

List of Hospital-wide/Department Policies & Procedures Submitted to JCC for Approval on March 13, 2018

1. <u>a. New Hospital-wide Policies and Procedures</u>		
Policy Number	Title	Comment(s)/Reason(s) for Development
None.		
<u>b. New Department Policies and Procedures</u>		
<i>Department: Rehab</i>		
Policy Number	Title	Comment(s)/Reason(s) for Development
110-04	Rehabilitation Services Community Evaluation	Created to define procedures for providing patient evaluations to assess community level skills prior to discharge.
110-05	Rehabilitation Services Home Evaluation	Created to define procedures for providing patient evaluations to assess home environment skills prior to discharge.
2. <u>a. Revised Hospital-wide Policies and Procedures</u>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
LHHPP 22-13	Bed Rail Use (re-titled)	Revised to meet new CMS requirements and describe procedures for bed rail use; added attachment for suggested alternatives; revised MR 172 form to combine safety assessment, bed rail order, and informed consent.
LHHPP 24-19	The C-625 Battery Operated Ceiling Lift	Revised to include Rehab staff in training; Attachment A has been updated; and developed an annual competency check.
LHHPP 26-05	Neighborhood Specialty Meal Program	Revised to reflect current procedures for providing the neighborhood specialty lunch program.
LHHPP 29-10	Non-Beneficial Treatment	Revised procedures to clarify steps for determining non-beneficial treatment and notification to the resident or surrogate decision-maker; added attachment for sample notification letter.
LHHPP 50-02	Resident Trust Account	Revised to meet CMS requirements and Social Security and Medi-Cal regulations for LHH to act as a fiduciary of resident funds.
LHHPP 50-08	Resident Notification of Excess Personal Assets in Trust Account (re-titled)	Revised to reflect current standard for spend down for assets in resident's Trust Account.
LHHPP 70-01	B1 Emergency Response Plan (restructuring/renumbering)	Revised to provide a clear guide for HICS activation in response to any event resulting in disruption of normal operation.
LHHPP 70-01	C1 Fire Response Plan (restructuring/renumbering)	Revised to clarify procedure for fire response in the Administration Building.

<u>b. Revised Department Policies and Procedures</u>		
<i>Department: Central Processing Department</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
3.21	Biomedical Technical Assistance	Revised to reflect changes in biomedical vendor procedures.
<i>Department: Facility Services</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
EM-1	Equipment Management Program: Testing and Maintenance of Patient Care Equipment	Revised to reflect updated procedures for the equipment management program.
<i>Department: Health Information Services</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
02.05	Continued Education and Training	Revised to include documentation of attendance.
<i>Department: Nursing</i>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
D 8.0	Post Mortem Care	<ul style="list-style-type: none"> Added: "If a resident, living in a semi-private or shared room, is nearing the end of his/her life, every effort will be made to relocate the resident into a private room for private and dignified terminal care." Added to Procedure C #3: "unless family/surrogate decision-maker request otherwise" about removing jewelry if possible Added Procedure H #1: new section b. "Record whether or not family or decision maker were notified of death by the physician"
G 1.0	Vital Signs	<ul style="list-style-type: none"> Updated the policy to reflect current movement to remove Pain as the 5th vital sign
K 1.0	Assessment, Prevention and Management of Pressure Ulcer/Pressure Injury	<ul style="list-style-type: none"> Included verbiage (with specific details on how soon to notify disciplines) from LHHPP into NPP on what to do following detection of a pressure ulcer
K 4.0	Applications: Heat or Cold Therapy	<ul style="list-style-type: none"> New policy: "Therapy aides may apply dry or moist heat to relieve musculoskeletal pain or tension prior to a treatment (Refer to Restorative Policy)" Added "impaired circulation" as a contraindication to cold therapy
M 2.0	Protocol for the Prevention, Assessment and Management of Dehydration	<ul style="list-style-type: none"> Policy converted into Protocol format to be consistent with orthostatic hypotension protocol

		<ul style="list-style-type: none"> • Included “inadequate intake” and “dysphagia” for risks for dehydration • Added “free water per MD order” for free water for enteral order
Department: Pharmacy		
Policy Number	Title	Comment(s)/Reason(s) for Revision
01.02.00	Automatic Stop Orders	Revised to include automatic stops for as needed psychotropics per CMS regulation.
03.02.00	Unit Inspections	Revised unit inspection checklist.
06.01.00	Medication Regimen Review	Revised to state how/where MRR findings are available to the RCT, and include new check box on pharmacist sign-off indicating presence of findings.
06.01.01	Psychotropic Medications	Revised to indicate documentation requirements for as needed psychotropics.
3. <u>a. Hospital-wide Policies and Procedures for Deletion</u>		
Policy Number	Title	Comment(s)/Reason(s) for Deletion
None.		
<u>b. Department Policies and Procedures for Deletion</u>		
Policy Number	Title	Comment(s)/Reason(s) for Revision
None.		

Rehabilitation Services Community Evaluation

POLICY:

The Rehabilitation Center may provide a community evaluation for each patient before discharge from facility to assess community level skills. This includes: use of public transportation, mobility or ambulation in the community, ability for street crossing and able to problem solve pathfinding.

PROCEDURE:

1. Consideration for a community evaluation will be discussed with resident care team to determine necessity and goals.
2. Obtain referral and/or appropriate plan of care to include needs.
3. Notify nursing and unit staff at least one day before community evaluation date.
4. Therapists can check out a cellphone from a Senior and obtain an emergency kit (located in office PG153) in preparation for home evaluation.
5. Therapists confirm stable vital signs OR receive acceptance of stability from charge nurse.
6. Therapist will accompany patient on evaluation and can address: abilities to effectively use public transportation, mobility or ambulation for community distances/surfaces/obstacles, safety for street crossing, ability to problem solve and path find appropriately.
7. In accordance to the Sugar Sweetened Beverage (SSB) Ordinance (effective 9/1/15), Therapist will notify patients not to purchase SSB drinks during community evaluation to comply. The following are acceptable choices:
 - 100% fruit and vegetable juice without added caloric sweeteners
 - Only beverages containing 25 calories or less per 12 ounces of beverage
 - Milk
 - Flavored milk containing no more than 40 grams of total sugar per 12 ounce
 - Unsweetened tea
 - Coffee
 - Water / sparkling water
 - Diet carbonated beverages
8. Expenditure of DPH funds for food is allowed if food is served for a business purpose.
 - a. Allowable Expenditures: 1. Food provided to clients for a legitimate client benefit or purpose (e.g. vouchers for groceries, food provided to clients, client incentives, etc.)..

9. Healthy Food: DPH employees that order, authorize, or purchase refreshments for any purpose must use their best efforts that ensure that all foods and beverages served at City Meetings or City-Sponsored Events and purchased using City funds meet the nutritional standards outlined in Ordinance 91-16.
10. Written evaluation and recommendations from OT, PT, or ST will be discussed with team and patient.
11. Follow up on any treatment plans and recommendations resulting from community evaluation.

ATTACHMENT:

None

REFERENCE:

Most Recent Review: 10/19/17
Revised:
Original Adoption:

Rehabilitation Services Home Evaluation

POLICY:

The Rehabilitation Center may provide a home evaluation for each patient before discharge from facility to assess the patient's skills within their home environment. This includes: car/van transfers, entry to home assessment, accessibility to bedroom, kitchen and living spaces as well as bathrooms and showering facilities with regards to safety. Caregiver assessment and training may also be included.

PROCEDURE:

1. Consideration for a home evaluation will be discussed with resident care team and determine necessity.
2. Obtain referral and/or appropriate plan of care to include needs.
3. Members of the RCT (social work, nurse and/or physician) will set potential date and alert team members of scheduled evaluation.
4. Therapists can check out a cellphone from a Senior and obtain an emergency kit (located in office PG153) in preparation for home evaluation.
5. Therapists confirm stable vital signs OR receive acceptance of stability from charge nurse.
6. Formal home evaluation will be performed and can address: transfers including car, functional mobility, stairs, toileting, bathing, home environment safety, patient and caregiver training.
7. Home evaluation may be conducted without patient being present. Assessment of the environment (bedroom and bathroom), stairs, walking path inside and outside of home and caregiver training will be addressed.
8. Written evaluation and recommendations from PT and OT will discussed with team and patient.
9. Follow up on any treatment plans and recommendations resulting from home evaluation.

ATTACHMENT:

None

REFERENCE:

Most Recent Review: 10/19/17
Revised:
Original Adoption:

SHORT STAY DISCHARGE PLANNING AND TRACKING PROCESS

BACKGROUND:

Laguna Honda Hospital and Rehabilitation Center (LHH) uses various service codes to denote the type of services provided to residents. The following service codes describes the common ones used for skilled nursing facility (SNF) services:

<u>Service Code</u>	<u>Description of Service Code</u>
<u>LHG</u>	<u>Longer stay general SNF services</u>
<u>LHP</u>	<u>Palliative and end of life care services provided on South 3</u>
<u>LIS</u>	<u>General SNF or short stay residents on transmission based precautions</u>
<u>LRE</u>	<u>Short stay respite services</u>
<u>LRH</u>	<u>Short stay rehab services</u>
<u>LSA</u>	<u>Short stay Positive Care services on South 2</u>
<u>LSS</u>	<u>Established on January 1, 2014, to denote short stay SNF services provided to residents who are expected to be discharged back to the community within 100 days of admission...</u>

POLICY:

1. Residents whose skilled nursing needs can be addressed in less than 100 days from admission are designated with a "Short Stay" hospital service code. The Short Stay service code triggers a set of discharge planning activities aimed at facilitating discharge and mitigating delays that would keep the resident at LHH longer than the anticipated skilled nursing facility stay of 100 days.
2. Effective March 13, 2018, the LSS service code shall be expanded to include residents who have resided at LHH and received SNF level of care services for more than 100 days under a different SNF service code. These include residents who have been identified by the Resident Care Team (RCT) as having a discharge potential to return to the community and is expected to do so within the next 100 days.
3. Allowance shall be made, due to extenuating circumstances within the discharge planning process that are unrelated to the resident's condition (e.g. housing delays, benefits delays), to maintain a resident's service code as LSS well beyond 100 days of stay for tracking purposes.
4. Residents assigned a short stay service code shall be reviewed for progress with discharge planning by the RCT, at a minimum every two weeks during Discharge Huddle.

PURPOSE:

To identify short-stay residents who have the potential to be discharged within 100 days of designation of a short stay service code and to improve the discharge planning process.

PROCEDURE:**1. Service Code Assignment on Admission and Readmission**

- a. The Admission and Screening Committee shall consider the resident's condition for admission using the Short Stay codes (LSS, LSA, LRH, and LRE), based on the anticipated course of treatment and the expected improvement in condition that the resident will be ready and appropriate for discharge within 100 days.
 - i. The LSS Short Stay code is used primarily for residents who are at a SNF level of care and have an estimated length of stay of 100 days.
 - ii. The three other Short Stay codes shall be used for residents receiving Positive Care, Rehabilitation, and Respite services.
- b. When the resident has been admitted and identified as Short Stay, the Admission and Eligibility (A&E) Unit shall input the service code for the resident into the electronic Admission, Discharge, and Transfer (ADT) system.
- c. For readmissions, the Patient Flow Coordinator (PFC) shall communicate the service code to the A&E Unit, receiving neighborhood and the Utilization Management (UM) nurses.

2. Discharge Planning Assessment

- a. As with all residents who are admitted at LHH, discharge planning for residents designated with Short Stay codes begins immediately on admission. Specifically, for residents who are designated as Short Stay, the following steps must occur between the resident's first day of admission and the seventh day post admission:
 - i. Social Services – All residents shall have an initial assessment within 48 hours of admission which shall be completed within 5 days, and a discharge assessment within 14 days of admission.
 - The Medical Social Worker (MSW) shall conduct an initial assessment for Short Stay residents within 48 hours of admission and a discharge assessment within seven days of admission. The MSW shall initiate discussion of discharge destination with residents who have decision-making capacity and with the responsible party, if consent is provided by the resident.
 - ii. RCT – An initial Resident Care Conference (RCC) shall be held within 7 days of admission to discuss the resident's goals of care and discharge plan including with family members and/or other caregivers, if appropriate. The RCT shall establish an estimated discharge date and discuss the meaning of

the Short Stay plan with the resident and/or responsible party during the first RCC meeting.

3. Discharge Huddles

- a. The RCT shall utilize the Discharge Huddle Guide and the Discharge Huddle Worksheet during Discharge Huddles to track residents who are assigned the short stay service code and/or residents who shall be change to a short stay service code.
- b. Discharge huddles shall be conducted at a minimum biweekly and is expected to take up approximately 2 to 5 minutes per resident.
- c. The RCT discharge huddle shall review the following information:
 - i. Residents who are newly admitted or relocated to the neighborhood, their discharge destination and confirmation of their short stay service code;
 - ii. Residents who were discharged during the past week;
 - iii. Progress at 30, 60 and 90 days with discharge planning for Short Stay residents with active discharge plans, including discharge barrier(s) or issues(s) that require some assistance in resolving from the Clinical Leadership Team;
 - If the resident has not discharged after 90 days of admission or LSS service code designation, the Social Worker, with input from the RCT shall notify the Patient Flow Coordinator and Social Services Director and provide status updates and progress toward discharge;
 - iv. Residents who were newly issued a discharge notice by the MSW and any concerns related to their upcoming discharge;
 - v. Updates on housing applications and acceptance from the Medical Social Worker;
 - vi. Residents who were identified by the Discharge Huddle Worksheet as potentially able to discharge within a 100 days;
 - vii. Resident who were assessed with significant improvement in function or condition who may be appropriate for discharge to the community based on the quarterly or annual RCT review from the prior week;
 - viii. Updates from the UM Nurse on modified or deferred Treatment Authorization Requests for residents deemed to be short stays.

- d. The MSW and Charge Nurse or designee shall document update(s) in their respective sections of the Progress Notes and update the resident's discharge plan as necessary.
- e. If the RCT determines that a resident with a Short Stay service code is likely to reside at LHH for longer than 100 days, the RCT shall submit a request to have their service codes changed according to Procedures 6, 7 and 8.

4. Discharge Planning Support and Guidance to RCTs

- a. Social Services Director and PFC – The Social Services Director and the PFC shall track the Short Stay resident's progress with discharge planning. Either the Social Services Director or the PFC shall address issues or barriers that are delaying the original discharge plan, and shall inform the a RCT Leadership member (Chief Medical Officer, Chief Nursing Officer or Assistant Hospital Administrator for Clinical Services) who can assist administratively with addressing the discharge barrier(s) or issue(s).

5. Monthly Short Stay Reviews

- a. The intent of the Monthly Hospital-wide Short Stay Reviews is to track the progress of discharge planning for short stay residents at 30 , 60, 90 days and longer.
- b. This review is facilitated by the Social Services Director and the PFC or designee, and attended by members of the Community Reintegration Performance Improvement Team.
- c. The intent of this discussion is to track residents' with all Short Stay codes and ensure that they are on track with their discharge plan. Any Short Stay resident that is not meeting the planned discharge timeline will be escalated to the Community Reintegration Performance Improvement Team for review and recommendations.

6. Changing Service Codes

- a. Data entry changes of service codes shall be performed by the A&E Department or the neighborhood Unit Clerk based on requests by designated individuals.
- b. The Short Stay dashboard will automatically be refreshed every twelve hours.
- c. The following individuals may submit a request to change a specialty service code (LSA or LRH to LSS) based on assessment by the RCT and according to the guidelines described under Procedure 7:
 - i. Nurse Manager,
 - ii. Nursing Director,

- iii. PFC,
- iv. Director of Social Services,
- v. UM Nurses, and/or
- vi. UM Nurse Manager.
- d. Approval for Short Stay service code changes described in Procedure 8 shall be made by the RCT.
- e. The South 3 Nurse Manager, Charge Nurse or designee is responsible for submitting requests for non-Short Stay service code changes from LHP to LHG, as appropriate, for residents who have received 1 year of palliative and end of life care following completion of the annual Minimum Data Set.
- f. The Nurse Manager, Charge Nurse, or designee is responsible for submitting requests for non-Short Stay service code changes from LHG to LIS as appropriate for bed control management.

