List of Hospital-wide/Department Policies & Procedures Submitted to JCC for Approval on July 10, 2018

1. *a. New Hospital-wide Policies and Procedures*		
Policy Number	**Title**	**Comment(s)/Reason(s) for Development**
LHHPP 45-05	**Molly's Fund – Assistive Technology Program**	Created to utilize Molly's Fund to provide assistive technology services and devices to residents.
b. New Department Policies and Procedures		
Department: Pharmacy		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
05.01.01	**Non-formulary Medication Requests**	Created as a separate policy ad procedure from 05.01.00 Hospital Medication Formulary.
2. a. Revised Hospital-wide Policies and Procedures		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
24-21	**Insertion and Maintenance of the Intraosseous Device**	Revised to reflect that physicians do not receive credentialing for EZ-IO insertion.
26-03	**Enteral Tube Nutrition**	Revised to reflect current practice.
70-01 A2	**Emergency Preparedness**	Revised to reflect current procedures for responding to an emergency.
70-01 C3	**Earthquake Response Plan**	Revised to reflect the current earthquake response plan.
76-03	**Animal Control**	Revised to reflect the current DPH policy for service and support animals.
b. Revised Department Policies and Procedures		
Department: Nursing		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
D5 3.0	**Cast Care**	o Clarified on policy that an RN must monitor and assess the cast and extremity frequently for complications. o Added to purpose the identification of cast-related skin and neurovascular abnormalities related to improper cast fit or maintenance and to prevent cast deterioration as a result of misuse by patient" o Included Definitions of: ▪ Cast • Plaster, Fiberglass, Synthetic ▪ Cast window ▪ Types of Cast • Sugar-tong splint, short-arm cast, long0arm cast, short-let cast, long-let

		cast, body-jacket cast, single-hip spica, double-hip spica o Added to procedure specific care of each cast (plaster, fiberglass, synthetic) o Specified monitoring and assessment by RN of CSM, monitoring for compartment syndrome, signs of infection, care for irritation, pruritus, and methods for minimizing swelling o Specified care for body-jacket or spica – superior mesenteric artery syndrome o Specified care for while showering or bathing o Included specifications for repositioning residents o Added to encourage active ROM to unaffected limb to prevent stiffness o Documentation: Added documentation of CSM or skin. Included reports of pain to DNCR
F 3.0	**Assessment and Management of Bowel Function**	Removed "The CAN or PCA may administer physician ordered non-medicated suppositories for the relief of constipation under the supervision of a licensed nurse."
J 1.0	**Medication Administration**	o New policy "Powdered medication should be diluted with 30-60 ml of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water o New policy "Each medication needing to be crushed for administration, must be administered individually, for both oral and enteral tube (do not mix medications together). o Suggestion to remove dotting in the initial box of the MAR or TAR as this will not be possible with EPIC. o Refer to Pain Policy for recording Pain due to pain no longer being a 5th vital sign. o New information on Crushing Medications: ▪ Meds to be crushed must be given individually and should not be combined with other crushed, uncrushed or liquid medications. ▪ Crushed medications given via feeding tube need to be flushed between each medication. o New section on: Administration of Medication(s) Through Enteral Tube ▪ 15 ml of fluids to be given before and after medications ▪ Per Aspen: Stop tube feeding for 15 minutes prior to administration

		▪ Each medication should be administered separately. After each med flush with 15 ml of water ▪ If on fluid regulation, different flushing schedule required ▪ Specify how increase water needed for medication administration impacts free water calculations
Department: Pharmacy		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
05.01.00	**Hospital Medication Formulary**	Revised to reflect that a Drug Formulary will be maintained by Pharmacy and made available via the intranet. Non-formulary medication procedures have been moved to a proposed new policy 05.01.01 Non-Formulary Medication Requests.
05.03.00	**Therapeutic Interchange and Generic Substitution**	Revised to reflect that pharmacists shall document therapeutic interchange in patient's chart.
Department: Volunteer Services		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
A 1.0	**Recruitment Process Life Cycle**	Revised to reflect that the volunteer coordinator or supervisor has the authority to dismiss a volunteer at his/her discretion.
A 6.0	**Record Keeping**	Revised to reflect the current record keeping procedures.
A 7.0	**In-Kind Donations**	Revised to reflect consistency with hospital-wide policy on donations.
A 8.0	**Clothing Room**	Removed the clothing room hours.
A 9.0	**Resident Library**	Revised to reflect time limit for iPad use.
3. ***a. Hospital-wide Policies and Procedures for Deletion***		
Policy Number	**Title**	**Comment(s)/Reason(s) for Deletion**
None.		
b. Department Policies and Procedures for Deletion		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
None.		

MOLLY'S FUND - ASSISTIVE TECHNOLOGY PROGRAM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) utilizes Molly's Fund to provide assistive technology services and devices to residents to maximize their level of functioning, decrease environmental barriers, improve quality of life, and to increase participation in daily activities, leisure pursuits, and socialization.

PURPOSE:

To provide appropriate and effective distribution of assistive technology services and equipment resulting from donations made to the LHH Gift Fund specifically related to Molly's Fund.

CHARACTERISTICS:

1. The funding source for assistive technology devices and services is Molly's Fund, a sub fund within the LHH Gift Fund. A project code has been established within the Gift Fund to accept contributions from donors who wish to support assistive technology programs at the hospital.

2. The distribution of assistive technology equipment and services is the responsibility to the Assistive Technology Committee, which includes members of Activity Therapy, Rehabilitation Services, Nursing, Accounting, and Administration.

3. Assistive Technology services are made available to residents is in accordance to a standard procedure when all other funding options have been explored.

4. Devices acquired through Molly's Fund and provided to residents, shall be the property of LHH and shall only become the property of the resident upon a planned discharge. A device may be repossessed by LHH and reallocated to another resident if a resident expires, or if the device is misused or not utilized for its intended purpose.

5. The definition of Assistive Technology includes:

   "Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve functional capabilities of a person with a disability." (IDEA2004, Disability Rights California), (The Role of the Occupational Therapy in Providing Assistive Technology Devices and Services, AOTA Fact Sheet, 2015)

PROCEDURE:

1. The Resident Care Team shall discuss assistive technology needs of the resident and designate a staff member to assist with completion of the Assistive Technology Fund application.

2. The completed form is submitted to the Assistive Technology Committee for consideration.

3. The Assistive Technology Committee is convened by the Accounting Partner and meets at least four times annually and/or when a Molly's Fund application/request has been received.

4. If the application is approved, the committee shall request an Occupational Therapy (OT) or Speech/Language Pathology (SLP) referral from the assigned physician as needed. OT/SLP shall conduct an assessment of the resident and develop a treatment plan including identification of an assistive technology device.

5. Every effort will be made to acquire a device, for trial purposes, from a community-based lending library to determine if it is appropriate for the resident.

6. When an assistive technology device or service has been determined to be appropriate for the resident, attempts will be made to acquire funding from all sources including insurance and resident/family.

7. If funding from Molly's Fund is determined to be the best option, OT/SLP will send Assistive Technology recommendations to the committee, to include goals and required devices or services. Information on attempts to secure funding from traditional sources shall also be provided to the committee.

8. The committee will approve or deny funding of devices or services.

9. If approved, The OT/SLP will review the Assistive Technology Contract with the resident and/or resident representative and get the necessary signatures. The signed contract will be kept on file in the Rehabilitation Services Department.

10. OT/SLP shall facilitate the purchasing process though Information Technology (IT) Procurement processes.

    a. Chartfield Codes includes:

        i. Fund: 22150

        ii. Department (Gift Fund): 207690

        iii. Project Code: 10000328

11. OT/SLP shall train the resident and neighborhood staff on the use of the assistive device.

12. The Rehabilitation Representative to the neighborhood will monitor the appropriate use technology equipment provided to the resident.

    a. If the determination is made that the resident is not meeting the terms of the Assistive Technology Contract, the Rehabilitation Representative will consult with the RCT to determine if additional support is needed.

    b. If the RCT determines that the appropriate course of action is to reallocate the equipment, the OT/SLP responsible for completion of the contract will be responsible to retrieve the equipment from the resident.

ATTACHMENT:
Attachment 1: Assistive Technology Application Form
Attachment 2: Assistive Technology Contract
Attachment 3: The Role of the Occupational Therapy in Providing Assistive Technology Devices and Services, AOTA Fact Sheet, 2015

REFERENCE:
LHHPP 45-01 Gift Fund Management
IT Procurement Guidelines
IDEA2004, Disability Rights California

Original Adoption: 18/07/10 (Year/Month/Day)

Assistive Technology Application Form

Please fill out this form and submit to Assistive Technology Coordinator.

Questions? Contact Deanna Chan, Occupational Therapist, at Deanna.w.chan@sfdph.org or x45734

Name: _____

Primary Diagnosis: _____

Unit and Room #: _____

How long have you been a resident of LHH? _____

Please indicate your current level of functioning in the following areas:

TASK:	No Help (Independent)	Set Up Help	Light Assist	Heavy Assist (Dependent)
Showering				
Toileting				
Dressing				
Eating				
Functional mobility (moving around room and unit)				
Functional mobility (moving around hospital grounds)				
Grooming/brushing teeth				
Written Communication (typed and/or long hand)				
Verbal Communication				

Please describe your leisure interests: _____

How much help do you require to participate in your leisure interests? Describe what kind of help you need. Please be specific. _____

What do you need help to do now that you want to be able to do with less or no help? _____

Would you be willing to use a new tool or piece of equipment to help you be more independent, even if it seems funny or awkward at first? _____

Please list current equipment or assistive technology tools currently used:

Assistive Technology Resident Contract

Resident Name:

MRN:

Laguna Honda Hospital and Rehabilitation Center

375 Laguna Honda Blvd

San Francisco, CA 94116

Dear _____,

Laguna Honda Hospital and Rehabilitation Center, through the Assistive Technology Fund, is happy to provide you with individualized assistive technology devices. These assistive technology devices have been chosen and ordered for your personal use. It is not intended to be used by any other individuals, whether they are family, friends or other Laguna Honda residents.

It is important that you understand the following rules:

1. You alone are intended to be the user of the issued assistive technology devices.
2. At no time shall you lend, sell, or otherwise give these devices to anyone.
3. These devices must be handled with utmost care. In the event of a repair need, please contact a Assistive Technology team member for further assistance.
4. Any devices issued to you shall be used for the intended use only. In the event the Assistive Technology team suspects misuse, the Assistive Technology Committee shall decide on appropriateness of this device for your further use.
5. If issued devices are not being used, the Assistive Technology team extends the right on an individual basis to re-obtain the devices and may issue to another resident.
6. The Assistive Technology Committee and team have the ability to take back any devices at its discretion.
7. The assistive technology devices will be <u>on lend</u> to you while you are a resident at Laguna Honda Hospital. While you are a resident here, Laguna Honda Hospital owns the assistive technology devices. In the event of your planned discharge to the community, the devices will become your personal property and you may take it with you when you leave. Ongoing repairs and responsibility of these devices will then by transferred to you.

By signing below, you agree to the above terms and acknowledge receipt of these items.

Thank you and good luck!

_____ _____

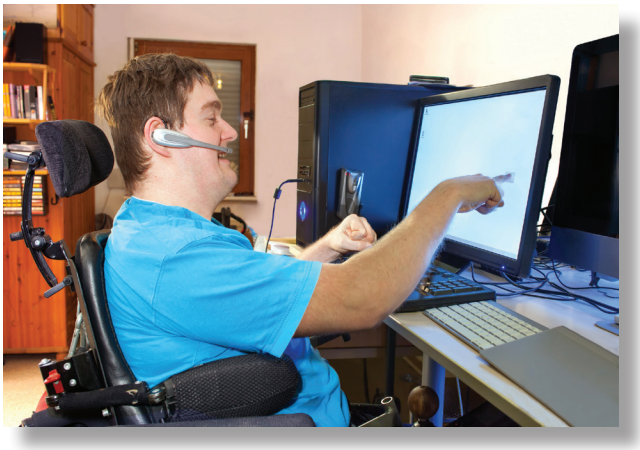
Print Resident Name Signature and date

_____ _____

Print Staff Name Signature and Date

The Role of Occupational Therapy in **Providing Assistive Technology Devices and Services**

Assistive Technology Defined



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Technology is a common element in our everyday lives. The goal of occupational therapy is to enhance or enable meaningful participation in the occupations (activities) important to the clients served. Therefore, technology is a component of providing occupational therapy services across practice arenas. However, just because an item is technological does not mean that it is assistive technology. Conversely, not all items used as assistive technology fall within the common definition of technology itself. The Technology Related Assistance for Individuals with Disabilities Act of 1988 put forth the definition of assistive technology that is used in most regulatory language. In the bill, assistive technology is defined as both a device and a service. An *assistive technology device* is any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities. *Assistive technology services* include the evaluation of need, the process of acquiring the device, fitting or customizing the device, coordinating the intervention plan, and providing training and technical support to the user and related support personnel. Occupational therapy practitioners provide both assistive technology devices and services.

Technology, Assistive Technology, and the Occupational Therapy Process

Practitioners use activity analysis in the occupational therapy process to meet the demands of each client's desired occupation in *context*. They consider the tools used to meet the demands of the occupation (activity) and consider the match between the skills and abilities of the client with the use of the tools. When these tools increase, maintain, or improve someone's functional capabilities, they meet the definition of assistive technology. If the tools typically used to perform an occupation do not align with a client's skills and abilities, the occupational therapy practitioner adapts or modifies them, or the way the individual uses them, to facilitate occupational performance. Therefore, providing assistive technology devices and services to support individuals with disabilities (and those who need assistance for a short-term illness or injury) and minimize barriers to function is a natural part of the occupational therapy process.

Based on their educational curriculum and clinical experience, occupational therapy practitioners have the knowledge and foundational skills to assess clients and provide assistive technology devices and services (American Occupational Therapy Association [AOTA], 2010). An important part of the occupational therapy practitioner role, based on observation and evaluation of the client's performance, is to make specific recommendations for the most appropriate assistive technology to facilitate improved functional ability. Matching the client's abilities, preferences, environmental contexts, and barriers to the technology device features is a distinct role that occupational therapy practitioners can fulfill, and which leads to productive outcomes for their clients.

However, this is *often* a collaborative multidisciplinary team process including consultation with other health care professionals on the team as well as educators, assistive technology device vendors, manufacturers, and of course, the client and family or caregivers. The rapid rate of change in available technology means that occupational therapy practitioners not only have to stay current for applications in their area of practice (AOTA, 2010), but they also must work closely with other professionals and particularly with relevant vendors as an advocate for

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the client, when necessary, to support the assistive technology decision-making process. The occupational therapist can then provide specific documentation about the purpose of the technology, how it will be used, and a rationale for its necessity to inform and support a physician order and payment. In addition, occupational therapy practitioners must exercise care and ethical judgment when recommending or using emerging technology, as supportive evidence and recognized standards may be limited or non-existent.

