin it was deposited, whether or not the document will cause resident/patient harm or is necessary to evidence the proper billing of services, and whether or not the document is able to be reproduced.
   b. The Privacy Officer shall determine if the document may be retrieved from the document shredding bin pursuant to this policy. To aid in that determination, the Privacy Officer shall confer with HIS to determine whether it is possible to reproduce the document.
   c. If the Privacy Officer determines that the document may be retrieved, he or she shall contact HIS to obtain the key to the appropriate document shredding bin.
   d. Both the Privacy Officer and the staff member’s supervisor shall retrieve the document from the document shredding bin using the following protocol:
      i. No other person except the Privacy Officer and staff member’s supervisor shall be present in the area around the document shredding bin. If the bin is in an enclosed room, all other persons shall be cleared from the room and the door shall be closed.
      ii. The Privacy Officer shall open the document shredding bin.
      iii. The Privacy Officer shall remove only as many documents from the document shredding bin as necessary to reach the erroneously deposited document. All documents shall be accounted for as they are removed.
      iv. The Privacy Officer shall remove the erroneously deposited document from the document shredding bin. All other removed documents shall be placed back into the document shredding bin immediately after retrieving the erroneously deposited document.
      v. The Privacy Officer shall lock the document shredding bin. Only after the document shredding bin is locked shall other persons be allowed back into the room or area.
      vi. The Privacy Officer shall return the erroneously deposited document to the staff member’s supervisor.
      vii. The Privacy Officer shall immediately return the document shredding bin key to HIS.
7. Staff members shall not deposit any documents into a document shredding bin if doing so will cause the documents to be visible through the bin's opening, or if doing so will cause the bin to be full or to overflow.

8. When documents are visible in a document shredding bin through the bin's opening, or the document shredding bin is full or overflowing, the following procedure shall be followed:
   a. Whenever a staff member sees that documents are visible through the opening of a document shredding bin or that the bin is full or overflowing, the staff member shall immediately notify his or her supervisor. The supervisor shall make every effort to ensure that the overflowing documents are secured inside the document shredding bin. The supervisor shall place a sign over the document shredding bin’s opening informing users that the bin is full and to place documents in another document shredding bin.
   b. Staff members shall not deposit documents into a full or overflowing document shredding bin.

9. The destruction of a large volumes of documents containing confidential information and/or PHI shall be handled according to the following procedure:
   a. The document shredding bins shall not be used for the disposal of large volumes of documents.
   b. HIS shall be notified prior to the commencement of a project to dispose of a large volume of documents. HIS shall arrange an additional collection based on the volume of documents to be destroyed.
   c. A department or staff member shall box and store the documents in a secure area until the date of the scheduled additional collection.

ATTACHMENT:
None

REFERENCES:
Laguna Honda Hospital-wide Policy 21-01, Medical Records Information: Confidentiality and Release
Laguna Honda Hospital Health Information Services Policy 13.6, Patient Access to Health Records

Original adoption: 17/03/14 (Year/Month/Day)
BREACH POLICY

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect resident's/patient's personal and medical information. It is the responsibility of all staff to immediately report a privacy breach that they become aware of, or suspect.

2. This policy pertains to all individuals at the Laguna Honda campus who have access to, use, or disclose Protected Health Information (PHI) regardless of DPH/LHH division, program, service or department.

3. The Office of Compliance and Privacy Affairs LHH site Privacy Officer (under the direction of the DPH Chief Integrity Officer & Director, Office of Compliance and Privacy Affairs) is responsible for monitoring the adherence to this policy.

PURPOSE:

The purpose of this policy is to define the responsibility for LHH’s response to a potential or actual privacy breach of PHI. This document establishes guidance for the reporting and investigation of the breach of PHI per the 1996 Health Insurance Portability and Accountability Act (HIPAA), the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act and the 2013 HIPAA Final Omnibus Rule. In addition, federal regulation 42 CFR Part 2 governs the privacy of resident/patient in substance use disorder programs. The California Medical Information Act (CMIA) as well as other state regulations requiring LHH to investigate, report and notify resident/patient of a suspected breach of resident/patient PHI. HIPAA requires that LHH notify resident/patient whose unsecured PHI has been compromised by such a breach. Depending on the circumstances and size of the breach, LHH must also report certain breaches to state and federal agencies and to the media.

DEFINITIONS:

1. “Breach” is the mislaying, theft, or the unauthorized access, use or disclosure of a resident's/patient's personal information and/or PHI. The personal information and protected health information includes data collected for clinical, business and/or research purposes. The privacy breach may be accidental or willful and specifically includes, without limitation, personal and/or medical information stored electronically on an unencrypted device or paper document that is lost or stolen.

2. “Health Insurance Portability and Accountability Act of 1996” or “HIPAA” is a federal privacy law that requires health care providers and organizations, as well as their business associates, develop and follow procedures that ensure the confidentiality and security of PHI when it is transferred, received, handled, or shared.
3. “Medical Information” is any individually identifiable information, in electronic or physical form, that is in the possession of, or derived from, a provider of health care, health care service plan, pharmaceutical company or contractor, regarding a resident’s/patient’s medical history, mental or physical condition, or medical treatment, or diagnosis.

4. “Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the resident’s/patient’s name, address, electronic mail address, telephone number, SSN, or other information that, alone or in combination with other publicly available information, reveals the individual’s identity.

5. “Protected Health Information” or “PHI” is health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual.

6. “Ransomware” is a type of malware (malicious software) distinct from other malware; its defining characteristic is that it attempts to deny access to a user’s data, usually by encrypting the data with a key known only to the hacker who deployed the malware, until a ransom is paid.

PROCEDURE:

1. Breach Notification
   a. DPH/LHH staff at the Laguna Honda campus shall report any potential breach as soon as is reasonably possible to the LHH Privacy Officer, or to their supervisor/manager who will then make the report to the LHH Privacy Officer. LHH staff may also report the potential privacy incident or violation to the DPH Privacy Hotline (855-729-6040).
   b. DPH/LHH staff shall report any potential breach as soon as possible even if they are not sure a breach has occurred and/or do not have all of the information regarding the incident.
   c. DPH/LHH staff or the LHH Privacy Officer shall file an Unusual Occurrence (UO) report immediately upon discovering or being informed about the potential privacy breach.

2. Breach Determination – Risk Assessment
a. The LHH Privacy Officer in consultation with the Department of Public Health’s Office of Compliance and Privacy Affairs (OCPA) will make the determination if a breach has occurred. The following criteria (per Federal code §164.402) will be used to determine if a breach has occurred:

i. The term “breach” does NOT include:

   - Unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of LHH if the acquisition, access or use was made in good faith and within the course and scope of their authority and does not result in further use or disclosure in a manner not permitted by the HIPPA Privacy Rule.
   - Any inadvertent disclosure by a person who is authorized to access PHI at LHH to another person authorized to access PHI at LHH, and the information received is not further used or disclosed in a manner not permitted by the HIPPA Privacy Rule.
   - A disclosure of PHI where there is a good faith belief that the unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
   - Devices that are lost or stolen that contain PHI if the devices are encrypted and meet DPH standards.

ii. There may be situations where there is a low probability of a breach based on a risk assessment of the following factors:

   - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification
   - The unauthorized person who used the PHI or to whom the disclosure was made
   - Whether the PHI was actually acquired or viewed
   - The extent to which the risk to the PHI has been mitigated
   - Examples of situations of a low probability of the PHI being compromised include sending PHI in the mail to the wrong address where the mail is returned unopened to the post office as undeliverable, or where a nurse mistakenly hands discharge papers to the wrong resident/patient, quickly realizes the mistake, and recovers the PHI before the resident/patient has time to read it.

iii. If it is determined that a breach did not occur, the decision-making process shall be documented and filed and the LHH Privacy officer shall issue a Findings and Recommendation to the appropriate LHH division.

iv. If it is determined that a breach did occur, the decision-making process shall be documented and the LHH Privacy Officer will initiate the DPH Breach Reporting Procedures (see DPH Breach Policy) in conjunction with the LHH Quality Management Department. The LHH division or staff involved in the
breach shall not directly contact the resident/patient unless directed to do so by the LHH Privacy Officer.

b. Determining a Ransomware Breach: The Office of Civil Rights has issued guidance regarding determining whether a breach has occurred in a ransomware situation. The following is from that guidance: “Whether or not the presence of ransomware would be a breach under the HIPAA Rules is a fact-specific determination.” When electronic protected health information (ePHI) is encrypted as the result of a ransomware attack, a breach has occurred because the ePHI encrypted by the ransomware was acquired (i.e., unauthorized individuals have taken possession or control of the information), and thus is a “disclosure” not permitted under the HIPAA Privacy Rule. In situations “where the ePHI encrypted by the ransomware was already encrypted to comply with HIPAA,” it is also a “fact specific determination” of whether a breach has occurred. Even if the ePHI is encrypted in accordance with DPH standards, “additional analysis may still be required to ensure that the encryption solution, as implemented, has rendered the affected PHI unreadable, unusable and indecipherable to unauthorized persons.” If that is the case, then a breach has not occurred.

i. OCPA in consultation with IT and the City Attorney’s Office (CAO), will determine if a breach has occurred due to ransomware.

ii. If it is determined that a breach has occurred, the decision making process will be determined and: a) IT will contact the FBI and OCPA will initiate the breach notification process and b) the LHH Privacy Officer will initiate the DPH Breach Reporting Procedures (see DPH Breach Policy) in conjunction with the LHH Quality Management Department.

3. Resident/Patient Notification Process

a. The LHH Privacy Officer shall notify resident/patient of confirmed breaches according to the following:

i. Resident/patient notices will be sent via first-class mail if the resident/patient has been discharged from LHH. If the resident/patient is still admitted to LHH at the time the notice is sent, the notice shall be delivered via interoffice mail to the resident’s/patient’s room. In all cases where the resident/patient has a designated decision-maker, the notice shall be sent to the decision-maker via first-class mail.

ii. If there is insufficient or out-of-date contact information for 10 or more individuals, a substitute individual notice will be posted on the home page of the LHH and DPH web site for at least 90 days.

iii. If there is insufficient or out-of-date contact information for fewer than 10 individuals, LHH will provide substitute notice by an alternative form such as a written notice to the emergency or other contact in the resident’s/patient’s health record or other DPH source or by telephone.
iv. If the resident/patient is a minor, notification shall be made to the parent or legal guardian. If the resident/patient is deceased, notification shall be made to the next-of-kin or personal representative in the resident’s/patient’s Lifetime Clinical Record (if contact information is available).

v. DPH maintains a separate toll-free phone number dedicated to all privacy breaches where individuals can learn if their information was involved in any breach.

vi. Resident/patient shall be provided notice without unreasonable delay and in no case later than 15 business days following the discovery of a breach. The notice will be written in plain language and must include, to the extent possible, the following:

- A brief description of what happened, including the date of the breach, date range of the breach and the date of the discovery of the breach, if known;
- A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number (SSN), date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
- Any steps the individual shall take to protect themselves from potential harm resulting from the breach; If the breach exposed a SSN, California Driver’s license or California ID card number, then provide the toll-free phone numbers and addresses of the major credit reporting agencies;
- A brief description of what DPH is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches; and
- Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, Web site, or postal address.
- If the breach involves a data security breach the notice shall include the header “SUBJECT: NOTICE OF DATA BREACH” and shall present the details of the breach by using the following subject headings: “What Happened;” “What Information Was Involved;” “What Are We Doing;” “What You Can Do;” and “For More Information.” The notification shall also include information about what LHH has done to protect the individuals’ information and advice on steps that the individuals may take to protect themselves.

b. Law Enforcement Delay of Notification: If a law enforcement official states that a notification, notice, or posting required under this subpart would impede a criminal investigation or cause damage to national security, the LHH Privacy Officer or OCPA shall immediately notify the City Attorney’s Office (CAO) for guidance. Upon the direction of the CAO, requests to delay notification will be handled as follow:
i. If the statement is in writing and specifies the time for which a delay is required, OCPA will delay such notification, notice, or posting for the time period specified by the official; or

ii. If the statement is made orally, OCPA will document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time.

iii. In either case, documentation related to the law enforcement delay request will be retained.

4. Reporting of Confirmed Breaches

a. Reporting to the California Department of Public Health (CDPH)

i. Upon determining that there is a privacy breach, the LHH Privacy Officer shall immediately request Risk Management to notify the CDPH of the breach. Risk Management shall then immediately notify the CDPH of the breach. The CDPH must be notified of the breach no later than 15 business days from the date the LHH Privacy Officer or OCPA was notified of the potential breach.

b. Reporting to the Office of Civil Rights

i. For breaches affecting less than 500 individuals, the LHH Privacy Officer shall notify the Office of Civil Rights as soon as possible and no later than 60 calendar days after the end of the calendar year in which the breach was discovered.

ii. For breaches affecting 500 or more individuals, the LHH Privacy Officer shall notify the Office of Civil Rights as soon as possible and no later than later than 60 calendar days from the discovery of the breach.

c. Reporting to the San Francisco Health Plan and other Insurance Plans

i. For any breach affecting a resident/patient covered by the San Francisco Health Plan (SFHP), the LHH Privacy Officer shall notify the SFHP within 24 hours of determining a breach occurred. The LHH Privacy Officer shall provide the SFHP with as much information as possible to date regarding the breach affecting its members.

ii. Notification letters to members of the SFHP shall be submitted to the SFHP for approval prior to being sent to the affected resident/patient.

iii. Upon completion of any investigation into the breach, the LHH Privacy Officer shall provide a detailed report of the circumstance surrounding the breach to the SFHP.

iv. For all insurance plans other than SFHP, the LHH Privacy Officer will determine if a plan requires LHH report to it that its members were affected by the breach, and the LHH Privacy Officer will follow the reporting procedures specified by each plan.
5. Remediation and Corrective Action

a. The LHH Privacy Officer is responsible for providing oversight and advisory assistance to the affected LHH divisions and to ensure that appropriate remediation occurs. This includes corrective actions such as implementation and ongoing monitoring of process change, technical measures, or individual disciplinary measures designed to prevent a breach in the future. Results of corrective actions will be reported to the LHH Privacy Committee by the affected LHH division at regular intervals to be determined by the LHH Privacy Officer.

b. The OCPA Findings and Recommendations form shall be used to document the incident findings and corrective actions.

6. Documentation

a. All documentation related to privacy breaches shall be minimally maintained from seven years from the date of the breaches or potential breaches. This documentation will include all notifications associated with the breaches and documentation if the incidents were deemed not to be breaches. Documentation will be maintained electronically on the OCPA shared drive on the DPH network.

RELATED POLICIES:

1. Complaints to DPH: Any individual who has a complaint about the Reporting of Unlawful or Unauthorized Access of Protected Health Information Policy including administrative requirements, may call the Privacy and Compliance hotline at (855) 729-6040 or contact by email at compliance.privacy@sfdph.org. Individuals may also call the City and County of San Francisco (CCSF) Controller’s office Whistleblower hotline at (415) 701-2311 or file a complaint.

2. Sanctions: Employees committing a breach will be subject to disciplinary action per their MOUs and Human Resource policies. Disciplinary actions may include separation. Fines and penalties apply not only to DPH but to individuals and can range up to $250,000. Employees are personally responsible for fines levied against them and violations may impact their professional license. Any sanctions applied will be documented in the breach case file.

3. Refraining from Intimidating or Retaliatory Acts: DPH employees may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual reporting a potential privacy breach.

4. San Francisco Department of Public Health’s (DPH) Breach Policy.

ATTACHMENT:
None
REFERENCE:
None

Original adoption: 17/03/14 (Year/Month/Day)
LAGUNA HONDA WELLNESS PROGRAM

POLICY:

The City and County of San Francisco (CCSF) has encouraged staff wellness as a priority for all its City departments. A Health Services System (HSS) Wellness Program and Center has been developed as a resource for bringing wellness opportunities to City departments’ worksites.

Laguna Honda Hospital and Rehabilitation Center (LHH) and its community support the City’s effort to improve the health and well-being of its employees (See Attachment A).

Employees choosing to participate in the wellness program as participants shall review and sign a waiver of liability (see Attachment B). Participation in wellness programming shall be on their own personal time (e.g. before start of shift, during breaks, and after completion of shift). Employees are encouraged to incorporate wellness approaches outside of the wellness programming into their daily work habits and routines.

Wellness Champions and those employees providing wellness activities shall do so on a voluntary basis and with the approval of their supervisor/manager (See Attachment C). Wellness activity program leaders will not be reimbursed to obtain any certifications or licenses for leading wellness activities.

The Assistant Hospital Administrator for Clinical Services shall be the Executive Committee representative to support and promote workplace wellness at the Laguna Honda campus community.

PURPOSE:

The purpose of the Wellness program is to support a workplace environment where participants can thrive and enhance their well-being. Consistent with the City’s Health Services System, the program’s goals are to improve physical and mental health, improve morale, aid in employee recruitment and retention, reduce absenteeism and assist with containment of healthcare costs.

DEFINITIONS:

HSS Wellness program: CCSF sponsored program and guidelines for participation in wellness programming.
Laguna Honda Wellness program: activities and programming that support the CCSF Wellness initiative on Laguna Honda campus.
Wellness program participant: a person from the campus community who may choose to participate in the Laguna Honda Wellness program.
Campus community: includes city employees, residents, residents’ families and volunteers.
**Wellness Champion:** a participant in the Wellness program who supports both City-wide and Laguna Honda specific Wellness initiatives. A champion may also be Wellness program participant separate from their duties as a Wellness Champion.

**Wellness Champion Coordinator:** a participant in the Laguna Honda Wellness program who volunteers to help the Executive Committee representative with the organization and planning of the wellness program. The Wellness Champion Coordinator may also be a Wellness program participant separate from their duties as a Wellness Champion.