7. Guidelines for Changing Short Stay Specialty Service Codes LSA and LRH to LSS

- a. Short Stay residents who have completed Short Stay hospital services LSA and LRH, but are not ready for discharge to the community due to housing needs shall have their Short Stay code changed to the LSS service code for continued tracking.
- b. The resident's length of stay begins anew only if the readmission occurs greater than 30 days after discharge.
- c. Residents readmitted as Short Stay will have 100 days to discharge from the date of readmission.
- d. Extenuating circumstances within the discharge planning process that are unrelated to the resident's condition (e.g. housing delays, benefits delays) will not be criteria for changing a Short Stay code to LHG.
- e. These factors shall be recorded and monitored via the Discharge Huddle Worksheet.
- f. Residents who are not discharged within 100 days and have not had a significant change in health condition warranting a change in hospital service code shall be changed to LSS until discharge.

8. Guidelines for Changing Short Stay Service Code to LHG

- a. A Short Stay code may be changed to a general SNF (LHG) hospital service code under the following situation:
 - i. In cases where the resident's medical condition has changed such that a discharge within 100 days of admission is no longer viable. The RCT shall notify the Social Services Director by email to request a change of service codes.
 - ii. The Social Services Director shall evaluate each Short Stay code change to LHG request and meet with the RCT to discuss the impact to the resident's discharge plans. The RCT Leadership Team members may also provide assistance and guidance to their respective discipline and RCT members to resolve discharge barrier(s) or issues(s).
 - iii. If the Social Services Director, with input from the PFC, approves the code change, s/he informs the A&E Department, who will be responsible for updating the code from LSS to LHG.
 - iv. The Social Services Director shall notify the RCT that the resident's discharge plan must change, and the RCT shall update the discharge plan with interventions to mitigate identified barriers to discharge.
 - v. If the request to change the LSS service to LHG is denied, the RCT may make a referral to the UM Committee to render a final decision on the matter.

9. Reports and Metrics

- a. Metrics described below track the effectiveness of discharge planning efforts for residents having the Short Stay code.
- b. SFGetCare reports include a Short Stay list showing Medical Record Number, Resident Account Number, Resident Name, Neighborhood, Bed Number, Date of Admission on Short Stay Codes, Last Date on Short Stay Codes, and Number of Accrued Days from Admission.
- c. The Community Reintegration Performance Improvement Team shall perform a quarterly analysis of Short Stay residents for identification of learning and improved opportunities. For trend analysis, the following metrics shall be reviewed quarterly:
 - i. Number and percent of residents designated as Short Stays
 - ii. Number and percent of Short Stay residents discharged within the 100-day timeframe.
 - iii. Average length of stay for Short Stay residents.

- iv. Summary characteristics of Short Stay residents (e.g. diagnosis, age, unit, discharge disposition) for trend analysis.
- v. Number and percent of General SNF residents NOT designated Short Stay that are discharged within 100 days.
- d. The SNF Performance Improvement and Patient Safety (PIPS) Committee shall review the CMS CASPER report on quality measure related to the percentage of short-stay residents who were successfully discharged to the community (claims-based) during scheduled meetings.
- e. Quarterly analysis shall be performed to support performance improvement projects targeted toward specific sub-populations. Outcomes shall be reported to both the Community Reintegration Performance Improvement Team, Admission and Screening Committee, UM Committee and ultimately to the PIPS committee.

ATTACHMENT:

Appendix A: Changing Service Code Flowchart

REFERENCE:

None.

Revised: 16/07/12, 16/11/08, 18/03/13 (Year/Month/Day)

Original adoption: 16/01/12

SHORT STAY**POLICY:**

~~Residents whose skilled nursing needs can be addressed in less than 100 days from admission are designated with the "Short Stay" hospital service code. The Short Stay code triggers a set of discharge planning activities aimed at facilitating discharge and mitigating delays that would keep the resident at Laguna Honda Hospital and Rehabilitation Center (LHH) longer than the anticipated skilled nursing facility stay of 100 days.~~

PURPOSE:

~~Identify and prioritize short stay residents who have the potential to be discharged in under 100 days and to improve the discharge planning process.~~

BACKGROUND:

~~LHH established the Short Stay hospital service code (LSS) effective January 1, 2014. This code designates residents expected to be discharged from LHH to the community within 100 days of admission as a skilled nursing facility resident. Historically LHH has~~

~~had other Short Stay codes such as LSA (Positive Care), LRH (Rehab), LRE (Respite), and LHP (Palliative Care) where residents' stay is expected to be 100 days or less.~~

~~PROCEDURE:~~

~~1. ADMISSION~~

- ~~a. The Admission and Screening Committee considers resident's condition for admission using the Short Stay codes (LSS, LSA, LRH, LRE, LHP), based on the medical assessment and the appropriate course of treatment for the resident and the viability of the resident improving sufficiently for discharge within 100 days.~~
 - ~~i. The LSS Short Stay code is used primarily for residents who are at a skilled nursing facility level of care and have a goal for a hospital stay of 100 days.~~
 - ~~ii. The four other Short Stay codes are used for residents on Palliative Care, Positive Care, Rehab, and Respite.~~
- ~~b. When the resident has been admitted and identified as a Short Stay, the Admission and Eligibility Unit inputs the hospital service code for the resident into the Invision system.~~
- ~~c. For readmissions, the Patient Flow Coordinator will communicate the service code to Admissions and Eligibility, the receiving unit and the Utilization Management nurses.~~

~~2. Discharge Planning~~

- ~~a. Day 1 – Day 14: As with all residents who are admitted at LHH, discharge planning for residents designated with Short Stay codes begins immediately on admission. Specifically, for residents who are designated as Short Stay, the following steps must occur between the resident's first day of admission and fourteenth day post admission:~~
 - ~~i. Social Services – All residents must have an initial assessment within five days of admission and a discharge assessment within 14 days of admission. The Medical Social Worker will conduct an initial assessment for Short Stay residents within two days of admission and a discharge assessment for Short Stay residents within seven days of admission. The Medical Social Worker shall initiate discussion of discharge destination with residents who have decision-making capacity and with the responsible party, if consent is provided by the resident.~~
 - ~~ii. Resident Care Team (RCT) – An initial Resident Care Conference shall be held within 14 days of admission to discuss the resident's goals of care and discharge plan including with family members and or other caregivers, if appropriate. The RCT shall establish a tentative discharge date and discuss~~

~~the meaning of Short Stay plan with the resident and or responsible party during the first Resident Care Conference meeting.~~

- ~~iii. Utilization Management Nurse shall affix a blue sticker on the spine of the chart to denote a Short Stay resident.~~

~~b. Day 15 – Day 45:~~

- ~~i. Social Services Director and Patient Flow Coordinator – The Social Services Director and Patient Flow Coordinator shall track the Short Stay resident's progress with discharge planning and notify the RCT when the resident's length of stay reaches 45 and/or 75 days since admission. Either the Social Services Director or Patient Flow Coordinator will address issues or barriers that are delaying the original discharge plan; and will also inform the Resident Care Team Leadership member (Chief Medical Officer, Chief Nursing Officer or Assistant Hospital Administrator for Clinical Services) who can assist administratively with addressing the discharge barrier(s) or issue(s).~~

~~c. Weekly Discussion of Short Stay Discharge Progress:~~

- ~~i. Short Stay Weekly Discharge Discussion – Neighborhood Discharge Huddle:~~

- ~~• Utilization Management Nurses shall verify that the Hospital Code is correct and reflective of Short Stay designation.~~
- ~~• Resident Care Team – Resident Care Teams shall discuss residents who have active discharge plans during the weekly discharge huddle. Resident Care Teams shall prioritize the discussion of Short Stay residents first.~~
- ~~• Charge Nurse or designee – Nursing shall document weekly update(s) on the progress of the resident's discharge plan.~~
- ~~• Any member of the RCT can inform their immediate supervisor or member of the RCT Leadership if there are discharge barrier(s) or issues(s) that need assistance in resolving.~~

~~d. Day 45:~~

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

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

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

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

~~e. Day 75:~~

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

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

~~f. Day 90 – Day 100:~~

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

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

~~3. Bi Monthly Hospital-wide Short Stay Review:~~

~~a. The intent of the Bi Monthly Hospital-wide Short Stay Review is to track the progress of discharge planning for short stay residents at 45 days, 75 days, 90 days and longer.~~

~~b. This review is facilitated by the Director of Social Services and the Patient Flow Coordinator or designee, and attended by the Neighborhood Nurse Manager or designee, Utilization Management Nurse, Primary Physician and the Social Worker for residents who have been identified as Short Stay residents.~~

~~c. The intent of this discussion is to track residents' with Short Stay codes and ensure that they are on track with their discharge plan. Any Short Stay resident~~

~~that is not meeting the planned discharge timeline will be reviewed to identify opportunities for improving discharge planning efforts at the monthly Community Reintegration performance improvement committee.~~

~~4. Change of Short Stay Codes~~

~~a. A Short Stay code may be changed to a general SNF (LHG) hospital service code under the following situations:~~

~~i. In cases where the resident's condition has changed such that a discharge within 100 days of admission is no longer viable, the resident care team notifies the Director of Social Services, either at a weekly Discharge Huddle or by direct contact.~~

~~ii. The Director of Social Services shall evaluate each Short Stay code change request and meet with the Resident Care Team to discuss the resident's discharge plans and how the change in condition impacts those plans. The RCT Leadership Team members can also provide assistance and guidance to their respective discipline and RCT members to resolve discharge barrier(s) or issues(s).~~

~~iii. If the Director of Social Services, with input from the Patient Flow Coordinator, approves the code change, s/he informs the Admissions and Eligibility Unit, who will responsible for updating the code from a Short Stay code to LHG for general SNF services or to another Short Stay, LSS.~~

~~iv. The Director of Social Services shall notify the Resident Care Team that the resident's discharge plan must change, and the Resident Care Team shall update the discharge plan with interventions to mitigate identified barriers to discharge.~~

~~b. Short Stay residents who have completed Short Stay hospital services (LSA, LRH, LRE, and LHP), but are not ready for discharge to the community shall have their Short Stay code changed to the LSS service code for continued tracking when relocated to a general SNF unit (if applicable), or upon request of the RCT members, with approval from the Director of Social Services and the Patient Flow Coordinator as described under Procedure 3a (iii).~~

~~c. The resident's length of stay begins anew only if the readmission occurs greater than 30 days after discharge. Residents readmitted as Short Stay will have 100 days to discharge from the date of readmission.~~

~~d. Extenuating circumstances within the discharge planning process that are unrelated to the resident's condition (e.g. housing delays, benefits delays) will not be criteria for changing a Short Stay code to LHG.~~

- ~~i. These factors will be recorded and monitored via the monthly Discharge Status Report.~~
 - ~~e. Residents who are not discharged within 100 days and have not had a significant change in health condition warranting a change in hospital service code shall be changed to LSS until discharge.~~
- ~~5. Reports and Metrics: Metrics described below track the effectiveness of discharge planning efforts for residents having the Short Stay code.~~
 - ~~a. Invision reports include a Short Stay list showing Medical Record Number, Resident Account Number, Resident Name, Neighborhood, Bed Number, Date of Admission on Short Stay Codes, Last Date on Short Stay Codes, and Number of Accrued Days from Admission.~~
 - ~~b. The Patient Flow Coordinator shall perform a quarterly analysis of Short Stay residents for identification of learning and improved opportunities. For trend analysis, the following metrics shall be reviewed quarterly:~~
 - ~~i. Number and percent of residents designated as:~~
 - ~~ii. Number and percent of Short Stay residents discharged within the 100-day timeframe.~~
 - ~~iii. Average length of stay for Short Stay residents.~~
 - ~~iv. Summary characteristics of Short Stay residents (e.g. diagnosis, age, unit, discharge disposition) for trend analysis.~~
 - ~~v. Number and percent of General SNF residents NOT designated Short Stay that are discharged within 100 days.~~
 - ~~c. Performance Improvement Committees shall review CMS quality measure on Percentage of short-stay residents who were successfully discharged to the community (claims-based) during scheduled meetings.~~
 - ~~d. Quarterly analysis shall be performed to support performance improvement projects targeted toward specific sub-populations. Outcomes shall be reported to both the Community Re-integration Performance Improvement Team and the Utilization Management Committee and ultimately to the Performance Improvement and Patient Safety (PIPS) committee.~~

ATTACHMENT:

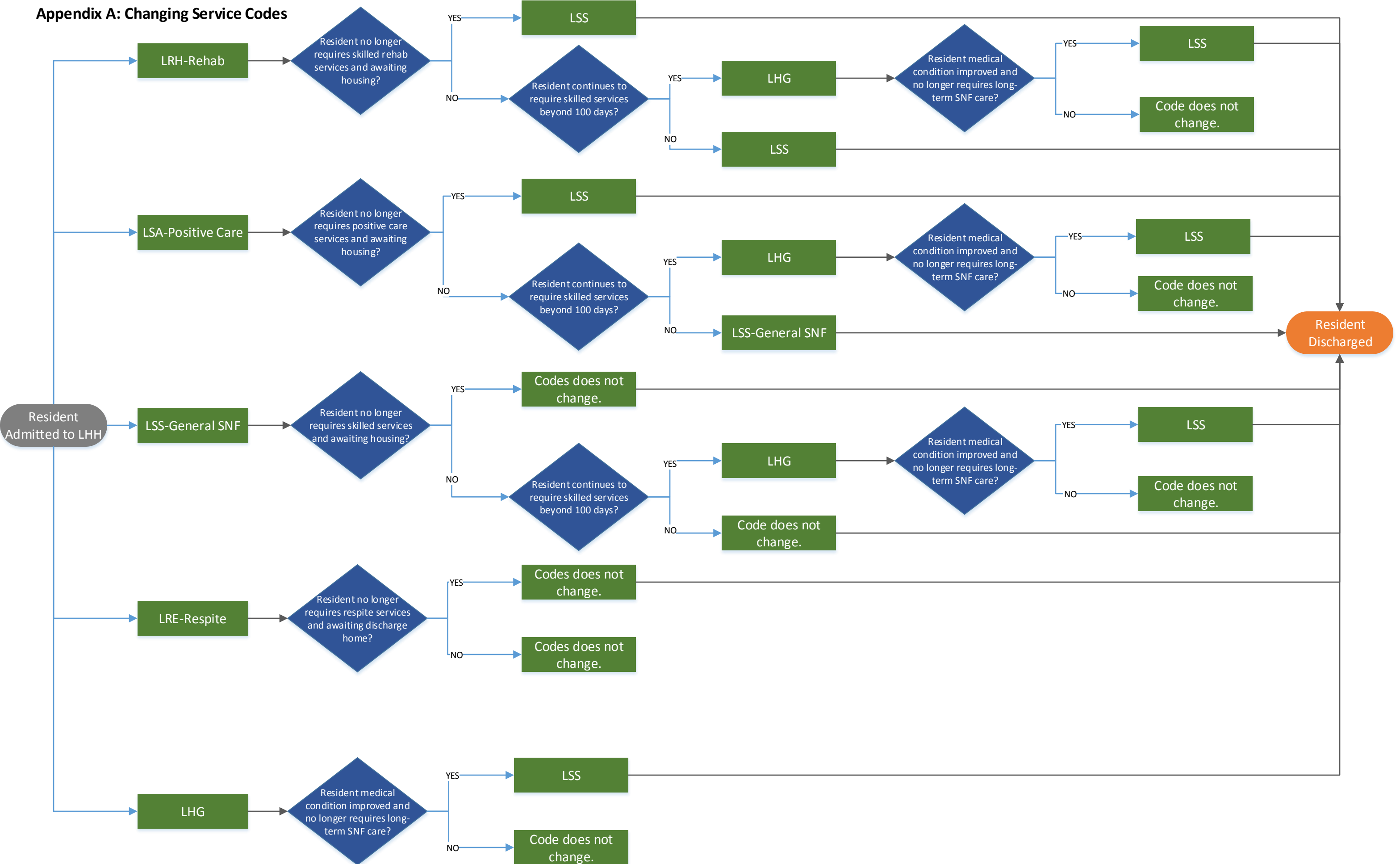
None.

REFERENCE:

None.