Case Examples of Occupational Therapy in Assistive Technology Intervention

- A fourth grade student with cerebral palsy has difficulty participating in classroom reading and writing tasks because of limited motor control in his arms. The occupational therapist introduces many high- and low-tech options, including a word processor with word prediction to increase his writing efficiency and legibility; a cut out desk with supports for his forearms so he can access a keyboard; highlighters to mark selections on multiple choice tests; and premade labels to use in group tasks without having to write. He reads using a tablet computer with access to a federally funded repository for digital books, and he uses the text-to-speech feature when he is getting fatigued. These supports allow him to function and learn in his classroom.
- An 81-year-old widow with vision loss lives at home. An occupational therapist helps identify and implement a variety of supports to increase her function in the kitchen, including a tablet with a camera to photograph and enlarge labels and recipes; voice output on the tablet to help her search for recipes online; high-contrast dials for the oven and stove; and large-print cookbooks and measuring tools. These interventions allowed her to remain independent and safe in her home without additional assistance.
- A college student with cerebral palsy who uses a power wheelchair for mobility has classes at lab tables that are difficult to reach. He is unable to reach some cabinets and work surfaces in his dorm when seated. He also struggles with constipation and loss of bone density. After observing his daily routine around campus, his occupational therapist helps him select the components of an appropriate seating and mobility solution, including a standing feature so he can access the lab tables and storage in his room, facilitating independence in self-care. The occupational therapist recommends and documents the rationale for a new chair, including the medical benefits related to digestion, elimination, and musculoskeletal integrity, for the physician and payer.

Conclusion

Occupational therapy practitioners' understanding of occupational needs and performance, coupled with their skills in activity analysis and focus on achieving client goals, strongly support the use of diverse types of assistive technology within models of best practice. That perspective helps identify and integrate desired features of assistive technology solutions, as well as address potential barriers to integrating assistive technology into the client's daily routines.

References

American Occupational Therapy Association. (2010). Specialized knowledge and skills in technology and environmental interventions for occupational therapy practice. *American Journal of Occupational Therapy, 64,* S44–S56. doi:10.5014/ajot.2010.64S44

Technology Related Assistance for Individuals with Disabilities Act of 1988. PL 105-394 Sec (3) (a) 3–4.





LAGUNA HONDA HOSPITAL 05.01.01
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR NON-FORMULARY MEDICATION REQUESTS

Policy:

Orders for non-formulary medication and medication orders with directions to "dispense as written" that are not covered by a patient's insurance or not routinely available from the pharmacy shall require non-formulary drug approval prior to dispensing.

Purpose:

To ensure proper use of the formulary, provide documentation of non-formulary drug use that facilitates submission of prior authorization to patient's insurance, and support responsible financial stewardship in regards to medication inventory.

Procedure:

I. Orders for non-formulary medication and medication orders with directions to "dispense as written" that are not covered by a patient's insurance or not routinely available from the pharmacy shall require documentation from the provider in the patient's chart with rationale as to how substitution or alternative therapy would result in patient harm

II. Orders for non-formulary medication and medication orders with directions to "dispense as written" that are not covered by a patient's insurance will be dispensed if available without initial non-formulary approval with a limited supply if the provider sufficiently documents that a delay would result in immediate patient harm or undue suffering

III. The pharmacy shall contact the provider for clarification of documentation or non-formulary rationale and suggest formulary alternatives prior to submitting the order for non-formulary drug approval

IV. Non-formulary drug approval process

1. A clinical pharmacist shall review the provider's rationale for each non-formulary drug request and evaluate financial impact based on third party payment or prior authorization.

2. The clinical pharmacist will contact the provider if additional documentation is required for a third party treatment authorization request (TAR) or prior authorization (PA)

3. The clinical pharmacist will contact the provider if the medication order cannot be dispensed on the basis of patient safety, lack of availability, inability to administer safely at LHH, insufficient equipment or materials to compound, or financial impact.

4. If the provider disagrees with the clinical pharmacist's basis for a denied non-formulary drug request then the provider will be referred to the director of pharmacy for additional discussion.

5. If the provider disagrees with the director of pharmacy or the director is not available in a timely manner then the non-formulary drug request shall be referred to medical leadership

6. A summary report will be included in the monthly pharmacy report to the P&T Committee. Non formulary medications which are used frequently will be considered for formulary addition.

New: 3/18

INSERTION AND MAINTENANCE OF THE INTRAOSSEOUS DEVICE

POLICY:

1. The EZ-IO® intraosseous device will be used to obtain vascular access in emergencies when intravenous access is not obtainable, or as determined by the physician to be the most effective route for rapid treatment.

2. Only physicians ~~who are credentialed on EZ-IO® insertion~~ may perform this procedure.

3. A ~~.trained~~ Registered Nurse (RN) shall assist with the following: accessing equipment, preparing extension set, applying the EZ-IO® stabilizer, flushing the line after successful access has been established, medication administration and/or fluid infusion, monitoring of the site, removal of device.
~~Competency will be checked yearly.~~

PURPOSE:

To provide safe and effective insertion and maintenance of the EZ-IO® intraosseous device during life-threatening situations.

BACKGROUND:

Intraosseous access is used to administer life-saving medications and to provide volume administration immediately for patients in life-threatening situations. Intraosseous devices are time-limited and should not remain in longer than 24 hours. Medication dosages through intravenous route and intraosseous route are considered to be dose equivalent.

INDICATIONS:

Early intraosseous access will be attempted when IV access is necessary for a life-threatening condition and IV access is not immediately achieved.

CONTRAINDICATIONS:

1. Acute fracture at or above insertion site of bone selected.

2. Prior attempt within 48 hours in bone selected.

3. Inability to identify anatomical landmarks.

4. Previous significant orthopedic procedures of selected bone for insertion.

5. Infection or vascular compromise at insertion site.

The physician will determine the risk/benefit to use of the intraosseous access device in life-threatening emergencies.

EQUIPMENT:

1. EZ-IO® Power Driver (drill).

2. Appropriate size intraosseous needle set, including stabilizer, and EZ Connect Fluid Transfer Set:

    a. 40 kg and greater: EZ-IO® AD 15ga 25 mm Needle (blue needle) and Fluid Transfer Set

    b. 40 kg and greater: EZ-IO® AD 15ga 45 mm Needle (yellow needle) and Fluid Transfer Set

3. 10 mL normal saline for flush:

    a. Note: Lidocaine 2 % (preservative free 20 mg/ml) for patients responding to pain.

        i. Will be kept in the medication tray in the crash cart.

4. Two pairs non-sterile non-latex gloves.

5. One sterile 2x2 or 4x4 gauze pad.

PROCEDURE:

1. Insertion

a. Locate appropriate insertion site

i. Proximal humerus (preferred site)-Insertion site is located directly on the most prominent aspect of the greater tubercle.

- Ensure that the resident's hand is resting on the umbilicus and that the elbow is adducted

    - If the resident cannot adduct the arm, place the resident's arm at their side and internally rotate the arm.

- Preferred site due to;

    - high flow and quick drug uptake

    - less painful if resident is awake/alert

ii. Proximal tibia-Insertion site is one finger width (2 cm) medial to the tibial tuberosity.

iii. Distal tibia- Insertion site is located two finger widths (4 cm) proximal to the most prominent aspect of the medial malleolus.

- May be preferred in the larger patient

b. Choose the correct size needle by assessing skin depth

i. Depress skin tissue to gauge depth

c. Prepare infusion system (RN or MD)

i. Unresponsive resident-prime EZ Connect Fluid Transfer Set tubing with 1-2 mL of normal saline

ii. Alert resident-prime EZ Connect Fluid Transfer Set tubing with 1-2 mL of preservative-free Lidocaine 2% (20mg/mL)

d. Cleanse skin with alcohol wipe or chlora-prep~~e~~

e. Ensure that driver and needle set are securely seated

f. Stabilize the extremity

g. Insert needle through the skin at a 90 degree angle

h. Assess for black line on needle when touching the bone

i. Activate the EZ-IO® driver, applying pressure until entering the intraosseous space.

i. Observe for visible blood flash or aspirate

j. Apply the EZ-IO® stabilizer dressing (RN or MD)

k. Connect tubing to the EZ-IO® needle port (RN or MD)

l. Flush for flow with 10 mL normal saline (RN or MD)

i. Note: Administer analgesia (preservative free Lidocaine 2%) prior to normal saline flush in residents who are responsive or alert. Lidocaine should be infused slowly, over 30-45 seconds to prevent discomfort. Allow at least 30 seconds after infusing Lidocaine before administering the normal saline flush.

ii. When flushing with normal saline, apply pressure to the syringe plunger due to the intraosseous space being filled with thick fibrin

m. Maintain flow (RN)

i. Infusions should be pressurized by use of IV pump or pressure bag

- Rationale: Medullary space pressure can stop flow

2. After insertion (RN or MD)

a. Check for the following;

i. Firmly seated needle,

ii. No leaking around site,

iii. No signs of extravasation,

iv. EZ-IO is secured using EZ Stabilizer,

v. EZ connect tubing is in place, and

vi. EZ-IO® wrist band is placed on resident with date/time/size of needle.

- Note: If resident is being transferred to the acute care hospital via EMS, communicate this information to EMS personnel

3. Removal of the EZ-IO® device (RN or MD)

a. Stabilize the resident's extremity.

b. Remove stabilizer dressing.

c. Attach luerlock syringe to the EZ-IO® needle port.

d. Rotate the catheter clockwise while gently pulling.

e. Do not rock or bend the EZ-IO® catheter during removal.

f. Check for integrity of needle after removal.

g. Apply dry dressing over site.

h. Place the used needle in the sharps container.

i. Return the EZ-IO® driver to Central Supply along with crash cart for cleaning and replacement.

4. Documentation

a. Physician-Document procedure in progress note.

b. Nursing-Document size of intraosseous needle used, site, time of insertion, stabilizer application, and any related medications or IV solutions on the following;

i. Code Blue Record

ii. Integrated Progress Note

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-16 Code Blue
SFGH Emergency Department Procedure (2013). Intraosseous-Use of the EZ-IO® intraosseous device. Accessed 5/4/2014 at http://in-sfghweb01.in.sfdph.net/CHNPolicies/production/Emergency%20Department/Intraosseous.pdf
http://www.vidacare.com/
http://www.vdh.virginia.gov/OEMS/Files_Page/symposium/2012Presentations/PREP-5013.pdf
The Consortium on Intraosseous Vascular Access in Healthcare Practice (2010). Recommendations for the use of intraosseous vascular access for emergent and non-emergent situations in various health care settings: A consensus paper. *Critical Care Nurse, 30(6), e1-e7*.

Revised: 18/07/10 (Year/Month/Day)
Original adoption: 14/09/09 ~~(Year/Month/Day)~~

ENTERAL TUBE NUTRITION

POLICY:

Enteral tube nutrition (ETN) is a form of medical therapy that is to be instituted only after careful resident assessment by the Resident Care Team (RCT). It requires monitoring to assure adequacy and appropriateness.

PURPOSE:

To promote and maintain optimal care of residents with decreased oral intake and for whom ETN is deemed appropriate. ETN may be appropriate when medical problems, including nutritional, clinical, functional, psychosocial and comfort status, result in decreased oral intake. However, decreased oral intake is a common feature of many terminal illnesses. ETN may not be indicated in cases where the burdens of the intervention outweigh the benefits to the resident.

PROCEDURE:

1. Assessment and Decision Making Process

a. Initial evaluation: When the RCT has completed an evaluation which may lead to placement of an enteral tube, a formal dysphagia evaluation is recommended for all alert residents unless clinically inappropriate or performed prior to admission. The evaluation shall be repeated when the resident's clinical condition improves.

b. Initiation: ETN shall be initiated only on written orders of the primary attending physician or designee, and only after informed consent has been obtained from the resident or surrogate decision maker (SDM).

   i. Family consult: The attending physician shall evaluate the prognosis for the individual resident and consider the expressed desires of either the resident or the resident's surrogate decision maker prior to beginning enteral tube nutrition. The decision to insert an enteral tube shall be made after consultation with the resident and/or family and the RCT members, and only after carefully reviewing risks, benefits, and other alternatives. Any advance directives should be carefully reviewed. ~~(Refer to Medical Staff policies MSPP D11-2 Guidelines for Advanced Directives, Decisions to Forego Life Sustaining Treatment, and CPR; and to MSPP C2-3 Advance Directives to Healthcare Providers).~~ If it is decided not to begin ETN in a resident for whom other feeding alternatives are not possible, comfort care and palliative interventions shall be considered and provided as appropriate.

   ii. Informed consent: Informed consent for enteral tube insertion shall be obtained from the resident or surrogate decision-maker in accordance with hospital policy (Refer to MSPP C02-01 Patient's Consent for Treatment and Operation).

If the resident has no surrogate decision maker the RCT may provide consent (Epple procedure) and Ethics Committee consultations shall be obtained if there is lack of consensus among the RCT members.

c. Time-limited trials: When the potential benefits and burdens of enteral tube insertion are unclear, a time-limited trial may be ordered. After a predetermined time, caregivers and the resident and/or family should reassess the response to the therapy, including nutritional parameters, resident well being, comfort and quality of life. An informed decision may then be made as to whether to continue with the therapy.

~~iii.~~i. There are possible side-effects and discomfort associated with the use of nasogastric tubes. There will be clinically pertinent documentation for extended use of nasogastric tube (e.g., greater than 4-6 weeks).

~~c.~~d. Withdrawal: The resident or surrogate decision-maker (SDM) may request withdrawal of an enteral feeding tube at any time. When withdrawal is not requested by the resident or ~~surrogate~~SDM, or when a resident lacks medical decision making capacity and ~~an incompetent resident~~ has no surrogate, consideration of withdrawal of ETN shall follow ~~MSPP D11-2 Guidelines for Advance Directives, Decisions to Forego Life Sustaining Treatment & CPR.~~LHHPP 24-05 Advance Care Planning and LHHPP 29-10 Non-Beneficial Treatment.

2. Care and Management

a. Refer to Nursing Policy and Procedure E5.0 Enteral Tube Feeding Management for the care and management of the resident with a feeding tube.

b. Facilities ~~will~~shall maintain enteral feeding pumps consistent with manufacturer's instructions to ensure proper mechanical functioning and calibration.

3. Replacement of a Dislodged Feeding Tube

a. A dislodged nasogastric tube shall be replaced by the licensed nurse, unless the physician orders state otherwise. Verification of tube placement by X-ray shall be obtained each time that a nasogastric tube is placed or replaced.

b. A dislodged gastrostomy or jejunostomy tube that is less than 6 weeks old shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.

c. A dislodged gastrostomy tube that is 6 weeks or more may be replaced by the registered nurse who has demonstrated knowledge and skill, unless the physician orders state otherwise. A gastrografin study shall be ordered by the physician to

confirm tube placement. The physician shall verify results of the radiology study before resuming orders for ETN.

If there is question about placement of the gastrostomy tube, or if the registered nurse is unable to replace the gastrostomy tube, the physician shall order the transfer of the resident to Interventional Radiology or the Emergency Room for gastrostomy tube re-insertion. There shall be direct communication between the Laguna Honda physician and the radiologist or the Emergency Room physician confirming correct placement of the tube before resuming orders for ETN.

d. A dislodged jejunostomy tube shall be replaced by Interventional Radiology or the gastroenterologist. The registered nurse can place a foley or gastrostomy tube to keep the tract open until the resident is able to be scheduled for the procedure.