**PROCEDURE:**

1. Health Services System Partnership and Wellness Champions

   a. LHH managers shall identify several employee Wellness Champions to act as liaisons to the HSS program and services. Employees can also volunteer to become a Wellness Champion.

   b. Every department shall have the opportunity to select a Wellness Champion to represent them in the program.

   c. Employees who express an interest in becoming a Wellness Champion must obtain written approval from their supervisor by completing the Wellness Champion commitment form prior to participation (See Attachment C).

      i. The operational needs of the department must be considered by the supervisor prior to approval. Overtime may not be used to cover operational needs left unattended due to Wellness Champion activities.

   d. The role of the Wellness Champion include:

      i. Attending HSS Wellness Program trainings. Trainings may be attended during regularly scheduled work time, with prior supervisor/manager approval.

      ii. Sharing HSS Wellness Program information with the LHH community regarding new program efforts and available classes, advance the implementation of on-site services, promote, advertise and generate interest in HSS Wellness programs and services.

   e. Wellness Champions shall work with their direct supervisor/manager to coordinate their schedules in order to be able to attend HSS Wellness Program activities and/or wellness related activities at Laguna Honda.

   f. Wellness Champions shall initiate re-authorization by their supervisor annually.

   g. Wellness Champions who express an interest in a leadership role will have the opportunity to volunteer to be Wellness Champion Coordinator.
h. The Wellness Champion Coordinator assists the Assistant Hospital Administrator with the coordination of Wellness program activities. Duties include but are not limited to:

i. Organization and coordination of wellness programs and services
ii. Coordination of Wellness Champion activities
iii. Act as a liaison to the HSS Wellness Program

j. If more than one Wellness Champion is interested in becoming the Wellness Champion Coordinator, the Assistant Hospital Administrator will convene a panel for competitive interviews.

ii. The Wellness Champion Coordinator shall initiate re-authorization by their supervisor annually and shall reapply annually to maintain their coordinator status.

2. Laguna Honda Campus Wellness Council

a. The Wellness Champion Coordinator, the Assistant Hospital Administrator for Clinical Services, and any interested Wellness Champions shall hold quarterly Wellness Council meetings open to the LHH community to encourage participation

b. The Laguna Honda Campus Wellness Council activities shall include:

i. The evaluation of current and consideration of recommended wellness programs and services
ii. Determining information that will be communicated to the Laguna Honda campus community, such as information regarding internal opportunities and champion activities
iii. Identifying items that need updating on the Wellness button of the intranet and the bulletin boards outside of the cafeteria; and assisting to complete these as needed

3. Wellness Activity Participation

a. Wellness activities shall be documented to assess program effectiveness and satisfaction, assist in program development, and for general data collection purposes.

b. All volunteer instructors/program leaders shall maintain participation records using the Wellness Program Waiver of Liability and Sign-in Sheet, (see Attachment B).
c. If a new wellness program activity is recommended, the interested instructor shall contact the Wellness Champion Coordinator and/or the Assistant Hospital Administrator for Clinical Services with the following information:

   i. Type of activity/class
   ii. Environmental considerations: type of room needed for activity, any equipment needed (audiovisual equipment, speakers, jump ropes), etc.
   iii. Time frame for group, including time of day, length of activity, duration of activity.
   iv. If all resources are available for the new program, it will be incorporated into the existing wellness program.

d. A quarterly instructors/program leaders meeting will be scheduled by the Wellness Champion Coordinator and/or the Assistant Hospital Administrator for Clinical Services to review the wellness activity program and to address any issues, provide trainings, and solicit feedback on programming.

4. Campus Community Member Commitment

   a. All members of the LHH community are welcome to participate in the Wellness Program and activities on campus. This includes, but is not limited to, city employees, residents, residents’ families and volunteers.

   b. Each participant shall be responsible to assess their own readiness for an activity and shall sign the Wellness Program Waiver of Liability and Sign-in Sheet, (see Attachment B).

   c. Each instructor/teacher/facilitator shall provide safety information specific to the activity prior to the beginning of each class.

ATTACHMENTS:
Attachment A: Memorandum DHR No. 01-2015, Encouraging Wellness Activities
Attachment B: Wellness Program Waiver of Liability and Sign-in Sheet
Attachment C: Champion Commitment Form

REFERENCE:
Memorandum DHR No. 01-2015 Encouraging Wellness Activities

Original adoption: 17/03/14 (Year/Month/Day)
Attachment A: Memorandum DHR No. 01-2015, Encouraging Wellness Activities

City and County of San Francisco
Edwin M. Lee
Mayor

Department of Human Resources
Micki Callahan
Human Resources Director

DATE: January 20, 2015
TO: Appointing Officers
Departmental Personnel Officers
FROM: Micki Callahan, Human Resources Director
SUBJECT: Encouraging Wellness Activities

The City and County of San Francisco launched its Wellness Plan for City employees in the fall of 2014. Wellness is the state of being in good physical and mental health, and the Wellness Plan was sponsored by the Mayor’s Office, the Controller’s Office, the Department of Human Resources (DHR), and the [Health Service System].

We chose a workplace wellness program because work time, lunch time, and commute time constitute over 50 percent of an employee’s waking hours on any given workday. Work environments, work culture, and coworkers can influence choices made during the workday, such as what to eat for lunch and what to do on a break. These decisions can have a significant impact on the health of each individual. Developing a culture of wellness will inspire and support healthy choices about exercise, nutrition, preventive care, stress management, and emotional well-being.

To this end, departments are encouraged to allow flexible work schedules where operationally feasible to facilitate the ability of employees to participate in wellness programs in conjunction with the workday. These flexible arrangements could include allowing later or earlier start and end times or longer lunches, with adjustments to start or end times to make up time (with supervisor approval). Floating holidays, vacation, and compensatory time off (CTO) are also available for these purposes.

The appropriate uses of sick leave are detailed in the Civil Service Commission Rules and the City’s Employee Handbook. Sick leave is not generally available for wellness activities unless the activity is delivered or led by a licensed medical professional. Use of sick leave is appropriate when an employee is consulting with a licensed medical provider for such purposes as biometric screenings, flu shots, classes led by nurses or physical therapists, and other preventive care provided by a licensed medical professional.

The following chart provides guidance and examples of when paid leave or flex time may be appropriate:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Approximate Length of Time</th>
<th>Type of Time</th>
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<tbody>
<tr>
<td>Biometric Screening</td>
<td>30 minutes (15 minute appointments)</td>
<td>Lunch time, flexible scheduling, sick leave, vacation, floating holiday, CTO</td>
</tr>
<tr>
<td>Flu Shots</td>
<td>20 minutes (10 minute appointments)</td>
<td>Lunch time, flexible scheduling, sick leave, vacation, floating holiday, CTO</td>
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<tr>
<td>Wellness Coaching</td>
<td>30 minutes (20 minute appointments)</td>
<td>Lunch time, flexible scheduling, vacation, floating holiday, CTO</td>
</tr>
<tr>
<td>Wellness Activities</td>
<td>Duration</td>
<td>Time Off</td>
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<td>--------------------------------------------</td>
<td>------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Interactive Seminars (aka Lunch and Learns)</td>
<td>60 minutes</td>
<td>Lunch time, flexible scheduling, vacation, floating holiday, CTO</td>
</tr>
<tr>
<td>Tobacco Cessation Classes / Weight Management Classes</td>
<td>2-3 hours – 7-10 days</td>
<td>Flexible scheduling, vacation, floating holiday, CTO</td>
</tr>
<tr>
<td>Classes Offered by Medical Provider or Health Plan</td>
<td>2 hours</td>
<td>Sick leave, vacation, floating holiday, CTO</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP) Counseling</td>
<td>60 minutes</td>
<td>Sick leave, vacation, floating holiday, CTO</td>
</tr>
<tr>
<td>EAP Work-Related Training Programs</td>
<td>1-8 hours depending on the training</td>
<td>Work time if assigned by a supervisor to attend for work-related purposes, vacation, floating holiday, CTO</td>
</tr>
</tbody>
</table>

Please visit [www.myhss.org/well-being](http://www.myhss.org/well-being) for more information about the City’s Wellness Plan.

Should you have any questions about this policy, please contact DHR Chief of Policy Susan Gard at susan_gard@sfgov.org.
Attachment B: Wellness Program Waiver of Liability and Sign-in Sheet

WELLNESS PROGRAM
WAIVER OF LIABILITY & SIGN-IN SHEET

Class Location ___________________ Instructor ___________________ Date ___________________

I recognize that my participation in the Wellness programs offered at Laguna Honda Hospital & Rehabilitation Center (Laguna Honda) could result in serious injury, including permanent damage to my health. I hereby willingly assume such risk. In consideration of the permission to participate in Wellness programs offered at Laguna Honda, I, for myself, my heirs, executors, administrators, successors and assigns hereby release, waive, and forever discharge the City and County of San Francisco, its officers, employees, and agents from and against any and all liability, loss, expense, attorneys' fees, or claims for injury or damages arising out of my participation, which is not work-related and conducted outside the course and scope of City employment.

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Department/Contact #</th>
<th>Signature</th>
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<tbody>
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Attachment C: Champion Commitment Form

CHAMPION ROLES AND RESPONSIBILITIES

Champions all approach their role and tasks differently. The following characteristics are commonly demonstrated by Champions and developed during their time as a Champion:

- Interested in promoting well-being
- Approachable by all levels of employees in your department
- Organized in handling multiple tasks
- Respected as a team player
- Influential and inclusive of all colleagues within the department

Being a Champion provides employees the chance to demonstrate their strengths and develop professionally. Champions are fully supported by three full-time, professional Well-Being Coordinators at the Health Service System (HSS).

EXPECTATIONS OF A CHAMPION

Time Commitment

- 2-8 Hours/Month: Champions use a minimum of 2-8 work hours each month to support well-being in the workplace. Those hours are generally able to be completed at times with minimal impact to business needs and priorities.
- 1-Year Commitment: Champion terms are for one year and may be renewed.

Responsibilities

1. Participate in Champion Trainings and Meetings: The HSS Well-Being Coordinators provide a variety of resources and support. Champions can expect monthly interactions with the Well-Being Coordinators in the form of phone meetings, in-person meetings, and periodic trainings at the worksite or HSS. Meetings and trainings are required for Champion and program success. A variety of efforts are made to make these opportunities as accessible to all Champions as possible. Time spent in these activities is included in the 2-8 hours/month time commitment.
2. Walk the Talk: Champions are expected to engage in well-being opportunities at the worksite.
3. Communicate and Promote: Champions spread the word about well-being initiatives and invite participation. They post flyers, send emails, talk with co-workers and make time during meetings to share information about well-being. Champions serve as a primary point of contact for HSS and the department head/designee on matters related to well-being.
4. Celebrate and Recognize Participation: Champions congratulate employees on making well-being a priority. They recognize and praise participation in programs.
5. Report Back: Champions will be asked to provide information in a variety of formats, for example: Well-Being@Work Awards, Spotlights, and surveys. This feedback is essential to HSS being able to improve Well-Being.
<table>
<thead>
<tr>
<th>Champion Commitment Form</th>
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</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td><strong>Title</strong></td>
</tr>
<tr>
<td><strong>Department</strong></td>
</tr>
<tr>
<td><strong>Work Address</strong></td>
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<tr>
<td><strong>Email Address</strong></td>
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<tr>
<td><strong>Phone Number</strong></td>
</tr>
</tbody>
</table>

The Well-Being Champion role requires designated work time hours to effectively perform Champion responsibilities. How many hours of work time (on average) can you commit to each month?

- [ ] 2 – 3 hours
- [ ] 4 – 5 hours
- [ ] 6 – 7 hours
- [ ] 8+ hours

The list below provides examples of Champion responsibilities. Place a check mark in the appropriate box to indicate your level of confidence.

<table>
<thead>
<tr>
<th>Champion Responsibility</th>
<th>I am confident in my ability to perform this responsibility</th>
<th>I may need support to perform this responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Send out Department emails to promote well-being initiatives</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Present well-being information at department meetings</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Host or co-host onsite well-being activities (i.e. seminars and screenings) by reserving rooms and greeting the presenter</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Provide feedback to HSS Well-Being for onsite activities (complete satisfaction surveys and track participation)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Organize at-work group activities (i.e. Meeting stretch breaks, recipe swap)</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

What communication methods will you use to promote Well-Being@Work? (i.e. Emails, department announcements at meetings, flyers)
Suggest 3 ideas that will support a culture of well-being in your department.

CHAMPION COMMITMENT
I agree to actively participate in the actions outlined under "Expectations of Champions" for at least one year, at which time I may have the opportunity to renew.

Employee Signature ___________________________ Date __________

MANAGER APPROVAL
As the employee’s supervisor, I agree to support (INSERT EMPLOYEE NAME HERE) in his/her role as a Champion. I recognize this is a minimum commitment of 2-3 hours monthly and that it may involve periodic training at the Health Service System, 1145 Market St, 1st Fl.

Manager Signature ___________________________ Date __________

Please email this form to Well-Being@sf.gov.org.
SUPPLEMENTAL CREDENTIALING REQUIREMENTS TO MEET NATIONAL COMMITTEE ON QUALITY ASSURANCE (NCQA) REQUIREMENT

POLICY:

1. It is the policy of Laguna Honda Hospital to assess and credential providers.

2. LHH does not delegate credentialing/re-credentialing processes.

3. LHH does not base credentialing decisions on an applicant’s race, ethnic or national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes in.

PURPOSE:

1. The purpose of this policy is to establish a process to assess and credential providers in order to meet NCQA guidelines.

PROCEDURE:

1. **Right to request or receive status update on application.** A practitioner, whose application for initial appointment or reappointment is in process, may request and receive from the Credentialing Office a status update on the application, including what elements may be outstanding to complete the process. Said contact may be either via telephone, in person, or in writing. The Credentials Coordinator will provide the requested information in a timely and courteous manner.

2. **Right to review credentials information.** A practitioner may request to review the information to evaluate his/her credentialing or re-credentialing application. This review will include all outside sources except professional references, recommendations, or other information that is protected under peer review statutes. Such access may be granted during regular business hours and in the presence of the Credentials Coordinator or his/her representative. The practitioner is not permitted to remove or photocopy documentation from the credentials file except what was originally provided by the practitioner upon application.

3. **Right to correct erroneous or inaccurate information.** In the event that credentialing information obtained from primary sources varies substantially from that provided by a practitioner, the practitioner will have the opportunity to correct information in the application, which is inconsistent with information received via primary sources during the credentialing or re-credentialing process. The Credentials Coordinator will inform the practitioner in writing within two weeks of the discrepancy and will return with the letter and a copy of the application submitted outlining the inconsistency. The notice to the practitioner will not include copies from
the National Practitioner Data Bank or protected peer review information. The practitioner has the right to clarify erroneous information received from the verification sources directly with the verifying source. The practitioner shall respond in writing regarding any conflicting information on the application and return a formal response to the Credentials Coordinator within 30 days of receipt of notice. The Credentials Coordinator will re-verify the information until the discrepancy is resolved. If the discrepancy is not resolved within 180 days, the application may be deemed incomplete and be administratively withdrawn.

4. **Right to Request Status, to Review Information and to Clarify or Correct.**
   Practitioners are notified of their rights via a copy of this policy and procedure included in the application and reapplication packet.

5. **Formal Notice of Committee Decision.** Upon final action relative to appointment or reappointment by the Credentialing Committee, a formal notice will be provided to each applicant within 60 days of the decision.

6. Relevant work history must only include work experience as a licensed health professional. Work history must include any work experience as a non-physician licensed health professional, if applicable. Requested information must be provided within 365 days of decision date.

7. Proof of current and valid license to practice must be provided within 180 days of decision date.

8. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner must be provided within 180 days of decision date.

9. Any state sanctions, restrictions on licensure or limitations on scope of practice must be provided within 180 days of decision date.

10. The following documents shall be provided:

Submission of Documents within 180 Days of Decision Date

a. Medicare and Medicaid sanctions (information may be obtained from NPDB, FSMB, OIG, Medicare Exclusion Database, Federal Employees Health Benefits Program department record, OPM, State Medicaid agency or intermediary and the Medicare intermediary.)

b. A current and valid license to practice

c. Applicable Board certification (If the Board does not provide the expiration date for a practitioner’s board certification, the organization must verify that the board certification is current.)
d. A history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner (The delegate must obtain either written confirmation of the past five (5) years of history of malpractice settlements from the malpractice carrier or query the NPDB.)

e. State sanctions, restrictions on licensure or limitations on scope of practice (Information may be obtained from NPDB, State Board of Medical Examiners, Federation of State Medical Boards, or the Department of Professional Regulations; State Board of Chiropractic Examiners or the Federation of Chiropractic licensing Boards; State Board of Dental Examiners; State Board of Podiatric Examiners; California Board of Psychology.)

i. Submission of Documents within 365 Days of Decision Date

f. Relevant work history and work history (Relevant work history must only include work experience as a licensed health professional. Work history must include any work experience as a non-physician licensed health professional, if applicable.)

g. Reasons for inability to perform the essential functions of the position

h. Lack of present illegal drug use

i. History of loss of license and felony conviction

j. History of loss or limitation of privileges or disciplinary actions

k. Current malpractice insurance coverage

l. Current and signed attestation confirming the correctness and completeness of the application

11. Actions in violation of Business and Professional code 805 and 805.01 shall be reported to the California Medical Board and NPDB within 15 days.

**ATTACHMENT:**
None

**REFERENCE:**
Laguna Honda Hospital and Rehabilitation Center Medical Staff Bylaws Rules and Regulations for appointment and re-appointment process.

Original adoption: 17/03/14 (Year/Month/Day)
LAGUNA HONDA HOSPITAL (LHH) PSYCHIATRY DOCUMENTATION AND BILLING GUIDELINE

POLICY:

Laguna Honda Hospital (LHH) Psychiatry providers document all clinical services and submit billing in accordance with pertinent LHH policies, CBHS policies, and state and federal regulations.

PURPOSE:

To ensure that LHH Psychiatry clinical documentation and billing practices meet regulatory and compliance requirements.