~~Revised: 16/07/12, 16/11/08 (Year/Month/Day)~~
~~Original adoption: 16/01/12~~

Appendix A: Changing Service Codes



SIDERAIL-BED RAIL USE**POLICY:**

1. Prior to bed rail use, consider the use of appropriate alternatives (see Attachment A-see appendix ##). Siderails-Bed rails may only be used-used after careful-careful consideration-assessment by the Resident Care Team (RCT) reviewing the risks and benefits of bed rail use, and considering the use of appropriate alternatives prior to its use.
2. Use of siderails shall be ordered by a physician using the Siderail Order Form (MR 172 Safety Assessment, Bed Rail Order and Informed Consent Form shall be completed for residents who use bed rail(s)).
3. A new MR 172 shall be completed when the resident uses a different type of bed.
- 2.—
- 3.4. If the siderail-bed rail is being utilized as a restraint, the hospital-wide policy and procedures outlined by in LHHPP 22-07 Physical Restraints (LHHPP 22-07) mustshall be followed. This includes completing the Consent for Physical Restraint form (MR 812).
5. Continued siderail-bed rail use requires renewal of the Siderail order utilizing the Siderail Order Form (MR 172) at a minimum, a quarterly bed rail safety assessment by the RCT on a quarterly basis.
6. Residents who have been using non-restrictive bed rails prior to November 28, 2017, shall be assessed to have their bed rails discontinued if appropriate, tapered in use, or a determination made as to the purpose for bed rail use and or the medical justification.
7. Facility Services staff is responsible for the proper installation of bed rails and tracking completion of annual preventive maintenance on the bed used by the resident.
8. Resident or representative may choose to use bed rails per preference.

PURPOSEurpose:

To ensure safe and appropriate use of sidebed rails.

DEFINITION:

1. Entrapment: its an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail.

1. ~~Physical restraint: Any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.~~

~~A list of devices has not been given because each resident and his/her response to a device should shall be evaluated from a functional standpoint (i.e., a device that acts as a restraint for one individual may not inhibit the movement of another).~~

2. Siderails-Bed rails are considered restraints when:
 - a. The purpose is to keep a resident from getting out of bed when he/she wants to get out of bed.
 - b. The use of the siderail a bed rail restricts freedom of movement.

PROCEDURE:

1. A safety assessment shall be completed by the RCT and documented on Form MR 172 by the Registered Nurse taking into consideration the resident's current medical diagnosis, physical condition (size and weight), functional ability (bed mobility, transfer, ability to toilet self), cognition, communication, sleep habits, medication(s), physical and/or behavioral symptoms.
2. The safety assessment takes into consideration the following:
 - a. Risk of entrapment,
 - b. Bed's dimensions are appropriate for the resident's size and weight,
 - c. Fall risk,
 - d. Physical restraint assessment,
 - e. Potential negative physical outcomes such as decline in function for activities of daily living and skin integrity issues, and
 - f. Potential negative psycho-social outcomes such as an undignified self-image, low self-esteem, and feelings of isolation, anxiety or agitation.
3. Use of bed rails shall be ordered by the physician by completing the Bed Rail Order and Consent/Education sections of form MR 172.
If resident/resident representative have requested bed rails and states it provides a sense of security, bed rail order should indicate preference.

- ~~The Resident or Resident Representative shall attest to consenting and receiving education on the benefits and risks associated with to bed rail use by signing on the Informed Consent section of form MR 172.~~
4. ~~Facility Services staff is responsible for the proper installation of bed rails and tracking completion of annual preventive maintenance on the bed used by the resident.~~
5. ~~Nursing staff is responsible for notifying Facility Services when they find a bed that is past due for preventive maintenance.~~
6. ~~The RCT is responsible for on-going monitoring and supervision of residents who use bed rails and for conducting a quarterly safety assessment and documenting the assessment in the RCT IDT meeting notes (IDT meeting notes???)~~
- 1.7. ~~See attached table for suggested alternatives/safety interventions, table is not all-inclusive and suggestions do not replace clinical judgment.~~
- ~~For new admissions, the RCT shall review and consider the alternatives listed under Appendix A and determine if any of the suggested interventions are appropriate as an alternative to bed rail use.~~
2. ~~Need to address alternatives to restraint use. Sub-group has not discussed this in detail. If the siderail is not considered a restraint, the RCT must educate the resident, family, or surrogate decision maker regarding siderail use. This should include discussion of the benefits and risks of siderail use (refer to the back of form MR 172 for educational points).~~

ATTACHMENT:

~~Attachment A: None~~MR 172 (revised xxxxxxxx).
Table for Alternatives to Bed Rail Suggestions

REFERENCE:

LHHPP 22-07 Physical Restraints

~~MR 172~~MR 172 Safety Assessment, Bed Rail Order and Informed Consent Form
 (revised 01/2018~~xxxxxxx~~)

Barclays Official California Code of Regulations: §72319. Nursing Service - Restraints and Postural Supports

Centers for Medicaid and Medicare Services: -42 CFR Part 482 Medicare and Medicaid Programs; Hospital Conditions of Participation: -Patients' Rights; Final Rule
<http://www.cms.hhs.gov/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf>

Revised: 10/11/10, 16/09/13, 18/03/13 (Year/Month/Day)

Original adoption: 08/21/09

ATTACHMENT A

This list is not all-inclusive and suggestions do not replace clinical judgment.

DRAFT Alternatives to Bed Rail Suggestions	
Alternative	Interventions
Resident/Resident Representative Education	<ul style="list-style-type: none"> • Reassure residents and/or resident representative as needed • Include family or friends as able
PT/OT/Restorative	<ul style="list-style-type: none"> • Positioning, transferring, strengthening, balance, ambulation etc. • Ambulation schedule or wellness/exercise programs
Bowel/Bladder Assessment	<ul style="list-style-type: none"> • Implement a bowel/bladder regimen for the resident as needed • Ensure elimination needs are being addressed on a consistent basis • Bedside commode/urinal within reach
Resident Safety Devices	<ul style="list-style-type: none"> • Utilize supportive/assistive devices to promote safe transfers • Ensure resident has walker, glasses, hearing aid to function accordingly • Trapeze to promote movement in bed if indicated • Motion sensor lights/night lights • Utilize low bed/safety mats beside beds if indicated • Bed positioning monitor/bed alarms if indicated
Exercise or Position Changes	<ul style="list-style-type: none"> • Evaluate for orthostatic hypotension and change positions slowly • Take resident for a walk if able • Turn resident every 2 hours if immobile • Regular exercise may eliminate or decrease restlessness and possible agitation • Encourage resident to mobilize to decrease time spent in bed
Medication Assessment	<ul style="list-style-type: none"> • Review medication administration times of bowel regimen to correlate with bowel/bladder routines • Assess for pain and provide pain medication as ordered
Diversional Activities	<ul style="list-style-type: none"> • Provide distractions such as music, television, or food/fluids for residents who do not sleep through the night • Provide meaningful/pleasurable activities that is relevant to resident
Environmental	<ul style="list-style-type: none"> • Provide a quiet environment (decrease stimulation) • Minimize sleep disturbances as able • Assess for appropriate lighting and adjust lighting options especially at night • Place a strip of tape across the door or the floor to help direct resident • Keep room free of clutter • Maintain personal items, call light, bedside stand within reach – use visual/verbal reminders • Maintain bed in lowest position after care delivery • Increase rounding frequency

ATTACHMENT A

This list is not all-inclusive and suggestions do not replace clinical judgment.

**Bed Rail Safety Assessment, Order Form,
and Informed Consent**
(DO NOT THIN FROM CHART)

BED RAIL SAFETY ASSESSMENT:

Type of Bed: ☐ Stryker ☐ Joerns ☐ Hillrom Bariatric Other: _____

Is/are there alternatives to bed rail use that would be appropriate for the resident? ☐ Yes ☐ No

Is bed rail properly installed? ☐ Yes ☐ No Is latest preventive maintenance current? ☐ Yes ☐ No

Based on the resident's current medical diagnosis, physical condition (size and weight), functional ability (bed mobility, transfer, ability to toilet self), cognition, communication, sleep habits, medication(s) and physical and/or behavioral symptoms:

Are the bed's dimensions appropriate for the resident's size and weight? ☐ Yes ☐ No

Is the resident at risk for entrapment with a bed rail order? ☐ Yes ☐ No

Is the resident at a higher risk for falls from bed with a bed rail order? ☐ Yes ☐ No

Is the resident at risk for decline in function with use of a bed rail order? ☐ Yes ☐ No

Is the resident at risk for psychosocial decline with use of a bed rail order? ☐ Yes ☐ No

RN Signature: _____ Date: _____

BED RAIL ORDER	<input type="checkbox"/> Upper ¼ Left <input type="checkbox"/> Upper ¼ Right This is <input type="checkbox"/> non-restrictive <input type="checkbox"/> restrictive (restraint)
<i>Specify when to be used and duration if applicable</i>	<input type="checkbox"/> In bed <input type="checkbox"/> During care <input type="checkbox"/> Other (specify): _____ _____
<i>Attachment/Devices</i>	<input type="checkbox"/> Padding <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> None
<i>Purpose for use of bed rail and or medical justification</i>	<input type="checkbox"/> Functional mobility <input type="checkbox"/> Neuromuscular Disorder <input type="checkbox"/> Functional/safety aide <input type="checkbox"/> Spasticity <input type="checkbox"/> Resident/Resident Representative Preference <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____
CONSENT/EDUCATION	<input type="checkbox"/> I have discussed and educated the resident/resident representative on the benefits and risks associated with the use of bed rail(s).
MD Signature: _____ Date: _____ Time: _____	
Noted by License Nurse: _____ Date: _____ Time: _____	

INFORMED CONSENT:

The above bed rail(s) has/have been ordered for me and I have been informed of the benefits and risks associated with bed rail(s) use. See reverse side of MR 172.

I understand the content of this form. I also understand that I have the right to refuse the use of bed rail(s) by telling the physician at any time.

I consent to the use of bed rail(s) prescribed by the physician as written above.

Date: _____ Resident/Resident Representative (Indicate Relationship)

Date: _____ Witness(es)

THE C-625 BATTERY OPERATED CEILING LIFT

POLICY:

1. Two trained staff members are required for operating and transferring residents using the C-625 battery operated ceiling lift.
2. The Nursing policy and procedure D6 1.4 Battery-Operated Ceiling Lift (C-625) is the guideline to be used by both nursing and non-nursing staff for the safe transfer of residents using the ceiling lift.
3. Individual resident slings are not required for use in the rehab gym and pool areas.

PURPOSE:

To provide residents weighing up to 625 lbs. with safe and dignified transfers.

PROCEDURES:

1. Staff Training

a. ~~Prior to operating the ceiling lift, All staff that are~~ required to use the ~~ceiling lift~~ during their duties ~~will~~shall be trained, upon hire and annually thereafter, ~~on use of the lift prior to it's operating, upon hire and annually thereafter.~~

a. _____

i. ~~The Physical Therapy, and Occupational Therapy, and Restorative Aide~~ staff ~~will~~shall be trained and ~~show demonstrate~~ competency to use the walking slings

~~ii. Restorative Aides~~ ~~Additionally, Restorative Aides~~ ~~will~~shall be trained to assist in the use of a transfer sling.

~~iii.~~ Activity Therapy staff assigned to the Wellness Center ~~will~~shall be trained on the ~~use of the aquatic ceiling lift and universal slings.~~

b. A competency checklist ~~will~~shall be used to validate competency on use of the ceiling lift ~~(- See Attached Attachment B).~~

c. Staff training ~~will~~shall comprise of topics on:

i. ~~Assessing Evaluating~~ the resident for lift transfers

ii. Procedure for transferring the resident using the C-625 battery operated ceiling lift

d. _____

e. ~~ceiling lift~~

~~i.iii.~~ Understanding the different types of slings and ~~applications~~ when to apply them

~~iv.~~ Charging the lift battery

~~ii.v.~~ Operating the emergency lowering/stopping function

~~iii.~~ Care ~~and~~ maintenance and infection control of the ceiling lift and slings

~~iv.~~

~~v-vi.~~

2. Resident Assessments

a. Respective members of the Resident Care Team are responsible for assessing the resident for tolerance and appropriateness of lift transfers for the activity planned.

b. The resident is also to be assessed for the appropriate type and size of sling by the respective discipline performing the transfer.

~~c.~~ Walking slings are one size fits all with multiple straps for adjustment to the ~~ee~~

~~d.~~ ~~in indi~~vidual based on manufactures instructions. Walking slings are used as

~~e.c.~~ ~~_____~~ aides for standing and mobility.

~~f.~~ Transfer slings come in multiple sizes based on weight and height but must ultimately be aligned with sling stripe to the resident's spine. The stripe and label will ~~shall~~ be on the outside. The top of the sling will ~~shall~~ align with the top of the ear and the bottom of the sling will ~~shall~~ align with the coccyx.

~~g.~~ ~~ultimately be aligned with sling stripe to the residents spine. The stripe~~

~~h.~~ ~~and label will be on the outside. The top of the sling will align with the top of the~~

~~i.~~ ~~ear and the bottom of the sling will align with the coccyx.~~

~~j.d.~~

e. Universal slings come in 3 sizes ~~in mesh~~ with and without a head support and are based on height and weight, but the sling's stripe must ultimately be aligned against the resident's spine from the top of the spine to the coccyx. If the sling has no head support, the top of the sling starts at the shoulders and the bottom/toileting access ends at the coccyx. If the sling has a head support the neck and head ~~should~~ shall rest on the head support.

3. Documenting Use of the Ceiling Lift

- a. Members of the Resident Care Team are responsible for documenting the plan on transferring the resident using the ceiling lift for the specified planned activity in the resident care plan.
- b. When the resident is no longer performing the activity, or no longer require the use of the ceiling lift for transfers, the care plan ~~will~~shall be discontinued.

4. Care and Maintenance of the Ceiling Lift and Sling

- a. Care and maintenance procedures of the ceiling lift and slings are to be followed according to the manufacturer's guidelines located in the Wellness Center.
- b. The ceiling lift, lifting strap, and slings are to be inspected prior to use by residents to ensure that they are in a safe and operable condition.

ATTACHMENT:

~~Attachment A: Ceiling Lift for Aquatic Staff Post-Test and Competency Check List~~C-625 Battery Operated Ceiling Lift Post-Test for Aquatic Staff Members

Attachment B: Competency Check for C-625 Battery Operated Ceiling Lift for Aquatics

REFERENCE:

C450/C625 Ceiling Lift Owner's Manual, Waverley Glen
Nursing Policy and Procedure D6 1.4 Battery-Operated Ceiling Lift (C-625)
Sling Instruction Sheet, Waverley Glen Universal Sling
Sling Specification Sheet Standing Sling
Swim-Lift Series Model Gallatin, Chair Lift Owner's Manual, Spectrum Aquatics

Revised: ~~N/A~~18/03/13 (Year/Month/Day)

Original adoption: 11/03/24

Attachment A

San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
Rehabilitation Center

Laguna Honda Hospital and

Ceiling Lift for Aquatic Staff Post-Test and Competency Check List

Trainer: _____

Date: _____

POST-TEST:

1. Safe Transfers:

What type of resident would use the ceiling lift to access the pool?

Explain: _____

a. ~~What type of sling is appropriate for use in the pool? (check one)~~

- ☐ universal sling ☐ walking sling ☐ standing sling
☐ hammock sling ☐ positioning sling

b. ~~Where should the carry bar be when placing straps? (check one)~~

- ☐ head level ☐ chest level ☐ behind the head
☐ any of the above locations

c. ~~When lifting a person, all the straps used should be the same (color and/or position) on all four points on the sling. (Circle one)~~

_____ True _____ False

d. ~~When using the remote the lift is able to go front to back and side to side. (Circle one)~~

_____ True _____ False

e. ~~Explain why it is required to have 2 people when using the ceiling lifts.~~

Explain: _____

f. ~~When would you use the emergency stop and lower on the ceiling lifts? (check one)~~

- ☐ resident is screaming ☐ wheelchair is broken ☐ power failure
☐ battery doesn't work ☐ Power or battery failure

2. Equipment Monitoring:

a. ~~When would you wash a universal sling?~~

- ☐ visibly dirty ☐ weekly ☐ monthly
☐ daily ☐ visibly dirty and weekly

b. When wouldn't you replace a universal sling?