4. Monitoring

a. Monitoring of side-effects: Residents should be monitored for problems with ETN. These may include chronic nasopharyngeal irritation, repeated tube removals and resistance to reinsertion, immobilization due to application of restraints, diarrhea, recurrent reflux and aspiration of gastric contents. If the side effects of the therapy are substantial, the physician should reevaluate the appropriateness of the enteral tube in consultation with the resident or the surrogate decision-maker and the RCT.

b. Monthly review: In reviewing monthly orders on residents receiving ETN, the attending physician should review the efficacy of the therapy. This should include a review of the resident's general medical and functional status as well as the resident's weight and nutritional intake. Resident well-being, comfort, dignity and quality of life should be evaluated on an ongoing basis. In addition, the attending physician should review the side effects and response to therapy as outlined above.

c. Periodic reevaluation: As part of the quarterly resident care conferences (RCC), the attending physician in concert with the other RCT members and the resident/family should reevaluate the goals of the enteral tube nutrition. The previous assessments should be considered as well as any change in the resident's condition or prognosis. Options of ongoing enteral tube nutrition, surgical tube placement or palliative care without enteral tube nutrition should be considered. It may be appropriate to consult the Ethics Committee at this time if it is decided to discontinue this therapy.

d. Nutrition reevaluation: The dietitian makes interval assessments of residents on enteral tube nutrition and provides suggestions for changes in nutritional therapy if necessary. During the quarterly RCC, the RCT shall review the nutritional plan and the dietitian's record for residents receiving ETN.

e. Interaction with medications: Certain medications (e.g., phenytoin) may be affected by enteral nutrition, and others (e.g., extended-release tablet and capsule formulations) should not be crushed or otherwise altered for enteral tube administration. For specific recommendations on medications known to be affected by enteral nutrition, and those with formulations that should not be altered, refer to the Nursing Policy and Procedures or consult the Clinical Pharmacist.

5. Documentation

a. Clinical documentation shall at a minimum include the following elements:

   i. Physician – completed physician order that shall include indication(s) for tube feeding, diagnosis and functional impairment(s).

   ii. Registered Dietitian – assessment of caloric needs, nutritional requirements that includes feeding flow rate and type of formula.

   iii. Nursing – technical and nutritional aspect of feeding tubes (e.g. tube size, location, feeding flow rate, care of tube site and replacement) shall be documented in Treatment Record; interventions for management of ETN and to minimize the risk of complications related to feeding shall be documented in care plan.

   iv. Speech Therapist – evaluation to restore normal eating skills to the extent possible.

b. Each discipline (Physician, Registered Dietitian and Nursing) shall evaluate resident's response to treatment and interventions in their progress notes at least quarterly.

6. Quality Assurance and Performance Improvement

a. An Unusual Occurrence (UO) report shall be completed by the licensed nurse when a resident is identified with a tube feeding complication. Examples of complications requiring the submission of a UO report include:

   i. Clogged tube

   ii. Dislodgement of tube

   iii. Aspiration

   iv. Leakage around the insertion site

   v. Erosion at the insertion site

vi. Abdominal wall abscess

vii. Stomach or intestinal perforation

viii. Peritonitis

ix. Tracheoesophageal fistula

x. Inadequate nutrition

xi. Metabolic complication

b. The Performance Improvement and Patient Safety Committee shall periodically review UO reports and case reviews to determine trends and patterns, and provide feedback on compliance issues with existing policies and procedures, and possible clinical and other interventions for performance improvement in clinical care.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-05 Advance Care Planning
LHHPP 29-10 Non-Beneficial Treatment
~~Medical Staff Policy and Procedure~~ MSPP C02-01 Patient's Consent for Treatment and Operation
~~MSPP C02-03 Advance Health Care Directives~~
~~Nursing Policy and Procedure~~ NPP E5.0 Enteral Tube Feeding Management
Nutrition Services Policy and Procedure 1.16 Nutrition Assessment Charting in the Medical Record
Nutrition Services Policy and Procedure 1.17 Nutrition Assessment as Part of the Care Plan Process

Revised: 98/11/16; 00/04/27, 13/05/28, 13/09/24, 17/09/12, 18/07/10 (Year/Month/Day)
Original adoption: 96/09/16

EMERGENCY PREPAREDNESS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) is committed to Emergency Preparedness through a continuous cycle of planning, organizing, conducting training exercises, evaluating processes, and implementing corrective actions.

2. ~~Laguna Honda~~LHH staff is responsible for participating in training, exercises, and achievement of departmental and hospital-wide goals for emergency preparedness.

3. Employees are provided with a disaster service worker identification badge that mandates city employee presence in the event of a disaster.

4. Staff are responsible for providing their current emergency contact information to the Department Manager and the Human Resources department. Department Managers are responsible for maintaining an accurate call back list.

5. The facility shall utilize the Hospital Incident Command System (HICS) for internal and external communication during emergency incidents and planned events.

6. Communication and coordination with public health and other hospitals city wide is achieved through regular meetings, joint exercises, and coordinated planning.

PURPOSE:

To have staff trained and prepared to respond to emergency situations.

PROCEDURE:

1. Training and Exercises

a. New employees are introduced to Emergency Preparedness concepts during their orientation.

b. Emergency Preparedness in-service is provided at least annually.

c. Additional training is provided through exercises that include defining and practicing departmental and individual roles with the Incident Command Structure (ICS) and development of next steps based upon exercise evaluation.

d. Training and department specific goals emphasize continuous home preparedness development and maintenance, including keeping an emergency wallet card with an out of area contact in the event that local telephone service is limited during an actual event.

2. Communication and Coordination

~~a.~~ Each department ~~and neighborhood~~ shall~~has~~ assign a representative ~~assigned~~ to the Emergency Preparedness Committee who is responsible for continuously enhancing and sustaining emergency preparedness. ~~by:~~

~~b.~~

~~c. Participating in regularly scheduled meetings and sending an alternative representative if unable to attend.~~

~~d.~~

~~e. Bringing back key information to the department or neighborhood.~~

~~f.~~

~~g. Serving as the champion and liaison for the achievement of department-specific and hospital-wide goals.~~

~~h.~~

~~i.~~a. ~~Maintaining a hard copy of Laguna Honda's Emergency Preparedness Manual in each department and neighborhood.~~

~~j.~~b. The department manager shall facilitate~~s~~ continuous updates for the emergency ~~Confidential~~ cC~~a~~ll bB~~a~~ck lL~~i~~sts. The confidential call back lists are kept securely in the HICS Command Center.

~~k.~~c. Coordination of meetings and related activities is achieved through the Emergency Preparedness Coordinator under the direction of the Department of Workplace Safety and Emergency Management.

~~l.~~d. Emergency preparedness updates are communicated to the~~at~~ leadership forum, executive committee, and neighborhood and departmental meetings as necessary.

~~m.~~e. ~~Laguna Honda~~ LHH participates in a city-wide ~~network of~~emergency preparedness healthcare coalition~~s~~ to support the goal of interoperability and coordination of planning, mitigation, response, and recovery activities.

~~n.~~f. Multiple communication systems are available and practiced to achieve redundancy in the event of technology downtime and to achieve coordination city-wide. 800 MHz radios and METS phone (Mayors Emergency Telephone System) are tested monthly.

3. Re-Assessment and Planning

a. A Hazards and Vulnerability Assessment (HVA) is completed annually to identify emergency incident risks to drive training and exercise development.

b. Opportunities to participate in state wide, city wide, DPH wide and other multi-jurisdictional exercises are incorporated into exercise plans each year for a

minimum of 2 ~~functional~~ exercises annually, no more than 6 months apart. Real incidents requiring HICS activation can substitute for exercises.

c. Response plans for the following list of hazards have been developed by the facility and are reviewed annually for performance improvement opportunities:

i. Earthquake ~~Preparedness~~

ii. ~~Emergency Responder Dispensing Plan (~~Mass Prophylaxis~~)~~

iii. Fire

~~iii.~~iv. Spill ~~Safety~~

~~iv.~~v. Medical Surge

~~v.~~vi. Water Disruption

vii. Power Outage

viii. Heat Emergency

~~vi.~~ix. Active Shooter

d. Emergency Supplies

i. Emergency equipment and supplies are stored in a central location near Materials Management Warehouse and in the HICS command center.

ii. ~~An inventory of supplies is kept by the Department of Workplace Safety and Emergency Management.~~

iii. ~~A list of AeroScout tagged equipment (including over 500 items such as intravenous and feeding pumps, gurneys, wheelchairs, suction pumps, vital sign machines, EKG machines, crash carts and AED's) is kept in both the Command Center and the Nursing Office HICS cabinets and is maintained by nursing informatics and~~ .

iv. The kitchen maintains a~~A~~ 7-day food supply for 2000 people and water to augment the 600,000 gallons of water in towers behind the 5th floor parking lot.

v. A par level of linen maintained by the Environmental Services Department.

vi. A cache of antibiotics for ~~Laguna Honda~~ LHH Pharmacy is available for delivery from DPH storage sites. (Refer to Appendix H: Hazard Specific Plans –Emergency Responder Dispensing Plan.)

vii. Par levels of medical and personal patient care supplies are available through most vendors.

4. Emergency Preparedness Manual

a. Provides the policy, purpose and procedures for emergency response with appendices for pertinent details.

b. The manual also provides lists of resources and serves as an informational tool for responding to emergencies. ~~describes the Hospital Incident Command System (HICS), DPH and LHH organizational structure, and general emergency response procedures.~~

5. Personal Preparedness

a. Staff are encouraged to continuously enhance their personal preparedness.

b. Key activities recommended are having a household plan, including a communication and meeting plan, as well as~~e~~ assembling preparedness supplies in a kit at home and as a "Go bag," for work or the car, and ~~to having a plan noted on~~completing a Red Cross Emergency Wallet Card (See Attachment A).

c. Information and links are provided on the WSEM web site on the LHH intranet ~~under the "Laguna Honda Emergency Management" button~~.

ATTACHMENT:
Attachment A: American Red Cross Emergency Contact Card

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan

Revised: 15/07/17, 15/09/08, 18/07/10 (Year/Month/Day)
Original adoption: 13/05/28

C3 Earthquake Response Plan

EARTHQUAKE QUICK REFERENCE RESPONSE GUIDE

ANTICIPATED IMPACT

Moderate to Significant

1. Disruption of normal operations and services
2. Influx of stable acute hospital level patients from SFGH or other hospitals
3. Influx of community residents who may have been impacted by an event and who are seeking basic first aid or guidance in the event of a large scale incident.
4. Need to provide shelter for community residents / others not able to return to their homes.
5. Seismic activity automatic shut down of all elevators until cleared and reset by maintenance company potentially impacting transport of persons and supplies by elevators.
6. Possible partial or total evacuation of the hospital potentially without the use of elevators.

MISSION

Take appropriate action during and following an earthquake to reduce injury and loss of life, prevent subsequent fires and other secondary problems, and facilitate recovery.

GOAL	ACTIONS
Coordinate activities with other hospitals, DPH and the community	Contact the Department of Emergency Management to report issues and coordinate resource requests. DEM coordinates with the Emergency Operations Center (EOC) for a city-wide response. State and Federal agencies are contacted as determined by local DEM and EOC authorities
Communicate to stakeholders	Notify the 24-hour watch engineer who will institute Facility Services policy for earthquake emergencies including checking the building for safety and hazards, extricating persons trapped in elevators and notifying elevator maintenance companies to check and reset elevators. (New building: ThyssenKrupp 520 Townsend San Francisco 415 544-8150 sanfrancisco@thyssenkrupp.com; Administration building: Otis @ 444 Spear Ste. 100 415 546 0880; night: 415 546 8100) Receive alerts: from CAHAN and DPH/ DEM Disseminate official notifications through Public Information Officer (PIO) Use public address system, email, pages/ page group, 800 Mhz radios, community meetings and other venues to disseminate information as directed by PIO with approval of Incident Commander Initiate call back lists if directed by Incident Commander Keep Hospital Incident Command and DPH Incident Command apprised of status and resources needed or available Refer ALL media representatives to the Hospital Incident Command Center
Remain as safe as possible during the quake to prevent injury or fatalities	Drop, Cover and Hold On – preferably under a sturdy table or desk and away from windows and other hazards such as tall furniture or heavy items that could fall. Do not stand in doorways. Stay Inside – many injuries and fatalities occur from people running out of buildings If outside, take cover as above and move away from buildings, electrical power lines, and overhanging structures.

Call 4-INFO (44636) to reach Hospital Incident Command

C3 Earthquake Response Plan

EARTHQUAKE QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS
Assure safety and well-being of residents and others	Proceed carefully due to hazards/ obstructions and be prepared for aftershocks Check for injuries and move residents away from window or other hazards such as shelves with heavy objects Check every space and every person to determine if anyone is trapped or in need of medical attention Account for all persons in your neighborhood or department Check the environment for fire and implement the Fire Plan if fire issues found Check for other hazards such as broken glass, electrical shorts, falling objects such as lights, ceiling tiles, wiring and report to Facilities 24-hour watch engineer or Hospital Incident Command Center, once activated. Call 42999 as usual for Code Blue or Code Red emergencies Call the Hospital Incident Command Center at 4-INFO (44636) to report status including account of persons in area, name of anyone missing, number of injuries, hazardous conditions, and resources needed Complete the Department Operating Status Report, Appendix F of the Emergency Response Plan (LHHPP 70-03)
Mitigate additional secondary hazards	Do not use elevators until advised of their safety Do not drink tap water until advised of its safety – use bottled water and refer to water disruption quick reference for more details on emergency water supplies Do not flush toilets or hoppers until advised to resume Participate in search activities, triage, labor pool and other activities as directed Perform Departmental Procedures as described in the Emergency Response Plan LHHPP 70-03 All Departments participate in emergency call backs if called for by Incident Command Facility Services automatically assesses building damage and notifies Incident Command. Sheriff's Department directs incoming visitors to specific areas and restricts hospital access if directed by Incident Command.
Provide essential services as usual and return to full service as soon as possible	Continue or re-establish usual care according to essential service priorities within the Laguna Honda Continuity Of Operations Plan (COOP)

OTHER REFERENCES

Laguna Honda Hospital Wide Policy and Procedure 70-02 Emergency Preparedness and 70-03 Emergency Response Plan

Appendix C of 70-03: Continuity Of Operations Plan (COOP)

Appendix H of 70-03: Hazard Specific Plans and Quick Reference Response Guides

- Emergency Responder Dispensing Plan

Call 4-INFO (44636) to reach Hospital Incident Command

~~**EARTHQUAKE QUICK REFERENCE RESPONSE GUIDE**~~

~~GOAL~~	~~ACTIONS~~
	• ~~Medical Surge Quick Reference Response Guide~~ • ~~Power Outage Quick Reference Response Guide~~ • ~~Water Disruption Quick Reference Response Guide~~

EARTHQUAKE REPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents even while responder to natural disasters such as earthquakes and any resulting challenges.