PROCEDURE:

1. General Requirements

   a. Documentation is part of the clinical work of all LHH Psychiatry providers. All clinical encounters must be documented.

   b. All clinical documentation by LHH Psychiatry providers are entered in AVATAR.

   c. There are three Reporting Units (RUs) in AVATAR for cases under different payer criteria:

      i. RU 38KJOP: Specialty Mental Health services
      ii. RU 8912ODF: Substance Treatment and Recovery Services (STARS)
      iii. RU LHNSPC: Non Specialty Mental Health and Primary Care Behavioral Health services

   d. Different services in different RUs are provided and documented based on staff service and billing privileges.

   e. Notes under the RUs 38KJOP and LHNSPC are uploaded to eCW according to established protocol. Notes under the RU 8912ODF are NOT uploaded to eCW.

   f. Documentation timeliness
      Documentation for all encounters shall be at least drafted at the end of the business day. All draft notes are to be finalized within 72 hours of the encounter, and submitted in AVATAR. For staff/trainees who require supervision/co-signatures, the documentation must be fully finalized, including the supervisors review/signature, within 72 hours of the encounter, and submitted in AVATAR.
Notes under the RUs 38KJOP and LHNSPC are to be saved for upload within 72 hours of the encounter as well.

g. Billing Codes and LHH Psychiatry Service Encounter Forms

i. All LHH Psychiatry providers shall choose billing codes in AVATAR that are appropriate for the services provided.

ii. In addition to entering billing codes in AVATAR, psychiatrists will use the LHH Psychiatry Service Encounter Form for Psychiatrists, and choose the proper LHH Service Codes for encounters under the RU LHNSPC.

iii. In addition to entering billing codes in AVATAR, psychologists will use the LHH Psychiatry Service Encounter Form for Psychologists, and choose the proper LHH Service Codes for encounters under the RU LHNSPC.

iv. When implemented, in addition to entering billing codes in AVATAR, licensed psychiatric social workers will use the LHH Psychiatry Service Encounter Form for Psychiatric Social Workers, and choose the proper LHH Service Codes for encounters under the RU LHNSPC.

v. Encounter forms shall only be submitted for encounters with finalized documentation in AVATAR. All encounter forms shall be submitted to the LHH Psychiatry Behavioral Health Program Director or designee on weekly basis.

vi. Counselors shall choose billing codes in AVATAR only. No encounter form submission is necessary for counselors.

h. It is each provider’s responsibility to ensure that his/her documentation for each clinical encounter meets the regulatory requirement for the billing code used.

2. Registering New Resident in AVATAR

a. All new residents shall be registered in AVATAR within one business day of the first clinical encounter.

b. At the first encounter, the clinician will search AVATAR to see if the patient already has a chart/BIS number in AVATAR:

   i. If yes, but no current LHH Psychiatry episode is opened, the clinician will open a new episode in the appropriate RU.

   ii. If no, the clinician will open a new chart and a new episode in the appropriate RU.

c. The clinician will inform the designated clerical staff for LHH Psychiatry about the new episode/RU/new chart so that the clerk can complete the AVATAR registration and enter financial information.

3. Paper Record Requirements (Specialty Mental Health and STARS)
a. Designated clerical staff will prepare a new set of paper forms required at initial encounter for each resident with a new AVATAR episode. These will be available at a designated location for LHH Psychiatry Staff. They include, but are not limited to:

i. HIPPA Notice of Privacy Practices
ii. Grievance Process Description
iii. Consent for treatment forms
iv. Authorization to Release Information forms, as appropriate
v. Resident Acknowledgement of Receipt of Materials

Upon completion, the LHH Psychiatry provider will submit to the designated clerical staff all required paper forms with required signatures and the encounter form for filling.

The designated clerical staff for LHH Psychiatry is responsible for filing the paper records, and for forwarding paper records on closed AVATAR episodes to CBHS Medical Records.

4. The “Golden Thread” of clinical documentation

All behavioral health clinical documentation for each resident in each episode must follow the “Golden Thread” steps for documentation, which is a concept in best practice documentation where:

a. The initial screening/assessment provides diagnosis, the information and direction for the treatment plan, then

b. The treatment plan provides direction for service delivery, then

c. The progress notes document the planned services that link to and are ordered by the treatment plan.

This best practice demonstrates a coherent clinical “story” about the care received from the provider that is logical and organized, as well as the resident’s response.

Each of the three components of the Golden Thread must be documented under the three RUs, whether or not a specific AVATAR form or code for each is required by a particular RU.

Crisis services are by definition an unplanned service, and not ordered on a treatment plan. Documentation for crisis services are usually located in a single progress note but shall contain elements of the “Golden Thread,” i.e. assessments, diagnosis, plan and intervention.

5. Admitting vs Attending Practitioner in AVATAR
a. The admitting practitioner is responsible for the initial and annual assessment and Treatment Plan of Care (TPOC). The admitting practitioner can be the psychiatrist, psychologist, social worker or counselor.

b. The attending practitioner can only be a psychiatrist. The attending practitioner is responsible for providing input into the TPOC developed by the admitting practitioner and the resident. For STARS services the attending or an MD with privilege under AVATAR RU 8912ODF must also sign the substance TPOC.

c. In some cases, the admitting practitioner and the attending are the same. This can only happen with a psychiatrist. In this case, the psychiatrist is solely responsible for the initial assessment and TPOC, and the annual assessment and TPOC.

d. Any changes in attending or admitting practitioner status shall be changed using the AVATAR Attending Practitioner Form. It is the provider’s responsibility to do this to ensure the accuracy of his or her caseload by updating the admitting/attending practitioner status in AVATAR.

6. Assessment

a. The initial services for all residents referred to LHH Psychiatry shall result in an assessment of and determination of their needs and willingness to engage in services. These initial services can include pre-admission behavioral screening, triage, screening, and clinical assessment along with motivational visits. ANSA rating must be completed in Avatar along with the Assessment.

b. All payers have specific requirements regarding the content and complexity of the initial assessment.

i. For Specialty Mental Health and STARS services, specific forms in AVATAR are to be used.

ii. For Non-Specialty Mental Health services, the Specialty Mental Health assessment in AVATAR shall be used.

iii. For Primary Care Behavioral Health, the Progress Note form in AVATAR shall be used to document the assessment. See coding manual for required elements.

c. For billing purposes, a separate progress note must accompany each finalized assessment form in AVATAR. The content of the note only needs to record the completion of the form. Any efforts to gather additional background from LHH staff, family, medical records, etc. for this assessment shall be billed in a separate progress note that states “Administrative Time for completing assessment”. All information gathered in this administrative time shall be included in the body of the assessment.
d. Timeliness:
The clinician shall determine and document medical necessity for services through screening within 5 business days of the case referral to LHH Psychiatry. Within 15 business days of medical necessity determination, the clinician shall complete and finalize a full assessment, a treatment plan (see below) and initiate planned treatment.

e. Signature Requirement
Signatures from both the provider and the resident are required on the TPOC (SMH). This is a minimum requirement for demonstrating resident participation in creating the TPOC. Best practice is that the provider assesses the resident goals for treatment in every session and document them. The goal is to formulate treatment objectives in the early sessions and document those in the assessment notes, which is the high-quality evidence of resident participating in development of goals.

Provider signature is required on Assessment Form (Specialty Mental Health and STARS). See LHH Psychiatry Coding Manual.

f. Updates and required intervals
Assessments (with new ANSA and Diagnosis form) and TPOCs must be done at least annually no earlier than 30 days prior to and no later than the episode opening anniversary date, with signatures from both the provider and the resident on the TPOC, and from the provider on the Assessment. See LHH Psychiatry Coding Manual.

7. Diagnosis

The resident’s diagnosis(es) shall be documented in AVATAR using the Diagnosis Form, in addition to documentation in progress notes and assessments. Time spent recording the diagnosis in the AVATAR form shall be counted along with the time spent completing the AVATAR assessment form.

First diagnosis shall be entered at the time of episode opening in an AVATAR RU. Non-specific diagnoses can be used to bill for screening, triage, and initial assessment visits. (See LHH Psychiatry Coding Manual.)

A specific and complete diagnosis is required at the time the assessment is finalized.

8. Treatment Plan of Care

a. A TPOC shall be developed for all residents who need ongoing treatment services from LHH Psychiatry providers.

i. For each RU a resident is registered in, a TPOC is required that covers all planned services in that RU.
ii. Within the same RU, multiple providers shall coordinate and produce a single comprehensive TPOC.

b. All payers have specific requirements regarding the content and complexity of the treatment plan of care.

i. For Specialty Mental Health and Non-Specialty Mental Health, the Adult/Older Adult MH Treatment Plan of Care form in AVATAR is to be used.

ii. For Primary Care Behavioral Health, the Progress Note form in AVATAR shall be used to document the treatment plan. See LHH Psychiatry Coding Manual for required elements.

iii. For STARS, the designated form in AVATAR is to be used.

c. A separate progress note must accompany each finalized TPOC form. The content of the note needs to record the completion of the form, and efforts to obtain the resident's signature (if the resident is not able/willing to sign the TPOC initially).

d. Timeliness:
   In cases where the resident is willing and able to receive services, the clinician shall complete a full assessment, finalize a TPOC and initiate planned treatment within 15 business days of medical necessity determination.

   In cases where the resident is unwilling/unable to receive services, the clinician shall make attempt to re-approach the resident as clinically indicated, and complete a full assessment, finalize a TPOC and initiate planned treatment as soon as possible, but no later than 60 days from the AVATAR episode opening. If the resident remains unwilling/unable to receive services within 60 days, the AVATAR episode is closed. The resident may be referred again for services at a later time.

   In cases where the resident is deemed to not meet medical necessity for services through the assessment process, a TPOC is not required. The Psychiatry provider shall communicate the medical necessity determination to the referring primary care physician and close the AVATAR episode within 60 days from the episode opening.

e. Signature Requirements

i. For Specialty Mental Health and Non-Specialty Mental Health, both the provider and resident signatures are required. See LHH Psychiatry Coding Manual.

ii. For STARS, an MD must sign the Treatment Plan of Care, in addition to the provider and the resident. See LHH Psychiatry Coding Manual.
f. Updates and required intervals
   TPOCs must be updated at least annually, more frequent if needed. Signatures from both the provider and the resident are required. See LHH Psychiatry Coding Manual.

9. Progress Notes

   A progress note shall be completed for every clinical encounter either with the resident or with others about the resident’s clinical care (e.g. family members, other providers and members of the RCT).

   A separate progress note must accompany each completed Assessment and TPOC forms. The content of these notes only need to record the completion of these forms. Behavioral consultations and Behavioral Plans shall be documented using a Progress Note form.

10. Discharge and Closing the AVATAR episode

   a. Upon the resident’s discharge from the LHH Psychiatry service, the provider shall complete the AVATAR Closing form for the appropriate RU:

      i. Specialty Mental Health (38KJOP):
         A Closing Summary with a new ANSA is required in Avatar for residents who have received more than 5 services in the episode.
      ii. Substance (8912ODF):
         - A discharge plan with required elements must be completed within 30 days prior to the last face-to-face treatment.
         - For unplanned discharge, a discharge summary with required elements is required within 30 days after the last face-to-face treatment.

   b. The clinician will inform the designated clerical staff for LHH Psychiatry about the resident’s discharge so that the clerical staff can complete closing of the AVATAR episode.

11. The following best practices for documentation must be followed:

   a. Individualized: Each note must be individualized. Notes which contain the same content from visit to visit or from one resident to the next are called “cloned” notes. Cloned notes shall NOT be submitted for billing as they do not meet medical necessity criteria.

   b. Stand alone: Each progress note must “stand alone” for auditing purposes. That is the auditor must be able to look at the note alone and determine that the service provided is medically necessary. This is usually done by linking the note and its contents to the TPOC. That linkage provides the evidence that the service
provided has been ordered on a plan of care as determined by a licensed provider.

c. Timely completion: Best practice for finalization of documentation is on the same day of the clinical encounter. If documentation cannot be completed on the same day, it is required to be completed with 72 hours of the encounter. After 72 hours, the note shall be labeled “[Late Entry]” at the beginning of the text.

d. Timely submission of encounter forms: Best practice is to complete and submit encounters forms at the end of each work day. Encounter forms are required to be submitted at least weekly. Encounter forms shall only be submitted if the documentation is complete and finalized in AVATAR.

12. The following practices must be avoided:

a. Cloning of documentation: see above under individualized

b. Submitting encounter forms before the services are documented or notes finalized

c. Failure to submit an encounter form after the services are documented

d. Use of “prn” or “as needed” in the interventions section of the TPOC

13. Quality Assurance

The LHH Psychiatry Behavioral Health Program Director oversees documentation and billing compliance in consultation with the Chief of Psychiatry. The Program Director/designee shall monitor LHH Psychiatry clinicians’ documentation and billing practices as well as provide feedback to clinicians on a regular basis, in order to ensure that documentation and billing practices meet compliance standards. Monitoring reports will be made to LHH Compliance Committee as needed.

ATTACHMENT:
None

REFERENCES:
CBHS Provider Documentation Manual
CBHS Substance Treatment Documentation Manual
LHH Psychiatry Coding Manual
LHH Psychiatry Encounter Forms

Original adoption: 17/03/14 (Year/Month/Day)
MENTAL HEALTH SERVICES

POLICY:

LHH Psychiatry provides specialty and non-specialty mental health services, as part of the comprehensive behavioral health services, for LHH residents with mental health needs.

PURPOSE:

Mental health services from LHH Psychiatry are to:

1. Help identify the resident care needs as expressed through psychiatric symptoms and resulting behavioral and functioning impairments, and identify professional clinical interventions to meet those needs;

2. Provide specialized interventions to reduce the resident’s suffering from mental health symptoms;

3. Assist and empower the resident in developing appropriate illness management and coping skills to move toward further recovery;

4. Be integrated with treatment and interventions by the Resident Care Teams (RCT).

5. Be integrated with services and consistent with standards by Community Behavioral Health Services.

DEFINITIONS:

1. “Mental Health Services” means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. Mental Health Services may be either face-to-face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community. At LHH, these are provided by designated mental health providers to address residents’ functioning impairments resulting from mental illnesses (see covered diagnosis by California Department of Health Care Services). This includes Specialty Mental Health and Non-specialty Mental Health Services. See MSPP D08-02 LHH Psychiatry Scope of Services and Organization, Attachment 1, Behavioral Health Medical Necessity.

2. Providers of mental health services at Laguna Honda Hospital are LHH Psychiatry providers with appropriate scope of practice as defined by the State of California, and
either as credentialed by LHH Medical Staff Service (if medical staff) or credentialed by CBHS (medical and non-medical staff).

PHILOSOPHY AND APPROACH:

LHH Psychiatry’s philosophy and approach for mental health services are aligned with the philosophy of care of SFHN and Community Behavioral Health Services, in that they are resident-centered, recovery-oriented, strengths-based, trauma-informed, with cultural humility to reduce stigma for residents with mental health care needs. Our central focus is meeting the residents’ care needs, reducing barriers for positive clinical outcomes, and facilitating the resident’s function at the least restrictive level of care.

PROCEDURE:

1. Access to LHH Psychiatry Mental Health services

All requests for LHH Psychiatry Mental Health services shall be made through the e-referral process. Urgent and crisis intervention requests shall be made through the LHH Psychiatry Urgent Pager. See MSPP D08-03 Access to LHH Psychiatry Services.

2. Levels of Mental Health Services: Specialty vs. Non-Specialty Mental Health

   a. Mental health services at LHH are to address the residents’ functioning impairment resulting from mental illnesses (as defined by covered diagnosis by California Department of Health Care Services). The differences between specialty and non-specialty mental health services are the level of functioning impairment (i.e. significant functioning impairment – specialty mental health, mild to moderate functioning impairment – non-specialty mental health).

   b. It is the responsibility of the assigned LHH Psychiatry provider to determine and provide the level of mental health services a resident may need based on the resident’s functioning impairment as a result of his/her mental illness.

   c. The level of mental health services shall be provided in accordance to the resident’s assessed level of functional impairment. E.g. if a resident is assessed to have functioning impairment severe enough such that the resident is unable to provide food, clothing and shelter due to his/her mental illness, and thus requires LPS conservatorship, the resident shall be provided specialty mental health services accordingly. Residents shall not be denied access to appropriate level of mental health services.

   d. While residents may qualify for different level of mental health services based on the level of functioning impairment, the basic components and documentation expectations are similar for both specialty and non-specialty mental health services provided by LHH Psychiatry providers.
3. **Components and Delivery of Mental Health Services** (see Attachment 1)
   a. Mental health assessment and re-assessment
   b. Diagnosis
   c. Treatment planning
   d. Unplanned services
      i. Crisis intervention
   e. Planned services:
      i. Psychotherapy/Counseling, individual and group
      ii. Mental Health Rehabilitation, individual and group
      iii. Family Therapy
      iv. Collateral Services
      v. Targeted Case Management
      vi. Medication Support (See MSPP D01-05 Psychotropic Medication Management)

4. **Service Discontinuation and Discharge**
   Once the provider determines that the resident no longer meets medical necessity for mental health services, the services will be discontinued and resident will be discharged from LHH Psychiatry mental health services. The resident may continue to receive other services from LHH Psychiatry (e.g. under STARS or Primary Care Behavioral Health). The provider shall notify the resident’s primary care physician about the service discontinuation, and complete discharge documentation.

5. **Documentation and Billing**
   Documentation for Mental Health Services will be completed in the designated electronic health record (EHR) for LHH Psychiatry, and uploaded to the Laguna Honda primary care EHR for the RCTs’ access. LHH Psychiatry staff shall follow the compliance and documentation standards for Mental Health Services. See MSPP D08-05 LHH Psychiatry Documentation and Billing Guideline.

**ATTACHMENT:**
Attachment 1: Mental Health Service Components

**REFERENCE:**
MSPP D08-01 Psychiatric Emergencies
MSPP D08-02 LHH Psychiatry Scope of Service and Organization
MSPP D08-04 Access to LHH Psychiatry Services
MSPP D01-05 Psychotropic Medication Management
MSPP D08-05 LHH Psychiatry Documentation and Billing Guideline
LHH Psychiatry Coding Manual
CBHS Specialty Mental Health Services Documentation Requirements At-A-Glance

Original adoption: 17/03/14 (Year/Month/Day)
ATTACHMENT 1. MENTAL HEALTH SERVICE COMPONENTS

1. Assessment and Re-assessment

   a. Definition
      “Assessment” means a service activity designed to evaluate the current status of a resident's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the resident's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures CCR, Title 9, 1810.204.

   b. The assessment is conducted prior to the provision of any planned mental health services.

   c. The information contained in the assessment is used to develop the treatment plan.

   d. The mental health assessment and re-assessment process is comprised of the evaluation/analysis of client’s historic and current mental, emotional, and/or behavioral disorders and includes mandated components including:

      i. Presenting Problem
      ii. Relevant Conditions/Psychosocial Factors
      iii. Mental Health History
      iv. Medical History
      v. Medications
      vi. Substance Exposure/Substance Use
      vii. Resident’s strengths
      viii. Risks
      ix. A Mental Status Examination
      x. A Complete Diagnosis
      xi. Any additional clarifying information

   e. In addition to the above, assessment process includes gathering and analyses of any relevant family, cultural, medical, substance abuse, legal and/or other complicating factors pertinent in developing a clinical formation and establishing the diagnosis. Other testing procedures may be used when indicated and medically necessary.

   f. The assessment of the resident's mental status examination, development of diagnosis, performance of psychological testing, and development of the clinical formulation must be completed by a credentialed clinician and consistent with his/her scope of practice.

   g. The mental health reassessment process is conducted on a regularly scheduled annual basis and/or when there is a noted change in the resident's condition,
circumstances, level of functionality or a marked change in symptoms and behaviors.

