

List of Hospital-wide/Department Policies & Procedures Submitted to JCC for Approval on January 9, 2018

1. <u>a. New Hospital-wide Policies and Procedures</u>		
Policy Number	Title	Comment(s)/Reason(s) for Development
LHHPP 24-25	Harm Reduction	Created to stay consistent with San Francisco Department of Public Health's harm reduction philosophy; to promote healthy behavior and reduce adverse consequences of risk behavior.
LHHPP 24-26	Dementia Care	Created to outline Laguna Honda's Dementia Care Program with a focus on person-centered care.
<u>b. New Department Policies and Procedures</u>		
<i>Department: Clinical Nutrition and Food Services</i>		
Policy Number	Title	Comment(s)/Reason(s) for Development
CNPP 1.677	Manual Ware Washing	Created to outline proper manual ware washing procedures.
<i>Department: Nursing</i>		
Policy Number	Title	Comment(s)/Reason(s) for Development
NPP E 2.0	Assisting Residents During Mealtime	Created to ensure that residents receive timely assistance during mealtime.
NPP G 7.0	Obtaining, Recording and Evaluating Residents Weights	Created to obtain timely weight measurements and identify unintended weight changes for effective care planning.
2. <u>a. Revised Hospital-wide Policies and Procedures</u>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
LHHPP 20-01	Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units	Updated to add language regarding SNF residents requiring short term acute care monitoring during the administration of high risk subcutaneous and intravenous medication.
LHHPP 71-06	Facility Decorations (re-titled)	Updated to meet requirements of NFPA 101, Life Safety Code for Combustible Decorations.
<u>b. Revised Department Policies and Procedures</u>		
<i>Department: Clinical Nutrition and Food Services</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
CNPP 1.71	Replenishing Juice and Coffee Dispensers, and Maintaining Ice and Water Dispensers in the Neighborhood Great Room	Revised to include maintenance of the juice, coffee, and water/ice dispensers.
<i>Department: Facility Services</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision

FSPP US-2	Emergency Power Generation System	Revised to reflect a change in frequency of inspections for the emergency generators.
<i>Department: Medical Staff</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
MSPP 001-03	Laguna Honda Acute Medical Unit Admission Guidelines	Updated to add language regarding SNF residents requiring short term acute care monitoring during the administration of high risk subcutaneous and intravenous medication.
<u>3. a. Hospital-wide Policies and Procedures for Deletion</u>		
Policy Number	Title	Comment(s)/Reason(s) for Deletion
None.		
<u>b. Department Policies and Procedures for Deletion</u>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
None.		

HARM REDUCTION

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that provision of services are consistent with the San Francisco Department of Public Health's harm reduction philosophy, and state and federal standards for the provision of person-centered care.

PURPOSE:

To provide strategies that promote healthy behavior and decrease the short and long term adverse consequences of risk behavior, even for those residents who continue unsafe practices.

SCOPE:

Harm reduction methods and treatment goals shall be used by LHH providers (including contractors), who deliver substance use treatment, mental health treatment, sexually transmitted disease (STD), and HIV/AIDS treatment and prevention services, and/or who serve residents who use drugs or alcohol.

DEFINITION:

Harm Reduction: It is a public health philosophy, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals, their family and community. The Harm Reduction model is person-centered and attempts to reach residents "where they are at," to assist them in making choices that lead toward better health. Harm reduction methods and treatment goals are free of judgement or blame and directly involve the resident in setting their own goals.

Unhealthy practices: Habits or practices that negatively impact one's health. Some examples include: 1) A resident continues to eat an excessive amount of sweets despite having unstable diabetes; 2) A resident continues to smoke cigarettes despite having a history of stroke, but is doing so off campus; 3) A resident continues to drink alcohol despite having liver failure, but is not disturbing others.

Unsafe practices: Behaviors that negatively impact the healing environment and recovery of self or others, but are not imminently dangerous. Some examples include: 1) A resident who is HIV positive brings used needles to the unit, increasing the risk of needle stick to others around them; 2) A resident continues to smoke cigarettes inside their room; 3) A resident (who is not being aggressive) brings alcohol to the unit and gives it to another resident.

Imminently dangerous behavior: Behaviors that if not intervened upon immediately, would cause immediate harm to self or others (e.g.: a resident is agitated and waving around a broken bottle while intoxicated).

RATIONALE:

People are responsive to culturally competent, non-judgmental services, delivered in a manner that demonstrates respect for individual dignity, personal strengths, and self-determination.

Service providers are responsible to the wider community for delivering interventions which attempt to reduce the economic, social, and physical consequences of drug and alcohol related harm and harms associated with other behaviors or practices that put individuals at risk.

Those engaged in unhealthy or unsafe practices are often difficult to reach by offering 'traditional services', (e.g. abstinence-oriented treatment) therefore, the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with those individuals who are unable or not yet willing to engage in treatment services. At LHH, this means that comprehensive treatments need to include strategies that reduce harm for residents who come for medical treatment, but may be unable or not yet willing to modify their unsafe practices.

Relapse or periods of return to unsafe health practices shall not be equated with or conceptualized as "failure of treatment", nor as "failure of resident."

Each service area within the system of comprehensive services at LHH can be strengthened by working collaboratively with other areas in the system. Harm Reduction methods are most effective when applied consistently across all services and providers.

People change in incremental ways and must be offered a range of treatment outcomes in a continuum of care from reducing unsafe practices (including but not limited to: changes in routes of administration, decrease in frequency of practices, or reduction of medical risks from practices) to abstaining from unsafe practices.

PROCEDURE:

1. Provision of Services

- a. Service goals shall be determined through collaboration between the resident and resident representatives, the staff, and the program, establishing realistic measurements of success, for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care^{42 CFR § 483.40}.

- b. Providers shall expand service options within existing programs or collaborate with other service agencies to be able to respond to residents and their special needs.
- c. As LHH is part of the San Francisco Health Network and a safety net institution, access to LHH services is allowed even for residents who are unable or not yet willing to abstain from unsafe practices, provided that LHH can provide safe and adequate care for the resident.
- d. Providers shall not deny services to individuals for exhibiting behaviors for which they seek or need help.
- e. Residents shall not be denied access to, restricted from participation in, or terminated from services on the basis of their use of prescribed medications.
- f. Provider language shall not reflect bias toward personal behaviors, experiences, ethnicity, sexual orientation, or personal choices.
- g. Programs shall broaden their treatment philosophies in order to provide quality, comprehensive care and coordinate care with other health care service providers.

2. Interventions

- a. Initiation and Resident Education
 - i. Clinical interventions shall be individualized based on the safety risk assessment, differentiating approaches for unhealthy practices and unsafe practices.
 - ii. The provider shall:
 - Meet with the resident to acknowledge and address the resident's unsafe practice as well as how it relates to the resident's recovery goals and goals for that session in particular.
 - Provide and document resident education regarding risk of unsafe practices to increase resident awareness, reduce the risk of negative consequences, and help resident in making an informed decision regarding unhealthy and unsafe habits. Education and training opportunities shall include reference to LHH's harm reduction philosophy as appropriate to the education and training content/topic. Education provided shall be documented in electronic progress notes by discipline providing the education.