~~Take appropriate action during and following an earthquake to reduce injury and loss of life, prevent subsequent fires and other secondary problems, and facilitate recovery.~~

PURPOSE:

To take appropriate action during and following an earthquake to reduce injury and loss of life, prevent subsequent fires and other secondary ~~problems~~effects, and facilitate recovery.

~~DEFINITIONS:~~

~~Anticipated Impact (Moderate to Significant)~~

~~Disruption of normal operations and services~~

~~Influx of stable acute hospital level patients from SFGH or other hospitals~~

~~Influx of community residents who may have been impacted by an event and who are seeking basic first aid or guidance in the event of a large scale incident.~~

~~Need to provide shelter for community residents / others not able to return to their homes.~~

~~Seismic activity automatic shut down of all elevators until cleared and reset by maintenance company potentially impacting transport of persons and supplies by elevators.~~

~~Possible partial or total evacuation of the hospital potentially without the use of elevators.~~

PROCEDURE:

1. Remain as safe as possible ~~during the quake~~while the ground is shaking to prevent injury.

~~or fatalities~~

   a. Drop, Cover and Hold On – preferably under a sturdy table or desk and away from windows and other hazards such as tall furniture or heavy items that could fall. Do not stand in doorways.

   b. Stay Inside – many injuries and fatalities occur from people running out of buildings

   c. If outside, take cover as above and move away from buildings, electrical power lines, and overhanging structures.

2. The Hospital Incident Command System (HICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander and HICS team will be responsible for managing the response to the earthquake with the following basic objectives:

   a. Ensure safety and security of all residents, staff, and visitors

   b. Minimize damage to property

   c. Facilitate the recovery of power and return to normal operations

3. Communication to Stakeholders - After completing immediate notification procedures in LHHPP 70-01 B1 Table 1, the HICS team shall:

   a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the outage using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

b. Initiate emergency call backs if the response to the earthquake requires extra labor resources not available on site.

c. Disseminate information to the public or the media ONLY with the approval of the LHH CEO or DPH Public Information Officer (PIO).

4. Staff Communication with Command Center (phone: 4-4636, fax: 415-504-8313)

a. Employees shall contact the command center to report hazards or to request resources to assist with safe, quality delivery of care.

b. Employees shall refer media representatives to the Hospital Incident Command Center at 415-759-4636.

5. Ensure Safety of all Persons and Continue Quality Care of Residents ~~Assure safety and well-being of residents and others~~

~~Proceed carefully due to hazards/ obstructions and be prepared for aftershocks~~

a. Check for injuries and move residents away from windows or other hazards such as shelves with heavy objects overhead.

b. Check every space and every person to determine if anyone is trapped or in need of medical attention

c. Account for all persons in your neighborhood or department.

d. Complete the Department Operating Status Report (DOSR) and fax it to the command center at 415-504-8313 or deliver to a DOSR bin.

e. Do not use elevators until advised of their safety.

f. Check the environment for fire and ~~implement the Fire Plan if fire issues found~~notify the command center of any fire safety concerns.

g. Check for other hazards such as broken glass, electrical shorts, falling objects such as lights, ceiling tiles, wiring and report to ~~Facilities 24-hour watch engineer or Hospital Incident~~the Command Center~~, once activated~~.

h. Be prepared for aftershocks. These may be as hazardous as the initial quake.

i. Facility Services shall assess building damage and notifies the command center of findings.

Call 42999 as usual for Code Blue or Code Red emergencies

Call the Hospital Incident Command Center at 4-INFO (44636) to report status including account of persons in area, name of anyone missing, number of injuries, hazardous conditions, and resources needed

Complete the Department Operating Status Report, Appendix F of the Emergency Response Plan (LHHPP 70-03)

6. Re-establish normal operations according to essential service priorities in 70-01 B2 Continuity of Operations Plan.

7. Follow appropriate procedures for any resulting effects, such as fire, power outage, or water disruption

Coordinate activities with other hospitals, DPH and the community

Contact the Department of Emergency Management to report issues and coordinate resource requests. DEM coordinates with the Emergency Operations Center (EOC) for a city-wide response. State and Federal agencies are contacted as determined by local DEM and EOC authorities

Communicate to stakeholders

Notify the 24-hour watch engineer who will institute Facility Services policy for earthquake emergencies including checking the building for safety and hazards, extricating persons trapped in elevators and notifying elevator maintenance companies to check and reset elevators. (New building: ThyssenKrupp 520 Townsend San Francisco 415 544-8150 sanfrancisco@thyssenkrupp.com; Administration building: Otis @ 444 Spear Ste. 100 415 546-0880; night: 415 546-8100)

Receive alerts: from CAHAN and DPH/ DEM

Disseminate official notifications through Public Information Officer (PIO)

EARTHQUAKE QUICK REFERENCE RESPONSE GUIDE

Use public address system, email, pages/ page group, 800 Mhz radios, community meetings and other venues to disseminate information as directed by PIO with approval of Incident Commander

Initiate call back lists if directed by Incident Commander

Keep Hospital Incident Command and DPH Incident Command apprised of status and resources needed or available

Refer ALL media representatives to the Hospital Incident Command Center

Remain as safe as possible during the quake to prevent injury or fatalities
Drop, Cover and Hold On – preferably under a sturdy table or desk and away from windows and other hazards such as tall furniture or heavy items that could fall. Do not stand in doorways.

Stay Inside – many injuries and fatalities occur from people running out of buildings

If outside, take cover as above and move away from buildings, electrical power lines, and overhanging structures.

Assure safety and well being of residents and others

Proceed carefully due to hazards/ obstructions and be prepared for aftershocks

Check for injuries and move residents away from window or other hazards such as shelves with heavy objects

Check every space and every person to determine if anyone is trapped or in need of medical attention

Account for all persons in your neighborhood or department

Check the environment for fire and implement the Fire Plan if fire issues found

Check for other hazards such as broken glass, electrical shorts, falling objects such as lights, ceiling tiles, wiring and report to Facilities 24 hour watch engineer or Hospital Incident Command Center, once activated.

Call 42999 as usual for Code Blue or Code Red emergencies

Call 4-INFO (44636) to reach Hospital Incident Command

EARTHQUAKE QUICK REFERENCE RESPONSE GUIDE

Call the Hospital Incident Command Center at 4-INFO (44636) to report status including account of persons in area, name of anyone missing, number of injuries, hazardous conditions, and resources needed

Complete the Department Operating Status Report, Appendix F of the Emergency Response Plan (LHHPP 70-03)

Mitigate additional secondary hazards
Do not use elevators until advised of their safety

Do not drink tap water until advised of its safety – use bottled water and refer to water disruption quick reference for more details on emergency water supplies

Do not flush toilets or hoppers until advised to resume

Participate in search activities, triage, labor pool and other activities as directed

Perform Departmental Procedures as described in the Emergency Response Plan LHHPP 70-03

All Departments participate in emergency call backs if called for by Incident Command

Facility Services automatically assesses building damage and notifies Incident Command.

Sheriff's Department directs incoming visitors to specific areas and restricts hospital access if directed by Incident Command.

- Provide essential services as usual and return to full service as soon as possible
  - Continue or re-establish usual care according to essential service priorities within the Laguna Honda Continuity Of Operations Plan (COOP)

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 A2 Emergency Preparedness
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity oOf Operations Plan (COOP)
LHHPP 70-01 C4 Medical Surge Plan

C3 Earthquake Response Plan
EARTHQUAKE QUICK REFERENCE RESPONSE GUIDE

LHHPP 70-01 C5 Emergency Responder Dispensing Plan
LHHPP 70-01 C7 Power Outage Plan
LHHPP 70-01 C8 Water Disruption Plan

Revised: 18/07/10 (Year/Month/Day)
Original adoption:

ANIMAL CONTROL

POLICY:

1. Animals at Laguna Honda Hospital and Rehabilitation Center (LHH) shall not interfere with hospital operations or pose a safety risk to residents, staff, volunteers, or visitors.

2. The hospital follows the guidelines outlined in Department of Public Health (DPH) Policy; Service and Support Animals in DPH when allowing service and support animals on the campus (see Attachment A).

3. Service animals may be untethered as long as they are under the owner's control via voice or physical signals; support animals must always be on a short leash or in a carrier. (Mayor's Office on Disability, 2017)

4. All pet companions shall be on a leash at all times while on hospital grounds. If the pet companion has been certified as a therapy animal, the animal can be untethered only while engaged in therapeutic interactions with residents so that residents can get the full benefit of the therapeutic interaction.

5. The feeding of non-domestic animals on campus is not allowed.

6. Staff, volunteers, residents or visitors shall assume all responsibility for any liability or damage caused by their pet companion.

7. Staff requesting to bring any service and/or support animal to the workplace shall be referred to Human Resources for a Reasonable Accommodation evaluation prior to bringing the service and/or support animal to the workplace.

PURPOSE:

To ensure an environment that is safe for all humans and animals while allowing for therapeutic interactions between animals and residents of ~~Laguna Honda Hospital and Rehabilitation Center~~LHH.

DEFINITION:

1. **Service animal**: any dog, or in some cases a miniature horse, that is individually trained to work specifically for a person with a physical, sensory, psychiatric, or other disability.

2. **Support animal**: animals of any species that are not trained to perform specific tasks. Their presence provides assistance to people with psychological disabilities.

3. **Therapy animal:** animals that have certified by a recognized animal assisted therapy program such as the San Francisco SPCA.

4. **Pet companion**: animals that provide comfort just by being with a person. They have not been trained to perform a specific job or task and they do not qualify as service or support animals under the ADA.(ADA National Network, 2014)

PROCEDURE:

1. The Activity Therapy Department Animal Assisted Therapy Program

a. The LHH Activity Therapy Department ~~at Laguna Honda~~shall implement~~s~~ an A~~a~~nimal A~~a~~ssisted T~~t~~herapy (AAT) program. The program is operated in such a manner that no animal under the care of the Activity Therapy Department is left unattended inside the Administration or H~~h~~ospital building~~s~~. Please refer to the Activity Therapy Departmental Policy and Procedure P5 Animal Assisted Therapy.

2. Volunteers

a. Hospital v~~V~~olunteers wishing to bring their pets to ~~the hospital~~LHH in order to participate in the Activity Therapy animal assisted therapy program ~~will~~ shall be directed to the San Francisco SPCA. After successful completion of the training and registration into the SPCA program, the two organizations can coordinate visits.

b. Volunteers from the SPCA ~~not allowed to~~shall not provide animal visits on the units without supervision at all times from Activity Therapy staff and/or LHH oriented volunteer.

3. Staff

a. LHH staff may bring their pets to the hospital to be used as pet companions for residents. Therapeutic interaction between ~~those animals~~pet companions ~~therapy animals~~ and the residents of LHH is the sole purpose of staff bringing their pets to work. ~~Employee animals~~Animals may not be brought to work for the convenience of LHH staff.

b. In order for LHH staff to bring their pets ~~to be used~~to LHH as pet companions for residents, the following steps must be completed:

i. The employee and their pet shall complete a training course from a recognized AAT program, such as the San Francisco SPCA. The cost of the program and/or courses is the sole responsibility of the employee. The employee ~~must~~ shall provide documentation as proof of program completion.

ii. The employee shall secures written approval from his or her supervisor; the animal ~~must~~shall not interfere with departmental operations.

~~i. In order for employees to bring their pets to be used as pet companions for residents the following steps must be completed:~~

c. Documentation

- ~~The employee secures written approval from his or her supervisor and the animal must not interfere with departmental operations.~~

- ~~The employee and his or her pet completes a training course from a recognized animal assisted therapy program such as the San Francisco SPCA. The cost of the courses is the responsibility of the employee. The employee must provide documentation to his or her supervisor.~~

i. The employee ~~must~~ shall provide current vaccination records and proof of AAT program completion to be kept on file with their supervisor.

ii. The employee's s~~S~~upervisor ~~will~~shall create a contract with the LHH staff and their~~between Staff,~~ co-workers highlighting:

- Schedule of animal visits with the residents;

- ~~Where A~~animal location ~~will be~~ when not with residents; and

- Verification that~~ying~~ co-workers ~~do not have allergies~~are aware a pet companion may be in their workspace and/or department on days of scheduled animal visits.~~.~~

~~In order for employees to bring their pets to be used as pet companions for residents, the following steps must be completed:~~

~~Approval~~

~~LHH staff may bring their pets to the hospital to be used support Animals and/or for residents. Therapeutic interaction between pet companions animals and the residents of LHH is the sole purpose of staff bringing their pets to work. Animals may not be brought to work for the convenience of LHH staff. Dogs, cats and hoofed animals will not be considered pet companions and must be processed as Therapy Animals.~~

~~Documentation~~

~~The employee secures written approval from his or her supervisor; the animal must not interfere with departmental operations.~~

~~Supervisor will create a contract between Staff, co-workers highlighting:~~

- ~~Schedule of animal visits with the residents~~
- ~~Where animal will be when not with residents~~
- ~~Verifying co-workers do not have allergies.~~

~~4. All pets must be on leash at all times while on hospital grounds unless the pet has been certified as a therapy animal and only while engaged in therapeutic interactions with residents so that residents can get the full benefit of the therapeutic interaction.~~

~~5. All Laguna Honda staff and/or volunteers must ensure that their animals do not interfere with the operations of the hospital, or the staff /volunteers' ability to perform their duties.~~

4. Visitors

a. Visitors are allowed to bring in their pet companions ~~-~~to visit residents, but must comply with the leash provision or the animal ~~must~~ shall be contained in an appropriate cage/container. If the visitor does not comply, they shall be asked to leave and/or the Sheriff's Department will be called.

5. Residents

a. Resident Care Team (RCT) approval

i. Those residents who desire to keep an animal (service/support animal or pet companion) on the premises must first obtain permission from their ~~Resident Care Team~~RCT. The acceptance of resident pets living at ~~Laguna Honda Hospital and Rehabilitation Center~~LHH ~~will~~shall be evaluated on a case by case basis, and shall follow DPH guidelines for Service and Support Animals in DPH (see Attachment A).

ii. If the RCT approves of a resident to keep an animal (service/support animal or pet companion) while at LHH, a care plan shall be written that describes the resident's abilities and responsibilities to care for that animal.

b. Resident responsibilities

i. The resident shall assume full responsibility for the care, feeding, behavior, health (vet visits), costs and cleaning of all animal waste.

c. Documentation

i. The resident shall provide initial documentation of health, current immunizations and evidence of periodic veterinary examinations when requested.

ii. A written agreement between the resident and RCT ~~will~~shall ~~be drafted and highlight~~include:

- ~~Areas noted in "Resident Responsibilites~~The responsibilities of the resident~~".~~

- Actions taken in the event the resident is no longer able to care for the animal~~,~~

iii. Activity Therapy ~~(or SW)~~ staff ~~will~~shall ~~collect~~ create documentation to track residents with approved pet companion on the premises.

- Progress of the program shall be noted in the resident's medical record.

- ~~Activity Therapy staff~~The Director of Therapeutic Activities and Wellness or their designee shall conduct an annual review of listed resident(s) with RCT approved pet companions on the premises at the end of each fiscal year and report to Quality Council.