2. Diagnosis

A comprehensive assessment of the resident’s functioning, living situation, history of physical, emotional, social and psychological functioning will lead to the most accurate diagnostic formulation. Mental health diagnoses are made by qualified clinicians based on DSM 5 criteria. A good diagnostic formulation supports compliance with regulations by documenting behavior and psychological impairments that significantly impair social and psychological function and substantiates medical necessity.

The following cannot be used for a primary diagnosis when billing planned mental health services: V-codes, Deferred codes, Rule-outs, Excluded diagnoses, and Non-psychiatric codes.

3. Treatment Plan Development

a. Definition:
   “Plan Development” means a service activity that consists of development of resident’s mental health service plans, approval of the resident’ plans, and/or monitoring of the resident’s progress CCR, Title 9, 1810.232.

b. The mental health Treatment Plan of Care (TPOC) is developed in collaboration and participation with the resident and all treatment providers, and it outlines the course of treatment including services and specific interventions to be provided to the resident during the course of care.

c. The treatment planning process includes activities designed to develop, evaluate or modify a resident’s treatment plan including:
   i. Meetings/phone calls with the individual, family and significant others about the plan;
   ii. Consultation (not clinical supervision) with other professionals who can contribute to the development of the plan; and
   iii. Case conferences or RCT meetings with or without the resident present to discuss plan development or modification.

d. The Initial Treatment Plan of Care (TPOC) is to be completed no later than 60 days from the date of opening the case or prior to the delivery of any “planned” mental health services (Individual, Group, Case Management, Medication Support, Collateral, etc.), whichever comes sooner.

e. All provided mental health service must be covered by a current and valid TPOC.
In order to bill planned services, a TPOC, complete with the resident’s signature indicating evidence of the resident’s participation in the formulation of the plan must be in place or explanation of why resident was unable to participate in plan development. Evidence of continued subsequent efforts to obtain resident’s participation and signature on the TPOC must be documented in the progress notes.

If there is a lapse between TPOC expiration and renewal dates, then services occurring during the lapse cannot be billed and will be disallowed.

f. All TPOCs are to be updated at least annually or as needed based on changes in resident’s status, diagnosis, and assessment. The TPOC must be updated any time there is a significant development or change in the focus of treatment. If this happens mid-year, the existing TPOC can be updated by adding the new information and goal(s)/objective(s) with a date and client signature. If there is a major change, a new TPOC may be necessary.

g. Medication support services clients also require a Treatment Plan of Care (TPOC). “Meds Only” TPOC is required to be developed at the time of service initiation and reviewed at least annually. “Meds Only” TPOC shall include medication compliance goals including self-management and active participation. Medication support progress notes must document the resident’s medication plan goals, and address progress or lack of progress towards these goals.

h. All TPOCs must be developed using person-centered principles.

i. The following are required elements for a TPOC:

   i. Specific Goals/Objectives
   ii. Proposed Interventions and Detailed Description
   iii. Frequency of Interventions
   iv. Duration of Interventions
   v. Focus of Interventions
   vi. Consistency of Interventions with Objective
   vii. Consistency with Qualifying Diagnosis
   viii. Staff Signatures (or LPHA) and Co-Signatures (for non-LPHA)
   ix. Resident Participation and Agreement with TPOC
   x. Evidence of Offering Copy of Plan to the Resident
   xi. Dates and Staff Signature, Degree, and Title/Licensure on TOPC

4. Crisis intervention

   a. Definition

   “Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a resident for a condition that requires more timely response than a regularly
scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy CCR, Title 9, 1810.209.

b. Crisis Intervention is an unplanned service that results in the evaluation of resident’s need for an immediate and/or emergency response to enable the resident and RCT to cope with the presenting circumstances. (See MSPP D08-01 Psychiatric Emergencies and MSPP D08-10 Behavioral Management Services by LHH Psychiatry, Attachment 1. Behavioral Consultation Protocol).

5. Psychotherapy/Counseling

a. Definition

“Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of residents and may include family therapy at which the resident is present CCR, Title 9, 1810.232.

Psychotherapy uses psychosocial methods within a professional relationship to assist the resident or residents to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, and to modify internal and external conditions that affect individuals, groups, or family. Business and Professions Code Section 4996.9

b. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention DMH/MHP Contract Exhibit A-Attachment 1-Section W-4.a-d.

c. All psychotherapy/counseling services must be documented and covered by a current and valid TPOC. All psychotherapy/counseling service interventions work towards measurable goals and objectives specified in the resident's treatment plan.

d. Individual psychotherapy/counseling

i. These are clinical direct care service activities comprised of therapeutic interventions that focus primarily on symptom reduction and management as a means to improve functional impairments and/or manage distress from a mental illness.

ii. Individual psychotherapy/counseling are planned, structured, scheduled face-to-face treatment of the resident’s diagnosed mental illness. Services are provided using those psychological, psychiatric, and/or interpersonal methods most appropriate to the resident’s needs according to current community standards of mental health practice, evidence-based and best practices.
iii. Individual psychotherapy services are face-to-face services with the patient and/or a family member(s). The resident must be present for some or all of the service.

e. Group Psychotherapy/Counseling
   i. Group psychotherapy/counseling is a clinical direct care service activity comprised of therapeutic interventions that focus primarily on symptom reduction and management as a means to improve functional impairments and/or manage distress from a mental illness.
   ii. A credentialed provider delivers group psychotherapy/counseling services to selected residents. Group participants are evaluated as clinically appropriate for group because of their emotional, behavioral, or social dysfunctions can derive benefit from treatment in a group setting.
   iii. Group psychotherapy/counseling is a form of treatment in which a selected group of approximately 8-10 clients are guided by a credentialed provider for the purpose of helping to effect changes in maladaptive patterns which interfere with functioning and are associated with a diagnosable psychiatric illness.
   iv. Group psychotherapy/counseling are provided using those psychological, psychiatric, and/or interpersonal methods most appropriate to the group participants’ needs according to current community standards of mental health practice, evidence-based and best practices.

f. Interactive Complexity in Psychotherapy/Counseling
   i. Definition: “Interactive Complexity” is an add-on service code that is used to signify that the psychotherapy session (individual or group) included communication factors that complicated the delivery of the service. The code may not be used on its own.
   ii. Interactive complexity usually will involve one or more of the following:
      - The use of a language translator or a request by the resident that others be involved in their care.
      - The use of assistive devices for residents who require these for communication.
      - The resident has other individuals who are legally responsible for their care, or
      - The service requires the involvement of other third parties

6. Mental Health Rehabilitation
   a. Definition
   “Rehabilitation” means a service activity which includes, but is not limited to improving, maintaining, or restoring a beneficiary’s or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education CCR, Title 9, 1810.243.
b. Mental health rehabilitation services are those that are primarily focused on the development of medically necessary skills needed to maintain the individual resident in the least restrictive environment possible. These services differ from psychotherapy/counseling that focus primarily on symptom reduction as a means to improve functional impairments.

i. A credentialed provider delivers mental health rehabilitation services. The provider has the appropriate competencies and scope of practice to deliver the services.

ii. Mental health rehabilitation services are usually curriculum-based in that the skill is broken down into reasonably achievable steps that are taught in order. Rehabilitation services usually include both didactic teaching and interaction/practice so that the skill is actually demonstrated by the resident allowing the provider to give constructive feedback, modeling and coaching to enhance the resident’s confidence and ability to use the skill in appropriate situations or environments.

iii. Mental health rehabilitation services often involve assigning the resident “homework” so that practice and skill development can continue in between sessions with the provider.

iv. Mental health rehabilitation are planned, structured, scheduled, face-to-face treatment of the resident’s functional impairments due to his/her diagnosed mental illness.

v. Services are provided using rehabilitation techniques and strategies most appropriate to the resident’s needs according to current community standards of mental health practice, rehabilitation-oriented evidence based and best practices.

vi. All services and proposed interventions must be documented and covered by a current and valid TPOC. All mental health rehabilitation service interventions are directed to accomplish measurable goals and objectives specified in the resident’s treatment plan.

c. Group mental health rehabilitation are services provided by credentialed provider to selected residents.

i. Group participants are evaluated as clinically appropriate for group because of their emotional, behavioral, or social dysfunctions that can derive benefit from treatment in a group setting.

ii. Group mental health rehabilitation is a form of treatment in which a selected group of approximately 10-12 clients are guided by a credentialed provider for the purpose of helping to effect changes in maladaptive patterns which interfere with social functioning and are associated with a diagnosable psychiatric illness.

7. Family Therapy

a. Definition
i. Family therapy is a clinical direct care service activity comprised of therapeutic interventions directed towards the family system as a strategy to support the resident in symptom reduction and management, skill development and mastery and functional improvement in those life domains impacted by the resident’s as diagnosed mental illness. Family therapy can be provided with or without the resident present and is delivered by a credentialed provider with the appropriate competencies and scope of practice to deliver the services.

ii. Family is defined as:

- Immediate family members – nuclear, extended and including domestic partners
- Primary caregivers who provide these services regularly, on an extended basis and are not compensated.
- Guardians or health care proxies

b. In family psychotherapy, the family is brought into the therapeutic treatment process. Dynamics within the family structure as they relate to the resident are the main theme of this type of psychotherapeutic session. The emphasis is on the resident’s care but therapy is aimed at the interactions with family system and the environment to which the resident may be discharged.

c. Family therapy are planned, structured, scheduled, face-to-face treatment of the resident’s diagnosed mental illness. Services are provided using those psychological, psychiatric, and/or interpersonal methods most appropriate to the resident’s needs and the family dynamics according to current community standards of mental health practice, evidence based and best practices. All services and proposed interventions must be documented and covered by a current and valid TPOC. All family therapy are directed to accomplish measurable goals and objectives specified in the resident’s treatment plan and for the exclusive benefit of the resident.

8. Collateral Services

a. Definition

“Collateral” means a service activity to a significant support person in a resident’s life for the purpose of meeting the needs of the resident in terms of achieving the goals of the resident's plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services education by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

9. Targeted Case Management
Targeted Case Management are those specialized mental health case management services to assist the resident in accessing needed mental health services. These service activities may include, but are not limited to:

a. Communication, coordination, and referral;

b. Monitoring service delivery to ensure access to continued services and the service delivery system;

c. Monitoring of the beneficiary’s progress; and

d. Plan development.

10. Medication Support

a. Definition

“Medication Support Services” means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the resident \(^{CCR, \text{Title 9, 1810.243}}\).

b. See MSPP D01-05 Psychotropic Medical Management for medication support services for LHH residents with mental health needs.

c. These services may be provided face to face or via phone by a credentialed provider whose scope of practice includes one or more of the services included in the definition of medication support.
COMMUNITY OUTING PROGRAM

POLICY:

1. The Activity Therapy Department plans, coordinates and implements community outings for residents of Laguna Honda Hospital (LHH).

2. Staff other than Activity Therapy staff may lead resident community outings when appropriate.

3. Department managers are responsible for providing staff with necessary safety training prior to outings according to Outing Safety Guidebook.

PURPOSE:

The goals of the program are to:

1. Provide safe, meaningful outdoor-off-campus community experiences and to enhance the quality of life for residents.

2. Reduce the isolation resulting from long-term hospitalization.

3. Promote a sense of normalcy though contacts with the surrounding community.

4. Promote the reintegration of residents back into the community by providing an opportunity for skill building and self-efficacy.

PROCEDURE:

1. Types of Outings
   
a. Neighborhood group outings
      Group outings (with 6 or more attendees) led by the assigned Neighborhood Activity Therapy team.

b. City tours
   Small group City Tours outings (between 1-3 attendees) are generally coordinated by the assigned Neighborhood Activity Therapist/Nursing and staffed by nursing. The goal of the outing is to provide opportunities for residents who, due to medical or behavioral challenges, have difficulty participating in the typical neighborhood group outings.

c. Discharge related discharge community re-integration outings
   These are individualized outings designed to support the resident’s community re-integration.

d. Hospital-Wide specialty trips
These are special community outings that result from the purchase or donation of special event tickets, special activity or community event that involve residents from one unit or more than one unit and are led by someone other than the residents’ Activity Therapist. This is also an opportunity for a select group of residents with particular interests, for example ball games, to socialize in the community.

2. Education and Training

a. List of mandatory education/training and certification/licensure for bus drivers:

i. CNA certification;
ii. Basic Life Safety CPR certification;
iii. Class B driver’s license;
iv. Trained to complete vehicle safety checks prior to each trip using the Driver’s bus condition report;
v. Complete initial and annual competency training;
vi. Trained to manage vehicle operations within the bus; and
vii. Trained to complete the driver checklist prior to departure and evaluation section upon return from community outings.

b. List of mandatory education and training for Activity Therapists:

i. Orientation training on procedures including the “Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request” (Outing Planning Guide) form, the “Staffing guidelines for community outingsOuting Safety Guidebook”, Restaurant outing list information, funding Community Outing Protocols;
ii. Orientation to the Driver competencies and checklist;
iii. Scheduled to shadow veteran-trained AT staff on a trip to see environmental safety assessment during the trip, etc;
iv. Provided opportunity to practice using muni with residents;
v. AT Supervisor and/or Outing Coordinator assessment and approval of staff;
vi. Orientation to the Driver competencies and checklist;
vii. If using driving the van, provide proof of a driver’s license and complete/pass a an initial van competency test.

c. Nurse Managers and Charge nurses are provided instruction on the “Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request” form and the “Outing Safety GuidebookStaffing guidelines for community outings”.

d. Staff who regularly attend outings shall participate in annual trainings, review best practices, evaluations of new destinations and practice emergency procedures which includes from the Outing Safety Guidebook a safety guidebook.
All staff and volunteer(s) participating in any outing shall attend a pre-outing safety huddle prior to departure.

Family members and volunteers participating in any outing shall receive individual instructions related to the outing by staff who is leading the outing.

Volunteers participating in an outing are required to receive safety instructions from the bus drivers.

3. Transportation

Several methods of transportation can be used to facilitate the above outings and may include the following:

a. The Bus: The Environmental Services Department (EVS) maintains buses that require a class B license to operate. They are inspected by the drivers each day they are used for an outing and are maintained by the city vehicle maintenance shop. Drivers are CNA certified.

b. Van/Car: The Activity Therapy Department has a small wheelchair accessible van that can accommodate a small trip group outing. It is also maintained by the city EVS. Orientation and training is provided by a supervisor to staff outing coordinator prior to use. Staff using van will inspect the vehicle before each use.

c. Muni: Public transportation is used when providing training to residents discharge or re-integrating into the community. Training for muni use is provided by shadowing another staff member in the AT Department.

4. Planning

The Activity Therapy staff are responsible for leading the overall outing effort, which includes focusing on resident enjoyment and safety, securing offsite logistics, facilitating operational procedures and coordinating support staff. Planning activities include coordinating the steps described below:

a. Creating and coordinating a monthly quarterly schedule of outings.

b. Using the “Therapeutic–Outing Planning Guide, Resident Assessment and Bag Lunch Request” form, the staff member and Nurse Manager or designee determines the residents who are scheduled to attend the outing, costs and other resources needed to support the activity, and processes the paperwork prior to the scheduled outing. The form includes consideration of the ten items listed below:
i. Physician order to participate – A resident must be living at LHH Laguna Honda for at least two weeks before being considered for participation in an outing for a resident to participate.

ii. Dietary limitations;

iii. Resident supervision – Prior to the day of the community outing, the team determines the level of supervision necessary for each resident attending and reviews the precautions needed for each resident;

iv. DNR status;

v. Bag lunch request if needed;

vi. Volunteer(s) request – All volunteers are processed through the Volunteer department;

vii. Funding request by AT staff;

viii. Nursing Manager’s signature – Signifies that the list of residents and clinical information has been reviewed and there is agreement on participation;

ix. Activity Therapy Supervisor’s signature – Signifies that the form has been correctly completed, the trip is deemed appropriate for the planned goals it’s being planned for and that other operational needs are addressed;

x. Prior to going on the community outing, nursing re-assesses the resident for any issues that may preclude their participation.

Using the “Staffing guidelines for community outings” Prior to the outing, Nursing and AT Activity Therapy staff and Nursing staff determine the necessary staff support for a safe and enjoyable outing.

Activity Therapy staff are responsible for:

- Obtaining receipts for compliance with City Controller’s requirements.
- Adhering to the spending guidelines to control costs by creating an outing budget, and monitoring the spending. Activity Therapy are responsible for managing the usage of FastTrak provided by the Accounting Department.

Activity Therapy staff collaborates with the resident to determine the resident’s personal spending options to meet the resident’s outing goals or discharge related needs.

Activity Therapy staff collaborates with Rehabilitation staff to address functional improvements and potential appointment conflicts.

Activity Therapy staff collaborates with interested family members to confirm that spending guidelines and safety measures will be followed.

5. Day of the Outing

a. Funds for the outing are provided to the Activity Therapist by the Activity Therapy Department Supervisor, as needed.
b. Activity Therapy staff meet to review the planning form and discuss logistics.

e. Activity Therapy and neighborhood nursing staff huddle to review residents for changes in condition, supervision needed and staffing support.

d. Residents who are assessed as unable to go out on pass independently shall receive, at minimum, line of sight close observation supervision for safety during community outings.

e. Buses are loaded outside of the main lobby at one of two designated loading areas (North loading dock area and outside the chapel).

f. Drivers complete the Checklist of the “Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request” form.

g. After the outing, all Activity Therapy staff who participated in the outing will promptly submit attendance and/or funds debrief and submit receipts to AT Supervisor to process. AT Supervisors will complete the Gift Fund Reimbursement form.

h. In case an incident occurs that results in a resident injury or poses a safety risk occurs, a debrief on the neighborhood shall be conducted immediately upon return, and an Unusual Occurrence report submitted.


Canceling Outing

Cancellations

a. Canceling an outing is up to the discretion of the any Supervisor. Weather, staffing, and other safety issues should be considered when canceling an outing.

b. After the outing is cancelled, AT staff responsible for that outing shall do the following:
i. When canceling an outing, staff is to cancel lunch requests from the kitchen.
ii. Notify venue of cancelation, as needed.
iii. Notify volunteers shall be notified of the cancelation.
iv. Notify other staff disciplines involved in the outing shall be notified.