- Utilize the principles in Trauma Informed System through mindfulness and awareness, and recognize personal trauma and triggers, and its impact to present behavior and coping skills. Use “what has happened?” perspective in developing plan of care to our residents.
- Include motivational strategies (e.g. motivational interviewing) that reduce the harm for those residents who are unable to or not yet willing to stop unsafe practices.
- Along with the resident care team, ensure that clinical interventions and initiated care plans are person-centered and shall take the resident’s own goals and values into consideration.

b. Monitoring and Follow Up

- i. Providers shall make a reasonable attempt, within the context of their programs, to follow-up with residents who demonstrate an inability or unwillingness to participate in treatment, and prior to discharge, make a reasonable attempt to find additional or alternative treatment.
- ii. Providers shall recognize relapse, or a return to unsafe practices as part of the recovery process, not as a "failure of treatment" or "failure of resident."
- iii. Successes shall be measured to include incremental improvement in housing, physical and mental health, finance, employment and family and social support system.
- iv. In the event that a resident is so impaired and/or uncooperative to present imminent danger to self or others, the provider shall follow LHH safety policies and procedures in managing the situation.
- v. Evaluation shall be completed by RCT at a minimum every quarter, and shall be discussed with resident or representative during resident care conference.

3. Quality Assurance

Performance measures shall be established to assure implementation, compliance, and continuous improvement in adopting harm reduction approach.

Documentation audits shall include a monthly neighborhood review of residents undergoing a harm reduction program to verify that:

- a. Harm reduction education was provided to the resident and documented

- b. Care plan was initiated and updated as needed
- c. Monthly neighborhood review of harm reduction plans shall be reported to Nursing Quality Improvement Committee.

ATTACHMENT:

None

REFERENCE:

42 CFR Section 483.40 Behavioral Health Services
San Francisco Health Commission Resolution No. 10-00: Adopting a Harm Reduction Policy for Substance Abuse, STD and HIV
<https://www.sfdph.org/dph/files/hc/HCRes/Resolutions/2000Res/HCRes10-00.shtml>
LHHPP 01-00: Value, Mission and Vision Statement
LHHPP 20-01: Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units
LHHPP 21-03: Resident Rights
LHHPP 22-10: Management of Resident Aggression

Original adoption: 18/01/09 (Year/Month/Day)

DEMENTIA CARE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center's (LHH) Dementia Care Program supports, honors, and nurtures individuals with dementia, and respects their values while optimizing their highest level of function.
2. Members of the medical staff (who may include primary care physicians, neuro-psychologists and psychiatrists) determine a resident's decision-making capacity.
3. A comprehensive assessment and person-centered care plan shall be developed by the Resident Care Team (RCT) with input from the resident and family or surrogate decision maker, with focus on meaningful social interactions and activities.

BACKGROUND:

LHH provides residents with major neurocognitive disorders (formerly called dementia) with a therapeutic, supportive environment to enhance quality of life. Care shall be tailored to maximize each resident's highest physical, social, intellectual and emotional state.

Definition of Key Terms:

1. **Neurocognitive Disorder¹ (Dementia):** A descriptive term for a collection of symptoms that can be caused by a number of disorders affecting the brain that are permanent and sometimes progressive. Major neurocognitive disorder is a decline in mental ability severe enough to interfere with independence and daily life.
2. **Behavioral or Psychological Symptoms of Dementia (BPSD):** Behavior or other symptoms in persons with dementia that cannot be attributed to a specific medical or psychiatric cause. This may include symptoms such as disturbed perception, thought content, mood and behavior.
3. **Behavioral Interventions:** Individualized approaches, including direct care and activities, that are provided as part of a supportive physical and psychosocial environment, and that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.
4. **Person-centered Care:** Care that is individualized and incorporates relevant physical, functional, and psychosocial aspects. Medical treatment shall be tailored to an individual's risk factors, current conditions, past history, and advance directives.

¹ Major neurocognitive disorder, known previously as dementia, is a decline in mental ability severe enough to interfere with independence and daily life. This term was introduced when the American Psychiatric Association (APA) released the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

PROCEDURE:**1. Functional Assessment:**

- a. The RCT reviews the current physical, functional, and psycho social status of each resident who has a neurocognitive disorder to formulate an accurate picture of their overall condition and functional abilities.
- b. Residents with neurocognitive disorder shall have their medical decision-making capacity assessed.

2. Interventions to help decrease behavioral distress in residents with cognitive impairment:**a. Person-Centered Care**

Staff shall ensure a supportive environment that promotes comfort and recognizes the specific needs of the resident as evidenced by the individualized preferences documented in the resident care plan. A two way flow of information between the RCT and resident, their families, and or surrogate decision makers shall help identify such individual preferences.

b. Quality and Quantity of Staff

An adequate number of consistently assigned and appropriately trained caregivers shall be provided to meet the individualized needs of each resident.

c. Thorough Evaluation of New or Worsening Behaviors from Baseline

The primary physician and the RCT shall evaluate the plan of care for residents with any new or worsening behaviors that emerge. Any potential triggers that are identified, such as visual/hearing impairments, pain, lack of social interaction or inappropriate strategies for care activities by staff shall be addressed prior to considering pharmacologic management.

- d. **Trauma Informed System Principles to Care:** Utilize the principles in Trauma Informed System through mindfulness and awareness, and recognize personal trauma and triggers, and its impact to present behavior and coping skills. Use “what has happened?” perspective in delivering care to our residents.

e. Individualized Approaches to Care

Nursing staff shall communicate the plan of care across shifts in order to focus on the resident's individualized needs. Consistent assignment, when possible, across disciplines, is a priority to help promote the recognition of an individual resident's change in condition and to establish a therapeutic relationship.

f. Psychotropic Medication Use

When non-pharmacologic interventions alone are not effective to manage dementia-related behaviors, psychotropic medications may be considered. If

psychotropic medications are used, specific target behaviors shall be identified and monitored. Residents taking chronic psychotropic medications shall be evaluated periodically for a potential gradual dose reduction.

g. Collaboration with Decision-maker

The RCT shall involve the resident's decision-maker in the discussion of potential approaches to address behaviors.

3. Monitoring and follow up

- a. Nursing staff shall monitor the resident for changes in condition and decline in function. Any changes or newly emergent behaviors shall be reported to the physician and discussed with the RCT.
- b. Based upon the resident's individual response to interventions as well as the progression of dementia, the RCT shall adjust the plan of care in cooperation with the resident and the decision-maker.
- c. The licensed nurse shall document any intervention changes in the resident's care plan and monitor for effectiveness using the Behavioral Monitoring Record. Other staff may also document behavioral changes.
- d. If resident is prescribed a psychotropic medication for symptoms of dementia, the licensed nurse shall record the effectiveness of the medication by regularly monitoring changes of the Target Behavior Symptom as well as the presence of any observable side effects of the medication. The physician may order other diagnostic tests for monitoring as appropriate to the particular psychotropic medication.

ATTACHMENT:

None.

REFERENCE:

2016 Alzheimer's Disease Facts and Figures. Alzheimer's Association.

<http://www.alz.org/facts/>

Alzheimer's Association. www.alz.org/what-is-dementia.asp?type=alzchptfooter

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Centers for Medicare and Medicaid Services, Department of Health and Human Services, *Advanced Copy: Dementia Care in Nursing Homes: Clarification Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for F309 – Quality of Care and F329- Unnecessary Drugs*, May 2013.

Dementia Care Practice recommendations for Assisted living Residences and Nursing homes (2006). Alzheimer's Association.