- ☐ see fraying ☐ torn mesh ☐ strap is loose
☐ faded ☐ stitching is missing

c. What is the maximum load the lift can transfer?

- ☐ 300 lbs. ☐ 450 lbs. ☐ 625 lbs ☐ 800 lbs

d. How do you know the lift is charging?

Explain: _____



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Attachment A

C-625 BATTERY OPERATED CEILING LIFT Post-Test for Aquatic Staff Members

Trainer: _____ **Date:** _____

1. Safe Transfers:

a. What type of resident would use the ceiling lift to access the pool?

b. What type of sling is appropriate for use in the pool? (check one)

- ☐ mesh sling ☐ walking sling ☐ standing sling
☐ hammock sling ☐ positioning sling

c. Where should the carry bar be when placing straps? (check one)

- ☐ head level ☐ chest level ☐ behind the head
☐ any of the above locations at least 12 inches away from resident

d. When lifting a person, all the straps used should be the same (color and/or position) on all four points on the sling. (Circle one) T F

e. When using the remote the lift is able to go front to back and side to side. (Circle one) T F

Explain why it is required to have 2 people when using the ceiling lifts:

Explain: _____

f. When would you use the emergency stop and lower on the ceiling lifts? (check one)

- ☐ resident is screaming ☐ wheelchair is broken ☐ power failure
☐ battery doesn't work ☐ Power or battery failure

2. Equipment Monitoring:**a. When would you wash the mesh sling?**

- ☐ visibly dirty ☐ weekly ☐ monthly
☐ daily ☐ visibly dirty and weekly

b. When wouldn't you replace a universal sling?

- ☐ see fraying ☐ torn mesh ☐ strap is loose
☐ faded ☐ stitching is missing

c. What is the maximum load the lift can transfer?

- ☐ 300 lbs. ☐ 450 lbs. ☐ 625 lbs ☐ 800 lbs

d. How do you know the lift is charging?

Explain: _____

e. What would you do if the lift would not move in any direction while your patient was in the lift?

Explain: _____



COMPETENCY CHECK FOR C-625 BATTERY OPERATED CEILING LIFT (for Aquatics)

EMPLOYEE NAME: _____ POSITION: _____ DATE: _____

S = Satisfactory and competent to perform procedure safely		U = Unsatisfactory and indicates need for follow-up		
INDICATOR		S	U	COMMENTS
1) Policies				
• Employee states a second staff will assist with the transfer of residents				
• Employee states action to do when using unfamiliar equipment / procedures (i.e. asks for assistance and ensures needed assistance is provided before proceeding)				
• Employee states action to take when new staff person works on pool deck who is not familiar with equipment (i.e. notifies supervisor to ensure employee receives training)				
• Employee is able to verbalize the most appropriate size of sling for resident prior to initial use of lift transfer				
• Employee is able to verbalize resident's other conditions that must be taken into account when choosing a sling in addition to resident's shoulder width, trunk length, & weight. Able to refer to Lift Sling Assessment Form				
2) Selecting the sling				
• Checks sling type and size in the resident care plan				
• States how the length of the back is measured				
• Demonstrates proper use of the size chart				
• Inspects sling for fraying or damage and can verbalize removing a defective sling from use and reporting it to supervisor				
3) Knowing Lift				
• Demonstrates how to position the lift over locked wheelchair				
• Identifies the method to raise and lower the resident using the button on the panel				
• Locates the emergency red pull strap and describes its purpose				
• Able to reset the system after the emergency pull is engaged				
4) Demonstrating the transfer lift procedure from pool to wheelchair				
• Positions the sling under the resident trunk and shoulders				
• Positions the sling so that the handles face down into the water				
• Centers the sling so that it covers the shoulders and comes to 2 inches below the base of the tail bone.				
• Fits the resident's left thigh, pulls the left wing under the thigh and places it on the top of the thigh. Does the same with the right leg (does not matter which leg is done first).				
• Moves the lift over the resident so that the lift is over the resident's stomach.				
• Attaches the shortest sling loops at the shoulder to the hooks on the spreader bars.				

<ul style="list-style-type: none"> Takes the wing that is over the right thigh and attaches it to the left hook using the longest loop. Does the same for the other leg (does not matter which leg is first). 			
<ul style="list-style-type: none"> When using mesh sling, crosses wings over but does not thread the wings through each other. 			
<ul style="list-style-type: none"> Pushes "up" button and raises the resident an inch above the water. Checks loops and hooks, ensures that resident's arms are in the sling and checks that the shoulders are covered and that sling is 2 inches below tail bone. 			
<ul style="list-style-type: none"> Continues to lift resident over wheelchair 			
<ul style="list-style-type: none"> Employee stands behind the chair, using the handles on the sling to position and lower the resident into the chair. 			
<ul style="list-style-type: none"> Unhooks the sling and carefully glides lift away. 			
5) Demonstrating the lift procedure from a wheelchair to a water			
<ul style="list-style-type: none"> Assists the resident to lean forward and places the sling in the chair with the handles away from the body and the crotch of the sling touching the back of the seat. 			
<ul style="list-style-type: none"> Arranges the sling underneath the resident placing the wings over the thighs and checking to see that the resident's weight is evenly distributed in the sling. 			
<ul style="list-style-type: none"> Positions the lift so that the separator bar is 12 inches in front of the residents head. 			
<ul style="list-style-type: none"> Attaches the straps at the shoulders using the shortest loops. 			
<ul style="list-style-type: none"> Takes the wing that is over the right thigh and attaches it to the left hook using the longest loop. Does the same for the other leg (does not matter which leg is first). 			
<ul style="list-style-type: none"> When using mesh sling, crosses wings over but does not thread the wings through each other. 			
<ul style="list-style-type: none"> Raises the resident 1-2 inches above the chair, ensures that the resident's arms are inside the sling and that the sling covers the shoulders and extends 2 inches below the tail bone; and there is no bunching. 			
<ul style="list-style-type: none"> Raises the resident and moves the resident to the pool deck and lowers the resident gently into the water. 			
6) Other Considerations			
<ul style="list-style-type: none"> States that all residents requiring lift transfers will have accurate weight, to size sling. 			
<ul style="list-style-type: none"> States how to apply sling to resident whose legs are extremely rigid. 			

Name (PRINT): _____ Signature: _____ Title/Job Class: _____

☐ Demonstrates competency to use the Lift

Signature of Observer _____ Title: _____

☐ Does not demonstrate competency to use the Lift

Signature of Observer _____ Title: _____

Follow up action plan:

NEIGHBORHOOD SPECIALTY MEAL PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide alternatives to the standard lunch meal plan for the benefit of the residents.
2. The Neighborhood Specialty Meal Program shall follow the guidelines set forth in the DPH Healthy Food and Food Expenditure Policy (see Attachment A).
3. All specialty meal orders shall only include provisions for the residents.
4. Cancellation of any and all planned specialty meals must be made at least 24 hours in advance.
 - ~~1. Laguna Honda Hospital shall provide alternatives to the standard lunch meal plan for the benefit of the residents.~~
 - ~~2. Resident Family members may bring in food, either commercially prepared or home-cooked, for consumption by the resident only and they may not share the food with other residents.~~

PURPOSE:

Goals of the specialty meal programs are:

1. To improve the dining experience for the residents.
2. To enhance the nutritional intake and individualized approach to care for the resident.
3. To address the cultural needs and interests of the residents and improve their quality of life.
 - ~~1. To improve the dining experiences~~
 - ~~2. To enhance the nutritional intake of residents~~
 - ~~3. To address the cultural needs and interests of the residents~~
 - ~~4. To provide individualized approach to resident care~~
 - ~~5. To improve quality of life~~

PROCEDURE:

1. Neighborhood Specialty Luncheons

- a. The schedule of neighborhood specialty luncheons and barbecques are coordinated by the ~~Activity Therapy Department and~~ Activity Therapist (AT), Registered Dietitian (RD), and Charge Nurse (CN) —communicated and communicated to the ~~Nutritional Food~~ Services Department.
- b. The number of specialty luncheons or barbecques may not exceed one per week hospital-wide.

- c. Selections are limited to the resident menu or sub entrée of the lunch meal and/or what is being served in the cafeteria lunch meal on the scheduled day. Additional baked products may be available in consultation with ~~the Nutritional Food Services Chefmanagement~~.

- i. To promote resident meal safety, hHot dogs and sausages cannot be ordered.

~~d. Luncheon orders shall only include provisions for the residents.~~

e.d. Planning for specialty luncheons shall include the participation of all members of the Resident Care Team (RCT). ~~The Chef Food Services management~~ is also consulted in the early planning stages.

- i. ~~Neighborhood Activity Therapy staff complete and submit a Special Events form to the assigned Activity Therapy Supervisor. After the RCT has identified a date for the specialty lunch event, a meal planning huddle that includes the Neighborhood AT, RD, and CN meet to complete the catering form.~~

- ii. To ensure that dietary restrictions shall be maintained through the residents' diet order, the RD shall ensure that food being served is appropriate for the resident population. If meal trays for special diets/texture modified (i.e. pureed diets) are needed they shall not be cancelled and will be delivered at the time of event on the neighborhood.

- iii. The AT or RD shall email the completed catering form to Food Services management no later than two weeks prior to the luncheon. Food services management will verify the availability of the requested foods.

~~Luncheon requests must include all food, beverages, and supplies including china, silverware and/or paper products.~~

- iv. ~~After being reviewed by Activity Therapist Supervisor, the order is then forwarded to the Director of Therapeutic Activities for funding approval. The form is then returned to the Activity Therapist who will forward the signed form to the Chef for final review no later than two weeks prior to the luncheon. If approved by Activity Therapy Supervisor, the order is forwarded to the Chef for review no later than two weeks prior to the luncheon.~~

- v.iv. ~~Changes are not permitted after the request is finalized by the Chef. The Chef Food Services Mmanager forwards a copy of the approved Special Events catering form to other the requesting AT, AT supervisor, RD, CN Chefs, and the Chief Dietitian. Changes are not permitted after the request is finalized by Food Services management.~~

~~, the Senior Nutritional Services Supervisor, and the Assistant Director of Nutritional Services.~~

- f.e. ~~The Chef approves the finalized request and confirms via e-mail to the Activity Therapist and Supervisor. Luncheon requests must include all food, beverages, and supplies including china, silverware and/or paper products.~~

~~g.f.~~ Neighborhood ~~Nursing or Activity Therapist~~AT staff will be responsible for canceling the appropriate meal trays prior to the day of the luncheon.

~~h. Cancellation of planned specialty luncheons must be made at least 24 hours in advance.~~

~~i. Dietary restrictions must be maintained through residents' diet order.~~

~~j.g.~~ Delivery

i. A food service worker ~~will~~shall deliver the order on the day of the luncheon. Neighborhood staff ~~will~~shall assist with delivery as necessary.

ii. Food is delivered in food warmers and on carts for cold items.

iii. Trays for special diets, i.e. pureed diets, will be delivered at the time of event on the neighborhood.

~~k.h.~~ Food Service

i. Food shall be served from the galley, using the steam tables.

ii. Hot food shall be served at a temperature no less than 141 and cold food must be served no higher than 41.

iii. A food service worker ~~will~~shall be assigned to the neighborhood to assist with plating the food during service. A neighborhood staff member ~~will~~shall assist with the plating of food.

iv. Food handlers shall follow food safety procedures, including hand washing, wearing gloves and wearing hair nets or caps.

v. Portion control shall be maintained.

vi. All available neighborhood staff ~~will~~shall assist with the distribution of food to the residents.

~~h.i.~~ Neighborhood staff shall create a pleasant environment through modalities such as positive and supportive conversation, ~~n and~~ the provision of music and/or noise-free ambiance.

~~m.j.~~ Clean up

i. Dirty pans and containers ~~will~~shall be placed in the warmers for return to the kitchen.

ii. All surfaces in the galley and the steam table shall be cleaned and sanitized by Nutritional-Food Services staff using the 3-bucket method.

- iii. The assigned food service worker returns all carts, inserts, and kitchen supplied equipment to the Nutritional Food Services Department.
- iv. Tables are wiped clean by neighborhood staff.
- v. Neighborhood staff ~~will~~shall buss soiled plates, cups, and silverware.
- vi. Food service workers ~~will~~shall clean and sanitize plates, cups, and silverware through galley dish machine.

2. Cooking projects

- a. Cooking projects on the neighborhoods are restricted to baking, blending, steaming or preparation of vegetables dishes.
- b. Authorized equipment used for cooking food is limited to convection ovens, ~~rice cookers~~, microwave ovens, induction plates, ~~induction plates, and and~~ blenders. No appliances with an open heating element ~~will~~ shall be allowed. The cooking appliances and equipment are maintained either on the neighborhood or checked out from the Activity Therapy Department. Appliances may only be used in the galley.
- c. Standard dry ingredients for cooking projects are maintained on the neighborhood galleys.
 - i. Activity Therapy staff shall request food, beverages, and supplies from the Nutritional Food Services Department using the Special EventsCatering form. Requests must be approved by the assigned Activity Therapy Supervisor and submitted to the Nutritional Food Services Department 2 weeks in advance.
 - ii. Activity Therapy staff ~~will~~ shall pick up requested supplies from the Nutritional Food Services Department, generally by 12:30 p.m. on the day specified.
 - iii. Dry ingredients are stored in sealed containers in the galley cupboards. The containers must be labeled and dated by Activity Therapy staff.
 - iv. A quarterly rotation of dry ingredients shall be implemented by Activity Therapy staff involving the disposal of ingredients older than 3 months.
- d. Perishable ingredients such as eggs and milk are requisitioned through the Nutritional Food Services Department.
 - i. Activity Therapy staff shall request perishable ingredients using the Special EventsCatering form. Requests must be approved by the assigned Activity Therapy Supervisor and submitted to the Nutritional Food Services Department at least 2 weeks in advance.

- ii. Activity Therapy staff will pick up requested supplies from the ~~Nutritional Food~~ Services Department by 12:30 p.m. on the day requested.
- iii. Perishable ingredients are labeled, dated and transferred to the galley freezer or refrigerator by Activity Therapy staff.
- iv. Any leftover perishable ingredients are disposed by Activity Therapy staff within 3 days of the date as labeled, and may be kept on hand for up to 3 days.
- e. Water used in cooking projects shall be obtained from the ice machines within the neighborhoods.
- f. Residents and staff may prepare food items in either the great room or the dining rooms.
- g. Cooking of food takes place only in the galleys.
- g-h. Food safety practices shall be maintained at all times including residents and staff washing hands, wearing gloves, and wearing hair nets or caps.
- ~~h.a. Cooking of food takes place only in the galleys.~~
- i. Residents are not permitted in the galleys at any time.
- j. Product left over after consumption is discarded immediately, except for baked goods, such as cookies, which may be kept on hand for up to 72 hours.
- k. All large and electronic equipment is cleaned, including interior and exterior surfaces, and sanitized using the 3-bucket method by Activity Therapy staff.
- l. Electronic cooking equipment is unplugged by Activity Therapy staff when not in use.
- m. Other equipment such as bowls, spoons, and other utensils are placed in a busing box and transported to the Nutritional Food Services Department by Activity Therapy staff for mechanical cleaning and sanitation at approximately 3:00 p.m. The equipment is returned to the neighborhood for storage by Activity Therapy staff on the day of use.

3. Barbecues

- a. Activity Therapy staff may plan barbecues for their assigned residents. The barbecues ~~may~~ shall be implemented on hospital grounds, either in the meadow or in the contained gardens adjacent to the neighborhood.
~~, or as part of a therapeutic community outing.~~
- i. Use of barbecues must be away from the building, at least 20 feet from any operable entrance or window.

b. The schedule of barbecues neighborhood luncheons is coordinated through the Activity Therapy Department and communicated to the ~~Nutritional~~ Food Services Department. The number of barbecues or luncheons may not exceed one per week hospital-wide.

~~c. Barbecue orders can only include provisions for residents only.~~

~~d.c.~~ Planning of the barbecue involves the neighborhood RCT and in consultation with Food Services management ~~the Chef~~.

~~e.d.~~ To ensure that dietary restrictions shall be maintained through the residents' diet order, the neighborhood RD shall ensure that food being served is appropriate for the resident population.