6.7. Safety Protocol

a. Standard emergency protocol for CPR and first aid shall be used for medical emergencies. 911 emergency services shall be called as necessary.

b. The neighborhood Nurse Manager or Charge Nurse, and the Activity Therapy supervisor shall be contacted immediately when an untoward-unusual event or medical emergency occurs for decision support in addressing the needs of the group.

7.8. Evaluation and Quality Assurance

a. Outings coordinated by the Activity Therapy Department are monitored by Activity Therapy Supervisors who regularly assess the safety and quality of outings.

b. Community outing data is collected and tracked by the Activity Therapy Department.

c. Data is shared with the Activity Therapy staff and neighborhood nursing leaders.

d. Information is used to develop ongoing training.

e. Clinical events that occur during the outing shall be reviewed by the Resident Care Team, no later than the next business day.
ATTACHMENT:
None

REFERENCE:
LHHPP 24-01 Missing Resident Procedures
LHHPP 76-02 Smoke and Tobacco Free Environment
CPR and First Aid for health care providers guidelines
Driver’s bus condition report
Laguna Honda initial and annual bus driver competency checklist
Staffing guidelines for community outings
Therapeutic outing planning guide, resident assessment and bag lunch request
Van trips management competency checklist

Revised: 17/03/14 (Year/Month/Day) N/A
Original adoption: 15/05/12 (Year/Month/Day)
SECTION 1: Planning

Outing Program Goal: to enhance the resident’s quality of life by providing community outings that are safe and enjoyable.

This section will review the safety considerations during the planning process for Therapeutic Outings.

1. What are the different types of Therapeutic Outings?

It is very important for Neighborhood Resident Care Teams (RCTs) to understand the different types of outings we offer. This way, Neighborhood teams can effectively determine the operations needed to ensure safe practices. Specifically for the following:

1. Staffing ratio - How many staff will determine how many residents should attend.
2. Management of clinical considerations - Determines the degree of assistance needed for outing participants.
3. Communication: e.g., how safety guidelines get communicated - Very important to have cohesive team. Team members need to communicate well to ensure the utmost safety for the outing participants.

1. Different types of Therapeutic Outings

There are 4 types of outings, each with different clinical emphases:

A. Neighborhood

Group outings led by the assigned Neighborhood Activity Therapy team and staffed by Nursing.

B. City Tour

City Tours are coordinated by the assigned Neighborhood Activity Therapist (AT) and Nursing and staffed by Nursing. The goal of the City Tour is to provide an inclusive outing opportunity for residents who are unable to be away from the neighborhood for a long period of time. The goal of the outing is to provide opportunities for residents who, due to medical or behavioral challenges, have difficulty participating in the typical Neighborhood outing. How about saying: “The goal of the City Tour is to provide an inclusive outing opportunity for residents who are unable to be away from the neighborhood for a long period of time.” -- this way we are not only targeting these for patients with medical or behavioral challenges (?) it didn’t sound right to me the way I’m reading above

C. Small Group/Discharge

Small group/discharge outings are led by ATs and other disciplines such as Rehabilitation, Nursing, and/or Social Services. These outings are
individualized outings designed to support the resident's preparation for discharge and community re-integration.

D. Hospital-Wide

Hospital Wide outings are led by ATs or Spiritual Services. These outings are special community outings that result from the purchase or donation of special event tickets, special activity or community event that involve residents from one unit or more than one unit/neighborhood. This is also an opportunity for a select group of residents with particular interests, for example Handicapables events or ball games.

A. Neighborhood group outings—Group outings (with 6 or more attendees) led by the assigned Neighborhood Activity Therapy team. These outings last approximately 3-5 hours per outing. Attendees are generally from, but not limited to, one specific neighborhood. Goal of this outing is to engage residents in the community & allow them to participate in and enjoy some of the Bays Area's educational, social and cultural activities. Clinically, it is recommended most of the residents are able to tolerate large groups, with some being more independent with their ADL’s. If more assistance needed for each resident, then staffing ratio should be reviewed.

B. City tour outings (aka Clinically Complex)—Smaller group outings (between 1-3 attendees) are coordinated by assigned Neighborhood Activity Therapy staff and implemented by nursing. Goal of outing is to provide opportunities for residents who, due to medical or behavioral challenges, have difficulty participating in the neighborhood group outings. These outings generally occur 1x a month per neighborhood, lasts approximately 2 hours.

C. Discharge related/ community re-integration outings—Individualized outings designed to support the community re-integration efforts of residents. These outings are generally 1 to 1 or 1 to 2 staff to resident ratio.

D. Hospital-wide specialty trips—Unique opportunities for community outings that result from the purchase or donation of special event tickets, special activity or community event. This is also an opportunity for a select group of residents with particular interests to socialize in the community.

2. How should the Outing Planning Workflow look?

Neighborhoods are encouraged to have formalize discussions among the clinical team (i.e. AT, Charge Nurse, PCA/CNA, Social Work) to—and complete the Planning form together. The planning form will highlight state who the targeted/potential residents outing participants/residents will be...
and develop an appropriate approach for their clinical needs. The outing planning form will be signed by Charge Nurse or Nurse Manager and AT Supervisor as a verification that a thorough review of precautions has occurred and needed resources are requisitioned. A copy of this form will be left at the Nurses station (via calendar or binder—this needs to be standardized for every neighborhood to reduce variation). Nurse managers and AT Supervisors are responsible for reviewing the planning guide prior to each outing, while Nursing and the Therapeutic Activities Directors are responsible for monitoring compliance with the overall workflow. [The plan of correction says that the nurse manager signs off on the planning form, but they are not referenced here.]

Some other Workflow recommendations:

- Neighborhoods should have consistent days for outings. This will allow neighborhoods to better organize their planning process and allocate staffing appropriately. There may be times when a neighborhood team may need to make exceptions on implementing a trip on their assigned day to accommodate for special trips.
- Outing "appointments" should be marked on 1) the individual resident’s white boards & 2) LCR and 3) Nursing Calendar.
- Writing outing days on white boards will clearly communicate with residents and nursing staff when the trip will occur & ensure appropriate precautions are taken.

3. Staffing Considerations:

It is LHH’s recommendation to have a minimum of 1 staff:3 residents staffing ratio for outings. In general, the 1:3 ratio works well for groups whose residents are more independent and have minimal clinical risks. However, if neighborhood teams have interested residents who need more transport, feeding assistance, or other clinical considerations, then it is recommended that the neighborhood consider a 1:2 staff:2 resident staff ratio. AT, with their neighborhood team, should consider 1 staff:1:1 resident ratio if the patient/resident has significant clinical or behavioral needs, needs close observation, or if staff is working with the resident’s care plan includes a goal of resident for community re-integration. Staffing ratio should not include available volunteers. If family members, guests or a 1:1 observation coach are interested in attending trip, be sure they understand their role is to support only the resident to which they are assigned, they are paired with.

Other staffing considerations:

- All efforts should be made to avoid sending float staff on bus trips.
- Rotate regular staff for the bus trip with some exceptions.
- Volunteers shall be trained on basic safety tips prior to outings. Untrained volunteers are not permitted on outings.
- It is preferable that the CNAs/PCAs know the residents prior to going on the outing. If they don't know, they will need to closely review the planning form, and have time to ask questions of those staff who do know the residents, have planning form to review.
- There are planning challenges when two different neighborhoods combine an outing. Challenges include potential conflicts between residents as well as a lack of familiarity between the staff and the residents. If neighborhoods are interested in combining two neighborhoods for a joint outing, all parties will need advance planning and review the safety precautions. Challenges such as potential conflicts between residents as well as a lack of familiarity between the staff and the residents should be considered when planning this type of outing.
- Loading and return times need consideration so staff can plan their breaks and meal times accordingly.

It is LHH's policy to have a minimum of 1:3 staffing ratio for outings. In general, the 1:3 ratio works well for groups whose residents are more independent and have minimal clinical risks. But if neighborhood teams have interested residents who need more transport, feeding needs, or other clinical considerations, then it is recommended that the neighborhood consider a 1:2 staffing ratio. Staffing ratio should not include available volunteers. If family members, guests or a 1:1 observation coach are interested in attending trip, be sure they understand their role is to support only the resident they are paired with.

Here are some other staffing considerations:
- Avoid sending float staff on bus trips
- Rotate regular staff for the bus trip with some exceptions.
- Volunteers should be trained on basic safety tips prior to outings.
- It is preferable that the CNAs know the residents prior to going on the outing. If they don't know, they will have planning form to review.
- There are planning challenges when two different neighborhoods combine an outing. Challenges include potential conflicts between residents as well as a lack of familiarity between the staff and the residents. If neighborhoods are interested in combining two neighborhoods, all parties will need advance planning and review the safety precautions.
- Loading and return times need consideration so staff can plan their breaks and meal times accordingly.

4. Location:
AT's generally refer to the "Complete Outings List" for appropriate site locations. Most of these sites have been reviewed by an AT and authorized by AT Department leadership. All sites should be wheelchair accessible, and/or have accommodations for those with decreased mobility, unless participants are not in need of this accommodation. If a team believes a site is unsafe, please report to AT Outing Coordinator and a safety review of that site will be initiated/completed.
Some considerations:
- Outing group should avoid crowded places.
- Consider traffic alerts, weather patterns, etc.
- Avoid places where parking is difficult.
- Be mindful of size and flow of elevators.
- Be mindful of steep hills or uneven pavement.
- Avoid going to sites that will take over 1.5 to 2 hours transport time.

5. Resident preference/quality of life considerations:
We AT and the neighborhood teams should do our best to assess the resident’s interest to be in the community, and the sites they would be interested in visiting. If there are clinical reasons that impact their participation, then the resident’s RCT team should discuss this with the resident. The outcome of this discussion should be noted in the Care Plan. Residents who like to go off to explore or smoke need to understand the importance of staying with the group and adherence to hospital policy when on an outing.

Other quality of life considerations:
- Ensure residents on outings are wearing comfortable clothes and appropriate for the weather that day.
- Residents should be asked how they felt about the trip e.g., was the trip enjoyable, determine if the resident felt have any safety concerns during the trip, any other feedback to improve their future experiences.
- Family members and/or loved ones should be encouraged to attend. However, it should be made clear they would be responsible for their own funding (e.g., meals, entrance fees, etc.) and should attend to only their family member or loved one and not to the needs of other group members.

6. Resident Clinical Considerations
The following are clinical considerations that should be discussed by the RCT neighborhood team (or Charge Nurse) and documented on the planning form:
1. Feeding Meals:
Diet considerations for outings such as diabetes, aspiration precautions, allergies etc.

Aspiration precautions should be reviewed more thoroughly and a copy of the site's menu should be reviewed prior to the outing.

Assistance with meals- either assistance with cutting or 1:1 feeding support.

Residents who require line of sight during mealtime.

2. Behavior:
   - Residents who have history of aggression, triggers and recent behavioral patterns.
   - It is recommended that RCT review how smoking effects the group and what house rules should apply to the specific outing. Possible aggression for smoking should be taken into consideration. Residents who have history of aggression, triggers and recent behavioral patterns.

   - Residents who have history of aggression, triggers and recent behavioral patterns (e.g., what are these behaviors and what are the interventions care planned to mitigate them)

   - AWOL or Risk of Elopement- Risk of Elopement residents tend to be more considered clinically complicated, and recommend City Tours or Group Outings with lower resident to staff ratio are recommended.

   - It is recommended that the RCT review how smoking effects the group and what house rules should apply to the specific outing. Possible aggression for smoking should be taken into consideration.

3. ADL's:
   - Bariatric resident who is interested in attending may need more review and planning.

   - Residents with limited mobility who are interested in attending may need more review and planning.

   - Fall risks- Extra supervision needs will be identified for those who are at risk of falling.

   - Need for Foot footrest- Some residents typically do not use foot rests in their wheelchairs because they use their feet to self-ambulate-propel. However, if the site is heavily sloped or is further than normal distance, staff may suggest the resident use a foot rest.
SECTION 2: Implementation Guideline

This Section will focus on safety tips for the staff who are implementing the Outing.

1. Effective communication is essential to a safe outing!

Teamwork and effective communication is the key component in creating a safe outing program. The following are ways to promote effective communication:

- Outing team should be formed 2-3 days prior to trip so to ensure appropriate updates and check-ins are communicated.
- Ensure staff and volunteers know each other’s names.
- Promote all hands on deck when boarding and getting off the bus and/or van: All staff, (Drivers, AT, CNACNA/PCA) will assist in the using the lift, strapping, etc. – Trainings will be offered for staff who are not comfortable operating lifts or securing straps.
- Review of the planning form: Staff who are attending should review the needs and clinical considerations that are indicated on the form and determine who should focus on particular areas.
- Set ground rules before bus trip with residents attending: Ground rules such as no smoking, stay together, no alcohol, ETOH, and/or drive electric wheelchairs slowly should be understood by staff, volunteers and residents. When ground rules are not followed, staff should actively clarify and discuss with each other and with the residents so the rules are understood.
All members of the outing team are required to be accessible via cell phone. LHH will provide cell phones for staff. If staff chooses to use their own device, they will assume responsibility for all data charges and must ensure their contact information is shared with the rest of the outing team.

Create a "transport" plan to ensure someone is watching every resident all the time and identify the various meeting points throughout the trip.

Resident precautions and diets are communicated through the Outing Planning Guide.

2. Preparation Needs the Day before the Trip:
- Ensure a copy of the Outing Planning Guide Planning form is located in the nurses’ station for AM and Morning Shift Nurses to review.
- All Wheelchair preparation:
  - Wheelchairs must be cleaned prior to outing. Dirty wheels often stop the brakes from locking properly. Report problems to Charge Nurse.
  - Ensure tires and brakes on all wheelchairs are working properly.
  - Also double check all alarms, ensure the batteries are working properly, and cushions are secured.
  - Minimize bags on handles; they obstruct loading capabilities.
  - If the Outing Planning Guide Planning guide indicates two footrests are required for a resident, ensure that two footrests are on that resident's wheelchair and that they are operational.
  - Report any and all wheelchair problems to the Charge Nurse for follow up.

3. Preparation Needs the Morning of Trip:
- Neighborhood nurses should check vital signs to ensure resident is feeling well enough to attend outing. Vitals should be inputted from each resident going on the outing into the Outing Participation Section of the Outing
Planning Guide. Vital signs are generally not checked if the resident does not have a physician’s order for this procedure.

- Charge Nurse, AT, Driver and CNA/PCA attending outing are required to review the planning form. “DOT” section will be checked by driver to indicate the staff have reviewed the precautions.

- Nurse Managers and AT Supervisors are responsible for reviewing the planning guide prior to each outing’s departure to ensure compliance with the guide and safety protocols. (could you please check the p&p and the plan of correction – I’m pretty sure we referred to the nurse manager to have responsibility, but I am not seeing it highlighted on this planning guide)

- Neighborhood staff will prepare clothes, blankets, and sunscreen as appropriate for the weather that day.

- All residents should be toileted prior to leaving the neighborhood and boarding the bus.

- Medication schedule should be reviewed and adjusted for attendees. No suppositories or laxatives should be given on date of prior to the bus trip.

- If possible, line up trip participants along the nurses station to ensure residents are reviewed and accounted for.

  - Be sure to plan for any wanderers/residents with elopement risks on the trip; they can be either first on bus so driver can assist in watching or last to load.

- Need for foot rests should be re-evaluated by outing team, installed if necessary.

- Residents’ name bands need to be readable.

Footrests were discussed and installed, residents lined up.

4. Safety Review:

- All staff and volunteers should know disaster protocols. To ensure this topic is reviewed, Drivers will initiate one-a-discussion about disaster protocols each trip outing.
• Remind each other that if resident gets injured, call 911. If possible, recommend SFGH-ZSFGH as emergency room destination.
• Always contact an AT Supervisor and Neighborhood Charge Nurse if something unusual occurs during the trip. The Outing team should ensure those phone numbers are programmed into their phones.

5. Safe Unloading and Loading Tips:

It is very important that the outing team communicate an effective system for transporting residents from the bus to the site and back. An important safety principle is residents should not be unsupervised outside of the bus while staff is loading other residents or attending to the bus. To avoid this, it is recommended the group remain together before unloading/ loading. "Staggering" transport will work if there are four staff/volunteers so that the staff can work as a pair. Staff should also discuss possible road hazards & how to navigate through them. For example:

- Steep grades - walk backwards with wheelchair and park in a sideways direction with both brakes locked.
- Muni Tracks - steer the wheelchair perpendicular to the tracks.
- Crowdedness of area - best to avoid crowds, but if this is not possible, discuss how the group can remain intact though a crowd.
- Survey the area to avoid gaps or cracks on the road.

• Make sure the "hands off" function is initiated on power chairs.
• Be very mindful of hills, ensure brakes are locked.
• Upon return to the hospital, it is recommended the outing team call their neighborhood to help unload residents.
• It is recommended that bag lunches are distributed when residents are unloaded, and individually brought to the dining site. Drivers will have bags ready so they can be hung on the wheelchairs. This will minimize the need for someone to carry the box with the lunches, as well the need to separate from the group to retrieve the box.

6. While on the bus:

• Ensure all residents are upright and secured, seat belts secured.
• With the exception of the driver, all remaining staff & volunteers should sit at the front and back of the passenger area so they can see all
of the residents and supervise as needed. Staff should not sit in the cab next to the driver.

- No eating or drinking on the bus. This includes while the bus is parked.
- Do not have music or radio too loud as it, this may cause agitation.
- Driver should obey all traffic laws, which includes driving the speed limit and not texting or using cell phone while driving.

Staff seated in front, middle and back of bus.

7. At the site:
Here are some safety tips while you are at the site:

- Be mindful of precautions when grouping residents. For example, try not to seat residents who are easily agitated near each other. On the other hand, those residents who may need assistance with feeding could be paired up.
- Determine when and how long the bus driver will be separated from the group to move the bus to the loading area. When the driver is ready to get the bus, s/he will check in with other staff and determine if anyone has toileting needs. Staff will need to consider how to handle residents who are wander at risk for elopement. Driver should go to the bus by themselves and not bring a resident because the driver needs to focus on preparing the bus. If the driver is needed to help transport, they will return to the group once the bus has been moved.
- Double check aspiration precautions, be mindful that popcorn in movies can be an issue.
- Have sunscreen or hats available if the event is outdoors, and rain ponchos if there is rain.
- Volunteers should not feed residents or assist them with purchasing food items.
- Staff should not break off from the group to manage personal business.
- Breaks are not to be taken at this time.
- If group is separated, establish meeting points and time, use cell phones to communicate.

8. Restrooms:
Let the other staff know if you will need to toilet a resident so they can keep an eye on the rest of the residents.