Gitlin, L.N., Kales, H.C., Lyketsos, C.G., Managing Behavioral Symptoms in Dementia Using Nonpharmacological Approaches: An Overview JAMA. November 2012; 308(19):2020-2029 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711645/>
National partnership to improve Dementia Care in Nursing Homes. Advancing Excellence in America's Nursing Homes.
<https://www.nhqualitycampaign.org/demntiacare.aspx>
State Operations Manual, Appendix PP. Centers for Medicare and Medicaid Services.

Original adoption: 18/01/09 (Year/Month/Day)

1.677 Manual Ware Washing

Established and Revised: 11/2017

Reviewed: 11/2017

Section: Sanitation and Infection Control

PURPOSE: To outline proper manual ware washing procedures

Policy: Multiservice utensils shall be effectively washed to remove or completely loosen soils by the use of manual or mechanical methods necessary, such as the application of detergents, hot water, brushes, scouring pads or high pressure sprays.

Procedure:

- Manual ware washing shall be accomplished by using a three-compartment sink where the utensils are first scraped, then washed, rinsed, sanitized and air dried.
- During manual ware washing, food debris on utensils is first removed by scraping over a waste disposal unit or compost bin.
- If necessary for effective cleaning, utensils will be pre-soaked or scrubbed with abrasives.
- The temperature of the washing solution and rinse sink shall be maintained at no less than 110°F. Ecolab product **Solitaire Detergent** is utilized for wash sink. The utensils shall then be rinsed in clear water before being immersed in a sanitizing solution. Wash and rinse water must be changed every two hours or sooner if becomes heavily soiled, or if temperature drops below 110°F.
- Manual sanitization shall be accomplished in the final sanitizing rinse by contact with a solution of 200-400 ppm quaternary ammonium (**Oasis 146 Multi-Quat Sanitizer**) for at least one minute. Pot-room personnel shall test sanitizer sink water each time sink is re-filled, and document results on **Ware washing Chemical Log**. Employees must document every time sanitizer water is changed and tested, as this is a patient safety issue.
- Pots, pans and utensils shall be inverted to drain and air-dry before they are put away in proper places.
- Ecolab provides routine preventative maintenance services on a monthly basis including inspection of three-compartment sink in pot room:
 - Checking on proper function of detergent dispenser system
 - Checking on Multi-Quat sanitizer reading

ASSISTING RESIDENTS DURING MEALTIME

POLICY:

1. All nursing staff will prepare residents for meals.
2. All nursing staff will ensure resident hygiene is performed.
3. All nursing staff will ensure that residents are provided with adaptive devices, dentures, eyeglasses, and hearing aids in place, if needed, during mealtime.
4. All nursing staff will verify that residents' meal tray matches menu ticket order.
5. All nursing staff will offer residents options for where in the neighborhood they prefer to eat.

PURPOSE:

To ensure that residents who need assistance with meals are adequately served their meals.

PROCEDURE:

A. Preparation

1. Prepare for meals by making sure the resident's hands and face are washed. Offer clothing protector all residents each time.
2. Orient the resident that it is meal time.
3. Adjust over bed table to proper height.
4. Nursing staff will wipe tables using facility-approved disinfectant.
5. Staff who are feeding or supervising residents designated to be at risk for aspiration are responsible for knowing and complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.
6. Position the food tray according to resident's ability (e.g., food in the line of vision, and place utensils on the functional side.)
7. Assist the resident to open cartons and to cut up food as necessary.
8. Set up adaptive equipment for residents who use it.
9. Inform blind residents of menu content and placement of food on their plate or tray.
10. When residents are out of bed during mealtime, if possible, arrange a group to allow residents the opportunity for socialization. Grouping will allow the staff to give close attention to several residents while assisting them with their food. By feeding one resident a spoonful, and successively rotating turns among the residents, each resident is allowed time to chew the food without hurrying

Assisting Residents During Mealtime

B. Positioning

1. Positioning in Chair:
 - a. Ensure resident is comfortable and in good body alignment to minimize any chance of aspiration.
 - b. Position yourself for level eye contact to avoid towering over the resident while you are feeding
2. Positioning in Bed:
 - a. Elevate the head of the bed to its highest position, approximately 90 degrees to position the resident in an upright position.
 - i. Support head with a pillow to keep the head in good alignment, positioned just slightly forward, chin not resting on the chest and head not tilted backward.
 - ii. Pillows may be used to support the resident's arms.
 - iii. If the resident has a tendency to lean to the side, a pillow may be used to maintain good spinal alignment.
 - iv. For residents with aspiration precautions and/or enteral feeding, leave head of the bed elevated for at least 20 minutes after meals.
 - v. When residents who need to be fed have adjacent beds the nurse is to feed two residents simultaneously. If a resident needs very close observation while eating, or beds of residents who need to be fed are far apart, the nurse may feed one resident at a time.

C. Assisting the Resident to Eat

1. Prepare the food for eating:
 - a. Check with resident if food temperature is comfortable
 - b. Do not overfill the glass or cup
 - c. Open all containers, even if resident may not eat the contents.
 - d. Cut up food into bite-size pieces
 - e. Thickener may be added to liquids as ordered for those residents who may choke or aspirate thin liquids. Mix thickener thoroughly with liquid to a consistency the resident tolerates.
2. Offer a sip or two of liquid first to moisten resident's mouth before feeding to stimulate secretions and swallowing.
3. Put a small amount in the mouth at one time in the area of the mouth where resident has the best muscle control and taste perception to promote safe swallowing. Allow enough time for chewing. Do not rush the resident.
4. Watch to see that food or fluids are swallowed before giving more.
5. Alternate food and fluids, offering food in the order the resident prefers.
6. During and after the meal check to see if there is any food being pocketed in the resident's cheeks, wipe the resident's mouth after each bite, if necessary, with a napkin to clean away food or liquid from the face. Clean nasal secretions away immediately.

D. After the meal

1. See that resident's hands and face are cleaned, soiled clothing protectors removed, and oral hygiene is provided after the meal.

Assisting Residents During Mealtime

2. Keep resident sitting upright for at least 20 minutes after the meal. If resident must lie down, position on their side.
3. Clean any adaptive equipment that the resident used. Keep adaptive equipment at the bedside and labeled with their name.
4. Place water pitcher within resident's reach unless resident is on fluid restriction, or otherwise ordered, and encourage fluid intake between meals.

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Nursing P&P E 1.0: Oral Management of Nutritional Needs

LHHPP File 26-02 Management of Dysphagia and Aspiration Risk

LHHPP File 26-04 Resident Dining Services

Original: 2017/10/18

Reviewed: 2017/10/18

Approved: 2017/10/18

OBTAINING, RECORDING AND EVALUATING RESIDENTS WEIGHTS

POLICY:

1. Any nursing staff except for Home Health Aide may obtain residents' weights.
2. Resident weight is obtained on the day of admission/readmission, monthly, as clinically indicated, and during the observation period of the Minimum Data Set (MDS) unless otherwise indicated by a physician order
3. Residents are weighed by the receiving neighborhood upon relocation.
4. Reweighs are performed each time the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g., planned weight loss).
5. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.
6. Monthly weights shall be obtained every first weekend of each month.

PURPOSE:

To obtain accurate weight measurements and identify unintended weight changes to facilitate effective care planning.

PROCEDURE:

A. Obtaining Weights

1. Check previous weight prior to weighing resident to immediately identify any potential discrepancy.
2. Resident will be weighed using the same scale, clothing, and/or linen with each reweigh.
3. Immediately prior to weighing resident, staff shall zero the scale.