~~documentation afnd note the progress of the program in the resident's medical record.~~

6. Safety

a. Any animals, including animals maintained within the Activity Therapy Department ~~Laguna Honda Animal Assisted Therapy~~AAT p~~P~~rogram,~~ and pet companions that~~ belonging to staff, volunteers, or visitors that ~~is~~ are deemed to be a safety concern or not in compliance with hospital policies shall be removed from the hospital.

~~7. Visitors, staff or volunteers who do not comply with the leash provision or cage/container will not able to bring their animal into the hospital. If the visitor does not comply, they will be asked to leave and/or the Sheriff's Department will be called.~~

~~8. Staff, volunteers, or visitors assume all responsibility for any liability or damage caused by their animal.~~

~~9.~~7. Reporting

a. Staff must complete an Unusual Occurrence report and submit to the Quality Management Department in the event of any animal related injury on hospital grounds~~, which is related to a pet or to a~~including feral animals. ~~Medical evaluation and treatment of residents, staff, or volunteers in facilities per applicable hospital policy.~~

i. Staff who have any animal related injury on hospital grounds shall inform their supervisor of the incident. The supervisor shall respond in accordance with LHHPP 73-01 Injury and Illness Prevention Program.

~~b. Those residents who desire to keep a pet animal on the premises must first obtain permission from their Resident Care Team. The acceptance of resident pets living at Laguna Honda Hospital and Rehabilitation Center will be evaluated on a case by case basis.~~

~~c. The resident must assume full responsibility for the care, feeding, behavior, health (vet visits), costs and cleaning of all excrement of their animal.~~

~~d. The resident must provide initial documentation of health, appropriate immunizations and evidence of periodic veterinary examinations when requested.~~

~~10.~~8. Non-domestic animals

a. The feeding of non-domestic (feral) animals is ~~discouraged~~not allowed. Reports of resident noncompliance will be forwarded to the ~~Resident Care Team~~RCT. Reports of staff or volunteer noncompliance ~~will~~ shall be forwarded to the appropriate supervisor.

~~11.~~9. Injured and Dead Animals

a. Anyone finding a dead animal must notify the Environmental Services (EVS) Department between the hours of 7:00 a.m. and 12:00 a.m. ~~During off hours~~From 12.a.m to 7 a.m., the report is made to the Nursing Office who ~~will~~ shall contact ~~Environmental Services Department~~EVS to arrange animal disposal.

~~a.~~b. Anyone finding an injured animal on hospital grounds shall attempt to locate the owner if appropriate or contact Animal Care and Control for pick up.

~~12. The hospital follows the guidelines outlined in Department of Public Health Policy; Service and support animals in DPH when allowing service and support animals on the campus.~~

ATTACHMENT:

Attachment A: Department of Public Health Policy & Procedure, Service and Support Animals in DPH

Attachment B: DPH Employee Reasonable Accommodation Request Form

~~None.~~

REFERENCE:

~~Department of Public Health Policy & Procedure Title: Service and Support Animals in DPH~~
LHHPP 28-02 ~~The~~Tthe Farm and Therapeutic Gardens
Activity Therapy Departmental Policy and Procedure, P5 Animal Assisted Therapy
Mayor's Office on Disability, http://sfgov.org/mod/service-and-support-animals-1
ADA National Network, Service Animals and Emotional Support Animals, https://adata.org/publication/service-animals-booklet

City and County of San Francisco Department of Human Resources Equal Employment Opportunity: http://sfdhr.org/equal-employment-opportunity

DPH's Service and Support Animals Policy

Revised: 10/12/01, 15/09/08, 16/01/12, 17/09/12, 18/07/10 (Year/Month/Day)
Original Adoption: 92/05/20

Date Received

EMPLOYEE REASONABLE ACCOMMODATION REQUEST FORM

Last Name _____ First Name _____ Last 4 Numbers of Social Security Number _____

Address _____ City _____ Zip _____ Work Phone _____ Home Phone _____

It is the policy of the City and County of San Francisco to provide reasonable accommodations to qualified individuals with disabilities in accordance with the federal Americans with Disabilities Act and the California Fair Employment and Housing Act. You may be required to provide documentation in support of your request for reasonable accommodation.

Please note that this information will be maintained in a separate confidential file from your personnel file and access will be limited only to those with a need-to-know.

1. Current Position:

Class: _____ Title: _____
Dept.: _____ Section: _____

2. Reasonable Accommodation Request:

What type of accommodation do you request?

- ☐ Purchase of assistive device(s)
- ☐ Removal of architectural barrier
- ☐ Reassignment
- ☐ Removal of communications barrier
- ☐ Job Restructuring
- ☐ Other
- ☐ Purchase of assistive services
- ☐ Modified Work Schedule

Please describe the accommodation: (use extra sheets if needed)

Please explain how you believe this accommodation will enable you to perform the essential functions of your position: (use extra sheets if needed)

3. Essential Duties of Your Position:

Please identify the essential duties (do not include marginal duties) of your position for which you are requesting an accommodation:

1. _____
2. _____
3. _____
4. _____

4. Health Care Provider:

Please provide us with the name of your health care provider(s) who can assist with this request: (use extra sheet if needed)

Name: _____
Address: _____
Phone: _____
Specialty: _____

Name: _____
Address: _____
Phone: _____
Specialty: _____

5. Major Life Activities:

Please check the major life activity(ies) you believe to be limited by your medical condition(s):

☐ Walking ☐ Breathing ☐ Seeing ☐ Caring for Oneself ☐ Working
☐ Talking ☐ Hearing ☐ Learning ☐ Performing Manual Tasks ☐ Other:_____

Please describe how the above activity(ies) is/are limited:

6. Is your medical condition temporary? ☐ Yes ☐ No
If yes, please state the expected duration: _____

7. Are you currently working? ☐ Yes ☐ No
If no, please specify the type of leave currently approved: _____
If no, when do you expect to return to work? _____

8. Have you applied previously for a reasonable accommodation within the City?
☐ Yes ☐ No If yes, please explain the status/circumstances:

I hereby certify that I believe I am a qualified individual with a disability as defined by the law. I have received and reviewed the information brochure and require an accommodation to perform the essential functions of my position. I understand that a detailed review of my disability status may be required, and I agree to cooperate fully in this process. I further understand that if my request is granted, I am obligated to report any changes in my disability status which may require a re-evaluation of this request. Granting of this request does not signify approval of any future reasonable accommodation request for any other position within this department or any other department within the City and County of San Francisco.

_____ _____
Employee Signature Date

CAST CARE

POLICY:

~~1. Replacement of existing casts is done in Orthopedic Clinic at LHH or S.F.G.H.~~

~~2. Licensed Nurses may teach cognitively intact residents how to care for and how not to abuse cast, as well as, how to identify and report potential problems for immediate attention.~~

1. Any nursing staff member (LN, CNA, or PCA) may provide care to a resident with a~~erform~~ cast.
~~3.~~2. ~~care~~A Registered Nurse (RN) must monitor and assess the cast and extremity ~~frequently~~ every shift or as ordered by Physician for complications.~~.~~

PURPOSE:

To ~~provide proper cast care, i~~dentify cast-related skin and neurovascular abnormalities related to improper cast fit or maintenance and to prevent cast deterioration ~~as a result of misuse by the patient. preserve the integrity and efficiency of the cast, maintain the resident in cleanliness and comfort, and prevent complications associate with cast use.~~

DEFINITIONS

1. **Cast:** supportive splints made of plaster, fiberglass, or other materials that surround and immobilize an injured extremity (i.e., limb, bone or joint) to protect it from further injury, provide alignment of a fracture by holding the bone fragments in reduction and alignment during the healing process, and promote comfort.
    a. **Plaster cast:** cast made from rolls of dry muslin (i.e., loosely woven cotton). A thin layer of cotton or synthetic material is applied to the skin to prevent direct skin contact with the plaster cast material. This type of cast is heavier than a synthetic cast.
    b. **Fiberglass cast:** cast made from rolls that are wrapped around the affected -body part after being activated by water or light. A protective layer of cotton or synthetic material is placed between the skin and the fiberglass cast.
    c. **Synthetic cast:** cast materials include fiberglass impregnated with polyurethane resin (cotton-polyester material) and synthetic materials that contain a stretchy polyester backing that allows for better molding to body contours and reduces the chance that the cast will be applied too tightly. The cast is lightweight, radiolucent and waterproof.
2. **Cast window:** used to detect and prevent pressure injuries, examine open wounds, and relieve pressure over external fixation devices.
3. **Types of casts:**
    a. **Sugar-tong splint:** commonly used in wrist injuries or when acute injury results in swelling of the injured part.
    b. **Short-arm cast:** commonly used for wrist or metacarpal injuries. Normally extends from the distal palmer crease to the proximal forearm.
    c. **Long-arm cast:** used for stable forearm or elbow fractures. It is similar to the short-arm cast but extends to the humerus.
    d. **Short-leg cast:** usually extends from the base of the toes to the inferior ~~of the~~ knee.
    e. **Long-leg cast:** usually extends from the base of the toes to the gluteal crease or groin.

f. Body-jacket cast: used to support stable spinal injuries of the thoracic and lumbar spine.
g. Single-hip spica: commonly used in stable femoral fractures and to immobilize the affected limb and trunk.
h. Double-hip spica: applied to both of the lower extremities and the trunk.

PROCEDURE:

A. FOR NEWLY- APPLIED CASTS

1. While the cast is still in the process of drying:~~,~~

a. Casts are usually not strong enough to bear weight for approximately 24 – 72 hours and until the cast has hardened completely.
i. Plaster cast: requires 24 - 48 hours to dry and harden. The case will appear smooth and white after it hardens. The resident must be careful during this period because the plaster might break or crack while it is hardening. Plaster casts require approximately 24 hours for a regular arm cast and up to 48 hours before weight bearing or external pressure can be applied, and 36-72 hours for large body casts
ii. Fiberglass cast: allows the resident to immediately apply body weight to the affect area. The cast will appear rough after it has dried.
iii. Synthetic cast: sets in approximately 15 minutes and can withstand pressure or weight-bearing after 20 minutes.
b. The cast must be exposed to air to dry properly and be well supported on firm surfaces. Never cover a fresh cast.
c. T~~t~~he resident should be turned regularly ~~at least every two hours~~ to promote even drying of the cast ~~and to prevent fatigue pressure areas and hypostatic pneumonia.~~.
~~a.~~ Avoid direct pressure to the cast during drying time. Use an open palm to handle the cast to prevent denting the cast (e.g., with fingerprints).
d.

~~When turning resident with wet cast, use palms of hands and not fingers to lift cast.~~
2. Keep the injured arm or leg elevated for 1-3 days after the cast or splint is applied.
3. Apply ice in a plastic bag or via an ice pack to the cast or splint at the site of the injury for 15 - 30 minutes at a time as needed. ~~The ice should be placed in an ice pack or a plastic bag to avoid direct contact with the cast or splint.~~
~~1. Fingers may make indentations in the soft plaster if it is not sufficiently set.~~

B. MONITOR THE CASTED -AREA CLOSELY

An RN will assess the cast and extremity every shift and immediately report to the physician if abnormalities are found. It is important to address abnormalities promptly because they can be due to ischemia and/or nerve compression that can results in compartment syndrome, palsy, ischemic myositis, pressure necrosis, and other severe complication

1. Monitor circulation, sensation and motion (CSM):

a. Circulation (cardiovascular):
i. Inspect the color of the fingers or toes on a casted extremity. Cool, discolored (e.g., pale, gray, blue), or swollen digits indicate impaired blood flow.
ii. Test capillary refill time in the fingernails or toenails on a casted extremity; normal capillary refill time is < 2 seconds

iii. Palpate the skin around the cast for warmth or coolness. Palpate for distal pulses.

b. Sensation (neurovascular):
   i. Inquire about sensation in uninjured portions of the extremity (e.g., ability to feel palpation and temperature, ability to distinguish between sharp and dull objects).
   ii. Ask the patient if he/she has paresthesias (abnormal sensation, numbness, or tingling), paralysis, pain or anxiety.

c. Motion:
   i. ~~Resident should be able to move his toes or fingers.~~ Test the resident's ability to move the fingers or toes on a casted extremity.

~~1. Report swelling or discoloration of the toes or fingers.~~

~~2. Resident should be able to move his toes or fingers.~~ ~~Report coolness.~~

~~3. Report resident complaints of pain or numbness.~~

~~4. Check skin around the edge of cast for signs of irritation.~~

~~To protect skin from rubbing and irritation, adhesive tape may be used to cover the cast edge when the cast is thoroughly dry.~~

2. Compartment Syndrome: a rare but potentially life- or limb-threatening complication that can ~~occur if the cast is applied too tightly~~if ~~or~~ swelling occurs under the cast. ~~Resulting~~ Ccompression of the nerves and blood vessels of the extremity under the cast can result in permanent nerve and tissue damage within 24 hours if the pressure is not relieved. Signs and symptoms of compartment syndrome include severe/intense/unrelieved pain, paresthesia, pallor, paralysis, and diminished pulses in the casted extremity. If signs and symptoms of compartment syndrome are suspected, notify the physician immediately (medical emergency).
3. Monitor for signs of infection (e.g., elevated temperature and heart rate). Fever, foul odor, drainage, pain, or a heat/burning sensation under the cast may indicate infection. The cast will need to be removed or windowed ~~in this case~~ to allow treatment of infection.
4. Monitor for signs of bleeding (e.g., elevated heart rate, decreased blood pressure).
5. Observe for skin redness, irritation or excoriation around the edge of the cast, which can indicate chafing of the skin. If irritation is seen, small pieces of adhesive tape (petals) may be applied to the edges of a dry cast to prevent further skin irritation:

   a. Cut multiple 7.5 – 10 cm (3 – 4 in) strips of water proof tape.
   b. Use scissors to cut a round or petal-shaped edged on each strip.
   c. Place the non-rounded end of the strip inside and against the cast until half the length of the strip has been inserted.
   d. Apply pressure to secure the strip.
   e. Wrap and secure the remainder of the strip over the outer edge of the cast.
   f. Overlap additional strips around the entire cast edge.

6. Assess for resident reports of pruritus (itchiness) on skin beneath the cast. Interventions to relieve pruritus include using a blow dryer set to "cool" to blow air under the cast, and administering prescribed antihistamines. Instruct the resident to avoid inserting any object to scratch under the cast, applying powder or lotion to the skin beneath the cast, hitting or kicking an item with the cast, or self-removing the cast under any circumstance.
7. Swelling can occur soon after injury, create pressure in the cast, and cause neurovascular compromise. Methods for reducing swelling include:

   a. Elevate the extremity

Exercise the affected extremity by moving the uninjured fingers or toes ~~of the affected extremity~~

b. ~~Administering ice.~~

c. Rechecking the extremity at regular intervals for a reduction in swelling after the interventions.

8. In the presence of a body jacket or spica:

a. Superior Mesenteric Artery (SMA) syndrome ("cast syndrome"): Rare but severe complication in which the cast compresses ~~of~~ the duodenum between the superior mesenteric artery and the abdominal aorta. This can result~~s~~ in an abdominal obstruction and place the resident at risk for gangrene. Signs and symptoms of SMA syndrome include feeling fullness, pain or pressure in the abdomen, nausea, vomiting, abdominal distension, and diminished bowel sounds.

b. Assess respiratory status, bowel and bladder function, and bony prominences (especially iliac crest).