~~f.e.~~ To promote resident meal safety, hHot dogs and sausages cannot be ordered.

~~g.f.~~ Activity Therapists Activity Therapists are responsible for making appropriate food requests using the pre-printed Barbecue form. Modifications to the pre-planned meals must be approved by the ~~Chef~~ Food Services management at least two weeks prior to the service date.

i. The request is submitted to the assigned Activity Therapy Supervisor for review. If approved, If approved by Activity Therapy Supervisor, the order will be submitted to the Director of Therapeutic Activities for funding approval. tThe form is then returned to the Activity Therapist who will forwardemailed to Food Services management the signed form to the Chef for final review no later than two weeks prior to the barbecueBBQ.

ii. Food services management approves the finalized request and confirms via e-mail the requesting AT, AT supervisor, RD, CN, and the Chief Dietitian. Changes are not permitted after the request is finalized by Food Services management.

iii. Requests shall include all food, beverages, and supplies including paper products. is forwarded to the Chef in Nutritional Services for review no later than two weeks prior to the event.

~~iv. Requests shall include all food, beverages, and supplies including paper products.~~

~~The Chef approves the finalized request and confirms via e-mail to the Activity Therapist and Supervisor. Other Chefs, the Chief Dietitian, Senior Nutritional Services Supervisors, and the Assistant Director of Nutritional Services are copied to the e-mail.~~

~~h.g.~~ Neighborhood Nursing or Activity Therapist staff will be responsible for canceling the appropriate meal trays prior to the day of the barbecue.

~~i. Cancellation of planned barbecues must be made at least 24 hours in advance.~~

~~j.h.~~ In case of inclement weather on the day of the planned barbecue, the barbecue will may be held on the neighborhood as a luncheon.

~~k. Dietary restrictions must be maintained through residents' diet order.~~

~~h.i.~~ Activity Therapy staff are responsible for picking up the food and supplies from Nutritional Food Services, generally by 10:00 a.m. on the day requested.

- i. When picking up food for barbecues, the Activity Therapist shall bring insulated containers stored in the Activity Therapy central office and utilize those containers during transport.

~~m.j.~~ If using the meadow, Activity Therapy staff shall request the set-up and takedown of tables and chairs from the Environmental Services (EVS) Department.

~~n.k.~~ Only gas grills may be used on hospital property.

~~o.l.~~ The Activity Therapy Department maintains barbecue supplies and utensils in its central office.

- i. After use, Activity Therapy staff takes the bin of barbecue supplies and utensils to Nutritional Food Services for cleaning and sanitation.

~~p. Charcoal for barbecues in association with community outings is funded through the neighborhood money program.~~

~~q.m.~~ Staff shall use food safety procedures during the preparation and handling of food.

4. Catered meals

a. Neighborhood staff may arrange for catered meals by ~~outside~~ Ceity approved vendors-suppliers to be served as part of a special celebration.

- i. After the RCT has identified date for the event, a meal planning huddle that includes the Neighborhood Activity Therapist, Registered Dietitian, and Charge Nurse meet to select menu items from a Ceity approved supplier.
- ii. To ensure that dietary restrictions shall be maintained through the residents' diet order, the neighborhood Registered Dietitian shall ensure that food being served is appropriate for the resident population.

~~b. The neighborhood dietitian must be consulted to ensure that food being served is appropriate for the resident population.~~
~~Dietary restrictions must be maintained through residents' diet order.~~

~~e.b.~~ Neighborhood staff will be responsible for canceling the appropriate meal trays prior to the day of the event.

~~d.c.~~ City suppliers that include serving staff with their ~~Catered-catered~~ meals ~~shall beshall~~ serve those meals from the Great Room of the neighborhood.

- i. ~~dfrom the galley of the neighborhood.~~ If Food Service worker assistance has been requested to assist with the catered meal, then the catered meal can be served from the neighborhood galley. This assistance needs to be requested from Food Service management no later than two weeks prior to the event.

~~e.d.~~ Neighborhood staff is responsible for the clean-up of the galley and dining area.

~~5. Other~~

- ~~a. Generally, food served to residents are obtained from a commercial source.~~
~~b. Home-cooked food brought to the hospital may not be shared with residents.~~

ATTACHMENT:

DPH Healthy Food and Food Expenditure Policy, (F\$C6, GAD2)

None

REFERENCE:

Activity Therapy Policy B4.0 Neighborhood Money/Shopping Time

Nutrition Services Policy 1.100 Labeling Food

Nutrition Services Policy 1.165 General Cleaning and Sanitizing Work Surfaces and Kitchen and Galley Equipment.

Infection Control 72-01 Infection Control Manual B2 – Hand Hygiene

Nutritional Services Policy 1.1 Food from Home or Outside Sources Served Directly to Residents

Revised: 18/03/13 (Year/Month/Day)

Original adoption: 12/05/22 (Year/Month/Day)



City and County of San Francisco

Edwin M. Lee, Mayor

San Francisco Department of Public Health

Barbara A. Garcia, MPA
Director of Health

San Francisco Department of Public Health

*Policy & Procedure Detail**

Policy & Procedure Title: DPH Healthy Food and Food Expenditure (F\$C6, GAD2)	
Category: Fiscal	
Effective Date: 9/1/15	Last Reissue/Revision Date: n/a
DPH Unit of Origin: Fiscal, Community Health Equity and Promotion (CHEP)	
Policy Contact - Employee Name and Title; and/or DPH Division: Anne Okubo, Deputy Financial Officer – Food Expenditure Policy, Christina Goette - Healthy Food Policy	
Contact Phone Number(s): Anne Okubo, 554-2825; Christina Goette, 628-206-7630	
Distribution: DPH-wide <input checked="" type="checkbox"/>	If not DPH-wide, other distribution:

**All sections in table required.*

1. Purpose of Policy

The purpose of this document is to identify the guidelines for expenditures of DPH funds for food.

In addition, effective September 1, 2015, and June 27, 2016, the San Francisco Board of Supervisors adopted two ordinances (99-15, 91-16) barring City departments from using City funds to purchase Sugar Sweetened Beverages (SSBs) and requiring City departments to use their best efforts to meet nutritional guidelines for food served at City events and meetings. In light of these developments, this policy has two additional objectives:

- a. To ensure that DPH and its contractors are compliant with recently enacted legislation prohibiting the use of City funds to purchase Sugar Sweetened Beverages; and
- b. To ensure that DPH staff make their best efforts to adhere to the nutritional guidelines when purchasing food served at DPH events and meetings.

2. Definitions

- a. **Prepackaged Food** has the same meaning as set forth in California Health and Safety Code Section 113876 as amended.
- b. **City Meeting/City-Sponsored Event** means a meeting or event that is convened, hosted, or organized by the City, regardless of whether the meeting or event occurs on City property or whether the attendees are limited to City officials or staff.

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.

We shall ~ Assess and research the health of the community ~ Develop and enforce health policy ~ Prevent disease and injury ~
~ Educate the public and train health care providers ~ Provide quality, comprehensive, culturally-proficient health services ~ Ensure equal access to all ~

- c. **Serving** has the meaning set forth in Section 101.9(b) {J} of Title 21 of the Code of Federal Regulations as amended.
- d. **Sugar Sweetened Beverage (SSB):**¹ any Nonalcoholic Beverage sold for human consumption that has one or more added Caloric Sweeteners and contains more than 25 calories per 12 ounces of beverage. Notwithstanding the foregoing sentence, it does NOT include any of the following:
- Milk;
 - Milk alternatives, including but not limited to non-dairy creamers or beverages primarily consisting of plant-based ingredients (such as soy, rice or almond milk products), regardless of sugar content;
 - Any beverage that contains solely 100 percent Natural Fruit Juice, Natural Vegetable Juice, or combined Natural Fruit Juice and Natural Vegetable Juice;
 - Any product sold for consumption by infants, which is commonly referred to as “infant formula,” or any product whose purpose is infant rehydration;
 - Medical Food;
 - Any product designed as supplemental, meal replacement, or sole-source nutrition that includes proteins, carbohydrates, and multiple vitamins and minerals;
 - Any product sold in liquid form designed for use as an oral nutritional therapy for person who may have a limited ability to absorb or metabolize dietary nutrients from traditional food or beverages;
 - Any product sold in liquid form designed for use for weight reduction.

3. Policy

a. Expenditures

Expenditure of DPH funds for food is allowed if food is served for a business purpose.

Allowable Expenditures:

1. Food provided to clients for a legitimate client benefit or purpose (e.g. vouchers for groceries, food provided to clients, client incentives, etc.).
2. Food provided to employees or others during a business event such as:
 - a. All-day event or an event where the location or the schedule of the event does not allow a recess for a meal or attendees cannot access food (e.g. conference, retreat, workshop, etc.).
 - b. Special purpose events or events that do not occur frequently such as quarterly or annual events where there is no opportunity for attendees to access food (e.g. staff training event, program-wide meeting, technical review panels etc.).

¹ Sugar Sweetened Beverage definition excerpted from Ordinance 99-15, available at <http://www.sfbos.org/ftp/uploadedfiles/bdsupvrs/ordinances15/o0099-15.pdf> and attached to this policy. This Ordinance is codified within San Francisco’s Administrative Code, Chapter 101.

3. Food provided to employees or others working on behalf of DPH during an emergency or critical incident (e.g. city disaster response, system failure, etc.).

Expenditures That Are Not Allowed:

1. Food provided to employees or others during routine events such as weekly or monthly meetings, staff meetings, routine training, etc.
2. Food provided to employees or others when a recess for a meal break has been provided or attendees have access to food (e.g. training that allows an employee a one hour break between the morning and afternoon sessions).
3. Food served for an entertainment purpose (e.g. staff celebrations, parties, etc.).
4. Food provided to a contractor or vendor as an incentive or reward for services provided.
5. Alcoholic beverages, sugar sweetened beverages, or other food items prohibited by city ordinances.

- b. **Food and Beverages for DPH meetings and events.** Please see attached flow chart. In accordance with Ordinances 99-15 and 91-16 outlining requirements for foods and beverages purchased with City funds:

1. **The Department of Public Health (DPH) and its contractors may not use City Funds to purchase SSBs.** Effective September 1, 2015, San Francisco Ordinance 99-15 prohibits all City Departments, including DPH, from using City funds to purchase Sugar Sweetened Beverages. Further, it bars the sale, provision or distribution of Sugar Sweetened beverages under a City contract or grant, thereby extending the prohibition to DPH contractors and grantees.

Employees should refer to San Francisco Administrative Code Chapter 101 for exemptions, waivers, exclusions, and enforcement parameters. An important exclusion is for the purchase of SSBs for DPH patients in cases where a “medical professional has determined that providing such beverages is part of the appropriate course of treatment for the patient.”²

2. **The Department of Public Health may not serve SSBs at any DPH-sponsored event or at any event held on DPH property.** In accordance with Ordinance 99-15, Sugar-Sweetened Beverages may not be served at any DPH-sponsored event or any event held on DPH property, including, but not limited to, meetings, gatherings, and conferences.
3. **The Department of Public Health must use its best efforts to ensure that all foods and beverages served at City Meetings or City-Sponsored Events and purchased using City funds meet the nutritional standards in section 4b below.**

² See Ordinance 99-15.

4. Procedures

a. Expenditures

1. The requesting program must identify budgeted funds to pay for food expenditures in advance of the purchase of food.
2. A purchase order must be set up with a compliant city vendor in advance of purchasing food; or follow other city purchasing procedures. Or an employee must have advance authorization to purchase food in order to be reimbursed for food expense.
3. The food expenditure must be reasonable (e.g. quantity of food purchased is consistent with the number of attendees, per unit cost is reasonable, type of food that is served is reasonable, etc.).
 - i. The cost of food per attendee must not exceed the maximum federal GSA per diem rates. Maximum per diem rates per person for San Francisco as of May 2016 are:
 - Breakfast \$17; lunch \$18, dinner \$34.
4. Supporting documentation demonstrating the business purpose of the food expenditure must be provided (e.g. purpose of event, number of attendees, location, duration, cost per attendee, invoice or receipt, etc.).

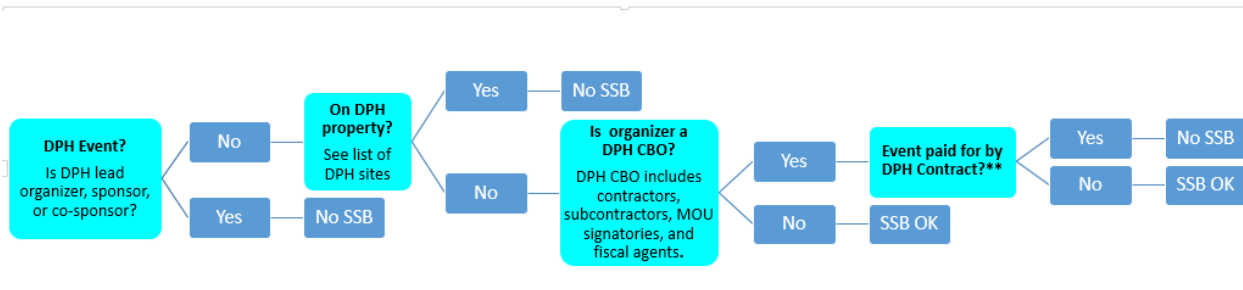
b. Food and Beverages for DPH meetings and events

1. Sugar-Sweetened Beverages
 - i. DPH employees that order, authorize or purchase refreshments for any purpose must ensure that SSBs are not purchased:
 - a) with DPH funds, regardless of origin; OR
 - b) for a DPH event/any event held on DPH property.
 - ii. The DPH SSB policy enforcement staff must ensure that all DPH contractors are made aware of this policy.
2. Healthy Food: DPH employees that order, authorize, or purchase refreshments for any purpose must use their best efforts that ensure that all foods and beverages served at City Meetings or City-Sponsored Events and purchased using City funds meet the nutritional standards outlined in Ordinance 91-16.

5. References

- a. Controller's Policies and Procedures.
- b. [Ordinance 99-15 re: Sugar Sweetened Beverages](#)
- c. [Ordinance 91-16 re: Prepackaged foods](#)

1. DPH SSB Purchase Policy



** Purchase restriction applies to any DPH funds, regardless of origin.

NON-BENEFICIAL TREATMENT

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) physicians and other resident care team members shall facilitate communication and consensus building among residents and surrogate decision makers about goals of care.
2. ~~Laguna Honda~~LHH physicians are not obligated to offer or to provide an intervention or treatment that in the physician's best judgment is determined to be non-beneficial.
3. When there is a disagreement among residents, families or surrogate decision makers and the ~~Laguna Honda~~LHH physician about certain treatments or interventions, a process for facilitating communication and conflict resolution shall be implemented.
4. This policy is applicable to residents/patients regardless of race, color, national origin, disability, age, sex, marital/family status, socioeconomic status, sexual orientation or gender identification

PURPOSE:

To outline the process for facilitating communication, consensus building and conflict resolution if there is disagreement between the resident/patient or surrogate decision makers and the attending physician about medical interventions or treatments.

PROCEDURE:

1. The physician and other care team members shall attempt to communicate proactively with residents and/or surrogate decision makers in a clear and consistent way in order to facilitate understanding about goals of care and beneficial interventions. All discussions shall be documented in the medical record.
2. Physicians and resident care teams ~~will~~shall negotiate solutions to disagreements between residents/surrogate decision makers and physicians/resident care teams using available hospital resources including the ethics committee, specialty consultants, palliative care services, and chaplaincy services.
3. If a disagreement persists, the attending physician shall notify the Chief of ~~the Medical Staff~~, or designee, who ~~will~~shall randomly assign another ~~Laguna Honda Hospital~~LHH primary care physician to review the case and provide a second opinion.