B. Reweighing

1. If there is a weight change greater than 5 pounds (+/-), immediately reweigh resident.
2. Continue to reweigh resident daily for the next 2 consecutive days.

C. Frequency of Weights

1. On admission/readmission, nursing will obtain resident weights on the day of admission/readmission.

Obtaining, Recording and Evaluating Residents Weights

2. Residents shall be weighed weekly for 4 weeks after admission, then monthly, unless otherwise prescribed by physician.
3. Nursing will weigh resident for a significant change in condition, change in food intake, and other evidence of altered nutritional status or fluid and electrolyte imbalance.

D. Reporting

1. Weights must be reported to the licensed nurse during the shift it was obtained
2. If the weight variation is greater than or less than five pounds (2.27 kilograms) and is unanticipated weight change, the licensed nurse notifies the physician and dietitian.
3. The nurse reports unintended weight loss or gain to the dietitian and physician:
 - a. 5% or greater over 30 days
 - b. 7.5% or greater over 90 days
 - c. 10% or greater over 180 days
4. The licensed nurse will notify the MDS Coordinator or Nurse Manager to include resident with significant weight change on the list of resident's for discussion at the next Resident Care Team meeting.

E. Documentation

1. Licensed staff documents all weights on the resident's electronic health record.
2. Licensed nurse will document on the electronic health record the assessment any actions taken for unintended weight changes.

REFERENCES

NONE

CROSS REFERENCES:

Nursing P&P Nursing P&P G 4.0 Measuring the Resident's Height and Weight

ATTACHMENT/APPENDIX:

NONE

Revised:

Reviewed:

Approved

ADMISSION TO LAGUNA HONDA ACUTE AND SNF SERVICES AND RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

Prospective residents are welcome to Laguna Honda Hospital and Rehabilitation Center (LHH) regardless of race, color, creed, religion, national origin, ancestry, gender, sexual orientation, disability, HIV status or related condition, marital status, political affiliation, or age over 16. LHH shall comply with California and federal laws pertaining to non-discrimination.

1. LHH shall accept and care for those San Francisco residents:
 - a. Who meet skilled nursing facility (SNF), SNF rehabilitation, acute medical or acute rehabilitation (inpatient rehabilitation facility (IRF) care criteria;
 - b. For whom it can provide safe and adequate care; and/or
 - c. Who are at least 16 years of age.
2. Applicants for admission to LHH shall be screened prior to any admission.
3. LHH shall assess the physical, mental, social and emotional needs of new and current residents to determine whether each resident's care environment is best able to meet these needs.
4. LHH shall accept pre-scheduled admissions of new and returning patients Monday through Friday.
5. LHH shall accept residents to the first available SNF bed appropriate to meet their clinical care needs when they have lost their bed hold.
6. New and returning patients from Zuckerberg San Francisco General Hospital (ZSFG) may also be admitted on Sundays if pre-arranged on Friday. Returning patients from UCSF may also be readmitted on Sundays if pre-arranged on Friday.
7. LHH shall centrally coordinate resident relocations to:
 - a. Optimize utilization of resources;
 - b. Optimize bed availability for new admissions; and
 - c. Minimize the potential for adverse impact on the resident.
8. LHH shall notify residents and their surrogate decision-makers of plans for relocation within the facility.

9. In case of emergency and/or medical surge conditions:
 - a. Physician may temporarily admit a patient to an in-patient acute care or skilled nursing facility bed.
 - b. The patient's stay shall be documented according to established procedures (i.e.: Inpatient, Acute, SNF and/or Outpatient Clinic/Rehab).

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or rehabilitation services who are admitted to LHH receive care in the most appropriate service setting.
2. To allocate services in coordination with available hospital resources.
3. To provide a standard procedure for relocation of residents within the facility.

ABBREVIATION:

1. A&E: Admissions and Eligibility Department
2. PFC: Patient Flow Coordinator
3. RCT: Resident Care Team

PROCEDURE:

1. Admissibility and Screening Procedures

- a. In accordance with Section 115.1 of the San Francisco Health Code, admission priority to LHH shall be given to residents of San Francisco. Exceptions may be made by the LHH Chief Executive Officer (CEO)/Designee based on special clinical or humanitarian circumstances. Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin.
- b. The LHH Chief Medical Officer (CMO) or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The LHH CMO is the ultimate authority over admissions. The following sequential priority will be followed unless the LHH CMO or designee in his/her professional judgment, based on risk assessment and the totality of circumstances consistent with the patient's best interest determines otherwise.
- c. People are accepted to LHH with the following priority guidelines:

- i. 1st Priority:
Persons not in a medical facility, as well as persons who are wards of the Public Guardian or clients of Adult Protective Services, who cannot receive adequate care in the present circumstances.
 - ii. 2nd Priority:
Patients at ZSFG ready for discharge to SNF level of care.
 - iii. 3rd Priority:
Persons not in a medical facility who are receiving adequate care in their present circumstances.
 - iv. 4th Priority:
Patients at other San Francisco medical facilities.
 - v. 5th Priority:
Patients who are San Francisco residents presently in a medical facility or private circumstance outside of San Francisco.
- d. LHH cannot adequately care for prospective residents with the following:
- i. Communicable diseases for which isolation rooms are unavailable
 - ii. In police custody unless approved by CMO, CEO, Chief Nursing Officer (CNO) or designees.
 - iii. Ventilator
 - iv. Medical problem requiring Intensive Care Unit care
 - v. Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care
 - vi. Highly restrictive restraints
 - vii. Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:
 - Actively suicidal
 - Violent or assaultive behavior
 - Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia
 - Sexual predation

- Elopement or wandering not confinable with available elopement protections
 - Applicants who will not sign the smoke free preadmission agreement
- e. Screening of applicants:
- i. The Screening Committee which includes the following: CMO or designee, CNO or designee, Admissions Coordinator, Patient Flow Coordinator and other members as designated by the Administrator, is responsible for screening referrals to LHH and accepting residents for admission.
 - ii. Patient/Resident referrals to the specialty units (Rehabilitation, Positive Care, and Hospice) will be screened and accepted by the unit screening physician or screener.
 - iii. When an immediate decision is needed outside the regularly scheduled meeting times of the Screening Committee, the CMO or designee, and the CNO or designee will screen and approve resident referrals.
 - iv. The Screening Committee and/or the LHH Specialty Unit will request behavioral screening of potential admissions that have behavioral or psychiatric problems.
- f. Admission of applicants:
- i. LHH shall admit a patient only on a LHH Admitting Physician's order.
 - ii. With the exception of admission to acute care units (Acute Rehab and Acute Medical), all admissions must meet SNF-level criteria as defined by Title 22.
 - iii. Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident's individual needs and preferences and with the participation of the resident or surrogate in the placement decision and continuing care planning. ¹Residents lacking capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.

¹ If stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each residents' individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing care planning to assure placement continues to meet resident's needs and preferences." CMS Guidance To Surveyors, LTC Facilities/State Operating Manual F223(b).

- iv. In all cases of admission from another facility, a physician to physician clinical hand off and a dictated discharge summary is required.
- g. Resolution of problem screening and admissions:
 - i. Problems shall be brought to the LHH CMO and LHH CEO for resolution.
 - ii. The LHH CEO shall have the final authority over admissions to LHH.
- h. The LHH CEO shall serve as the Hospital's review board in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices shall be forwarded to this Committee for investigation and review.