In general, all residents should be escorted to the restroom. Depending on the residents’ ability to do their ir-ADL's, more assistance may be needed and this should be indicated on the precautions on the Planning form. If two staff are required for toileting needs, an appropriate plan should be established and this should be addressed prior to the outing, so an appropriate plan can be established.

While staff will try to be respectful of matching gender designated restrooms, there may be situations where staff (or resident) may need to use a restroom not designated for their gender.

Volunteers should not be directly assisting residents with their toileting needs.

9. After the trip:

- CNACNA/PCAs will report back to CN how the outing went and if anything needs to be done differently for next time.
- Evaluation of trip should be discussed amongst the outing team, driver will document this discussion.
- In the event a significant incident occurred, Activity Therapy Supervisors will be notified ASAP and will facilitate a formal debriefing. The UO will also be completed at this time by the staff that was involved with the Outing.
SECTION 3: The Planning Form

The Planning form is titled "Therapeutic Outing Planning Guide, Resident Assessment & Bag Lunch Request Form".

1. Type of Outing: – Check the type of outing. Staffing, types of residents, funding & workflow are dependent on the type of outing indicated.

2. Neighborhood – Indicate the neighborhood. Fill in "N/A" for Hospital Wide Outings.

3. Activity Therapist – Name of the AT who initiated the planning of this trip. Please also indicate your name when initiating and completing the planning for city tours.

4. Driver – Name of the driver assigned. Outing Coordinator will provide name of drive in advance.

5. Day & Date – Day & Date of Planned trip.

6. Loading time – Indicate the time when the group plans to leave the neighborhood & begin loading.

7. Return Time – Indicate time when the residents will return to LHH. Please be mindful of staff lunches and breaks.

8. Destination/Address/Contact Name/Phone – Indicates where the trip is going to. Contact name/phone indicates whom the Activity Therapist is or...
has been in contact with in planning the outing and that contact’s phone number. Updated from “Destination” and “Address”.

9. Address of Destination

9. Attendees & Precautions:

a. **Resident Name** - Full Name as indicated on their chart.

b. **MD Order** - Check that a physician’s order for the resident to participate in activities outside of hospital has been verified.

c. **Bed #** - Include full number of room (i.e. S231C)

d. **Diet** – Indicate Aspiration Precautions (Reg, Mechanical Soft, Puree) & type of diet. (NCS, NAS, liquid thickener)

e. **Line of Sight** – (need info here that matches the inservice given in December 2017) Indicates the resident can self-feed but is at high risk for aspiration and must be watched at all times during meals.

e.f. **Communication Barrier** – Indicates whether the resident is English-limited, need language assistance, non-verbal, aphasic, or has other issues clearly communicating points of view, feelings, needs, and wants.

f. **Allergy** – Check to see if allergies need to be considered. Write the detail in the “Diet” section.

g. **Assistance with Meals** – Check if resident needs feeding assistance. This can range from assisting with cutting up food to 1:1 feeding.

h. **Behavior Problems** – Check if resident is easily agitated or impulsive & will require more monitoring

i. **Wander Elopement Risk** - (I don’t think we use the term “wander” but use “Elopement Risk” – probably need to change the form to reflect this) – Check if resident is at risk for Wander an elopement risk.

j. **Fall Risk** – Check if resident is Fall risk

k. **Smoker** – Check if resident is a smoker. If ”smoke” is checked, double check that the resident understands the outing ground rules. Managing residents who want to smoke is often difficult, please consider how many smokers will be taken out at once during the planning process.

l. **DNR/ DNI** – Check if resident is coded DNR/ DNI (Do Not Resuscitate & Do Not Intubate). If unchecked, it is presumed the patient is full code. It is not necessary to put specific details about DNR/ DNI status, the important thing is that the outing team knows the initial code status for an EMS worker. Defer the details to the charge nurse in the event of an emergency.

m. **Limited Mobility** – indicates that patient needs partial or full staff support to transport.
10. Bag Lunch Request
   a. *# of Resident Lunches – Indicate the count of residents who are listed as Planned and Back Up in order for the kitchen to have ready the bag lunches for the attendees and potential attendees.
   b. # Staff Lunches – Indicate number of staff and volunteers attending the trip and require a bag lunch.
   c. *Total # Lunches – Indicate the total number of requested bag lunches from the Resident and Staff lines.
   d. Pick up time – Approximately what time to food will be picked up from the kitchen the morning of the outing.

11. Funding Request –
   a. *Resident – Indicate number of residents and amount per resident for meal and/or entrance fees.
   b. *Staff – Indicate number of Staff and amount per resident for meal and/or entrance fees.
   c. *Snack – Indicate number of residents and amount per resident snack.
   d. *Other – Any possible funds for items not mentioned above.

12. Volunteer Request.
   a. Check "Yes" if staff wishes for Volunteer Coordinator to initiate a "shout out" call for interested volunteers. Also, indicate the number of volunteers interested. Check "No" if no volunteer support is being requested.

13. NM/Charge Nurse – Have either staff sign this section to indicate Sections 1-11 have been completed. –From this point, AT will make copies for Nurses Station.
14. Activity Therapist Signature and date submitted to AT Supervisor.

15. Supervisor Signature and Date.
   - AT Supervisor signs and dates this section to ensure the appropriate planning has been initiated, and that the form has been properly completed

Page 2: *Outing Participation and Evaluation Section:
The following Section will be completed on the original copy by the Driver.

17. Driver – Name of Driver completing this form

18. Activity Therapist – Name of Activity Therapist leading the trip (including City Tours)

19. PCA/CNA – Name of PCA attending the trip

20. Volunteer(s) (if any) – Indicate volunteers who supported the trip. Please include volunteers from CSM or family members attending the trip.

21. Destination – Indicate destination of activity. For city tours, indicate general area where bus went.

22. Departure Time – Indicate time leaving LHH.

23. Return Time – Indicate time returning to LHH.

24. *Final List of Residents. Blood pressure is Vitals are to be completed by nursing and this section is to be checked by the AT and driver before leaving the LHH Campus.
   a. Indicate First Name and Last Name initials of resident-attendee and any special precautions identified that was not listed in the other page.
   b. Vitals – T, P, R, Pain, BP. Under the T, P, R, Pain, & BP letters, the nursing team will indicate that the T (temperature), P (pulse), R (respiration), and BP (blood pressure) was taken by entering the vital of the resident who is planned and readied to go and confirming that they have the appropriate vital levels to go off-campus and on the outing.

25. Safety Checklist: (Check the following has been completed by Driver)
   a. 1st – Is the 1st time loading from LHH to destination
   b. 2nd – Is the 2nd time loading, from destination back to LHH.
1. Examine Foot, Arm and Head Rests, report issues to Charge Nurse or AT staff
2. Examine wheel locks, report issues to Charge Nurse or AT staff
3. Use all wheelchair seat belts
4. Lock both wheelchair brakes when on the lift
5. Use four security floor straps on wheelchair, check if they are in good condition (no tearing or shredding).
6. Apply bus seat belts for each resident and other passengers both in wheelchairs & in seats.
7. Recheck all security straps before starting the bus.
8. Ensure optimal seating arrangement for other accompanying staff.

26. Transport & Emergency Checklist:
   a. Column 1 is for AT to initial, Column 2 is for Nurse to initial- Staff can state 1 emergency procedure: (Fire, earth quake)
   b. Column 1 is for AT to initial, Column 2 is for Nurse to initial- Staff acknowledges they met to discuss specific transport plan and verify they have a plan to ensure safety protocols are met:

27. Evaluation Notes – First, indicate if an UO has been initiated.
   a. Then highlight communication, unloading & loading, transport plan and general practices at the site.

28. AT Supervisor Follow up relating to UO’s:
    a. AT Supervisor will complete this section in the event a UO has been initiated and briefly describe what the follow up actions taken.
SECTION 4: The Evaluation

Once a quarter, an Activity Therapy Supervisor will randomly complete a direct evaluation of the outing and complete the evaluation form. The evaluation form should include observations regarding the following:

1. Communication:
   a. Did evaluator observe the Safety Guidelines practiced as outlined in Section 2, line 1? Important notes are transport, loading plans discussed, outing team know each other’s names, and they all understand the ground rules.

2. Loading and Unloading Procedure:
   a. Did evaluator observe Safety Guidelines practiced as outlined in Section 2, line 4? Important notes are how grouping was initiated, how the group handled incline areas.

3. Seat Belts:
   a. Were all residents and staff properly in seat belts?

4. At the site:
   a. Did evaluator observe Safety Guidelines practiced as outlined in Section 2, line 6? Important notes are how grouping was initiated, how clinical considerations were communicated and implemented.

5. General Impression:
   a. Evaluator will summarize the outing, indicate how much of the safety guide book was utilized, and identify and initiate follow up items for areas of unsafe practices.

Once an evaluation has been completed, an Activity Therapy Supervisor will review the observations with the members of outing team. For areas where safety guidelines were not practiced, the Activity Therapy Supervisor will initiate a discussion with the team and help them develop strategies to ensure the Safety Guidelines will be followed for future outings.
EMERGENCY PREPAREDNESS COMMITTEE

POLICY:

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

PURPOSE:

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

PROCEDURE:

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

2. Meeting
   a. The Committee shall meet six times a year, or more often as the need arises.

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

4. Responsibilities of Emergency Preparedness Committee Members
a. Attend monthly-scheduled meetings and designate an alternate attendee if unable to attend.
b. Assist Department Manager in maintaining a current departmental or neighborhood staff call back roster.
c. Provide communication updates to Department Manager and/or al or neighborhood staff on emergency preparedness activities, plans and procedures discussed at the committee meetings.
d. Assist Department Manager in maintaining a current Emergency Preparedness binder in respective departments or neighborhoods.
e. Participate in internal and external disaster drills at least two times a year, as applicable.
f. Collaborate in completing the annual Hazard and Vulnerability Assessment and annually.
g. Assist in the review, development and implementation of emergency preparedness policies and procedures for process or systems improvements. 

h. Represent Laguna Honda at external disaster preparedness meetings to support and enhance the collaborative efforts of mutually involved city, state and federal organizations as necessary.

ATTACHMENT:
None

REFERENCE:
LHHPP 77-02 Emergency Preparedness Program
LHHPP 73-01 Injury and Illness Prevention Program (IIPP)

Revised: 95/05/01, 98/11/16, 11/08/29, 13/01/29, 15/09/08_17/03/14 (Year/Month/Day)
Original adoption: 92/05/20
Appendix L

Lists:
  1. Radios
  2. Vehicles
## Emergency Radio

### 800 MHz

<table>
<thead>
<tr>
<th>Radio #</th>
<th>Location</th>
<th>Staff Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>119-3</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; Floor Administration Building</td>
<td>Mivic Hirose, CEO</td>
</tr>
<tr>
<td></td>
<td>Executive Administration Suite</td>
<td></td>
</tr>
<tr>
<td>137</td>
<td>4&lt;sup&gt;th&lt;/sup&gt; Floor Administration Building</td>
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INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

POLICY:

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

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

PURPOSE:

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

PROCEDURE:

1. Responsibilities

   a. The Manager of the Laguna Honda Department of Workplace Safety and Emergency Management shall be the IIPP administrator and have the authority and responsibility for administering and maintaining the overall program and for updating the program periodically. The Department of Workplace Safety and Emergency Management will also be responsible for the following:

      i. Providing initial and ongoing health and safety training to employees during hospital-wide orientation and periodic in-services.

      ii. Chairing the Occupational Safety and Health (OSH) Committee.

      iii. Providing assistance to Department Managers as requested in implementing the IIPP. This might include assessing hazards, training employees, and investigating accidents.

      iv. Reviewing all incident reports and investigating when necessary.

      v. Analyzing and summarizing injury/illness data. Reports will be provided to PIPS twice per year and to the Executive Team once per year.

      vi. Making recommendations for injury/illness prevention based on hazards and injury/illness data.

   i. The Laguna Honda Occupational Safety and Health (OSH) Committee’s primary mission is to provide support to enhance the Laguna Honda IIPP (see Appendix A). The Committee will serve to facilitate the anticipation, recognition, evaluation, and control of workplace hazards in a timely and effective manner so as to prevent occupational illness and injury. In addition to this primary mission, the Occupational Safety and Health Committee will
encourage employees to participate in the safety process and to communicate openly about health and safety concerns without fear of reprisal.

b. Department Managers will shall be responsible for implementing the components of the IIPP within their work areas. This willshall include the following:

i. Identifying risks and informing workers of risks and how to minimize them.
ii. Providing job-specific health and safety training
iii. Promoting a positive atmosphere of open communication regarding safety and health that is free from harassment, discrimination, and fear of reprisal.
iv. Making sure that employees follow safety procedures.
v. Conducting incident investigations and identifying corrective actions.
vi. Take appropriate disciplinary action when employees do not comply with Laguna Honda health and safety policies and procedures.

c. All employees willshall:

i. Comply with Laguna Honda health and safety policies and procedures;
ii. Use and maintain required personal protective equipment (PPE), including respirators;
iii. Promote and facilitate a safe and healthy environment for themselves and their co-workers;
iv. Report injuries, illnesses, and incidents involving a risk to health and safety immediately to their supervisor;
v. Report any potential safety or health risk immediately to their supervisor, including perceived physical or emotional risk;
vi. Abate risks immediately when possible and safe to do so;
vii. Not undertake a task or operate equipment unless authorized and trained to do so safely and to ask for assistance when they do not understand how to complete a task safely;
viii. Attend required health and safety training and medical surveillance examinations.

d. The Laguna Honda Executive Team willshall:

i. Provide the necessary resources to implement and maintain an effective IIPP.
ii. Assign Department Managers responsibilities for implementing the IIPP in their areas of responsibility.
iii. Calendar at least annually a review of a report from the LHH Department of Workplace Safety and Emergency Management including analyses of injury and illness data.
iv. Review recommendations from the Industrial Hygienist and the Laguna Honda OSH Committee.
v. Take action as appropriate to minimize health and safety risks.
2. Communication

a. Laguna Honda promotes a system of open communication between management and staff in which staff are encouraged to report hazardous conditions and near-misses without fear of reprisal. Employees are encouraged to report any hazards immediately to their supervisors, who are expected to investigate and mitigate the hazards.

b. Employees may also choose to report health and safety hazards directly to WSEM or through a hazard reporting form, which is available in hard copy outside WSEM offices located in A401 as well as online. The hazard reporting form may be submitted anonymously.

c. All Laguna Honda employees will receive an introduction to WSEM and an overview of this IIPP during new employee orientation.

d. All Laguna Honda employees will receive health and safety training specific to their jobs on initial hire, including information about this IIPP during hospital-wide orientation and in periodic in-service trainings throughout the year.

e. Department Managers will be instructed on the hazards in their work areas either during Leadership Forum or individually by the Laguna Honda Industrial Hygienist.

f. Employees will receive task-specific health and safety training within their departments on initial job assignment and additionally when:

i. Assigned to a new job or task for which they have not been trained previously;

ii. New substances, processes, procedures, or equipment are introduced and pose a new hazard;

iii. A previously unrecognized hazard is brought to the attention of the Supervisor.

e.g. Departmental/neighborhood safety meetings will be held periodically and time will be allocated in regular staff meetings to discuss health and safety issues. Department Managers are encouraged to invite WSEM staff as technical experts to safety meetings as appropriate.
Monthly meetings of the Laguna Honda OSH Committee provide an open forum for communication across functional areas regarding occupational health and safety issues. Any Laguna Honda employee is welcome to attend these meetings.

A health and safety bulletin board on the first floor of the main Administration building will be maintained by the Industrial Hygienist. Information about the LHH Occupational Safety and Health Program (OSHP), including a schedule of OSH Committee meetings and the most recent Cal/OSHA Injury Log Form 300A, will be posted.

The main page of the Laguna Honda Intranet site is accessible to all employees and has an Occupational Safety and Health button linking users to safety and health resources including injury reporting procedures and safety data sheets, and the online hazard reporting form.

3. Hazard Identification and Evaluation

a. Hazards will be identified primarily by Department Managers, but may also be identified in any of the following ways:

i. Health and safety surveys conducted by the LHH Industrial Hygienist either randomly or at the request of an employee or Manager.

ii. Supervisors introducing new tasks, substances, or equipment into their area.

iii. Employee(s) bringing the hazard to the attention of the Supervisor, Department Manager, Industrial Hygienist, or OSH Committee or WSEM.

iv. Employee(s) using the Workplace Hazard Reporting Form available on the Laguna Honda intranet Occupational Safety and Health button and in hard copy in the Admin building lobby. (Appendix AB)

New hazards will be evaluated by the supervisor, the Laguna Honda Industrial Hygienist, or the Laguna Honda OSH Committee as appropriate to determine necessary safety procedures and training.

4. Reporting and Investigation of Occupational Injuries and Illnesses

a. Notification

i. All incidents involving health and safety hazards will be reported immediately to the supervisor of the employee involved.
ii. In the case of injuries that do not require immediate emergency treatment, the employee will report the injury to his/her supervisor prior to seeking medical treatment.

iii. In the case of injuries that do require immediate emergency medical treatment, the employee must inform the supervisor as soon as possible. Unless they are medically unable to do so, employees must inform their supervisors on the same day/shift of the injury.

iv. In the case of occupational illnesses, it may be difficult to associate a specific event or exposure. The employee will report the illness to the supervisor as soon as there is a suspicion of diagnosis of an occupational illness.

v. In the case of needle sticks and bloodborne pathogen exposures, the incident should be reported to the supervisor in the same manner as other occupational injuries and illnesses. In addition, there is a 24-hour phone hotline which allows employees to obtain more specific information on follow-up for this type of exposure.

b. Medical Treatment

i. The supervisor shall assist the employee in obtaining prompt medical treatment of occupational injuries and illnesses, as necessary. The employee may proceed to any one of the twelve approved service sites for San Francisco City and County employees. A list of these service sites can be found in Appendix BC.

- An ambulance shall be called for transport if the employee’s condition is serious or medically unstable.

- If the employee’s condition is not serious or medically unstable, the supervisor shall arrange for safe and appropriate transportation to designated treatment facilities.