4. If the second opinion disagrees with the primary physician's plan of care, transfer of the resident's/patient's medical care to another ~~Laguna Honda LHH~~ primary care physician ~~will~~shall be ~~arranged~~considered by the Chief of ~~the Medical~~ Staff, or designee.
5. If both ~~physicians' opinions~~ agree that the medical interventions requested ~~or demanded~~ by the resident or surrogate decision makers are determined non-beneficial, the physician(s) shall request consultation through the chair of the Bio-ethics committee.
6. If the ~~Bio-ethics~~ Bio-ethics ~~c~~Committee concurs with the recommendations of both ~~physicians' opinions~~ and there is still disagreement with the patient/resident or surrogate decision maker, then risk management, legal counsel and administration shall be notified and the following actions taken:
 - a. The patient/resident and/or surrogate decision maker shall be promptly notified in writing that the non-beneficial treatment ~~will~~shall not be provided. A copy of the non-beneficial policy and procedure and a list of alternative skilled nursing facilities shall be included with the written notification.
 - a.b. _____ The written notification shall be signed by the primary physician and ~~Chief Medical director~~ Officer or designee and ~~will~~shall be delivered in person or by certified mail.
 - b.c. _____ The patient/resident or surrogate medical decision maker shall be informed that they may either have the option to seek a judicial mandate to provide the disputed treatment, or arrange a transfer to another facility.
 - e.d. NewAny treatment which has been determined to be non-beneficial will not be initiated ~~Once~~ written notification has been delivered to the resident or surrogate decision maker, ~~no treatment which has been determined to be non-beneficial will~~shall be initiated unless it is court ordered.
 - d.e. _____ If ~~a decision~~ the patient/resident or surrogate decision maker decides ~~is made~~ to transfer to an alternate facility, it is the responsibility of the resident or surrogate medical decision maker to locate the accepting facility. ~~Laguna Honda LHH~~ Social Workers shall ensure that the proper steps are taken to appropriately discharge and transfer the resident to the accepting facility and will make other reasonable efforts to assist ~~in this process~~ if requested by the resident or surrogate decision maker.
 - e.f. If treatment that is being administered to the patient/resident is determined to be non-beneficial, If withdrawal of treatment that is determined to be non-beneficial is involved, the resident or surrogate decision maker ~~will~~shall be given a reasonable timeline ~~reasonable amount of notice in writing~~ for the withdrawal

of treatment, not to exceed 30 days.

7. If the ~~Bio-ethics~~ ~~c~~Committee disagrees with the recommendation of the ~~two~~ ~~physicians~~ referring physician and the second opinion panel, the dispute ~~will~~ shall be resolved by the ~~Medical Director~~ Chief Medical Officer or designee, with input from the Chief of ~~the Medical~~ Staff, Director of Risk Management or designee, and legal counsel.

ATTACHMENT:

Attachment A: ~~None~~ Sample Notification Letter for Non-Beneficial Treatment

REFERENCE:

~~None~~ California Probate Code Sections 4735, 4736 and 4740.

Revised: 16/08/30, 18/03/13 (Year/Month/Day)

Original adoption: 13/05/28



ATTACHMENT A

City and County of San Francisco
Laguna Honda Hospital & Rehabilitation Center
Hospital Administration
375 Laguna Honda Blvd.
San Francisco, CA 94116

To:

[Name of patient/surrogate]

[Address]

[Date]

Re: Medical care of patient, [Name and MRN] at Laguna Honda Hospital and Rehabilitation Center

Dear [Name of patient/Surrogate],

After careful review and discussion, we do not believe that the requested treatments would be beneficial under the circumstances.

We have been caring for your [relationship to patient], [Patient's Name], during his/her current hospitalization at Laguna Honda Hospital and Rehabilitation Center. We have been asked by you to provide treatments for [Mr./Mrs. Last Name] which includes treatments like [Name each treatment deemed to be non-beneficial]. We understand why you are requesting this care and have carefully considered your reasons for requesting this care.

Our goal in caring for our patients is to provide them with medical treatments most appropriate for their condition. We have consulted with our colleagues and we have evaluated the potential outcomes of the treatment requested. We have also consulted our hospital ethics committee and they agree that the treatments mentioned above would not be beneficial to [Mr./Mrs. Last Name] and would not be appropriate. We are providing you with this written notice of our decision in compliance with the hospital's policy and the California Probate Code that addresses requests for medical treatments which physicians believe are non-beneficial. We have also asked our Chief Medical Officer to sign this letter. He has reviewed this matter and his signature indicates the hospital's support of our decision.

We recognize that making treatment decisions for gravely ill persons is challenging for everyone involved. If you disagree with our decision, you may seek out another physician and institution willing to accept [Mr./Mrs. Last Name] for transfer and provide the care you are seeking. Although you are responsible for locating alternative providers, we will make reasonable efforts to assist you. You may also seek a court order that directs our hospital to [continue/provide] the treatment in question. You must carry out these alternatives within 30 days of this notice. **After that time, we will not continue to provide the non-beneficial treatments.**

We do recognize how difficult this time is for the patient, clinicians, and family. We will continue to provide the current services and treatment to [Mr./Mrs. Last Name], and continue to work with you to develop a mutually acceptable plan of care.

Respectfully,

[Insert Name and degree]
Attending Physician

[Insert Name and degree]
Chief Medical Officer

RESIDENT ~~TRUST FUND~~TRUST ACCOUNT

POLICY:

~~It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) to enable and encourage residents to manage their personal funds, and, upon written authorization of the resident, for~~ It is the policy of Laguna Honda ~~Hospital and Rehabilitation Center (LHH) to abide by CMS regulations~~ Laguna Honda ~~to to act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.~~ hold, safeguard, manage, and account for the resident's personal funds that are deposited with Laguna Honda. ~~If the resident has a burial trust account, Laguna Honda~~LHH is responsible for managing ~~all that Burial Trust Accounts~~ as in accordance of the Social Security Operations Manual and Medi-Cal regulation requirements.

PURPOSE:

~~To provide~~ The purpose of the policy is to provide guidance ~~guidelines~~ for setting-up, managing and ~~to safeguarding~~ resident's ~~monies~~ funds deposited into the ~~Laguna Honda~~LHH Trust Accounts and identifying the roles and responsibilities of each department/staff involved in carrying out the procedure.

PROCEDURE:

1. ~~PATIENT TRUST ACCOUNT~~TRUST ACCOUNT:

- a. ~~Laguna Honda~~LHH ~~set-up~~establishes a Patient Trust AccountTrust Account to assist residents in managing their funds during their stay at LHH. ~~The bank account is the revolving funds of \$100,000 available for the use of the residents for disbursement purposes.~~ The ADL module system issued to record deposits and disbursements in the individual ~~trust account~~Trust Account for each resident. At the end of each month, accounting ~~—~~performs a reconciliation to balance ADL.
- b. The Accounting department may consolidate into a single account per admission or multiple accounts over the residents stay at LHH. However, the resident's Trust Account shall not be co-mingled with facility funds or with the funds of any other person.

2. ~~Set-Up of Resident Trust Account~~Trust Account: Residents admitted ~~LHH~~ are assigned a medical record and account number. A new account number is assigned with each readmission. When resident is discharged to acute and re-admissionmitted to skilled nursing, the resident's money remaining on the prior account is transferred to the new account number ~~when is readmitted~~.

~~3.~~

~~2.~~

4.3. **Checks:** LHH receives check payments from various sources, including SSA/SSI, Private Retirement Pensions, or other sources.

~~a. Checks received for SOC addressed to patient accounting and intended for SOC only are mailed related only or a combination or SOC/PN are mailed/sent directly to the the patient account Billing office Department. Billing Department shall complete the check log listing the check number, resident's name, episode number, and check amount. After completing the log, the check log and checks are sent to the Cashiers. also known as the cashier's office.~~

~~a.~~

~~— Checks received by A&E for PN only are sent directly to the Cashiers. A&E shall complete the PN check log listing the check number, resident's name, episode number, and check amount. After completing the log, the check log and checks are sent to the Cashiers. Income Checks received from Checks received from SSA Social Security, Pension Plans, VAVeterans~~

~~b. — Administration etc. that are addressed to Laguna Honda are listed on the are opened, sorted and check log with recorded with resident's name, account number, name and name, account amount number of the check and After completing the log, the check log and checks sent forwarded to the cashiers.~~

~~c. The cashiers enter — checks in the Trust Account daily, generates batch entry reports, and posts information into the Optimum ADL system. The cashiers photocopy the checks and file the photocopies with the batch entry report in the department deposit files.~~

~~— office~~

~~d. Checks addressed to the resident are A&E does not open checks addressed to residents without approval. They are mailed to the unit, or delivered to the resident or picked up by the MSW.~~

~~e. Checks for discharged or expired residents are returned to the sender by A&E. unopened~~

~~The cashier enters checks in the Trust Account daily, generates batch entry reports, and posts information into the Optimum ADL system. The — cashiers photocopy the checks and file the photocopies with the batch entry report in the department files. When the checks are identified as — SOC payment, accounting sends the checks to the billing department for verification and allocation of funds. Checks are entered into ADL (the Patient Trust Account System) daily and a batch entry report is generated and information posted into the system.~~

f. All funds received are divided into share of cost and ~~personal-use~~PN. ~~Person receiving SSI do not have a share of cost. Their monthly~~Personal needPN allowance for residents receiving Social Supplemental Income (SSI) is posted in the PN account.

~~— The operation cashier photo copies the checks and files the photocopies with the batch entry report in the department files.~~

5. Interest: The department of Human Services calculates the amount of share of cost based on the resident's income. The resident allowance is the current monthly PN allowance. If the resident does not use his monthly PN allowance, it remains in the PN account. ~~and at \$50.00~~When the amount reaches \$50.00, ~~it~~ it will start to earn interest. Interest is posted ~~monthly~~after the interest distribution from the ~~Ce~~ontroller's Office, City and County of San Francisco. ~~Accounting, A&E and Patient accounting~~Billing receives the monthly adhoc SOC report. ~~Accounts of discharged or expired residents will~~shall not earn interest after A&E completes the ~~D1.~~After the patient expires or discharges with zero fund balance, Accounting ~~will~~shall write off any interest amount up to \$10.00. Interest that is writing off ~~will~~shall be used to compensate a portion of the bank charge in operations.

4.

5. Cash Deposits at the Cashier Window: Cash deposits ~~are~~ accepted only ~~by~~at the ~~C~~cashiers window. After ~~the~~ verifying the cash amount, the cashier prepares the ~~cashiers~~ daily log, ~~and~~ cash receipt and issues the receipt to the depositor. ~~C~~After the transaction is completed, the cashier places a copy of the receipt and cash into the safe, for the next bank deposit ~~and input it into the ADL System.~~

~~—~~**Wire Transfer:** SSA and VA, or other pension plan may send benefits by wire transfer directly to the Bank of America "Patient ~~Trust Account~~Trust Account" on a monthly basis. A

6. ~~report detailing the transfer from the CCSF Department of Treasury is emailed to the Accounting Department.~~

a. Accounting divides all received into share of cost and ~~personal-use~~PN based on the SOC list that the Accounting Department receives from the Billing Department on the first of the each month. ~~Patients~~erson receiving SSI do not have a share of cost. Accounting posts the monthly SSI allowance in the PN account.

7. Definition:

~~8.—~~

~~a. DEFINITION:~~

~~b.—~~

~~c.—~~ Medi-Cal current rate: A dollar amount per month that qualified residents may draw. Medi-Cal periodically changes this current rate, which is available from the Laguna Honda LHH Admissions & Eligibility (A&E) ~~financial counselor~~ Financial Counselor. B.

~~d.—~~

~~e.a.~~ SSI Current Rate: A dollar amount per month that qualified residents may draw. SSI periodically changes this current rate, which is available from the Laguna Honda LHH A&E ~~financial counselor~~ Financial Counselor.

~~9.—~~ **Representative Payee Program, Legal Conservator and Public Guardian:**

~~10.—~~

~~8.~~ In most situations, a resident is presumed to be capable of managing their funds. Residents may have a Public Guardian or other legal conservator appointed to manage the residents' money. As an alternate option, the resident or legal conservator may elect to have Laguna Honda LHH as the representative payee. The main responsibility is to ensure that money spent is to pay for the needs of the resident and properly save any money not needed to meet current needs. Laguna Honda LHH as representative payee must also keep records of expenses. To become the representative payee, Laguna Honda LHH must submit forms SAA-787 and SSA-11 (completed by A&E ~~financial counselor~~ Financial Counselor

~~4.—~~

~~Regulations Defined by the Medi-Cal Program~~

~~Personal Need~~ PNs Allowance:

~~Residents who are Medi-Cal eligible may receive up to the Medi-Cal current rate for personal use~~ PN:

~~Residents on SSI may receive up to the SSI current rate for~~ personal use PN:

~~Medi-Cal/SSI Asset Limit and Share of Cost:~~

~~For Medi-Cal recipients, the responsible A&E financial counselor~~ Financial Counselor ~~contacts the resident or other responsible person to initiate spend-down of their trust fund. Refer to A&E policy number 05-02, Notification of Excess Personal Assets.~~

~~Recipients in the SSI program do not have a share of cost. When admitted to LTC a person's SSI benefits are decreased to \$50.00 for their~~ personal need PNs. ~~Asset must remain below \$2000.00~~

~~The New Medi-Cal Eligible ACA Program does not have an asset limit or SOC and does not require residents to Spend-down.~~

~~Traditional Medi-Cal, which includes aged and disabled persons, still requires eligible persons to have assets below \$2,000 to remain eligible for the Medi-Cal Program.~~

~~Burial Account: Burial funds must be for the indeed purpose of either burial expenses or purchasing a burial plan. Burial trust account~~Trust Account s will not be set-up for short stay admissions including:

~~PM SNF Rehab~~

~~PM Acute Rehab.~~

~~LSS Short Stay (Any Unit)~~

~~Money Funds set aside for burial are irrevocable and are not subject that is not subject to the resident's resource limit amount. A&E completes the Accounting~~

~~Resident may reserve amounts \$1500.00 plus interest in a prepaid burial trust (or as otherwise allowed by law) money that is not subject to the resident's resource limit amount. The A&E financial counselorFinancial Counselor will send requests to Accounting via email to have funds transferred to the burial fund.~~

PROCEDURE:

9. Establishing Resident ~~Trust Account~~Trust Account: At the time of the resident's admission to ~~Laguna HondaLHH~~, the ~~Admissions & Eligibility (A&E) financial counselorFinancial Counselor~~ assists the resident in establishing a patient ~~trust accountTrust Account~~ at ~~Laguna HondaLHH~~. The A&E ~~financial counselorFinancial Counselor~~ ~~willshall~~ encourage~~ask~~ the resident to ~~sign the arrange for~~ direct deposit form to have his/her funds deposited electronically to the ~~Laguna HondaLHH Trust Account~~.

~~of his/her funds into a resident trust account~~

~~11.. The Accounting Department may consolidate into a single trust two or more trust accounts of a given resident; however, the resident's trust account shall not be co-mingled with facility funds or with the funds of any other person.~~

~~12.~~

10. ~~Accounting of Resident Trust Account~~Trust Account Quarterly Statements:

The Accounting Department issues a fiscal quarterly "Resident ~~Trust Fund~~Trust Account Statement" (hereafter Statement) ending September, December, March and June. The Statement is delivered thru interdepartmental mail to individual Nursing Neighborhood and the nurse manager or designee of each Nursing Neighborhood ~~willshall~~ distribute the Statement to residents. When a legal representative ~~has been designated to manage~~s the residents' funds, Accounting Department delivers the Statement to the A&E Department who then in turn distributes by mail to the residents' legal representative.

11. Distribution Funds after Death: Upon the death of a resident, the A&E Department ~~willshall~~ convey within 30 days the resident's funds and a final accounting of those funds to the individual for probate jurisdiction administering the resident's estate. It

is the responsibility of the A&E ~~financial counselor~~Financial Counselor to withhold any overpayment from SSI/SSA and SSA, VA or retirement system.

a. To avoid negative account balances/accounts.:

i. A&E ~~will~~shall request that all ~~fund~~overpayment amounts received electronically be after the resident expired by requesting the Accounting to transferred the fund to SS-Rsv Rreserve fund for future 'Take Back' from SSI/SSA. ~~electronic reverse payment that may cause a negative payment in the future.~~

ii. All other funds not identified as overpayment must be distributed to the family, conservator, or Public Administrator.

Accounting shall provide the

b. Over payments received by check are returned via US postal service. Funds received after death are held until FC receives notice or email confirming that resident has no over payment.

c. Accounting shall provide the SS-reserve balance report quarterly to A&E and A&E shall review the SS-reserve balance report quarterly and cleanup annually when necessary to avoid accumulation. Funds received by check are returned via US postal service.