2. Specific Admission Procedures

- a. Pre-Admission Procedures
 - i. The Conditions of Admission agreement shall state that all residents are assessed upon admission for appropriate placement and/or relocation within the facility.
 - ii. Residents (or their representatives) shall receive a copy of the Conditions of Admission agreement upon admission to the LHH. The Conditions of Admission agreement shall be reviewed and signed by the resident or the resident's surrogate decision-maker.
 - iii. Residents (or their representatives) shall receive a copy of House Rules and Responsibilities and Smoke-Free Campus Pre-Admission Agreement. As a condition of admission, the resident or resident's surrogate decision-maker must agree to these conditions by signing these agreements before or upon admission.
 - iv. The Screening Committee shall make placement decisions based on the identified physical, mental, social and emotional needs of the resident, family connection with staff; if any; and bed availability and communicate with the nursing unit and Resident Care Team including the primary physician and nurse manager admitting the new resident.
 - v. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until the Admissions Coordinator has evaluated the referral packet.
 - vi. The specialty unit RCTs may place and take care of residents on other units, e.g., in isolation rooms or in other satellite beds.

b. Acute Medical Unit

Policies Specific to Acute Medical Unit Neighborhood

- i. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.
- ii. All admissions to the Acute Medical Unit are subject to ongoing utilization review as outlined in the Utilization Management Plan.
- iii. SNF residents who require blood transfusions, but who are not acutely ill, shall be provided care on the Acute Medical Unit as “come and go” cases.
- iii.iv. SNF residents who are not acutely ill but require close monitoring while receiving a subcutaneous or intravenous medication, and for the post treatment period, shall be provided for in the Acute Medical Unit as a “come and go” case, after approval by the CMO.

Procedures Specific to the Acute Medical Unit

- i. All residents admitted to the Acute Medical Unit, except those residents admitted on a “come and go” basis, shall have a separate complete medical record covering the period of their acute hospitalization.
- ii. Whenever a resident is admitted to the Acute Medical Unit from either a LHH SNF care unit or from the Rehabilitation Department, she/he is discharged from the previous care unit and resident’s medical record is closed, except in those cases where residents “come and go” for transfusion.
- iii. A new SNF resident record shall be started upon the resident’s re-admission to a SNF care unit.

c. Acute and SNF Rehabilitation Care Units

Admission Criteria Specific to Acute and SNF Rehabilitation Care Units

- i. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.
- ii. Patient must be medically stable.
- iii. Patient requires rehabilitation physician management.

- iv. Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:
 - Training in bowel and bladder management
 - Training in self care
 - Training or instruction in safety precautions
 - Cognitive function training
 - Behavioral modification and management
 - Training in communication

Admission Criteria Specific to Acute Rehabilitation Unit

- i. The LHH Pavilion Mezzanine Acute Rehabilitation Unit is designated as an Inpatient Rehabilitation Facility (IRF)
- ii. Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:
 - Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation.
 - 24 hour availability of nurses skilled in rehabilitation.
 - Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals (e.g., physical therapists, occupational therapists, speech language pathologists, and prosthetists and orthotists) in a time-intensive and medically-coordinated program. One of the therapy disciplines shall be physical or occupational therapy.
- iii. The medical and/or surgical stability and comorbidities of patients admitted to the unit must be:
 - Manageable in the rehabilitation program
 - Permit participation in the rehabilitation program
- iv. Patients must be capable of fully participating in the patient rehabilitation program as evidenced by:
 - Ability to respond to verbal, visual and/or tactile stimuli and to follow commands.

- Ability to participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week).
- v. Patients must demonstrate the ability to progress towards objective and measureable functional goals that:
 - Will offer practical and beneficial improvements.
 - Are expected to be achieved within a reasonable period of time.
- vi. Patients must require and intensive and coordinated interdisciplinary team approach to care.
- vii. Patients in most circumstances, has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

Admission Criteria Specific to SNF Rehabilitation Unit

- i. Rehabilitation needs shall include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the SNF-level Rehabilitation Unit.
- ii. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.
- iii. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a long term care unit.

Admission Procedures Specific to Acute Rehabilitation Unit

- i. A physiatrist or designee shall perform pre-admission screening (PAS) to assess the patient's ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services. Pre-screening performed by a non-physiatrist must have a physiatrist co-sign that the patient meets the requirements for acute rehab (IRF) admission.
- ii. A new SNF record shall be started if the patient is discharged to a LHH SNF Care Unit.
- iii. Refer to Guidelines for Inpatient Rehabilitation Facility Documentation LHHPP 27- 06

Admission Procedures specific to SNF Rehabilitation Unit

- i. The Chief of Rehabilitation Services/designee shall perform pre-admission screening to assess the patient's ability to achieve significant improvement in a reasonable period of time with rehabilitation services.

d. Positive Care Unit

Admission Criteria Specific to the Positive Care Unit

- i. Patients who have HIV infection and require SNF level or palliative care and prefer an HIV / AIDS focused unit.

e. Hospice and Palliative Care Unit

Admission Criteria Specific to Hospice and Palliative Care Unit

- i. Patients who have a terminal disease or would benefit from a palliative approach (see Medical Staff P & P Hospice and Palliative Care).

f. Secure Memory Care Unit

Policies Specific to Secure Memory Care Unit

- i. The goals of the Secure Memory Care Unit are:
 - To promote the well-being and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and
 - To meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming while minimizing the use of individual restraints.

Admission Criteria Specific to Secure Memory Care Unit

- i. Residents who are mobile;
- ii. Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for him/herself;
- iii. Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and
- iv. Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended

conservator does not disagree with placement of the resident in a secured setting.

- v. The requirements above do not preclude LHH from placing a resident in the memory care unit on an emergency basis to ensure the resident's safety but the placement must be authorized by the CMO.

Exclusion Criteria Specific to Secure Memory Care Unit

- i. Residents whose aggressive behavior cannot be safely managed in this setting.
- ii. Residents without surrogate or conservator.

Procedures Specific to Secure Memory Care Unit

- i. The Admissions Coordinator and Screening Committee personnel will coordinate admission in collaboration with the Secure Memory Care Neighborhood RCT.
- ii. On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.
- iii. The RCT shall reevaluate residents for unit appropriateness one month after admission, then quarterly. The RCT shall explore interventions that may reduce the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the RCT shall document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.
- iv. A resident of the LHH Secure Memory Care Unit shall be relocated as soon as practicably feasible to other LHH units or transferred to another facility or the community if the resident's status changes such that the resident is no longer mobile, the resident's cognitive status improves such that secured placement no longer is needed; or the resident's cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.
- v. Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and RCT. To ensure availability of Secure Memory Care Unit beds when needed, attempts shall be made to adapt such a resident to another unit.