~~5.~~

C. CAST CARE

Licensed Nurses may teach cognitively intact residents how to care for and how not to abuse cast, as well as, how to identify and report potential problems for immediate attention.

1. Keeping Cast Dry and Clean

a. Showering or bathing:

i. Plaster cast: must be kept dry at all times and cannot get wet because excessive moisture can cause the material to warp and disintegrate. Notify the physician if the cast does not dry or the skin underneath the cast becomes wet.

1. The resident with an extremity cast may take a shower if the cast is covered by a plastic bag secured to prevent water from entering.
2. When taking a tub bath, an upper extremity cast must be kept out of water.
3. If the cast is soiled from stool, clean by using a damp cloth and a mild cleanser for slight soiling (do not wet cast).

ii. Fiberglass cast: casts are waterproof. ~~, and li~~f the padding underneath the cast is also waterproof, the resident can get the cast wet (e.g., shower). Using a spray nozzle or flexible shower head to wash or rinse the inside of the fiberglass cast with warm water may reduce the odor and irritation and improve the overall skin condition of the cast area. The cast must be thoroughly dried after wetting. Lightly towel off excess water and use a hairdryer on cool or low setting to dry the inside of the cast. Do not cover the cast while it is drying.

iii. Synthetic casts: Manufacturer instructions indicate if the specific cast material can get wet.

~~a. The resident with an extremity cast may take a shower if the plaster cast is covered by a water-tight plastic bag secured to prevent water from entering.drawn close to the skin above the cast and taped in place.~~

~~b. When taking tub bath, an upper extremity cast must be kept out of water.~~

~~c.~~
~~d. If soiled from stool, clean by using a damp cloth.~~
~~e.~~
~~f.~~
~~g.~~
~~h.~~b. Powders and lotions may only be used outside the cast. Powder inside a cast can cake and cause sore areas.

~~a.~~
~~a)~~
~~b)~~
~~c)~~
~~b.~~
~~a)~~
~~c.~~

~~2. When Using a Bed Pan~~
~~a. Elevating the resident's head and shoulders by using pillows when he is on the bedpan will tend to keep the cast from becoming wet with urine running back from the pan.~~
~~b. A folded soft cloth or gauze pad placed on the back of the bedpan will absorb any moisture and will help to keep the cast clean and dry. It must be removed with the bedpan.~~
~~3. Keeping cast clean~~
~~If soiled from stool, clean by using a damp cloth.~~

~~4.~~2. Repositioning Resident:

~~a. If only one leg is enclosed in cast, turn resident toward the uncasted leg. Turn the body simultaneously to prevent undue pressure on the cast at the groin.~~
a. ~~Do not use bar to turn resident in a hip spica or body cast.~~Notify the physician is the cast breaks, cracks, develops soft spots, becomes too loose, ~~or~~ becomes badly soiled, d~~or~~ ~~d~~evelops ~~a fever or~~ foul odor under the cast or if an object gets stuck inside the cast. Notify the physician if the patient develops a fever. ~~Notify the physician immediately if the cast cracks or becomes soft or loose, if an object gets stuck under the cast, or if a plaster cast gets wet.~~
b. Lift the cast by supporting the joints above and below the casted area to prevent~~s~~ injury to underlying soft tissues.
c. If only one leg is ~~enclosed in~~ cast~~ed~~, turn resident toward the uncasted leg. Turn the body simultaneously to prevent undue pressure by the ~~on the~~ cast at the groin.
d. When using a sling for an upper extremity cast, ensure that the axilla well-padded to prevent skin excoriation and pressure on the neck.
e. In the presence of a body cast or spica, never use the separation bar (abduction bar) to assist with turning or moving the resident.
f. Use a fracture bedpan to promote comfort and ease of movement on and off the bedpan.
g. Perform the following for patients with a spica or body cast:

i. The edges of the cast should be covered when eating to prevent crumbs from getting inside the cast.
ii. The stabilizer bar should not be used when repositioning.
iii. The patient may lay on the stomach with a pillow under the legs, on the back with the head of the bed at 30 degrees or propped on the side with pillows.

~~a.~~

~~C.~~D. EXERCISING THE RESIDENT IN A CAST

~~A~~While resident with a~~is in~~ cast~~, s/he~~ should be taught to tense or to contract muscles without moving the joints.

1. If the resident is in a long leg cast, place your hand under the knee and instruct the resident to "push down."

2. If the resident is in an ~~has~~ arm cast, instruct him to "make a fist."

3. Instruct the resident to actively exercise his fingers or ~~and~~ toes frequently when in an arm cast or leg cast, respectively.

~~3.~~4. Encourage active range of motion (ROM) to the unaffected limb to prevent stiffness.

~~D.~~E. REPORTING AND DOCUMENTATION:

1. Interdisciplinary Progress Notes:
   Document CSM and skin observations and report to physician any ~~untoward signs of poor~~ CSM ~~or skin~~~~circulation.~~abnormal findings.

2. Resident Care Plan
   ~~Document plan for~~ The care plan for a resident in a c~~the c~~ast should include type of cast, ~~t, including,~~ mobility interventions, coping with mobility impairment, risk of complications and other individual cast care needs.

~~2.~~ ~~3.~~ DNCR: The CNA or PCA shall record and report any skin changes, increased motion within the cast, sensation ~~or motion~~ changes or resident reports of pain
~~2.~~3. ~~ed pain or sensation changes~~.

REFERENCES

Sorrentino, Mosby's Textbook for Nursing Assistants, 6th edition, 2004

EBSCO – Cast Care: Performing
http://web.b.ebscohost.com/nrc/detail?vid=7&sid=b07f4ac2-b8c1-4c64-b01d-74e7f94789dd%40sessionmgr101&bdata=JnNpdGU9bnJjLWxpdmU%3d#AN=T705094&db=nrc

Lehman, C. (2015). *The specialty practice of rehabilitation nursing: a core curriculum.* Chicago, IL: Association of Rehabilitation Nurses.

Perry, A. G., Potter, P., A., & Ostendorf, W. (2017). *Clinical nursing skills & techniques*. St Louis: Mosby.

Revised: 8/2000, 2/2010, 3/2016

Reviewed: _____

❒ Reviewed by _____ and no revision recommended at this time.

Approved: _____

Assessment and Management of Bowel Function

POLICY:

1. License Nurse ~~assesses~~ shall evaluate all residents for bowel function at admission and whenever clinically indicated.~~, and care plan the potential or actual bowel problems as appropriate.~~

2. After other interventions for constipation relief have been unsuccessful, licensed nurses may remove a fecal impaction with a physician's order.

3. Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) will monitor and record bowel movements each shift.

~~Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) will monitor and record bowel movements each shift.~~

~~The CNA or PCA may administer physician ordered nonmedicated suppositories for the relief of constipation under the supervision of a licensed nurse.~~

~~2. Licensed nurses may remove fecal impaction without a physician's order unless contraindicated by the resident's medical condition.~~

PROCEDURE:

~~1.~~
~~1.~~
~~1. See on-unit text: Nursing Interventions & Clinical Skills~~
~~See on-unit text: Lippincott Manual of Nursing Practice~~
~~See on-unit text: Mosby's Textbook for Nursing Assistants~~

1. Upon admission and as needed, the licensed nurse will observe the following:
   a. Inspect, palpate and auscultate abdomen
   b. Indications of tenderness
   c. Verbal and nonverbal signs or symptoms of gas, pain and/or discomfort
   d. Characteristics of stool
   e. Frequency of bowel movements
   f. Presence of blood or mucus
   g. Presence of continence
   h. Mode of elimination (e.g., commode, toilet)
   i. Last bowel movement

2. Licensed nurse will complete bowel and bladder assessment on the Admission Assessment Form (MR 321).

DOCUMENTATION:

~~1.~~3. The licensed nurse completes the bowel and bladder assessment in The Admission Nursing Assessment (MR321)

~~2.~~4. The CNA or PCA records bowel function in the Daily Nursing Care Record (DNCR) each shift.

~~3.~~5. Licensed nurse develops, evaluate~~d~~s and revises related care plans when indicated for actual or potential bowel problems.

CROSS REFERENCES:

Nursing ~~Policies and Procedures~~P&P~~:~~ F 1.0 Assistance with Elimination
Nursing P&P F 2.0: Assessment and Management of Urinary Incontinence

REFERENCES:

~~Elkin, Perry & Potter, Nursing Interventions & Clinical Skills, 4th edition, 2007~~
Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier
Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadelphia, PA: Lippincott Williams & Wilkins
Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

~~Lippincott, Williams, & Wilkins, Lippincott Manual of Nursing Practice, 9th edition, 2010~~
~~Sorrentino, Mosby's Textbook for Nursing Assistants, 6th edition, 2004~~

Revised: ~~7/~~2006/07, ~~9/~~2008/09, ~~10/~~2010/10, 2016/12

Reviewed: 10/24/10

POLICY OWNER: MARIA-ELENA

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) are responsible and competent for administering, monitoring and documenting medications consistent with their scope of practice.

    a. Only RN may administer intravenous medications, whether by IV piggyback or IV push.
    b. The LVN may administer medications per LVN scope of practice.
    c. The Nursing Assistant (CNA / PCA) may, under supervision of Licensed Nurses, administer: medicinal shampoos and baths, ~~laxative suppositories and cleansing enemas, and~~ non-legend topical ointments, creams, lotions and solutions when applied to intact skin surfaces.

2. All medications, including over the counter drugs, require a physician's order and indication for use.

    a. If indication for use is not on order, consult with physician.
    b. Topical creams/ointments available in the neighborhood (e.g., Dimethicone, Enzo) do not require a physician's order.

3. Licensed nurses will confirm the right resident, right drug, right dose, right time, right route and right documentation (6 Rights or known as 6 Rs). Medication administration times may be modified to accommodate residents' preferences in consultation with the physician and pharmacist.

4. The safe administration of psychotropic, hazardous and high risk/high alert medications and reporting of Adverse Drug Reactions will be followed as outlined in other LHH policies and procedures.

5. Medications may not be added to any food or liquid for the purpose of disguising the medication unless informed consent has been granted by the resident or the surrogate decision maker.

~~5.~~6. Each medication needing crushed for administration, must be administered individually, for both oral and enteral tube (do not mix medications together.)

~~6.~~7. Two licensed nurses are required to verify type and correct insulin dose and accuracy of warfarin dose.

~~7.~~8. It is the legal and ethical responsibility of the licensed nurse to prevent and report medication errors.

PURPOSE:

Medications will be competently and safely administered.

PROCEDURE:

A. Physician Order

1. Licensed nurses may accept verbal or telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident's medication allergies with prescriber and read back the order for accuracy before carrying out.

2. Stat medication orders are processed immediately, and administered no later than four hours after the order was written.

3. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

4. Stop medication order. (Refer to Pharmacy Administration P&P 01.02.02).

B. Administration of Medication using 6 R's

Six Rights: Resident, Drug, Dose, Route, Time, and Documentation

1. **Right Resident:** Two forms of identification are mandatory.
   a. Verify identity of resident using any two methods:
      i. Check the identification band.
      ii. Ask the resident to state his/her first and last name? (without prompting)
      iii. Check the Resident Medication Profile Photograph and bring it next to the resident for comparison.
      iv. Ask the resident to state date of birth? (without prompting)
      v. In situations where the licensed nurse can positively identify the resident, visual identification is acceptable as a second form of identification.
      vi. Ask a family member or fellow caregiver to identify by standing next to or touching the resident (caregiver should not point from a distance).

2. Right Drug, Dose, Route
   a. Checks for allergies to medications.
   b. Checks or verifies information about medication using one or more of the following references, when needed:
      i. Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
      ii. Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
   c. Checks medication and prescription label with Medication Administration Record (MAR) transcription. Checks physician order when there is a question.
   d. Special precaution needs to be applied when preparing and handling hazardous medication administration (Refer to LHHPP 25-05).
   e. Review routes of administration
      i. Aerosol/Nebulizer: Refer to NPP J1.3
      ii. Enteral Tube Drug Administration: Refer to NPP E ~~and E~~ 5.0
      iii. Eye/Ear/Nose Instillations: Refer to J1.4

IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

3. Right Time

a. Medications will be administered one hour before or one hour after the scheduled time on SNF units and 30 minutes before or after scheduled time on acute unit.
b. All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
c. See Appendix I for routine medication times and abbreviations.
d. Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.
e. Modifications to routine times of administration at resident's preference will be discussed with physician and pharmacist.

4. Right Documentation

a. Place a dot in the initial box of the MAR or TAR immediately after preparing the dose. Initial the MAR and Treatment Administration Record (TAR) immediately after the medication was administered.
b. Document on the back of the MAR, the reason or indication for PRN administration and the result or effectiveness of the medication 1-2 hours after administration.
c. Document medication refusal on the MAR by circling initial, and on the reverse side document reason for refusal and, as appropriate notify MD.
d. Record injection sites on medication sheet, in square beneath nurse's initial, using the codes in the MAR.
e. Discontinued medications are highlighted in yellow on MAR and dated.

C. Reporting

a. In shift report describe:
   i. Any new medications started, indication and monitoring required.
   ii. Any suspected Adverse Drug Reactions (ADRs).
   iii. If receiving medication requiring monitoring, report clinically relevant data including abnormal VS or laboratory results.
   iv. Time or food sensitive medications to be given on incoming shift.
   v. PRNs given at end of shift requiring evaluation of effect.
   vi. Refusal of medication.

D. Monitoring

1. Cardiovascular Drug Parameters
   a. Every cardiovascular drug requires vital sign monitoring as outlined below:
      i. If physician does not specify hold parameters the default parameter is hold for SBP < 105; hold for HR < 55 and shall be printed on the MAR, along with the frequency of monitoring.
      ii. Heart rate – Monitor/record antiarrhythmic or combined antiarrhythmic /antihypertensive drugs before each dose, consistent with BP for 7 days, then weekly.
      iii. Blood pressure – Monitor/record antihypertensive and combined antiarrhythmic/antihypertensive drugs before each dose for 7 days, then weekly.
      iv. If the physician desires more frequent monitoring they will discontinue the standard monitoring protocol as above and write a separate order to indicate frequency (e.g. Monitor vital signs daily).
      v. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per scope of practice.
   b. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held and physician notification on the reverse of the MAR.

If a resident is on weekly cardiovascular monitoring schedule and a medication is held the licensed nurse will monitor/record cardiovascular monitoring before each dose for a minimum of 3 additional days to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after MD has been notified of outcome of monitoring and the resident's vital signs has been outside of the hold parameters for 3 consecutive days.