13-12. Burial Account:

a. The preference is to purchase a burial plan vs. setting up a burial fund in ADL. The resident may reserve \$1500.00 plus interest in a prepaid Burial trust accounts (or as otherwise allowed by law) money that is not subject to the resident's resource limit amount.

i. Burial funds must be for the indeed purpose of either burial expenses or purchasing a burial plan.

ii. Burial Accounts ~~will~~shall not be offered if the resident has a Legal Representative, Social Security Rep. Payee or if patient is admitted for short stay, which includes patients admitted to the following services, PM SNF Rehab, PM Acute Rehab. , LSS Short Stay (Any Unit).

b. Transferring funds to and from the burial fund: The A&E Financial Counselor ~~will~~shall complete the Authorization form to Accounting Office and to cashier's office ~~form~~ to request transfer of funds to and from the burial account ~~and the form to the cashier's office.~~

c. Disposition of Burial Funds when resident discharges;

i. If ~~Laguna Honda~~LHH is the Rep. Payee, Burial funds ~~will~~shall be sent to the new rep. payee or legal representative identifying funds as burial funds.

- ii. A&E shall notify Social if Laguna Honda is Rep Payee and patient is discharged and funds withdrawn or forwarded to the new Rep. Payee.
- iii. If residents withdraw funds from the burial fund, they willshall be informed that the with-drawl from the burial account may be counted as income and may affect their monthly SSI benefits.
- iv. If the resident or their decision maker withdraws funds, the A&E FC shall inform them of the Medi-Cal/SSA requirement to deposit funds into a Burial Trust Account.

14.13. Funds Transferred to Billing for late SOC payment:

- a. The billing department is responsible for ensuring that the current months SOC is credited to the patient's account by the 15th of the month.
- b. The biller must contact the FC if the SOC payment is for previous months. FC willshall verify that funds in the Trust Account are designated as SOC funds for previous months. The FC willshall inform the biller if money is for personal needPNs or SOC payment.

15.14. Funds Credited from Patient AccountingBilling to the Patient Trust Account:

- a. Patient AccountingBilling willshall contact A&E via email to notify them of overpayment on Share of Cost to be credited back to the trust account.
- b. A&E Financial Counselor willshall respond with a date that funds willshall be transferred back to the Patient Trust Account.
- c. On the date of transfer, Patient AccountingBilling willshall notify Accounting Department via email to proceed with the credit to the Patient Trust Account.

~~16.~~

~~17. Nursing Neighborhood Money Held by the Nurse Manager or Designee~~

- a. ~~Money held by the nurse manager or designee is secured in the Nursing safe with restricted access. The nurse manager or designee is not to hold more than \$50 for the resident. However, for a certain period of time, but not more than 30 days, the nurse manager or designee may have more than \$50 for the resident when private funds belonging to the resident have been entrusted to the nurse manager or designee and have not yet been deposited into the residents' trust account.~~

~~18.~~

- ~~a. Residents who have financial decision-making capacity must sign a transaction record when money is received.~~
- ~~b. they receive the funds from nursing staff.~~
- ~~c. At the time of the resident's death, the nurse manager promptly shall deposit all of the resident's funds into the residents' trust account.~~

15. Resident Has Financial Decision Making Capacity and Requests Withdrawal of Money from the Patient Accounts/Cashier Window:

- ~~1. If the resident wishes to withdraw funds from his/her patient ~~trust account~~Trust Account, the resident completes the "Authorization to Accounting Office form (ATAO). The form must be signed by the resident or resident's representative and countersigned by A&E Supervisor and/or A&E Manager, or designee.~~

~~The A&E Supervisor must sign requests for check. The A&E Supervisor must counter sign authorizations over ~~fifty-one dollars~~SSI current rate. The A&E Manager must counter sign authorizations over \$1,000; or \$1500 dollars with residents or legal conservators signature. The Authorizations over \$300 must be counter-signed by A&E Supervisor and A&E Manager, or designee. The Director of Patient Financial Services (PFS) or designee must sign authorizations over \$1000.00 without the resident's signature. Authorizations over \$300 must be counter-signed by A&E Supervisor and A&E Manager, or designee.~~

~~A&E PFS Director's signature is not required for authorization amounts up to required for amounts over \$15001000.00 or \$1500 if the resident or legal conservator signs authorization. \$300 for discharge only.00 Refer to 18e for window cash withdrawal over \$300.~~

- ~~a. Cash ~~will~~shall be authorized if resident is being final discharged from ~~Laguna Honda~~LHH.~~

- ~~d.b. Any questions regarding an unreasonable request by a resident who ~~may~~ needs guidance in managing his/her funds are to be ~~discussed and~~ resolved by the members of the resident's care team.~~

- ~~19-16. Annual Authorization to Withdraw Monthly Allowance: Annual Authorizations (A&E and Cashier). The resident ~~or MSW~~ may choose to receive ~~his/her~~ monthly allowances (Medi-Cal current rate or SSI current rate) through Annual Authorization by completing and signing the ~~Annual~~ ATAO form. The A&E ~~financial counselor~~Financial Counselor writes on the top of the form "Annual Authorization", and an expiration date. The A&E ~~financial counselor~~Financial Counselor forwards the original copy to the Cashier. ~~A and a~~ copy of the form is filed in A&E file. The Cashier ~~will~~shall file the ATAO original copy to use as reference to verify residents who participate in Annual Authorizations. Annual authorization covers monthly allowance not to exceed ~~\$5051.00~~the SSI/Medi-Cal current rate. Amounts over the~~

~~\$50.00 limit or additional~~ Additional requests for withdrawal requires resident to sign an ATAO form for each request. Annual Authorizations are renewed on December ~~31st~~31, of each year. Residents/MSWs wishing to continue with annual authorizations must complete a new authorization for the upcoming year.

~~The annual authorization form is used only for residents with decision-making capacity and are able to handle their own funds. All other requesting funds must use the regular ATAO form.~~

~~20.~~ Steps for Authorization of **Funds:**

~~21.~~

~~22.~~17. **The Funds:** The expensediture of the funds is intended for the resident's use to provide for his/her comfort and happiness. Included in the legitimate use of resident's funds, but not limited:

~~to these are:~~

~~a.—~~

~~b.a.~~ _____ ~~t~~The purchase of specially prepared or alternative food that meets the resident's dietary needs instead of the food generally prepared by Laguna Honda LHH;

~~c.b.~~ _____ ~~telephone~~Telephone; clothing; personal comfort items, including novelties, and confections; cosmetics and grooming items in excess of those for which payment is under Medi-Cal or Medicare;

~~d.c.~~ _____ ~~reading~~Reading materials; social events and entertainment offered outside the scope of the activities program;

~~e.d.~~ _____ ~~flowers~~Flowers and plants; and television/radio/audio appliances for personal usePN.

~~f.—~~ Discretionary (Personal NeedPNs) funds may not be used to pay past-due SOC or other hospital bills

~~g.—~~

~~e.~~ Other than current months SOC, transfer of funds to patient accountingBilling must be approved by the A&E ~~financial counselor~~Financial Counselor via Email

The following chart displays required signatures for authorization or withdrawal from the resident's account. Exceptions are listed below:

Withdrawal Amount	Amounts up to <u>Medi-Cal or SSI Current rate</u> \$5051.00	Additional signature if Amount exceeds \$5051.00 <u>Medi-Cal or SSI Current rate</u>	Additional signature if amount Amount exceeds \$300.00	Additional signature if amount Amount exceeds \$1,000500.00 w/o Residents signature signature or \$1500.00 with residents or conservators signature
PFS staff Signature signature Requirements requirements	Resident or Medical Social Worker and A&E Financial Counselor <u>Financial Counselor</u>	A&E Supervisor or designee	A&E Manager or designee	Director of PFS, CFO, or designee
<p>The Laguna Honda LHH A&E Manager may approve authorization for any amount when funds are intended for:</p> <ul style="list-style-type: none"> a. Resident's Burial or purchase of a burial plan, b. Resident Discharge or Pending Discharge c. Distribution of funds to family/estate after resident expires d. Funds sent to the Department of Human Services, Public Guardian, Public Administrator, or a legal representative or Rep. Payee. e. Payment of resident's bills f. Authorizations approved by the resident or Legal Representative. <p>Funds distributed to expired residents family/estate</p> <p>Payment of resident's bills</p> <p>— Authorizations approved by the resident or Legal Representative via email or letter, by signing the authorization form</p>				

~~— The Laguna Honda A&E Manager may approve authorization for any amount when funds are intended for:~~

- ~~— burial Burial or to purchase a burial plan,~~
- ~~— pending Pending discharge,~~
- ~~— distribution Distribution of funds to family after resident expires for a deceased~~
- ~~— resident or funds authorized to Funds sent to the Department of Human Services, Public Guardian, Public Administrator, or a legal conservator.~~

~~1. Medi-Cal Spend down:~~

- ~~a. LHH is the decision maker: A&E sends an email notification to the social worker and nurse manager when the residents account reaches \$1500.00. A second notification after 30 days at \$1700.00. The final email notification is sent 30 days later or when the account reaches \$1900. (See attachment A for notification letters.)~~

~~b. Resident/Family or Conservator is the decision maker: A&E financial counselor~~ Financial Counselor will contact the family to spend down

~~23.~~ 18. Authorizations Requested by Resident:

a. Residents who are capable of managing their own funds ~~will~~ shall complete the authorization form for withdrawal of funds:

~~b.~~

~~e.b.~~ The A&E financial counselor Financial Counselor reviews ~~trust account~~ Trust Account ledger to verify that funds are available.

~~d.~~

~~e.c.~~ If authorization is a final liquidation of the resident account due to discharge ~~or death,~~ ADL (1) screen of resident's account ~~will~~ shall be printed and attached to ATAO.

~~f.~~

~~g.d.~~ The A&E financial counselor Financial Counselor completes the ATAO and has the resident sign the form to authorize withdrawal of funds.

~~h.~~

~~i. If amount of the request exceeds \$50.00, the A&E Supervisor's signature is required on the authorization form. (Refer to authorization chart above).~~

~~24.~~

~~i. A&E financial counselor~~ Financial ~~will authorize if requested funds are for the benefit of the resident.~~

~~25.~~

~~a.e. Any amount over~~ Counselor If Cash withdrawals over \$300 is dependent on funds available in the cashiers offer. \$300 For withdrawal requests for amounts over \$300, A&E ~~will~~ shall contact the cashier office two business days in advance to ask if cash is available. If not, will be issued by check. resident can arrange to pick up the cash the following day when available or the cashier's office ~~will~~ shall issue a check for amounts over \$300.00.

~~i. Cash will be authorized if resident is final discharged from Laguna Honda.~~

~~26.~~

~~a.f.~~ For cash requests, the Financial Counselor gives the white copy of the authorization ~~is given to the authorized decision maker~~resident to take to Cashier, ~~the to get his/her funds;~~ yellow copy is placed in the A&E supervisor's mailbox for auditing purposes; ~~p,~~ and the pink copy is placed in resident's chart along with copies of identification and receipt(s) or invoice to A&E copy of ATAO.

~~b.~~

~~e.g.~~ For check requests, the A&E ~~financial counselor~~Financial Counselor sends the white copy and yellow copy of the ATAO form to Cashier and files pink copy in residents' file.

~~d.~~

~~e.h.~~ When A&E ~~financial counselor~~Financial Counselor receives the check and yellow copy of the ATAO, check is delivered/mailed, yellow copy replaces pink copy in resident file and pink copy is forwarded to A&E supervisor.

~~h.~~ Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be ~~discussed and~~ resolved by the members of the resident's care team.

~~f.i.~~ **Reimbursement to Authorized Decision Maker when Resident Lacks Financial Decision Making Capacity**

~~g.i.~~ If a resident lacks capacity to make financial decisions, person identified by the Medical Social Worker (MSW) as the person having authority to access ~~that the~~ resident's ~~Trust Account~~Trust Account.

~~h.k.~~ If ~~Laguna Honda~~LHH is the Rep. Payee, the Social Worker must sign ATOA form. Resident may sign the form if he/she has capacity to make decisions~~Persons who are not the authorized decision maker will be referred to the MSW.~~

~~i.~~ ~~Steps for Establishing and Authorizing Funds to the Authorized Decision Maker:~~

~~j.~~

~~k.l.~~ MSW ~~will~~shall provide A&E with name and contact information of person authorized to access the resident's ~~trust account~~Trust Account.

i. The A&E ~~financial counselor~~Financial Counselor ~~will~~shall enter authorized decision makers name and contact information into Invision Clinical Management System.

- ii. The A&E ~~financial counselor~~Financial Counselor ~~will~~shall verify that person requesting funds is the authorized decision maker. If not, the person ~~will~~shall be referred to contact the resident's social worker.
- iii. If the person is authorized to access funds, the A&E finance counselor ~~will~~shall review the ~~trust account~~Trust Account ledger to verify that funds are available and ask the person to provide Government identification.
- iv. The authorized decision maker must submit a written request for funds indicating amount and reason for the request.
- v. ~~Receipts for resident purchases must be submitted for reimbursement by authorized decision makers~~Authorized decision makers must submit receipts for resident purchases for reimbursement when the resident lacks financial ~~decision-making~~decision-making capacity.
- vi. Refer to item 8a thru 8k for steps on authorization of funds.

27.19. -Authorization Request by MSW

- a. If in the opinion of the residents' care team, the resident is unable to manage his/her funds and the resident does not have a legal representative, the hospital or designee ~~will~~shall designate the MSW to manage the resident's funds. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident's care team.
 - b. Steps for Authorizing Funds to the Medical Social Worker:
 - i. The MSW ~~will~~shall notify the A&E ~~financial counselor~~Financial Counselor of request for funds in writing indicating amount and reason for the request.
 - ii. The MSW ~~will~~shall submit receipts for purchases to the A&E ~~financial counselor~~Financial Counselor within one week.
 - iii. The MSW ~~will~~shall maintain a transaction record, which must be signed by the resident whenever money is distributed to the resident. The transaction record ~~will~~shall be forwarded to the A&E ~~financial counselor~~Financial Counselor, who ~~will~~shall place the form in the resident's file.
 - iv. MSW signature is required when requesting funds for residents or reimbursement for purchases or services
- iii.v. MSW signature is not require if:
- Resident is able to sign bill payment

- Funds sent to Medi-Cal Recovery Unit – California Department of Health Services
- Funds returned to Social Security
- Funds used for Burial Plans
- Funds sent to Public Administrator
- Funds sent to family/estate after death

~~iv.vi.~~ Refer to item 8a thru ~~8k-8h~~ for steps ~~on~~for authorization of funds.

~~28-20.~~ Monitoring Compliance:

- a. A&E: The A&E supervisor ~~will~~shall conduct a random sample audit each month, reviewing and reconciling receipts against funds withdrawn and reimbursed to the authorized decision maker. The A&E Manager is responsible for monitoring compliance.
- b. Accounting Department performs monthly Trust Fund bank reconciliation. The CFO is responsible for reviewing this reconciliation.

ATTACHMENT:

None.

REFERENCE:

Nursing Department Policy for Handling Money Held on the Nursing Neighborhood

Revised: 98/11/16, 00/05/25, 04/12/02, 07/12/18, 10/04/27, 10/08/10, 11/03/24, 16/01/12, 18/03/13 (Year, Month, Day)

Original adoption: 93/09/01

LAGUNA HONDA RESIDENT NOTIFICATION OF EXCESS PERSONAL ASSETS IN TRUST ACCOUNT

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) Admissions and Eligibility (A&E) Department, to ensure that residents residing at ~~Laguna Honda~~LHH adhere to the Medi-Cal Program regulation regarding personal property limits.