3. Sunday Admissions

a. From ZSFG

- i. LHH primary physician shall refer the ZSFG team to LHH Admissions and Eligibility (A&E) once the patient is accepted.
- ii. Pre-scheduled admissions shall be accepted for Hospice, Positive Care, General SNF, SNF and Acute Rehab (IRF) patients on Sundays.
- iii. Sunday admissions from ZSFG must be approved by the LHH admissions screening committee, and accepted by the primary LHH team (including primary physician) by the Friday afternoon preceding admission.
- iv. LHH A&E shall inform ZSFG (UM and MSW) via LHH tracking and text page by 3pm on Friday of admissions scheduled for Sunday. LHH A&E shall inform ZSFG MSW of LHH primary physician's pager number.
- v. Approval by LHH weekend admitting physician is not required for admission.
- vi. LHH A&E shall complete the admission referral sheet and deliver this along with the referral packet to the unit scheduled to receive the weekend admission by Friday afternoon.
- vii. LHH primary physician shall receive clinical hand off from ZSFG physician by the Friday preceding the weekend admission, and a dictated discharge summary must be available at the time of admission.
- viii. LHH nursing shall receive report from ZSFG nursing on the day of transfer.
- ix. LHH A&E shall remind ZSFG MSW to arrange ambulance transport to leave ZSFG no later than 11 am.
- x. Admissions are scheduled to arrive to LHH early in the day and no later than 12 noon.

b. From UCSF

- i. Only prearranged readmissions are accepted, as stated above.

4. Procedures Related to Coming and Going from the Hospital

- a. Return of current residents after come-and-go procedures at other acute facilities.

- i. Before return of a LHH resident who has been referred to another facility for come-and-go surgery or other invasive medical care, the physician responsible for the resident at the other facility must provide a summary of information on the procedure that includes:
 - Procedures done
 - Complications, if any, both intra- and postoperative
 - New orders recommended for the first 24 hours at LHH
 - Recommendations for special studies and follow-up care
 - ii. A checklist reminding the responsible physician of the need for this information shall be sent with the resident from LHH to the other facility. The physician responsible for the resident at that facility may complete either the checklist or another form from their facility that provides the same information.
 - iii. If a resident is returned from another facility after come-and-go surgery or other medically invasive procedure without recommendations for follow-up care, the Laguna Hospital attending physician shall contact the physician responsible for the resident at the other facility and shall document the information in the medical record. If the regular unit attending physician is not present when the resident returns, the charge nurse will contact the on-call physician to carry out this policy.
- b. Bed hold definition: A bed hold is a bed held for a specific resident discharged to an acute unit or facility. A bed can be held up to seven (7) days, with the date of discharge being day 1. A bed hold cannot be placed on a bed on LHH acute units.

5. Relocation of Current Resident From One SNF Unit to Another SNF Unit

- a. Relocation Guidelines
 - i. Nurse Manager will explain process. Upon admission to a resident care unit, the nurse manager shall be responsible for explaining to the resident or surrogate decision maker (SDM) the process by which the RCT assesses the resident for the purpose of appropriate placement.
 - ii. Decision criteria. Criteria for determining the appropriate unit shall be based on an assessment of the resident's needs and knowledge of services available, including knowledge of available shift staffing and skills within the respective care units. Decisions regarding resident relocation between units shall be made by the PFC in collaboration with the CMO or designee and

CNO or designee and the respective referring and receiving resident care teams of the neighborhoods.

- iii. Relocation requests. Requests for relocation to another unit by the resident, surrogate, or RCT shall be evaluated by the PFC who facilitates the decision-making process.
- iv. Relocation. In the event that a resident is to be relocated involuntarily in order to better match the resident's needs with unit focus and resources, the nurse manager shall give the resident or representative notice in advance of relocation. This shall be documented by completing the Transfer of Room Notification form, which includes:
 - Reasons for the relocation;
 - Date the relocation will occur;
 - The care unit to which the resident will be relocated; and

The RCT shall take into consideration the resident's response in deciding whether to continue with the relocation. This discussion must be documented in the medical record. In a contested relocation the medical social worker shall notify the ombudsman.

- v. Problem resolution. Prior to making a relocation referral to the PFC for a reason other than a change in level of care, the RCT shall utilize resources at its disposal to resolve the problem, address the concern, or meet the need behind the referral.
- vi. Re-evaluation of problematic relocations. RCTs shall re-evaluate complex or problematic relocations and roommate assignments at least one month after the relocation.
- vii. Appeal route for conflict intervention. Conflicts about relocation process shall be referred to the CNO and CMO for joint resolution.
- viii. Neighborhood moves. When large scale, permanent or temporary care unit moves are anticipated, the details of the move, such as how and when residents and families shall be informed, must be worked out in advance by the RCT.

b. Relocation Procedures

- i. All relocation requests, including plans for relocation to and from specialty units which accept direct admission from the community, shall be routed

- through the designated PFC. For relocations to specialty units, the PFC shall communicate with the unit RCT and A&E.
- ii. The resident and appropriate family/surrogate decision maker(s) shall be notified when the relocation is being planned and be informed of the reason and the estimated waiting period, if known. They shall be offered an opportunity to visit the new location, if possible.
 - iii. The sending unit nurse manager shall communicate with the receiving unit nurse manager prior to relocation and the sending physician shall communicate with the receiving unit physician, if possible, at least one day in advance of the relocation.
 - iv. Once an appropriate bed becomes available, the PFC shall confirm relocation plans and confirm that the sending and receiving care units are notified.
 - v. A physician's order is required for the relocation.
 - vi. To promote continuity in care, the sending physician shall document in the medical record, a relocation note.
 - vii. The receiving RCT shall review the existing treatment plans initiated by the previous team, and review the plan and all changes with the resident.
 - viii. Each discipline shall take appropriate measures to assure continuity of care.
 - ix. Ancillary Service departments, who receive the Daily Census report, shall make this information available to clinical staff on a daily basis so that caregivers can track resident transfers and readmissions.

ATTACHMENT:

- Appendix A: Relocation Checklist for Individual Resident
- Appendix B: Behavioral Screening

REFERENCE:

- LHHPP 22-03 Resident Rights
- LHHPP 23-01 Development & Implementation of an Interdisciplinary Resident Care Plan
- LHHPP 24-06 Resident Suggestions and Complaints
- LHH 20-10 Transfer and Discharge Notification
- Internet Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual
- Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual

File: 20-01 Admission to Laguna Honda Acute and SNF Services and
Relocation Between Laguna Honda SNF Units Revised ~~November 14, 2017~~[January 9, 2018](#)

Revised: 00/07/13, 04/02/06, 04/03/02, 04/12/16, 09/08/24, 10/11/09, 11/01/25,
11/09/27, 12/01/31, 12/07/31, 13/11/21, 14/07/29, 14/11/25, 16/09/13, 17/11/14,
[18/01/09](#) (Year/Month/Day)

Original adoption: This is a consolidation of 12 previous policies

Appendix A

RELOCATION CHECKLIST FOR INDIVIDUAL RESIDENT

FROM CARE UNIT: _____

TO CARE UNIT: _____

DATE: _____

ADDRESSOGRAPH: _____

ITEMS CHECKED:

1. ADDRESSOGRAPH CARD
2. TRANSFER ORDER NOTED
3. ALLERGIES DOCUMENTED
4. IMMUNIZATIONS: PD dT PNEUMO FLU
5. VITAL SIGNS
6. FAMILY AND/OR RESIDENT NOTIFICATION DOCUMENTED IN NURSING NOTES
7. PROGRESS NOTES
8. M.D.S.
9. RAP REVIEW & SUMMARY
10. RESIDENT CARE PLAN
11. MED / TX SHEETS & BEHAVIORAL MONITORING= SUMMARY
TALLY SHEET
12. ADL NOTES
13. ACTIVITY ATTENDANCE RECORD
14. CHRONOLOGICAL RECORD
15. SIGN CONSENT: PSYCH Rx RESTRAINT TUBE FEED dT
16. ADAPTIVE DEVICE(S) SENT,
Specify _____
17. SUMMARIZE RESTORATIVE NURSING PROGRAM:
18. PROPERTY: BEDSIDE SAFE BAGGAGE ROOM
19. MEDICATIONS: MED CART TREAT CART FRIG
20. SOCIAL SERVICE & DIETARY NOTIFIED
21. APPOINTMENTS:
22. OTHER INSTRUCTIONS:

CHECKED BY:

Appendix B

BEHAVIORAL SCREENING

1. Overview

- Referrals to LHH that have significant psychiatric, behavioral and substance use histories and/or current behavioral issues shall be screened by a LHH mental health professional.
- The primary behavioral screeners are mental health professional staff assigned by the Chief of Psychiatry or designee, and who are available for consultations and screening as needed.
- The behavioral screener does not make admission decisions, but convey behavioral assessment information and recommendations to the LHH Admissions Screening Committee, which has the final decision authority.