- Incident forms do not have to be completed prior to the employee seeking medical treatment.

c. Documentation

i. On the same day/shift of an employee reporting or a supervisor having knowledge of an occupational injury or illness, the Supervisor (not the employee) will complete the following forms found in Appendix CD. These forms are available as fillable pdf forms on the Laguna Honda intranet Occupational Safety and Health button:

- Supervisor’s Incident Investigation Form (SIIR)
- Employer’s Report of Occupational Injury or Illness (Form 5020)
- Employee’s Claim for Worker’s Compensation Benefits form (Form DWC-1).
ii. If the employee loses work time or seeks medical treatment, the employee must complete and sign their section of the Form DWC-1.
iii. Fax all completed forms to DPH OSH at 415-554-2562 as soon as possible and then send a hard copy in interoffice mail.
iv. If all the details of the incident cannot be obtained quickly or are not known due to the employee’s unavailability, submit the form with as much information as possible and submit a written supplement to the form as soon as possible when you have more detail.

d. Fatality / Serious Injury

i. In the event of a fatality or a serious occupational injury or illness requiring hospitalization: the attending supervisor will complete the LHH Supervisor Serious Injury/Fatality Tool
ii. The supervisor will contact the LHH Senior Industrial Hygienist, Industrial Hygienist, Administrator on Duty, or the Nursing Supervisor as indicated on the LHH Supervisor Serious Injury/Fatality Tool
iii. The LHH Senior Industrial Hygienist, Industrial Hygienist, Administrator on Duty, or the Nursing Supervisor will notify the nearest Cal OSHA office immediately @415-972-8670.

ATTACHMENT:

Appendix A: Laguna Honda Occupational Safety and Health Committee Charter
Appendix AB: Workplace Hazard Reporting Form
Appendix BC: List of Workers’ Compensation Designated Clinics
Appendix CD: Injury Reporting Checklist and Paperwork

REFERENCE:

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

Revised: 95/05/01, 98/12/24, 99/11/22, 00/03/02, 08/04/29, 14/03/25, 14/05/27, 16/07/12, 17/03/14 (Year/Month/Day)
Original adoption: 92/05/20
Appendix A:  
Laguna Honda Hospital and Rehabilitation Center  
Occupational Safety and Health Committee Charter

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

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

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

The Occupational Safety and Health Committee will meet monthly to:

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

HAZARD REPORTING FORM

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

HAZARD

Unsafe Condition or Practice:

Specific Location:

Suggestion for Improving Safety:

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

Would you like to be notified when this issue has been addressed?  □ Yes  □ No

If yes, please provide contact information.

YOUR INFORMATION (OPTIONAL)

Name:
Department:
Phone:
E-mail:

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

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

For Injuries Occurring During Normal Business Hours:

**St. Francis Treatment Room**
1199 Bush Street, Suite 160  
Hours: 7:30 a.m. to 5:30 p.m., Monday through Friday  
Telephone: (415) 353-6305

**AT&T Clinic – St. Francis Health Center** (at the Ballpark)  
24 Willie Mays Plaza  
Hours: 7:30 a.m. to 5:00 p.m., Monday through Friday  
Telephone: (415) 972-2249

**Kaiser Occupational Health Clinic** (Opera Plaza)  
601 Van Ness Avenue, Suite 2008  
(Inside the Opera Plaza building, 2nd floor)  
Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday  
Telephone: (415) 674-7000

**California Pacific Medical Center – Davies Campus**  
Castro & Duboce Streets  
Hours: 7:00 a.m. to 11:00 a.m. and 1:00 p.m. to 5:00 p.m., Monday through Friday  
Telephone: (415) 600-6600

**San Francisco International Airport Medical Clinic**  
International Terminal, Level 3, “A” Side  
(Departures Level, Pre-Security)  
Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday and  
9:00 a.m. to 1 p.m., Saturday  
Telephone: (650) 821-5600

**US Healthworks**  
1893 Monterey Road, Suite 200  
San Jose, -CA  
Hours: 7:00 a.m. to 7:00 p.m., Monday through Friday  
Telephone: (408) 288-3800

**Valley Care Occupational Health Clinic**  
5565 W. Los Positas Blvd. Suite 150  
Pleasanton, -CA  
Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday  
Telephone: (925) 416-3562
For Injuries Occurring After Normal Business Hours:

San Francisco General Hospital Emergency Department
1001 Potrero Ave
San Francisco, CA
Telephone: (415) 206-8111

California Pacific Medical Center – Davies Campus Emergency Department
Castro and Duboce Streets
Telephone: (415) 600-0600

Kaiser Permanente Medical Center – San Francisco
Urgent Care Clinic
2238 Geary Blvd., 8th Floor S.E.
Hours: 5:00 p.m. to 9:00 p.m.

Kaiser Permanente Medical Center – San Francisco
Emergency Department
2200 O’Farrell Street at Baker
Hours: 9:00 p.m. to 8:00 a.m.
Telephone: (415) 202-2000

Saint Francis Memorial Hospital Emergency Department
1100 Bush Street, between Hyde and Leavenworth Streets
Telephone: (415) 353-6300
Laguna Honda Supervisor’s Injury Reporting Checklist

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

☐ Complete the Supervisor’s Incident Investigation Report (DPH SIIR).

☐ Complete the State of California Employer’s Report of Occupational Injury or Illness (DPH OSH Form 5020).

☐ Give the employee a blank Workers’ Compensation Claim Form (DWC-1) and Notice of Potential Eligibility.

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

☐ Have the employee complete and sign the top section of the DWC-1. You must complete the Employer section (bottom half).

☐ Fax all three forms (SIIR, 5020, and DWC-1) to DPH OSH at 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail.

☐ Provide the employee with the list of workers’ compensation designated clinics. The employee must seek treatment at one of these facilities unless they have submitted a pre-designation form to HR to see their personal physician.

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

☐ Fax the SIIR and 5020 ONLY to DPH OSH at 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail.

☐ If they change their mind and turn in a completed DWC-1, follow the instructions in section 2.
4. If the reported incident involves exposure to blood, body fluids, or other infectious material:

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

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

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

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

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

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

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

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

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and healthy workplace for all employees.

PURPOSE:

1. To implement procedures for the prevention of noise-induced hearing loss in Laguna Honda employees.

2. To comply with the Cal/OSHA standards for the control of occupational noise exposure.

PROCEDURE:

1. Noise Monitoring

   a. Identification of Noise Sources

      The kitchen, (particularly the dish room and tray line area) and the boiler room have been identified as locations where equipment and processes generate a significant amount of noise. Measurements with a sound level meter in these areas have demonstrated that depending on the amount of time spent in these areas, employees could have time weighted average exposures that exceed the Cal/OSHA action level of 85 dB.

   b. Personal Dosimetry

      Personal dosimetry has been conducted on representative employees working in the kitchen and the boiler room. Time weighted average noise exposures that were measured are presented in the table below.

<table>
<thead>
<tr>
<th>Job</th>
<th>8Hr TWA Noise Exposure (dB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dish Unloader</td>
<td>91</td>
</tr>
<tr>
<td>Dish Loader</td>
<td>86</td>
</tr>
<tr>
<td>Cook (grill)</td>
<td>82</td>
</tr>
<tr>
<td>Cook (steam kettles)</td>
<td>76</td>
</tr>
<tr>
<td>Cold Food Station</td>
<td>72</td>
</tr>
</tbody>
</table>
Based on the monitoring results, the fact that Food Services Workers rotate jobs, and the fact all staff in the Nutrition Services Department move freely around the kitchen through noisy areas, all Nutrition Services staff shall be included in the Laguna Honda Hearing Conservation Program. Facility Services Engineers are not anticipated to have exposures that exceed the Cal/OSHA action level, so are not included in the Hearing Conservation Program. They are, however, provided with hearing protection that is available to be worn voluntarily in the boiler room or when operating loud equipment such as power tools or landscaping equipment.

c. Ongoing noise monitoring

Additional noise monitoring shall be conducted any time a new source of noise is introduced into the facility or when there is reason to believe that the noise exposure of an individual or job classification might exceed the Cal OSHA action level of 85dB. Any employee who has a concern about their noise exposure at work should contact the Department of Workplace Safety and Emergency Management for an evaluation.

2. Audiometric Testing

a. All employees included in this program shall be provided with audiometric testing on initial hire and annually. This testing shall be provided by the ZSFG Occupational Health Service (OHS) during work hours on the Laguna Honda campus.

b. Employees shall be informed of the need to avoid high levels of noise for 14 hours prior to their test. This may require use of hearing protection at work on the day of the test.

c. Audiograms shall be evaluated by the ZSFG OHS audiologist, who shall determine whether there has been a standard threshold shift. In determining whether or not there has been a standard threshold shift, the audiologist shall use the age correction procedure in Appendix F of the Cal/OSHA Occupational Noise Standard.

d. If an employee experiences a standard threshold shift:

i. The audiologist shall notify the employee and the Director of Workplace Safety and Emergency Management in writing within 21 days of the determination.

ii. The test may be repeated if there is reason to believe that there was noise exposure during the 14 hours prior to the test.

iii. The employee may be referred for clinical evaluation.
3. Noise Exposure Control

a. The primary sources of noise in the kitchen are the china plates, the dish machine, the tray line, and the exhaust hoods over the steam kettles and grill area. Engineering controls such as sound dampening insulation are not feasible in the kitchen due to the need for sanitation of all surfaces.

b. Administrative controls that have been implemented include the rotation of Food Service workers through different assignments in the tray line and dish room areas and some rotation of Cooks through various assignments in the production kitchen. Some employees, however, still spend much of their time in noisy areas.

c. Hearing protection is available to all Nutrition Services employees to further reduce their noise exposure.

4. Hearing Protection

a. Hearing protection is required for:

   i. Work in the dish room;
   ii. Employees who have experienced a standard threshold shift.

b. Hearing protection is recommended during any work in the kitchen or grill area of the cafeteria, including supervisory work.

c. Two different brands of ear plug and one type of ear muff are available to employees in the Nutrition Services Department for hearing protection.

   i. Ear plugs are available out on the work floor for easy access during the work shift.
   ii. Ear muffs are provided to individuals who choose to use them. Ear muffs shall be kept in the employee’s locker when the employee is not working.

d. Proper use of hearing protective devices (HPDs)

   i. Ear Plugs

   - With clean hands, hold earplug between thumb and forefinger.
   - Roll and progressively compress the entire tapered end of the earplug to a small crease-free cylinder.
   - Reach opposite hand over head and gently pull ear upward and outward to open the ear canal.
   - When properly inserted, as much of the ear plug as possible should be inside the ear canal for maximum effectiveness.
5. Training

a. All employees included in this program shall receive training on initial assignment to a job with noise exposure. The training shall include the following topics:

i. The effects of noise on hearing;
ii. The purpose of HPDs and when they must be used;
iii. The advantages and disadvantages of the various types of HPDs and instructions on selection, fitting, use, and care;
iv. The purpose of audiometric testing and an explanation of the test procedures.

6. Recordkeeping

a. Records of audiometric tests and audiometric test rooms shall be maintained by the ZSFG OHS for the duration of employment of each affected employee.

b. Records of noise exposure measurement shall be maintained by the Department of Workplace Safety and Emergency Management for a minimum of two years.

c. Records shall be made available to employees, former employees, any representative designated by an employee, or to Cal/OSHA on request.

REFERENCES:

73-01 Laguna Honda Injury and Illness Prevention Program
CCR Title 8 Subchapter 7, Group 15 Article 105 Sections 5095-5100

Most recent review: xx/xx/xx (Year/Month/Day)
Revised: xx/xx/xx17/03/14
Original adoption: 126/0925/25xx
CATERING SERVICES

POLICY:

Catering services for Laguna Honda Hospital events are available only through the Nutrition Services Department or approved city vendors, and is consistent with City Controller’s policy.

PURPOSE:

1. For resident catering services: to support quality of life for Laguna Honda residents.

2. For non-resident catering services: to contribute to successful events through the provision of food, beverages, and related services in a manner that is safe, cost effective, and in compliance with City Controller’s policy.

CHARACTERISTICS:

1. Approvals Required:

   a. Approved catering requests are made internally with Nutrition Services first. If Nutrition Services Manager determines that any given request cannot be cost effectively fulfilled in-house, then the order may be made with outside city-approved vendors.

   b. All catered services for resident related events require approval by designated supervisory staff within the requesting department.

   c. All catered services for resident related events being charged to the Resident Gift Fund also require approval of Gift Fund Program Monitor(s).

   d. All non-resident catered services require the approval of the Chief Operations Officer (COO).

   e. Any catering services by outside vendors require the approval of the COO.

   f. No sugary beverages may be provided, which is consistent with DPH; Food Expenditure and Health Foods policy

2. Required Forms:

   a. Internal catering requests:
i. Most catering requests to the Nutrition Services Department are made on the Catering Request/Order Form. A separate form is required for each separate event, except for standing orders.
ii. The pre-printed B.B.Q. Menu/Order Form is used for barbeques.
iii. Bag lunches for the Activity Therapy Community Outing program are requested using the Community Outing Planning Form.

b. External catering requests:

i. All catering requests from a city approved vendor shall be submitted on an RPO (Request for Purchase Order) with a vendor quote.

3. Nutrition Services:

a. Nutrition Services provides catering within the hospital when fiscally and logistically feasible.

b. Nutrition Services is available for consultation of all catering requests.

c. Calculates and retains costs of catered services it provides.

d. Takes all opportunities to charge the requester department or to credit Nutrition Services for the total cost of service plus the cost of lost supplies and equipment.

e. Requires the requester department to provide all required information on the top of the request forms.

f. Reserves the right to plan all menus and to modify or eliminate any catered service without prior notice, as may be required to sustain resident food services.

g. Shall advise the requester in advance in the event that cancellation of services or menu change is necessary due to budgetary constraints.

h. Does not supply linen service, tables, chair, podium set-up, audio-visual, and wait staff. Requesters shall make event set-up arrangements with the appropriate hospital departments.

i. May require user departments to sign for any food, supplies, and equipment.

j. Requires requester department to ensure the security of its equipment and return equipment promptly after the event.

4. Vendor Provided Catering

a. All vendors providing catering for hospital-related events must be city approved.
b. The requesting (user) department establishes a purchase order with the vendor for the provision of catering services per policy of the Materials Management Department.

c. The request for purchase order (RPO) must be approved by the COO prior to submission to Materials Management.

d. COO has the right to modify or eliminate any catered services without prior notice if determined inappropriate.

5. Budget

a. All catering expenses should be charged to the hospital’s operating budget, except for those involving resident related activities that can be reimbursed by the Gift Fund*. (*Please see Gift Fund Policy)

b. Catering purchase orders for hospital-wide or inter-division meetings should be charged to HLH448662 – Hospital Administration cost center. Catering orders for departmental/divisional meetings are charged to the division’s index cost center. Internal catering orders though Nutrition Services will be tracked and expenditures will be posted to the division’s index cost centers quarterly by Accounting journal entries.

PROCEDURE:

1. Procedures For Resident Services:

   a. The requester consults with the assigned Nutrition Services Manager and/or Catering Chef to determine if the request will be processed internally or through an outside vendor.

   b. Internal catering

      i. Resident services – resident activities that substitute for the regular meals for example: neighborhood luncheons, barbecues, and community outings (maximum 60 persons).

         • Requestor completes all required information on the top section of either the Catering Request/Order Form, BBQ Menu/Order Form, or the Community Outing Planning Form, obtains the approval/signature from the appropriate Nurse Manager or Activity Therapy Supervisor, and delivers to Nutrition Services’ diet office at least fourteen (14) days (two weeks) prior to the scheduled event.

         • Requestor must attach notice of cancellation of resident trays to the catering request to initiate cancellation of meal trays for those meal(s) for which the event will substitute.
ii. Resident services – activities and special events for residents / resident groups served separate from regular meals and nourishment, for example, coffee service, cookies, punch (60 persons maximum).

- Requester completes all required information on the top section of the Catering Request/Order Form, obtains departmental approval/signature from appropriate Nurse Manager or Activity Therapy Supervisor, and administrative approval/signature of the appropriate Gift Fund Program Monitor, and delivers to Nutrition Services’ diet office at least fourteen (14) days (two weeks) prior to the scheduled event.
- Standing orders must be renewed at least annually with submittal of a new form by requester.

iii. Resident services — special events and large receptions (greater than 60 residents).

- Requester completes all required information on the top section of the Catering Request/Order Form, obtains departmental approval/signature from appropriate Nurse Manager or Activity Therapy Supervisor, and administrative approval/signature of the appropriate Gift Fund Program Monitor, and delivers to Nutrition Services’ diet office at least four (4) weeks prior to the scheduled event.

b. External catering

i. Requester contacts a City approved vendor and obtains a quote for catering services.

ii. Requester completes a RPO and obtains approval/signatures from department supervisory staff, Gift Fund Program Monitor and the COO.

iii. The requester delivers the RPO to the Materials Management Department at least two weeks prior to the scheduled event.

2. Procedures For Non-Resident Services

a. The requester consults with the assigned Nutrition Services Manager and/or Catering Chef to determine if the request will be processed internally or through an outside vendor.

b. Non-resident catering services shall only be provided for work related training, meetings and/or events. Guidelines for non-resident catering services are as follows:

<table>
<thead>
<tr>
<th>Meeting-Event Type</th>
<th>Participants</th>
<th>Duration</th>
<th>Services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Catering Location</th>
<th>Minimum Duration</th>
<th>Catering Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-house DPH training (e.g. new employee orientation)</td>
<td>LHH/DPH, and contract staff</td>
<td>2 hours or greater with no recess for or access to food</td>
<td>Light refreshment e.g. beverage, light healthy snack e.g. fruit, yogurt, cookies.</td>
</tr>
<tr>
<td>Hospital departmental or division staff meetings</td>
<td>LHH/DPH, and contract staff</td>
<td>N/A</td>
<td>No catering</td>
</tr>
<tr>
<td>Business Meetings</td>
<td>Includes non LHH/City staff, e.g. State agencies</td>
<td>2 – 5 hours with no recess for or access to food</td>
<td>Light refreshments or one meal (via city approved vendor) Light refreshments and one meal (via city approved vendor)</td>
</tr>
<tr>
<td>All-day Retreats</td>
<td>LHH/DPH, and contract staff</td>
<td>5 hours or greater All-day</td>
<td>Light refreshments and one meal (via city approved vendor)</td>
</tr>
<tr>
<td>Annual Discipline/Department Celebrations</td>
<td>LHH/DPH staff</td>
<td>N/A</td>
<td>Light refreshment e.g. cake or healthy snack and beverage</td>
</tr>
<tr>
<td>Recognition of Retiring Staff, 25 Years of DPH Service or Greater</td>
<td>LHH staff</td>
<td>N/A</td>
<td>Light refreshment e.g. cake or healthy snack and beverage</td>
</tr>
<tr>
<td>Night shift on-call Physicians</td>
<td>LHH physicians</td>
<td>No recess for or access to food</td>
<td>Midnight snack bag</td>
</tr>
</tbody>
</table>

c. Internal Catering

  i. Requester completes all required information on the top section of the Catering Request/Order Form and secures departmental approval from designated supervisory staff and secures administrative approval from the COO, and delivers to the Nutrition Services diet office at least fourteen (14) days prior to the scheduled event.

d. External Catering
i. Requester contacts a City approved vendor and obtains a quote for catering services.

ii. Requester completes a Request for Purchase Order form (RPO) and obtains approval/signatures from department supervisory staff, and the COO.

iii. The requester delivers the RPO to the Materials Management Department at least two weeks prior to the scheduled event.

iv. The requester provides meeting agenda and completed sign-in sheet with approved invoice to Accounting for process of payments after the event.