2. PRN Cardiovascular Medication Orders
   a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the medication administration. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

3. Antibiotics
   Record VS once every shift for duration of therapy.

4. Pain
   Record pain scores ~~(pain intensity ratings or PAINAD) in the LCR with VS, after PRN administration on reverse of MAR and as otherwise clinically indicated~~per pain management policy. (Refer to HWPP 25-06**)**

5. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

6. High Alert Drugs (Refer to HWPP 25-01)

7. Hazardous Medications (Refer to HWPP 25-05)

8. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

9. Anticoagulant therapy nursing procedures (See Appendix III – Anticoagulant Administration Protocol)

E. Special Consideration

1. Fentanyl Transdermal (Patch) Application and Disposal (Refer to Pharmacy P&P 02.02.02 and 09.01.00)
   a. Application
      i. Select appropriate site for patch (as chest, back, flank or upper arm). Apply patch to non-irritated, non-irradiated skin.
      ii. Date and initial patch after application.
   b. Documentation on the MAR
      i. Document the following information:
         Fentanyl (Duragesic)_____mcg/hr. q
         _____hrs Application
         date/time
      ii. Document site of application on the MAR
      iii. Verify placement every shift
   c. Verification of patch placement and monitoring

i. Inspect site of application every shift to verify that the patch remains in place.

ii. If the patch has come off, attempt to locate the patch and dispose. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.

d. Disposal
   i. Remove the old patch before applying a new patch.
   ii. Fold the old patch in half so that the adhesive sides are in contact and discard in medication disposal container.

2. Crushing Medications for Oral Administration
   a) Crushing medications is based on nursing judgement and resident ~~preference~~care plan.
   b) Hazardous, enteric or sustained release medications may not be crushed.
   c) Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.
   d) Staff may choose to wear mask when crushing or cutting pills.
   e) Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food ~~or via feeding tube~~).
   ~~Crushed medications given via feeding tube need flushed between each medication. (Refer to Enteral Tube Management E 5.0).~~
   f) Separating crushed medications may not be appropriate for all residents. If combining crushed oral medications is in the best interest of the resident:
      i. Requires a physician order
      ii. Requires pharmacy review for safety and efficacy of combining crushed medications
      iii. Care planned

A. Administration of Medication(s) Through Enteral Tube

1. Request medications be in liquid form whenever possible. If liquid form is not available from Pharmacy and tablet form must be used, crush tablets (except for enteric coated or sustained release medications). Dissolve tablets or dilute medication sufficiently for medication to pass through the tube. Refer to Medication Administration (NPP J 1.0).

2. **Each medication should be administered separately. After each medication flush the tube with 15 mL of water.**

3. Preferred administration of medications or fluids through enteral tubes is by gravity with 15 mL of water given before and after medications. Gentle pressure using a 60 ml catheter-tip syringe may be used as needed.

4. Give medication at the appropriate time in relation to feeding. Some medications should be given with food, while some should be given on an empty stomach with tube feeding withheld for a prescribed interval before and after medication is given (e.g., Dilantin suspension). For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility. Refer to Medication Administration (NPP J 1.0 Appendix 1).

5. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

6. Confirm correct placement of enteral tube (refer to Procedure C-4: "Checking Enteral Tube for Correct Placement" as outlined above).

7. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle pressure with the syringe.

8. Make sure medicine is sufficiently dissolved. Draw up medicine into 60 ml syringe or instill tip of syringe into the end of the enteral tube and pour medication into the syringe. Allow medication to drain into the tube by gravity (gentle pressure on syringe plunger may be used as needed).

9. After all medication is administered, instill approximately 15 mL of water to flush medication.

10. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

4. Shaking Medications or Mixing a Suspension
   a. Medications labeled "shake well" must be shaken vigorously to dilute the dose thoroughly immediately before administration.
   b. Medications which require mixing, but are not to be shaken, should instead be "rolled."
      i. Any rolling motion used is acceptable as long as the suspension appears milky and the rolling action has not created bubbles.

3. Self-Administration and Bedside Medication
   Resident must be assessed by Resident Care Team (RCT) and determined to safely self-administer medications before medications are kept at bedside.

   a. Self-Administration
      i. Licensed Nursing and other disciplines, as indicated, will collaborate to assess the resident's ability to participate in medication self-administration using the Self-Administration of Medication Record (MR 341a).
      ii. Nursing, and/or other disciplines, will discuss the assessment of the resident's ability to self-administer medication with the RCT.
      iii. The resident will prepare and take own medications, which are kept in medication cart, unless ordered for bedside by physician as indicated in the care plan (see also viii).
      iv. The nurse will observe medication preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated. If the nurse notices the resident is about to make an error, he/she will intervene to stop the preparation. He/she will also discuss and clarify with the resident the accurate manner of self-administering medications. The RCT will be kept informed of any change in the resident's ability to self-administer medications safely, or the need to re-evaluate the resident for self-administration of medications.
      v. Documentation will include the following;
         1. Topic/training skills taught and resident's progress with learning on Medication Self-Administration Teaching Plan and Record (MR 341b).
         2. The Licensed Nurse who observes/teaches the resident on self-administration of medication will sign at the space provided on the Medication Self- Administration Teaching Plan and Record (MR 341b).
         3. Resident's agreement for participation in the self-administration of medications on the care plan. ~~The care plan will also indicate whether the~~
         4. Documentation of the self-administration of the dose of medication is done on the MAR.

~~vi.~~ Any follow-up plan identified by the RCT, necessary to reinforce safe and skilled medication self-administration will be documented using the Medication Self-Administration Evaluation Progress Note (MR 341b).

~~vii.~~vi.

b. Bedside Medication
   i. Prescribed medications allowed at the bedside in a locked drawer must be original pharmacy labeled containers are:
      a. Sublingual nitroglycerin tablets in original bottle of 25 tablets
      b. Inhaled medication for immediate use
      c. Topical ophthalmic medications in liquid or ointment form
      d. Prescribed over-the-counter drugs

ATTACHMENTS:

Appendix I and II - Routine Medication Times and Abbreviations; Specific Medication Administration Times

Appendix III – Anticoagulant Administration Protocol

REFERENCES:

Lexicomp Online website: http://www.crlonline.com/crlsql/servlet/crlonline

Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. *Institute for Safe Medication Practices*. Retrieved from http://www.ismp.org/tools/donotcrush.pdf

CROSS REFERENCES:

LHHPP File: 25-01 High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal Telephone Medication Orders
LHHPP File: 25-04 Adverse Drug Reaction Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-10 Use of Psychoactive Medications

LHH Pharmacy P&P 01.02.02 Stop Orders
LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets
LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches

Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds

Nursing P&P E 5.0 Enteral Tube Management

Revised: 2000/10, 2006/01, 2008/01, 2010/10, 2011/03/15, 2013/09/24, 2017/01/05, 2017/11/04, 12/2017

Reviewed: 2017/11/04

Approved: 2017/11/04

LAGUNA HONDA HOSPITAL 05.01.00
DEPARTMENT OF PHARMACEUTICAL SERVICES

~~POLICY AND PROCEDURE FOR FORMULARY AND NON-FORMULARY MEDICATION REQUESTS~~

POLICY AND PROCEDURE FOR HOSPITAL MEDICATION FORMULARY

Policy:

The Pharmacy Department will maintain a Drug Formulary available via the Intranet.

Purpose:

To provide hospital staff with a current list of drugs and biologicals available from the pharmacy.

Procedure:

I. The P & T Committee is responsible for approving drug products for addition to or deletion from the formulary.

A. Addition of Drugs:

1. To initiate a formulary addition, the requesting physician fills out a "Request for Formulary Addition" form, which is available in the pharmacy.

2. The completed form is forwarded to the Pharmacy for review.

3. The request is forwarded to the P&T Committee for processing, setting a date for presentation and responding to the requesting physician.

4. The P&T Chairman is responsible for preparing or assigning preparation of research materials for presentation to the P&T Committee for the consideration of the request at the first available meeting.

5. The requesting physician is invited to the meeting, the drug is discussed, a decision is made, and the information is disseminated to the hospital staff.

B. Deletion of Drugs:

1. To request a formulary deletion, the requesting physician should contact the chairman of the P&T Committee.

~~Policy:~~

~~The pharmacy will request physicians to fill out a NONFORMULARY REQUEST FORM whenever a non-formulary medication is ordered.~~

~~Purpose:~~
~~To ensure proper use of the formulary, and to provide documentation of non-formulary drug use.~~

~~Procedure:~~

~~Each order for a non-formulary medication must be accompanied by a NF request form. The form will be completed either by physician or by pharmacist on verbal instruction of the physician.~~

~~The pharmacy will consult with the prescriber for clarification of non-formulary requests, and suggest formulary alternatives when they are available.~~

~~In an emergency situation or when the pharmacy is not open, non-formulary medications will be dispensed before the NF form has been completed. The NF form must be completed within 24 hours.~~

~~The completed form will be reviewed for appropriateness, and will be filed in the Pharmacy Department.~~

~~A summary report will be included in the monthly pharmacy report to the P&T Committee. NF medications which are used frequently will be considered for formulary addition and for educational programs or studies.~~

New: 9/92
REVIEWED: 02/05dw, 01/08, 04/09, 2/10, 4/11, 5/12, 8/13, 8/14
REVISED: 8/15, 3/18

LAGUNA HONDA HOSPITAL 05.03.00
POLICY AND PROCEDURE FOR THERAPEUTIC INTERCHANGE AND GENERIC SUBSTITUTION

Policy:

The Pharmacy and Therapeutics Committee shall determine drugs that may be therapeutically interchanged by the pharmacist without consultation with the physician. Generic substitution of bioequivalent drugs is permitted unless a written order by the physician specifies that the drug is to be dispensed as written.

Purpose: To provide timely, efficacious, and cost efficient pharmaceutical care services.

Procedure:

1. The Pharmacy and Therapeutics Committee shall review all pertinent literature and analyze the cost benefit relationship of drugs proposed for therapeutic interchange.

2. Upon determination of efficacy, safety and cost effectiveness, the Pharmacy and Therapeutics Committee shall approve the addition of the proposed drugs to the Laguna Honda Hospital Therapeutic Interchange List.

3. The Pharmacy and Therapeutics Committee may also remove drugs from the Therapeutic Interchange List at its discretion.

4. The Chairman of the Pharmacy and Therapeutics Committee and the Pharmacy Director shall communicate changes to the Therapeutic Interchange List to the Medical, Pharmacy, and Nursing staff of the Hospital.

5. Pharmacists may interchange drugs listed on the Therapeutic Interchange List without first consulting with the physician.

~~6.~~ The pharmacist shall document the therapeutic interchange in the patient's chart (electronically or written if electronic chart is not available) and subsequently communicate the change to the ordering provider (electronically or written if the electronic chart is not available) ~~If required to assure clarity and decrease the possibility for medication error, the pharmacist shall document an order for the therapeutic interchange drug on the patient's chart.~~

7. Unless specifically prohibited by a written or electronic physician order, pharmacists may dispense bioequivalent generic medication.

8. Medication orders with directions from the provider to "dispense as written" shall require non-formulary approval (see pharmacy policy 05.01.00) if the medication ordered is not covered by the patient's insurance or if it is a medication (or specific brand) not routinely carried by the pharmacy

~~7.~~

NEW: 3/94 sk
Revised: 4/97, 6/99, 5/00dy, 8/01dy, 10/03dw, 2/15, 7/15, 3/18
Reviewed: 02/06, 01/08, 04/09, 2/10, 4/11, 5/12, 8/13

VOLUNTEER RECRUITMENT PROCESS LIFE CYCLE

POLICY:

The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center is responsible for the full business life cycle of volunteers, including recruitment, placement, encouragement and retention, and dismissal.

PURPOSE:

1. To outline formal steps involved in developing and maintaining a general pool of volunteers available to the hospital.

2. To meet the specific human resource needs of hospital departments requesting the assistance of Volunteer Services Department.

3. To ensure that hospital residents receive the highest quality volunteers to provide companionship and support.

PROCEDURE:

Volunteer Recruitment

1. Friends of Laguna Honda Website
    a. Friends of Laguna Honda (a private non-profit auxiliary that supports the functions of the Volunteers Services Department), maintains a website with information about volunteer opportunities, registering for orientation and requirements at Laguna Honda Hospital.
2. Outreach
    a. The Volunteer Coordinators go to schools, health and career fairs, and other organizations as they are identified, to present information on volunteer opportunities at the hospital. Brochures, signage when appropriate, orientation dates, and contact information are used as presentation materials.
    b. When a specific need or request is identified, the Volunteer Coordinators will target key organizations in an effort to tailor the volunteers to the particular request.
3. Media
    a. The Volunteer Services Department and Friends of Laguna Honda may utilize Public Service Announcements written and electronic media for recruitments of volunteers as needed. The Volunteer Services Department plan to continue to increase our internet presence through strategically placed links on volunteer related and career websites.
4. Volunteer Organizations
    a. The Volunteer Services Department maintains listings of volunteer opportunities at Laguna Honda Hospital with local community volunteer organizations such as the Volunteer Match and Hands on Bay Area.

Volunteer Placement

1. Orientation
    a. Each prospective volunteer is required to participate in the volunteer orientation prior to placement.
    b. At the conclusion of the orientation, the volunteer is scheduled for an interview with a Volunteer Coordinator.
    c. Each volunteer is required to complete a volunteer application prior to the interview.
2. The Interview
    a. Content of the interview include:
        i. Review information on the application
        ii. Visual inspection of a picture ID
        iii. Reasons and motivations for doing volunteer work
        iv. Discussion of areas of interest and hospital placement need
        v. Review abuse reporting policy and sign form
        vi. Review volunteer agreement and sign form
        vii. Review statement of privacy laws and acknowledgement of responsibility and sign form
        viii. Arrangements for TB test, ID badge, and parking permit
        ix. Criminal background check and fingerprinting
    b. During the interview the Volunteer Coordinator will observe the prospective volunteer's ability to appropriately interact and understand directions.
    c. The decision to accept a prospective volunteer is made at the discretion of the Volunteer Coordinator and the department of where he/she will volunteer in.
    d. The Volunteer Coordinator contacts specific hospital departments to confirm the need for volunteers in the area discussed with the volunteer.
    e. A pre-placement interview with hospital staff is arranged for volunteers working in sensitive assignments.
3. Placement
    a. The Volunteer Coordinators make every effort to accommodate the schedule and the specific areas of interest of the volunteer, while addressing the specific scheduling needs of the unit, activity, or resident involved.
    b. Volunteers are assigned a supervising staff member from the department in which they are placed for accountability and liability. All volunteers are required to have a schedule, notify their supervisor if they are sick or plan to be on vacation and must comply with all hospital rules and regulations (e.g. annual tuberculosis and flu vaccination).
    c. If the volunteer is placed within Volunteer Services, one of the Volunteer Coordinators assumes responsibility for supervision of the volunteer.
    d. The Volunteer Coordinator will introduce the volunteer to the appropriate point of contact (POC) in the specific department he/she is interested in. The POC and the volunteer will then further discuss logistics

(commitment, time, schedule, etc.) to finalize placement. Occasionally the Volunteer Coordinator may not be available at the proposed meeting time, and may arrange a meeting between the volunteer and supervising staff member.

e. Number of hours per week or month is negotiated between the volunteer and the supervising staff member in consideration of the needs of the activity, neighborhood, resident, and the availability of the volunteer.
f. The Supervisor is given contact information for their volunteer. Volunteers are given explicit instructions that once placed, to contact the supervising staff member and/or department to report absences or schedule changes.
g. Supervising staff members are responsible for reporting excessive absences, tardiness, or other concerns back to Volunteer Services. Volunteer Services will, in turn, work with the department or Supervisor to address and resolve these types of issues. Resolution of performance issues may include the reassignment or termination of the volunteer (per Dismissal Policy).