2. Responsibility of the Screener

- Conduct behavioral screening of certain LHH admission referrals.
- Follow status of referrals whose condition may be changing over time, as needed.
- Prepare a Screening Report that summarizes behavioral issues and other potential risk factors, behavioral care plan approaches and their efficacy, with assessment conclusions of 1) whether the patient's behavioral health service needs can be met at LHH, and 2) any clinical issues and management strategies the Resident Care Team (RCT) should be aware of, in the event the patient is admitted to LHH.
- Consult LHH Psychiatry providers as needed, especially for patients who have previously been evaluated and/or treated by LHH Psychiatry providers.
- Consult LHH Chief of Psychiatry as needed on disputed cases.
- If the referred individual has potential need for behavioral health services (e.g. psychiatric medication management, substance use treatment, mental health services, behavioral consultation/planning), the behavioral screener will provide information on available services at LHH, and if applicable, obtain a LHH Treatment Agreement signed by the patient and/or decision-maker, endorsing compliance and participation in Substance Treatment and Recovery Services (STARS) at LHH.
- Does not include making decisions about admissions.

3. Areas of Review

- Review the screening packet for background history plus contact information of most knowledgeable care-providers and surrogate decision-makers. Phone calls to these individuals may be helpful.
- Review LCR and any current paper chart noting especially diagnoses, medications, conservatorship status (and any Affidavit A's and Affidavit B's), prior

APS contact, recent progress notes, use of PRN medications, daily nursing flow sheet.

- Especially note records of current and prior history of aggression, self-harm, emotional lability, active psychotic symptoms, personality disorder, elopement risk, drug and alcohol use, history of criminality, fire-setting, predatory behaviors (sexual, aggressive, fiscal or other abuse), treatment non-compliance, and any other behavioral issues.
- Review prior and current behavioral management plans/techniques and their efficacy.
- When indicated, review current legal status, including whether the patient has any pending charges. The screener will check all behavioral referrals on the California Megan's Law website (<http://www.meganslaw.ca.gov/>) and the national database (<http://nsopw.gov>) to verify whether the patient is a registered sex offender (RSO). If the patient is a RSO, obtain from the referring agency the registration documentation and history information regarding the sexual offense status.
- Obtain copy of psychotropic medication consent when available if the patient is on psychotropic medications.

4. Screening Schedule and Communication

- Behavioral screening requests are sent to the Chief of Psychiatry/designee by a member of the Admission Committee verbally or in writing.
- The referral information packets are usually available from A&E a few days prior to screening.
- The behavioral screener shall screen within one work day in general, or as soon as possible, but no later than within three work days unless otherwise arranged.
- The Screening Report shall be documented as an Initial Risk Assessment in the designated Electronic Health Record (EHR) for LHH Psychiatry.
- The screener will forward a copy of the Screening Report to members of the LHH Admissions Screening Committee, as well as the admitting RCT if applicable.
- The LHH Admissions Screening Committee meets every Tuesday and Thursday, and as needed. A behavioral screener/designee shall attend the meeting or be available by phone.
- The behavioral screener may be available to answer questions from the admitting RCT about screening information on the resident. Such information is for screening purposes only and does not substitute the RCT members' own clinical assessments.
- Consents and agreements obtained by the screener will be forwarded to the Admissions Screening Committee.

5. High Behavioral Risk Admissions

Potentially high behavioral risk admissions shall be identified by the behavioral screener, the Admissions Screening Committee and the admitting RCT if applicable.

Prior to Admission

- The behavioral screener shall screen or re-evaluate the referred patient within one week of and before the admission date.
- The behavioral screener shall brief the RCT and all LHH Psychiatry staff on potential behaviors and management recommendations prior to admission, include the behavioral plan, if any.
- Transfer/Discharge summary must be received by the admitting MD the day before the patient is transferred, and the sending MD must be available for phone sign out to the primary care physician and the LHH Psychiatry consultant.

Day of admission

- The admission should take place early in the week, Monday through Wednesday if possible.
- The admitting MD shall make e-referral to LHH Psychiatry upon admission as indicated.
- The LHH Psychiatry assigned consultant(s) shall prioritize evaluating the resident upon receiving the e-referral.

After Admission

- The behavioral screener shall do a follow up evaluation of the patient and discuss with RCT members within 24 hours of admission, or the next work day.
- The RCT shall discuss the patient in unit huddle at least daily for the first week. The behavioral screener and/or the assigned LHH Psychiatry consultant(s) shall attend when possible.

6. Returns and Re-admissions from PES/Inpatient Psychiatry

PES/Inpatient Psychiatry shall contact the patient's primary physician and assigned LHH Psychiatry consultant for returns and re-admissions. The behavioral screener/designee is available to assist with in-person evaluations as needed. The re-admission decision shall be made by the primary physician in consultation with the LHH Psychiatry consultant. Disputed cases shall be referred to the Chief of Psychiatry and/or the Chief Medical Officer.

HOLIDAY FACILITY DECORATIONS

POLICY:

~~Live Holiday decorations, such as Christmas cut trees and or anyall~~ flammable holiday decorations are prohibited at Laguna Honda Hospital.

PURPOSE:

To ensure a safe environment for residents, visitors and employees.

PROCEDURE:

1. Artificial trees must be either fireproof or flameproof, and need to have documentation with ~~either sticker or tag stating date of fireproof treatment.~~
2. Decorations of paper, plastic, and all other materials ~~not distributed by the Hospital must be accompanied by documentation indicating that they are either fireproof or flameproof.~~ shall not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment.
3. Electrical ornaments are not permissible.
4. Each department head, nurse manager, or supervisor is responsible for enforcing this directive. Necessary documentation must be made available ~~on-demand~~ when requested as proof of compliance.

ATTACHMENT:

None

REFERENCE:

~~None~~ NFPA 101, Life Safety Code, 2012 Edition

Revised: 92/05/20, 12/09/25, 17/12/418/01/09 (Year/Month/Day)

Original adoption: 88/01/22

1.71 Replenishing Juice and Coffee Dispensers, and Maintaining Ice and Water Dispensers in the Neighborhood Great Room

Established and Revised: 12/10, 7/12, 8/14, 8/15, [11/17](#)

Reviewed: 8/13, 8/14, 8/15, [11/17](#)

Policy: To ensure that residents and staff have access to juice, [water](#), and coffee at all times [in each Neighborhood](#), a Food Service Worker [or designee](#) will replenish the juice and coffee dispensers, ~~located in each Neighborhood~~ [and restock sufficient numbers of new cups for residents to use whenever they get a cup of water to drink from the water and ice dispenser](#). In addition, the dispensers will be cleaned and sanitized once a day.