ATTACHMENT:
None

REFERENCE:
LHHPP 26-05 Specialty Meal Program
LHHPP 45-01 Gift Fund Management
LHHPP 90-01 Environmental Services Department
Activity Therapy Policy P 2.0
LHHPP 28-01 Community Outing Program
Materials Management Policy 3.2 Request for Purchase Order
Nutrition Services Policy 1.132 Catering Requests
DPH Food Expenditure and Health Food Policy

Revised: 00/04/27, 14/03/25, 17/03/14 (Year/Month/Day)
Original adoption: 92/05/20
BLOOD GLUCOSE MONITORING

POLICY:

1. A bar code scanner is used to enter patient ID and/or operator ID in the facility-approved glucometer machine.

2. When the physician determines blood glucose “panic values,” they are to be indicated on the resident care plan. Whenever blood glucose values change from the resident’s usual range, or reach the panic value or when the resident’s condition is not consistent with the value obtained, the nurse is to repeat the test, assess for symptoms of hypoglycemia or hyperglycemia, treat according to order and inform the physician STAT.

3. Capillary whole blood glucose quantitative measurements ranging from 50 to 600 mg/dl may be performed using the facility-approved glucometer machine with a physician’s order and PRN at the discretion of the Licensed Nurse at any time a diabetic resident’s symptoms indicate a change in condition. When an initial test indicates a value outside of the parameter per physician’s order or when the resident’s condition is not consistent with the value obtained, the resident will be re-tested and the physician notified.

4. Blood glucose is to be tested by the clinical laboratory if the blood glucose value is above 600 mg/dL, if the resident has a hematocrit above 55% or below 20%, if there is excessive water loss with dehydration, or in situations of decreased peripheral blood flow.

5. Quality control tests of the check strip, the high, and the low glucose control solutions are to be performed every AM shift by the Licensed Nurse who is to enter an individually assigned ID code. Quality control tests that fall outside of designated parameters are reported to Central Supply Room (CSR).

6. The Point of Care Coordinator or designee coordinates any updates or changes to the initial setup of the facility-approved glucometer machine.

7. The Point of Care Coordinator or designee is responsible for coordinating facility-approved glucometer machine quality management tracking and reporting.

8. AC (Meal time) blood glucose checks should be taken no more than 30 minutes before meal.

9. Insulin being administrated is timed prior to meals and based on blood sugar monitoring:
   a. For Regular insulin, should be given no more than 30 minutes before meals unless otherwise specified.
   b. For Rapid Insulin (Lispro/Humalog and Aspart/Novolog) should be given within no more than 15 minutes before or immediately after a meal.

10. If fasting blood glucose check is accidentally taken after resident has already eaten and there is a missed and taken instead after resident has already eaten, and the order was to check blood glucose pre meal (AC), do not give rapid insulin (Lispro/Humalog, Aspart/Novolog), regular insulin or intermediate (NPH) acting insulin per the scale. order to check BG pre meal (AC), do NOT give rapid or regular insulin ordered per scale. Notify MD.

11. Long acting insulin is not held unless patient is hypoglycemic. After treatment per protocol and BG ≥100, it can be given unless given there is an order to hold by MD.

12. All licensed nurses will complete an annual review of Point of Care blood glucose testing.
PURPOSE:

1. To monitor accurately blood glucose levels using facility-approved glucometer machine.
2. To initiate appropriate nursing intervention when blood glucose levels are not within normal range. 
   Refer to medication orders for treatment of hypoglycemia and hyperglycemia.

PROCEDURE:

A. Equipment:

Refer to the facility-approved glucometer machine user’s manual for the following procedures:

1. Patient Preparation
2. Coding (Calibration)
3. Patient Testing
4. Quality Control Testing
5. Facility approved disinfectant wipes for the glucometer
6. Instrument Care/Maintenance
7. Linearity (performed by Point of Care Coordinator or designee)
8. Troubleshooting

B. Blood Glucose Check

1. Test strip
   a. Test strips are available through the CSR.
   b. Test strips must be stored at room temperature. Test strips are stored in the same tightly capped vial in which they are packaged. The vial cap is immediately replaced after removal of a test strip. Test strips are stable until the expiration date on the vial. Outdated test strips are discarded.
   c. The test strip code displayed by the facility-approved glucometer machine must match the code of the test strips in use.
   d. Test strip code information must be verified in the facility-approved glucometer machine by the operator whenever a patient or quality control test is performed.

2. Proper infection control procedures are followed when using the facility-approved glucometer machine and testing with blood glucose monitoring equipment.
   a. Glucometer machine is cleaned after every each use and in between patient with facility-approved disinfectant wipes for the glucometer. Disinfectant wipes are available in Central Supply.
   b. Using gauze, thoroughly dry the glucometer after cleaning and disinfecting. Verify that the meter is dry and there is no solution left on the meter.

3. If the meter is not functioning properly:
   b. For problems that cannot be resolved, contact CSR.
   c. Meters that are not functioning properly will be exchanged through CSR.
4. The most recent facility-approved glucometer machine available on each neighborhood is referenced for procedural information.

5. When preparing a resident for discharge, glucose monitoring teaching must be done using the type of device that the resident will be using when discharged.

C. Documentation

1. Record results of facility-approved glucometer machine test on the medication administration record sheet.

2. Inform physician when results meet the panic value listed on the resident care plan or at any time the test results do not reflect how the resident feels.

3. Check mark date column on the emergency equipment checklist to indicate quality control tests on the glucometer were done.

2. Guidelines for Hypoglycemia Documentation:
   (1) Front page of MAR:
      (i) When checking blood glucose levels, always document the first result you obtain on the front page of the MAR. If the level is below 60 or what the MD has defined as a hypoglycemic value, circle the result and record interventions and results on the reverse page.
   (2) Reverse page of the MAR, record:
      (i) Document observations/resident symptoms (eg. Dizzy, sweaty, hunger, etc.) or "asymptomatic" as applicable
      (ii) Action taken and results of interventions
      (iii) Repeat treatment and document until resident’s blood glucose reaches satisfactory level as directed on hypoglycemic protocol
   (3) Glucometer:
      (i) Always record actions taken in the glucometer using codes provided. Information documented in the glucometer, must be consistent with information documented on MAR or in chart.
   (4) Integrated Progress Notes and Unusual Occurrence Report:
      (i) Documentation of hypoglycemic events in the integrated notes is required when:
      (ii) Blood sugar is below 50 whether the resident is asymptomatic or symptomatic
      (iii) Blood sugar is equal or greater than 50 AND resident has symptoms of hypoglycemia
      (iv) Routine interventions (eg. Juice, glucotabs) are NOT effective and the resident’s blood sugar continues to drop
      (v) Resident’s hypoglycemic event is so significant as to require non-routine interventions (eg. Administration of IV D50W or Glucagon, transfer out to acute care, prolonged monitoring

3. Data is transferred from the facility-approved glucometer machine to a computer with specialized software immediately upon docking the meter in the base unit. Data retrieval is coordinated by a Point of Care Coordinator or designee.
Blood Glucose Monitoring

REFERENCES:


http://www.accu-chekinformii.com/pdf/05234654001_ACI2_QRG_forWEB.pdf

ATTACHMENTS/APPENDICES:

None


Revised: 2016/09/13, 2017/03/14

Approved: 2016/09/13
NURSING CARE OF THE RESIDENT WITH SEIZURES

SEIZURE MANAGEMENT

POLICY:

1. Code blue shall be called in the event of seizure, unless an anticipated emergency plan has been put in place to address seizure.

1.2. The Registered Nurse (RN) and Licensed Vocational Nurse (LVN) and Certified Nursing Assistant (CNA), Patient Care Assistant (PCA) are responsible for observing, reporting, monitoring, and documenting seizure activity.

2. RNs monitor and assess residents with seizure activity and other related problems, collaborate with Interdisciplinary Team (IDT) members to differentiate between actual seizures and conditions with similar presentations (e.g. TIA or CVA), and contribute nursing expertise in developing implementing and evaluating an interdisciplinary plan of care.

3. In the event a resident experiences a seizure, a Code Blue shall be initiated.

   3.1. Code blue shall be called in the event of seizure, unless an anticipated emergency plan has been put in place to address seizure for convulsive seizure unresolved after two (2) minutes.

PURPOSE:

To provide safe and effective nursing care to the resident experiencing a seizure, and to minimize the risk for harm to the resident.
To ensure that the resident who seizes is kept safe from harm, has seizure activity accurately assessed, and has preventive, supportive and educational strategies implemented.

CHARACTERISTICS:

The following definitions apply:

- **Preictal Phase** - A period of mood, behavioral or sensory (aura) changes that may precede the actual onset of seizure activity by minutes to days.

- **Ictal Phase** - The period of actual seizure activity (see Appendix 2).

- **Postictal Phase** - The often slow recovery period that follows a seizure. The precise characteristics of this period vary widely among individuals depending on a variety of factors, such as the type, duration and intensity of the seizure.

PROCEDURE:

A. Preventive Safety and Anticipatory Measures
1. Assess the newly admitted or relocated resident within eight hours to determine seizure risk. Risk factors include but are not limited to medical diagnosis of seizure disorder, known history of seizure activity, and anticonvulsant therapy (excluding when administered for behavioral management or neuropathic pain management).

2. When a resident is assessed at risk for seizure activity:
   a. Note seizure risk in the precautions section of the Resident Care Plan;
   b. Provide the resident with a blue ID band;
   c. Place a blue color code dot on the resident’s bed card;
   d. Coordinate development of an IDT resident care plan entry, indicating the type and any special characteristics associated with the resident’s seizures (see Appendix 1);
   e. Communicate special approaches and interventions to front-line staff;
   f. Address resident and family educational needs.

3. Administer anticonvulsants as prescribed and monitor side effects, lab results and effectiveness of medications. (If resident is concurrently on enteral feedings, see Medication Administration policy for special considerations).

4. Care plan and initiate individualized seizure precautions/safety measures as appropriate to as dictated by the resident’s seizure type and pattern, which may include consideration of the following:
   a. Applying side rail pads to the side rails that resident utilizes.
   b. Use of a Joerns bed (low bed).
   c. Use of a floor pad placed next to the resident’s bed.
   d. Keep bedside clutter free.
   e. Suction set-up at bedside.
   f. Padding edges of furniture at resident’s bedside.
   g. Helmet (e.g., history of TBI, craniectomy)
   h. Hip protectors.

B. Acute Seizure Management

1. Pre-Ictal Phase (period immediately before the seizure)
   a. Monitor the resident for signs and symptoms of impending seizure (aura).
   b. If possible, when signs of impending seizure are reported or observed, and before seizure activity has begun/commenced, remove the resident to a quiet and safe environment, as indicated by historical seizure type, severity and characteristics.
   c. Provide calm reassurance to the resident.

2. Ictal Phase (period of seizure activity)
   Convulsive Seizures (tonic, clonic, tonic-clonic)
   a. Initiate Code Blue (call 42999).
   b. Stay with the resident and provide reassurance.
   c. When possible, keep the resident in a lateral side-lying (decubitus) position.
   d. As the seizure progresses, provide supportive care including the standard C-A-Bs of basic life support (i.e., circulation, airway patency and protection, breathing) as needed by protecting
the airway, maintaining normothermia, and protect against skeletal and soft tissue injury. Consider the following:

i) Oximetry and oxygen as needed
ii) Vital sign monitoring
iii) Check blood glucose
iv) Oral or nasal suctioning
v) Neurological monitoring
vi) Prepare for intravenous or intraosseous access per MD order
vii) Cardiac monitoring (i.e., especially when administering intravenous antiepileptic medications such as Dilantin)

e. Do not attempt to force anything into the resident’s mouth. Do not try to hold the resident down.

f. Due to the possibility of urinary and/or bowel incontinence during a seizure, place a towel over the resident’s lower abdomen and groin to provide privacy.

g. Observe and document carefully note the following:
   i) how the seizure started,
   ii) location and duration of motor activity,
   iii) resident’s report of sensory changes,
   iv) pattern, duration and intensity of seizure development,
   v) and any other pertinent details.

c. As the seizure progresses, provide supportive care as needed by protecting the airway, maintaining normothermia, and protecting against skeletal and soft tissue injury.

d. Do not attempt to force anything into the resident’s mouth. Do not try to hold the resident down.

Complex Partial Seizures

a. Ensure resident safety. Stay with and/or follow the resident. Resident may wander about and occasionally drop or knock over objects.

b. Nothing should be put into the resident’s mouth.

c. Calmly direct the resident to a safe environment.

d. Avoid trying to restrain or physically redirect the resident as this may lead to aggression or violence.

e. Carefully observe and accurately describe movements, verbalizations and behaviors and their pattern of development.

3. Post-Ictal Phase (after the acute seizure)

a. As indicated, place the resident on his side to maintain a patent airway. Maintain resident is a lateral side-lying (decubitus) position until resident is able to maintain airway and secretions. Administer oxygen as needed.

b. Do not offer anything to eat or drink until fully awake and able to swallow safely.

c. Assess the resident’s post seizure status, carefully noting vital signs, neurological findings and changes, presence of injury, and resident’s emotional response to the event.

d. Report seizure activity and resident status to the physician according to the Physician’s Notification Guidelines.

e. Provide incontinence care as appropriate. Assist the resident in cleaning up if incontinence, drooling or soiling has occurred.

f. As appropriate to the resident’s cognitive status, explain to the resident the circumstances of the seizure and provide reassurance.

g. Encourage periods of rest. Allow resident to sleep after the seizure.
Offer support to the resident, family and friends, addressing issues of embarrassment, anxiety, depression, and helplessness as they arise. If the resident requests, provide a brief summary of his activity during the seizure.

During regularly scheduled or special IDT conferences, present information regarding seizure control, frequency, pattern and effectiveness of interventions.

**C. Education**

1. Provide resident, family and friends with information regarding seizure type and pattern, and appropriate interventions before, during and after seizure activity.

2. Inform frontline staff of individualized interventions and seizure management strategies.

**D. C. Documentation**

1. **Resident Care Plan:** Identify seizure type and characteristics, related safety problems, and individualized interventions for monitoring, ensuring safety, managing seizure activity, and providing support and education (see Appendix 1).

2. **Interdisciplinary Progress Notes:**
   
   a. Document the following: describe seizures completely. Include presence, pattern and duration of prodromal symptoms, duration of seizure, pattern of progression, vital signs, loss of consciousness, associated behaviors, incontinence, color, skin pallor, injuries sustained, neurological and neurological findings during the ictal and post-ictal phase.
   
   b. Evaluate resident response to specific interventions.
   
   c. Document physician notification and subsequent interventions.

   d. Record strategies for follow up, e.g., special IDT conference, modification of resident care plan.

**ATTACHMENTS:**

Appendix 1: Nursing Seizure Clinical Practice Guideline
Nursing Practice Guideline: Seizures (need update) c/o Kathleen by next week (9/5/14)

Appendix 2: Classifying Seizures: A Quick Reference Guide

**REFERENCES:**


**CROSS REFERENCES**

Nursing Policies and Procedures B 5.0 Color Codes – Resident Identification

Nursing Policies and Procedures C 4.0 Notification of Change in Resident Status

Nursing Policies and Procedures G. 2.0 Neurological Status

Nursing Policies and Procedures J 1.0 Medication Administration

Laguna Honda Policies and Procedures 70-32 Code Blue
Ostomy Management

POLICY:

1. The licensed nurse is responsible for the management of ostomy.

2. Licensed nurse is to consult the Wound Care CNS for peri-stomal skin irritation that is not improving with routine care.

3. The certified nursing assistant (CNA) or patient care assistant (PCA) is responsible for emptying or changing the pouch/bag every shift and as needed.

4. Residents who have demonstrated ability to manage their own ostomy may change or empty their own ostomy pouch/bag.

PURPOSE:

To provide appropriate ostomy management.

BACKGROUND:

Ostomy care includes containment of excrement, urinary drainage, skin protection, patient education, and patient support.

PROCEDURE:

A. Equipment

Select appropriate ostomy product (Attached as Appendix Formulary (Coloplast))

B. Emptying or Changing Ostomy

1. An ostomy pouch/bag should be checked for leakage at least every shift and pouches changed PRN. The pouch/bag should be emptied when 1/3 full to prevent dislodgement of the appliance.

2. Resident with a urostomy may wear a urinary leg bag during daytime. During nighttime, connect the urostomy pouch to a Foley drainage bag.

C. Ostomy Maintenance for Aquatic Services

1. Ensure that ostomy site is cleaned.

2. Empty/dispose of ostomy pouch.

3. Securely place a new/empty ostomy pouch.

4. Check for leakage and patency.

5. Cover resident with a robe provided by the Wellness Center.
D. Documentation

1. DNCR - the CNA/PCA records output every shift.

2. Interdisciplinary Progress Notes (Licensed Nurse)
   a. Any change in appearance, discharge, bloody drainage or discoloration of stoma and peri-stomal skin
   b. Resident and family education when provided

3. Treatment Record Assessment (TAR)
   a. Record date of change of the ostomy wafer (change at least every 7 days or as needed) and check condition of peri-stomal skin.
   b. Use new pouch once/day (2-piece pouch). 1-piece pouch – change up to Q 3-7 days or as needed

4. Resident Care Plan (RCP)
   a. Front Card of RCP 1st page – document type of ostomy product(s)

ATTACHMENTS:

One-piece Ostomy (SenSura® - 1 Piece Pouch Colostomy)
Two-Piece Ostomy (SenSura® Flex – 2 Piece Pouch
Coloplast Types of Colostomies and Accessories

REFERENCES:

Basic Ostomy Skin Care. A Guide for Patients and Healthcare Providers
2007. Wound, Ostomy and Continence Nurses Society


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