4. The Volunteer Services Department remains aware of the need for volunteers within the organization through formal assessment, volunteer requests, and informal communications with hospital staff.

Encouragement and Retention

1. The Volunteer Services Department, in conjunction with Friends of Laguna Honda, take actions during the annual National Volunteer Week in April to express appreciation toward all volunteers.

a. These actions may include an appreciation luncheon/dinner or other similar event.
b. Banners or posters will be displayed throughout the hospital recognizing National Volunteer Week.

2. The appreciation Luncheon/dinner will recognize volunteers for the number of cumulative hours served, and the number of years given in service.

a. Certificates will be awarded with the total number of volunteer hours as of April 1st. These certificates are signed by the president of Friends of Laguna Honda.
b. Service pins are awarded to Volunteers with the following years of service
   i. Five years
   ii. Ten years
   iii. Fifteen years
   iv. Twenty years
   v. And so on in increments of 5 years

3. Volunteer supervisors are given the opportunity to nominate a volunteer(s) from his/her department to be recognized at the event called “Special Awards”. These awards are based on the Volunteer Coordinator’s discretion for their commitment to ongoing volunteer service and who feel have made a significant impact on the hospital.
4. Volunteers who are on duty during the day are entitled to a 50% discount at the hospital’s cafeteria for one meal during their shift.

   a. Volunteers must show their volunteer identification badge to the cashier to receive the discount.
5. Thank You Cards will be sent to individual volunteers to recognize those who help above and beyond the call of duty (i.e. special events volunteers, special projects, Holiday Program and those who come in on days they are not scheduled.)
6. Volunteer Coordinators will make an effort to respond to volunteer questions, concerns or needs in a timely manner.

Volunteer Dismissal

Volunteers who do not adhere to the policies and procedures of the program or who fail to satisfactorily perform their volunteer assignment are subject to dismissal. At the discretion of the Volunteer Coordinator, any volunteer not meeting the requirements of what was agreed upon in their application can be dismissed at any given time.

Corrective Action

Corrective/ disciplinary action may be taken if the volunteer's work is unsatisfactory. The procedure for disciplinary action is usually aa~~a~~ three step process but the Volunteer Coordinator or Volunteer Supervisor has the authority to dismiss a volunteer at his/her discretion at any given time. ~~.~~

1. First a formal written notice is sent to the volunteer from the Volunteer Supervisor.

2. Second formal notice is sent and a meeting is scheduled with the volunteer, their supervisor from the area they volunteer and the Volunteer Coordinator is set up.

3. Notice is sent to the volunteer being dismissed of their duties from their Supervisor. A copy will be given to the Volunteer Services Department to be placed in the volunteer's record. The volunteer will be responsible to turn in their ID Badge and a parking permit (if they have one).

Conduct or behavior which may lead to disciplinary action includes, but is not limited to:

- Poor Timekeeping and or unreliability of their time.
- Not following rules, policies or procedures as described in the Orientation Packet.
- Rudeness or hostility towards residents, staff or other volunteers
- Intoxication through alcohol or other illegal substances
- Theft of property
- Accepting compensation for assisting residents

- Failure to perform volunteer duties as agreed
- Bringing illegal substances on to the hospital campus
- Breach of confidentiality
- Falsification of any materials

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 2015/20/03, 2015/08/19, 2017/02/05
Original Adoption: 1998/06/01

RECORD KEEPING

POLICY:

Laguna Honda Hospital Volunteer Services maintains records of participating volunteers.

PURPOSE:

To adequately record volunteer activity for recognition, operations improvement and volunteer references.

PROCEDURE:

1. The Volunteer Services Department utilizes the Volgistics database system in managing volunteer records.

    a. The Volunteer Services Department also maintains a hand-written application ~~binder~~ with information froor~~r~~m each active volunteer. The following information is~~n~~ maintained in the- Volunteer Services offices~~Activity Volunteer Binders~~.
        i. Application form
        ii. Adult Abuse Reporting Requirement form
        iii. Volunteer Agreement/Checklist
        iv. Volunteer Confidentiality form

2. Upon acceptance and placement within the volunteer program, the Volunteer Coordinator is responsible to ensure that the volunteer's information is entered into Volgistics including, but not limited to, assignment, schedule, and emergency contact information.

3. The Volunteer Coordinator is responsible to file all hard copy forms in the ~~Active~~ Volunteer Services office~~Binders~~.

4. All volunteers are required to log onto Volgistics and the beginning of their shift and log out at the end of their shift using the kiosk located in the lobby of the pavilion building, outside of the medical clinic on the first floor and outside Volunteer Services offices in the administrative building.

5. If the computer is not operational, volunteers are required to enter their name, time in/out on to the Volunteer Sign in Sheet located by the kiosk, so that the Volunteer Coordinator can input the hours into the Volgistics database.

6. The Volunteer Services Department is able to generate reports from Volgistics to be used for recognition activities and productivity reports.

7. Volunteers are required to notify the Volunteer Services Department when they plan to discontinue their volunteer service.

    a. Records for volunteers who complete their service or who are separated are archived within Volgistics.

    b. Hard copy files are removed from the binder and discarded appropriately.

8. At the end of each month, a Volunteer Coordinator runs an inactivity report to identify volunteers who have not reported to their assignment within the past~~over the preceding 3~~ month~~s~~.

    a. The Volunteer Coordinator makes a determination as to whether the records should be archived or to maintain the volunteer's active status.

9. Volunteers who resume their service after a period of inactivity have their files restored within Volgistics by the Volunteer Coordinator.

    a. The information is reviewed and up-dated as appropriate.

10. Volunteers who resume their service after a period of inactivity must complete all applicable hard copy forms which are filed in the Volunteer Services office~~Active Volunteer Binders~~.

ATTACHMENT:
None

REFERENCE:
None

Revised: 2014/06/09, 2015/08/19, 2018/07/10
Original Adoption: 1998/06/01

Non-Designated In-Kind Donations

POLICY:

The Volunteer Services Department is routinely responsible for accepting and processing non-designated in-kind donations for the hospitalLaguna Honda Hospital and Rehabilitation Center (LHH).

Laguna Honda HospitalTheLHH hospital does not arrange for the pick-up of donated items. The donors are responsible for getting donated items to the hospital.

PURPOSE:

To process donations in an effective and efficient manner; to and ensure that donations are allocated to appropriate areas.

PROCEDURE:

1. Non-designated iin-kind donations are non-financial donations of items such as clothing, furniture, medical equipment, books, etc.

2. The Volunteer Services Department maintains a list of suggested donation items; as well as a list of items that cannot be used at the hospital. The Volunteer Services Department makes the list of suggested donations available to a potential donor upon request. The department may also use the list of suggested donations to advertise or solicit for donations in support of resident programs.

3. Donations are accepted in front of the Volunteers Services Department, Monday through Friday, from 8:30AM to 4:305:00PM. Donations may be dropped off in front of the Volunteer Services Department even if staff are unavailable.

4. A Laguna Honda Hospital and Rehabilitation Center Gift Receipt Form is completed for all donationsAll donations received by LHH will have a Gift Receipt form completed.

    a. Gift Receipt forms filed for donations will be kept on file.

    b. Gift Receipt forms are available outside the Volunteer Services Department offices in a prominent place with instruction to accommodate donors.

    c. Donations that are distributed to the Gift Shop for sale will be indicated on the Gift Receipt form.

d. If donations are dropped off when Volunteer Services staff are unavailable and no Gift Receipt Form is completed by the donor, Volunteer Services staff document the donor as being "anonymous" on the form.

3. The Volunteer Services Department provides the Finance Department with copies of all completed Gift Receipt forms on a quarterly basis for donations.

4.

a. The donor may request an acknowledgement letter unless information is unknown.

5.

6. Donations may be dropped off in front of the Volunteer Services Department even if staff are unavailable.

a. Gift Receipt forms are left in a prominent place with instruction to accommodate donors.

b. If donations are dropped off when Volunteer Services staff are unavailable and no Gift Receipt Form is completed by the donor, Volunteer Services staff document the donor as being "anonymous" on the form.

6. Acknowledgement letters are prepared by the Volunteer Services Department and signed by a Volunteer Coordinator and the Executive Administrator with the exception of anonymous donors.

Completed Gift Receipt Forms are kept on file. for three years.

7. The Volunteer Services Department provides the Finance Department with copies of all completed Gift Receipt forms on a quarterly basis for donations. received as of the last day of January, April, July, and October, of each year.

7. A Volunteer Services staff or volunteers areshall be responsible for processing or distributing donations.

a. Donated items determined to be inappropriate for use within the hospital will be either donated to other community organizations or distributed to the hospital Gift Shop for sale.

b. Proceeds from the sale of non-cash value items in the Gift Shop will be distributed to the Resident Gift Fund.

8. Donated items shall follow appropriate processing guidelines.evaluated determined to be inappropriate for use within the hospital will be donated to other community organizations. or discarded.

a. Clothing and Shoes

i. Are taken to the Clothing Room for processing.

ii. Must be in good, clean condition.

iii. Larger sizes in men's and women's clothing are preferred.

iv. Practical and functional clothing and shoes will be stored in the Clothing Room and distributed to residents per Clothing Room Policies and Procedures.

b. Books are evaluated for appropriateness and are either taken to the Resident Library, recycled or to another organization with a need.

c. Medical Equipment

i. Medical supplies and food items are not accepted (i.e., bandages, gauze, Ensure or any other supplemental drink).

ii. LHH does not accept beds, prescription drugs, diapers, syringes, tubing and commodes.

iii. Durable medical equipment accepted include but are not limited to: manual wheelchairs, electric wheelchairs, canes, crutches and other assisted devices.

iv. The equipment must be clean and in good condition.

v. Upon receipt of donated medical equipment, the Volunteer Services Department will contact Rehabilitation Services to evaluate equipment for appropriateness.

vi. Central Supply does not accept donated medical products (and miscellaneous equipment) due to quality control issues.

vii. Any equipment deemed inappropriate by Rehabilitation Services will either be disposed of or donated to another community organization.

d. Food

i. Due to food safety concerns, food items are generally not accepted as a donation.

ii. All donated foods must be from a commercial source, which may be accepted at the discretion of the Volunteer Services Department.

e. Miscellaneous items are distributed to resident neighborhoods, the Activity Therapy Department or used as holiday gifts.

ATTACHMENT:
None

REFERENCE:
LHHPP 45~~85~~-03 Donations

~~Most recent review and revision: 15/01/06~~
Revised: 12/05/21, 15/08/19, 18/07/10
Original Adoption: 98/06/01

CLOTHING ROOM

POLICY:

Laguna Honda Hospital (LHH) will provide a process for distribution of clothing and to residents.

PURPOSE:

To provide clothing for the needs of the residents of LHH.

PROCEDURE:

1. The Clothing Room is under the management of the Volunteer Services Department and is staffed by LHH volunteers.

2. All clothing brought to the Clothing Room is either donated or recycled from resident units. Clothing is sorted, cleaned if necessary, and organized for selection by LHH volunteers or staff.
3. Any clothing determined to be inappropriate is donated to other community organizations.

4. Residents must be accompanied by a staff member or unit volunteer, or provide a signed clothing room form from unit staff to receive clothing, which must indicate the items needed.

5. Hospital staff, Clothing Room Volunteers or Unit Volunteers must accompany the resident in selecting clothing at the Clothing Room.
6. The resident is not to be left alone in the Clothing Room.

7. Residents should be actively involved in selecting clothing, if this is not feasible, nursing staff or volunteers may assist the resident in selecting clothing.

8. The Clothing Room Form must be completed by hospital staff or volunteers and submitted to the Clothing Room.

9. If a Clothing Room Volunteer is unavailable, hospital staff Social Worker, Nursing staff, Activity Therapist or Neighborhood Volunteer may obtain the key from the Nursing Station. All Neighborhoods have access to the clothing room 24/7. An ID badge which gives access to the 4th floor entrance as well as a key to the clothing room was made available to all neighborhoods as well as the Social Work Department and the Administrative Office. Hospital staff and volunteers must ensure that the Clothing Room is left in an orderly fashion.

10. Clothing room forms will be compiled, and quarterly reports of clothing usage will be made to the volunteer coordinator.

11. ~~Clothing Room H~~hours are ~~Mondays and Fridays from 10AM to 2PM.~~ The extension to reach the Clothing Room at Laguna Honda Hospital is x44036.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 12/08/17
Revised: 12/08/17, 15/07/01, 18/07/10

RESIDENT LIBRARY

POLICY:

Laguna Honda Volunteer Services manages the operations of the resident library, including the acquisition and organization of donated and purchased reading materials, the provision of computers and internet access, and volunteer staffing of the library.

PURPOSE:

To enhance the quality of life of LHH residents.

PROCEDURE:

1. The ~~L~~library is open Monday to Friday 8:30 a.m. to 8:30~~00~~ p.m~~. .During the week, the library is opened by the Activity Therapy Department Supervisors clerk and closed by EVS Staff~~automatically, after cleaning.~~ On ~~W~~weekends, ~~Activity Therapy Staff open~~ the ~~Library is~~Library is open at 9:30am and close~~s it~~ at 4:30pm. The door is set to a timer for opening and closing.

2. The Volunteer Services Department acquires books for the library through a book share program with the San Francisco Public Library and the Friends of the San Francisco Public Library. The library also acquires books from donations from the public.

3. The Volunteers Services Department maintains subscriptions of periodicals financed by Friends of Laguna Honda a private non-profit volunteer auxiliary.

4. Computing:

   a. Computers with internet access are available to the residents during regular library hours. The library computers are for use by residents only, or staff assisting residents who are present.

   ~~a.~~b. The library IPad is for resident use only and is limited to an hour at a time if other residents are waiting.

   ~~b.~~c. The internet access is restricted from pornography in the library. Residents & visitors have the right not to be exposed to sexually explicit materials or behaviors, under the LHH Resident's Sexual Rights and Responsibilities Policy.

   ~~c.~~d. Library computer internet access is maintained by Volunteer Services staff and volunteers. IT at Laguna Honda does maintain problems with access to the internet.

5. The Resident Library has a large selection of enlarged print books~~,~~ and has equipment designed to magnify text for the visually impaired.

6. Volunteer librarians staff the library providing assistance to and supervision of responsibilities. Responsibilities of volunteer librarians include:

   a. Assist residents with locating reading materials
   b. Enforce library policies
   c. Assist residents with use of the computers (internet, email, etc.)
   d. Enforce the rule that the computers are for resident use only
   e. Shelve books appropriately (by genre, then alphabetically, by author, then title)
   f. Organize periodicals in a manner that enhances access and utilization by residents.
   g. Organize/clean up tables and chairs to provide the greatest access possible for residents.

7. The Resident Library may not be used for any staff-related functions, unless approved by Volunteer Services.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 15/07/23
Revised: 14/08/20, 18/07/10
Original Adoption: 98/06/01