Procedure:

1. Each morning, two food service workers are assigned to replenish the coffee and juice in each of the thirteen neighborhoods. One will complete the North Building and the other will complete the South Building and Pavilion Building. The Food Service Worker will fill out a check form and return the form to the Supervisor.
2. The Food Service Worker will gather the necessary containers of bulk juices from the refrigerator (Apple and Orange), quart size cranberry juice and packages of coffee (regular and decaf) from the storeroom. The Food Service Worker will gather the necessary cleaning supplies using the three bucket method.
3. Before replenishing the dispensers, the Food Service Worker will use the three bucket method to wash, rinse and sanitize the outside and interior of **all the dispensers (juice, coffee and water/ice)**. They will empty the catcher on the juice machine **and ice/water dispenser**.
4. The Food Service Worker will restock the Galley Refrigerator up to the designated par of quart size cranberry juice. They will look at the date of any opened container of cranberry juice and dispose of the product if it's been more than three days (72 hours). They will date any container of opened cranberry juice if there is no date.
5. The Food Service Worker will report any concerns or problems with the product or dispenser units to the Food Service Supervisor. The supervisor will take the necessary corrective action in reporting conditions to either the coffee or juice manufacturer or Facility Services.
6. On a monthly basis, the juice vendor will complete a check on all juice dispensers. The service will be noted on each machine.
7. On a monthly basis, the coffee vendor will complete a check on all coffee dispensers. The service will be noted on each machine.

EMERGENCY POWER GENERATION SYSTEM

POLICY: The hospital shall provide a reliable emergency power system.

PURPOSE: To assure essential emergency electrical power for all hospital.

I. CHARACTERISTICS:

During a power outage two 2000kW, 3200A emergency diesel generators will supply essential power via 5000A paralleling main switchboard MSBG to the new Hospital buildings. There are eight Auto Transfer Switches automatically switch the loads from PG&E power to the Emergency Generators.

II. PROCEDURE:

~~1.~~ 1. Watch Engineer shall perform a weekly inspection of the emergency generators.

~~4-2.~~ 2. Watch engineer ~~shall will~~ test the emergency generators on the first ~~and third~~ Wednesday/Tuesday of each month at 14:00 for 30 minutes minimum.

~~2-3.~~ 3. Watch engineer shall observe the operation of the generator and automatic transfer switches. All test readings and any deficiencies shall be documented and submitted to the Senior Engineer for review.

~~3-4.~~ 4. ~~Each time the generators will be started from the different transfer switches simultaneously~~ Watch Engineer shall initiate each test from a different transfer switch and document the switch initiating the test.

~~4-5.~~ 5. Senior Engineer shall review the documentation and report the result of the test to the Chief Stationary Engineer.

~~5-6.~~ 6. ~~Chief Stationary Engineer/Director of Facility Services~~ shall report the failure of the test to the ~~Safety Committee/PIPS Committee.~~

~~6-7.~~ 7. ~~Watch~~ Senior Engineer shall check the fuel supply daily and report any unusual gauge readings to the ~~Chief~~ Senior Engineer and take all steps to assure that the hospital has ~~an~~ essential emergency electrical power at all times.

~~7-8.~~ 8. When the fuel in the generator system tank ~~will reaches the level of~~ reaches 6,000 gal., the Senior Engineer shall order ~~the~~ fuel to fill it up to 90% of the max capacity 15,000x.9=13,500 gal in order to maintain 72 hours of emergency service.

~~8-9.~~ 9. Auto transfer switch ATS/C (Critical equipment) is the close transition power supply switch. There is no power supply interruption at the time of the power supply shift for the testing from ~~the~~ PG&E to the emergency generator and back to normal. There is a power supply interruption if any other transfer switches will be used for the generator test.

~~9-10.~~ 10. Emergency Generators will automatically start and engage the load demand within 10 seconds whenever ~~at the~~ power interruption from the PG&E Company occurs.

~~10-11.~~ 11. A qualified Service Technician or Service Vendor ~~Engineer~~ shall inspect the generators annually.

~~11-12.~~ 12. Main electrical breakers of the switch boards and automatic transfer switches will be inspected and ~~tested every three (3) years by qualified service Engineers~~ serviced annually by

a qualified vendor.

~~42.13.~~ At an unscheduled generator test, the Senior Engineer will notify IT, Radiology, Respiratory Therapy, Medical Records, Food Services, Administration and ~~Operator for the~~ Nursing Office 30 minutes before the test.

~~NEW-~~NEW: September
2010 P&P US-2

File: 001-03 Revised January ~~21, 2016~~, 2018

ACUTE MEDICAL ADMISSION GUIDELINES Laguna Honda Medical Staff Policies and Procedures

Laguna Honda Acute Medical Unit Admission Guidelines

POLICY:

Admissions to the Acute Medical Unit will meet criteria for intensity of care and severity of illness and will be consistent with the wishes of the patient or surrogate decision maker.

PURPOSE:

To provide guidelines to be used when evaluating residents for admission to the Acute Medical Unit.

PROCEDURES:

- 1) Advanced Directives must be reviewed on all residents being considered for admission to the Medical Acute Unit. Residents who have "No transfer off neighborhood" orders should not be admitted to the acute unit except in very unusual circumstances (for example higher level of care required for resident comfort) and after discussion with family, surrogate or conservator.
- 2) Medical Acute Unit admissions are done at the discretion of the Medical Acute Unit admitting physician. Any disagreement between the SNF and Acute physicians regarding admission to the acute unit or discharge back to the SNF unit shall be referred to the Chief of Medicine for resolution.
- 3) When a resident is ready for discharge back to their SNF unit after Medical Acute Unit admission, the SNF physician shall write admission orders.
- 4) Appropriate admissions shall be consistent with Interqual Acute Admission Criteria and include:
 - Acute infections (pneumonia, urosepsis, skin infections) with hypoxia, abnormal electrolytes or WBC, or abnormal vital signs.
 - Dehydration or acute renal insufficiency requiring continuous IV hydration.
 - Significant electrolyte abnormalities requiring continuous IV hydration and electrolyte correction.
 - Altered mental status.
 - Acute exacerbation of chronic conditions such as COPD, CHF or ESLD.
- 5) Consider acute admission to outside facility for:
 - Residents requiring ICU level care, telemetry or surgical intervention and whose advanced directives are consistent with receiving this level of care, ie "Full Code".

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- Residents with abdominal pain or tenderness who require evaluation for possible surgical intervention and whose advanced directives are consistent with receiving this level of care.
- 6) Other circumstances:
 - Residents who have a known infection requiring a prolonged course of antibiotics (i.e. osteomyelitis) may initiate their treatment on the Medical Acute Unit if they are acutely ill, but once stabilized should be readmitted to their SNF unit to complete their course of therapy.
 - SNF residents who require blood transfusion, but are not otherwise candidates for Medical Acute Unit admission, should transfer to Medical Acute Unit on a "come and go" basis in order to receive close monitoring during the transfusion. This is not an admission to the Acute Unit. Informed consent is required prior to starting transfusion, and should be obtained by the primary physician.

- SNF residents who are not acutely ill but require close monitoring while receiving a subcutaneous or intravenous medication, and for the post treatment period, shall be provided for in the Acute Medical Unit as a “come and go” case, after approval by the CMO.