~~Laguna Honda~~ A&E financial counselors works with Social Services, Nursing, Legal Representatives and family members to spend down funds, e. ~~Ensuring that the funds~~w in the trust account remain within the Medi-Cal asset limit. ~~are responsible for understanding the Medi-Cal Regulations and rules regarding excess assets and spend-down. They also have responsibility for ensuring that an application is completed and submitted to the Medi-Cal Program once residents' assets are within Medi-Cal limits.~~

Regulations Defined by the Medi-Cal Program:

PROCEDURE:

1. Program Definitions:

- a. ~~Medi-Cal/SSI Asset Limit and Share of Cost: Medi-Cal/SSI current rate: A dollar amount per month that qualified beneficiaries may draw. Information on the current rate can~~may be located on the Medi-Cal and Social Security Website.
- b. ~~For Medi-Cal recipients, the responsible A&E financial counselor contacts the resident or other responsible person to initiate spend-down of their trust fund. Refer to A&E policy number 05-02, Notification of Excess Personal Assets.~~
- c. ~~—~~
- d.b. The New Medi-Cal Eligible ACA Program does not have an asset limit or SOC and does not require residents to s~~Spend-down.~~
- e.c. Traditional Medi-Cal, which includes aged and disabled persons, still requires eligible persons to have assets below \$2,000.00 to remain eligible for the Medi-Cal Program.
- f. ~~Recipients in the SSI program do not have a share of cost. When admitted to LTC a person's SSI benefits are decreased to \$50.00 for their personal needs. Asset must remain below \$2000.00.~~
- g. ~~—~~
- h. ~~The New Medi-Cal Eligible ACA Program does not have an asset limit or SOC and does not require residents to Spend-down.~~
- i. ~~—~~

~~j. Traditional Medi-Cal, which includes aged and disabled persons, still requires eligible persons to have assets below \$2,000 to remain eligible for the Medi-Cal Program.~~

~~k.d.~~ Medi-Cal Certified/ Retro-active lump sum payment from SSA/SSI: Retroactive benefit payments from Title II (RSDI) and Title XVI (SSI/SSP) are not included in the property reserve for a period of nine (9) months following the month in which the payment is received. This rule applies to persons eligible for Medi-Cal under the Pickle Amendment, Disabled Adult Child(ren), Disabled Widow(er)s, Medically Needy/Medically Indigent Programs and other programs following Medically Needy Property rules. (The Social Security Protection Act of 2004)

~~l.e.~~ Medi-Cal /SSI Asset Limit and Share of Cost:

- i. Social Security Beneficiaries in the SSI program do not have a share of cost. Instead the person's income is decreased to the SSI current rate. To be eligible for SSI, the persons income must remain below \$2000.00.
 - ii. The Medi-Cal ACA program does not have an asset limit or SOC and does not require spend down of assets.
 - iii. Traditional Medi-Cal requires eligible persons to remain within the Medi-Cal asset limit of \$2,000.00.
2. Steps for Spend down for residents or resident's legal representative: If resident has a legal representative, funds ~~will~~[shall](#) be forwarded to the representative once the account reaches \$300.00.
3. Steps for spend-down of Assets without a legal representative or ~~Laguna Honda~~LHH is the Rep. Payee: If the resident has capacity, the MSW ~~will~~[shall](#) work with the resident to spend down \$400.00. If resident has capacity to make financial decisions, the Financial Counselor must obtain resident's permission prior to sending excess funds to CDHS.

~~3.4.~~ Trust Account Balance Notifications:

- a. When residents trust account reaches \$1500.00, the A&E Supervisor notifies the resident's MSW and Nurse Manager via email with a list of residents with funds that are \$1500.00 or more.
- b. When the residents trust account reaches \$1700.00, the A&E Financial Counselor ~~will~~[shall](#) send the 2nd request for spend-down via email to the MSW and Nurse Manager. The MSW and Nurse Manager ~~will~~[shall](#) assess the resident's personal needs and make the necessary purchase on behalf of the resident to reduce the personal property.

- c. When the residents trust account reaches \$1900.00 and there is no spend-down of funds after second notification, the ~~Laguna Honda~~LHH A&E financial Counselor ~~will~~shall send 3rd notification (see attached spend down notices).
- d. A&E mails the check to California Department of health Services, Recovery Section MS 4729, P.O. Box 997421, Sacramento, CA 95899-7421. A copy of the check is filed in the A&E file.
- e. The A&E supervisor ~~will~~shall review the ADL balance report to monitor spend-downs during the third week of the each month.
 - i) —

PROCEDURE: _____

- ~~5. Prior to admission, the Laguna Honda Hospital and Rehabilitation Center admission coordinator or designee will inform residents requesting admission to Laguna Honda, or their representative of payment requirements described below in sections a-c.~~

~~A&E financial counselors are responsible for informing current residents, or their representatives of Medi-Cal requirements, including updates on Medi-Cal Regulations for property limit and spend-down of excess assets.~~

~~a. Medical Spend Down of a Medi-Cal Applicant~~

- ~~i. A&E financial counselor informs persons requesting admission to Laguna Honda with assets exceeding the Medi-Cal Property limits of Laguna Honda's deposit and payment policies. Residents, their families or legal representatives are provided with the Laguna Honda payment agreement. A signature confirming that the document has been reviewed and understood must be submitted to the Laguna Honda admission coordinator before admission to Laguna Honda. In addition, a minimum deposit is required based on the type of service and estimated days of admission to Laguna Honda as described further below.~~

~~b. Medical Acute Admission~~

- ~~i. Requires a minimum deposit equal to the estimated length of acute stay, up to a 45-day stay, or until the resident's assets are within the Medi-Cal asset limit.~~

~~c. Acute Rehabilitation Admission~~

- ~~i. Requires a minimum deposit equal to estimated length of stay, up to a six-week stay, whichever is shorter.~~

- ~~d. SNF Admission—A minimum deposit up to three months stay, or until the resident's assets are within the Medi-Cal asset limit.~~

~~6. A&E financial counselors will use the following Medi-Cal regulations to base determination of excess assets: Medi-Cal Eligibility Manual Procedures Section No: 50421 Manual Letter No.: 131 (Excess Assets Applied to Residents Bills)~~

~~a. A Beneficiary (resident) remains responsible for medical expenses incurred by him/her when:~~

~~i. The applicant (resident) has medical bills in a month for which retroactive coverage is being requested and property was reduced to pay those bills before the end of that retroactive month.~~

~~ii. When excess property was reduced during the month to pay for medical expenses.~~

~~iii. When a period of ineligibility due to a transfer of property occurring before January 1, 1990, expires mid-month and actual medical expenses in that month were used to reduce the period of ineligibility.~~

~~iv. The actual medical expenses used to reduce the period of ineligibility is not refunded to the beneficiary or billed to Medi-Cal. All other medical services not paid by the beneficiary may be billed to Medi-Cal.~~

~~v. NOTE: Under the share of cost process, where a beneficiary's excess income must be applied towards his/her medical care. The same medical expenses cannot be used to meet an applicant or beneficiary's share of cost.~~

~~b. Non-Exempt Assets:~~

~~i. Non-exempt assets, which may include inheritances, gifts, sale of real property or a revocable trust fund may cause a loss of benefits to an otherwise Medi-Cal eligible person. Residents who are discontinued from the Medi-Cal Program due to excess assets are responsible for payment of all charges associated with their admission. (Refer to section 1a-d). Non-exempt lump sum payments from the following are included in the property reserve effective the month of receipt:~~

~~• Annuities~~

~~• Veteran's Payments~~

~~• Pensions~~

~~• Railroad Retirement~~

~~• Unemployment Benefits~~

- ~~• Non-SSA Disability payments~~
- ~~• Non-SSA Retirement payments~~
- ~~c. Exempt Assets:~~
 - ~~i. Cash- Current Months Income~~
 - ~~ii. Retro-Active lump sum payments from SSA/SSI~~
 - ~~iii. Irrevocable Trusts~~
 - ~~iv. Funds associated with Burial Insurance, Burial Plots, Irrevocable Burial Funds~~
- ~~d. Medi-Cal Certified/ Retro-active lump sum payment from SSA/SSI~~
 - ~~i. Retroactive benefit payments from Title II (RSDI) and Title XVI (SSI/SSP) are not included in the property reserve for a period of nine (9) months following the month in which the payment is received. This rule applies to persons eligible for Medi-Cal under the Pickle Amendment, Disabled Adult Child(ren), Disabled Widow(er)s, Medically Needy/Medically Indigent Programs and other programs following Medically Needy Property rules. (The Social Security Protection Act of 2004)~~
- ~~e. Irrevocable Trusts~~
 - ~~i. _____ burial fund. However, other Non-liquid assets, such as a car or real property, cannot be designated for burial expenses. Interest earned on or appreciation in value of a revocable burial fund shall be exempt if it is allowed to accumulate and become part of the separately identifiable burial fund.~~
 - ~~ii. _____~~
 - ~~iii. **Steps for Review and Spend-Down of Assets in Laguna Honda Trust Account:** The A&E financial Counselor generates the Resident's Fund Balances Report (Spend-down Report) on the 15th of each month.~~
 - ~~iv. _____~~
 - ~~v. _____ Resident or residents' representative (including Conservative or Payees) manages funds: The A&E Laguna Honda financial counselor will notify the resident or the resident's legal representative when the trust fund account reaches \$1500.00 dollars. If the resident is incapable of making financial decisions, the resident's representative will be notified by telephone and /or mail.~~
 - ~~vi. _____~~
 - ~~vii. _____ Medical Social Worker (MSW) manages residents' funds: If the resident is unable to manage his/her funds and the resident does not have a legal representative, unless otherwise designated the MSW is responsible for managing the residents trust account. The A&E financial counselor will take the following steps to monitor the trust account balance, and spend-down when the balance is near the Medi-Cal personal property limit.~~

viii. _____

ix. _____ When residents' trust fund accounts reaches \$1500.00, the A&E financial counselor will notify the resident's MSW of spend down request via email and copy the nurse manager and A&E supervisor.

x. _____

xi. _____ When the residents' trust account reaches \$1700.00, the A&E financial counselor will send the 2nd request for spend down via email to the MSW and Nurse Manager. A copy of email stating second request will be sent the Director of Social Services, Nursing Director, and A&E Manager, CNO and CFO.

xii. _____ The social worker and nurse manager will assess the resident's personal needs and make the necessary purchase on behalf of the resident to reduce the personal property.

xiii. _____ After 30 days, and there is no spend down of funds after second notification, the Laguna Honda A&E financial Counselor will send notification (see attached spend down notices) to all persons listed in section 9b-ii. A separate email is sent to the billing department to inquire on patient accounting balances.

xiv. If no purchase(s) or payment is made to reduce the trust account, the financial counselor will prepare the authorization to cashiers for release of the resident's funds to California Department of health Services, Recovery Section.

xv. The cashier's office will issue a check, which the Laguna Honda A&E financial counselor will include a copy of the check in the residents A&E file and mail the check to California Department of health Services, Recovery Section MS 4729, P.O. Box 997421, Sacramento, CA 95899-7421.

xvi. The A&E supervisor will review the ADL balance report to monitor spend-downs during the third week of the each month.

7.5. Spend-down of Resident's funds to Purchase Durable Medical Equipment:

- a. Resident's funds may be used to purchase Durable Medical Equipment (DME) for the exclusive use of the resident.
- b. Resident's funds may be used to purchase Durable Medical Equipment not covered by Medi-Cal, which includes wheelchairs, wheelchair positioning devices, orthopedic shoes, etc.
- c. A referral for a formal evaluation shall be completed by the resident's physician and submitted to the Rehabilitation Department.
- d. If the resident needs DME, the Rehabilitation Professional (OT, PT, or ST) ~~will~~[shall](#) contact the vendor to get a quote for the equipment.

- e. The social worker ~~will~~[shall](#) contact the A&E financial counselor for the resident's trust account balance. If the resident has funds, an MD order is faxed to the vendor.
- f. Once the vendor provides the quote, the Rehabilitation Department contacts the MSW for final approval.
- g. Once approved by the MSW and the funds and authorization are received from the A&E department, the Rehabilitation Department ~~will~~[shall](#) place the order for DME with the vendor.
- ~~h.~~
[i.h.](#) The Rehabilitation Department coordinates with the vendor for delivery and final fitting of the DME.

ATTACHMENT:

Attachment A: 1st Request Memo from E.W. to Nursing Manager and MSW

Attachment B: Spend down 2nd Request

Attachment C: 3rd Internal Memo from E.W. to Department Heads of Nursing, Social Services, and Admissions

REFERENCE:

Medi-Cal Eligibility Manual – Procedures Section

Revised: 12/05/22, 16/01/12, [18/03/13](#) (Year/Month/Day)

Original adoption: 10/08/24

Attachment A: 1st Request Memo from E.W. to Nursing Manager and MSW

Date:

From:

To:

Re: List of Resident's with Release of Patient's Funds to DHS-Medi-Cal Recovery Unit Trust Account Balances \$1500.00 and over

~~Resident's trust fund account has reached \$_____.~~

The Medi-Cal Program allows a maximum of \$2,000.00 personal property limit for a single adult in a family budget unit.

~~Eligibility is initiating a spend-down on the above resident. Please spend-down \$200, otherwise LHH will return the excess money to Calif. Dept. of Health Services. When funds in the trust account reaches \$1900.00 A&E will send \$400.00 to the Medi-Cal Recovery Unit-CDHS.~~

cc: MSW, Nurse Manager

Attachment B: Spend down 2nd Request

Date:

From:

To:

Re: Spend down request memo from A&E to Department Heads of Nursing, Social Services (2nd Request):

Resident's trust fund account has reached \$_____.

The Medi-Cal Program allows a maximum of \$2,000.00 personal property limit for a single adult in a family budget unit.

When funds in the trust account reaches \$1900.00 A&E ~~will~~shall send \$400.00 to the Medi-Cal Recovery Unit-CDHS.

~~Eligibility is initiating a spend-down on the above resident. Please spend-down \$200, otherwise LHH will return the excess money to Calif. Dept. of Health Services.~~

Cc: Nurse Manager, Nursing Director, MSW, CFO, CNO, A&E Supervisor and Manager

Attachment C: 3rd Internal Memo from E.W. to Department Heads of Nursing, Social Services, and Admissions

Date:

From:

To:

Re: Release of Patient's Funds to DHS-Medi-Cal Recovery Unit (Final Notice)

Resident's trust fund account has reached \$_____.

The Medi-Cal Program allows a maximum of \$_____ personal property limit for a single adult in a family budget unit. The resident's Social Worker and Nurse Manager have indicated that resident currently has no personal needs.

To reduce the residents trust account, an amount of ~~\$200~~400.00 has been withdrawn from the trust account and forwarded to the Medi-Cal Recovery Unit -.California Department of Health Services

cc: Cc: Nurse Manager, Nursing Director, MSW, CFO, CNO

EMERGENCY RESPONSE PLAN

INTRODUCTION:

~~Disasters or emergencies can happen suddenly, interrupting normal resident care services and overwhelming the functional capacity of the hospital at large. Laguna Honda Hospital and Rehabilitation Center (LHH) has developed an emergency response plan that outlines the immediate actions and operations required to save and protect the lives of residents, employees, volunteers and visitors, provide essential services and operations, and manage resources effectively during the emergency period.~~

~~The procedures written for the LHH Emergency Response Plan are part of an all hazards plan designed to provide guidance for any emergency incident or planned event by utilizing the SEMS-compliant (Standardized Emergency Management System) Hospital Incident Command System (HICS) in coordination with community partners. LHH is linked to the City and County of San Francisco (CCSF) Emergency Operations Center (EOC) and DPH's Department Operations Center (DOC) in accordance with the CCSF Emergency Operations and DPH Emergency Operations Plans.~~

POLICY:

~~1. The Emergency Response Plan shall provide the management structure, key responsibilities, emergency assignments and general procedures to follow during an emergency.~~

~~2.1. The immediate priorities of LHH-Laguna Honda Hospital and Rehabilitation Center (LHH) during a disaster are:~~

- ~~a. the p~~Protection of lives
- ~~b. ,stabilization~~ Stabilization of the incident, and
- ~~c. —Protection of minimize damage to~~ property and the environment.
- ~~d-c. —~~

~~3. LHH's emergency response goals and objectives are to:~~

- ~~a. Rapidly and effectively respond to emergency situations;~~
- ~~b. Manage the process of maintaining or restoring essential resident care services for Continuity of Operations;~~
- ~~c. —Account for all residents, staff and visitors;~~
- ~~d. —Expand treatment areas to provide basic first aid, additional skilled nursing or acute (non-surgical) care, and temporary shelter; and~~

~~e. Work in partnership with Zuckerberg San Francisco General Hospital (ZSFG) to expedite admissions to LHH to help off-set the influx of casualties at ZSFG.~~

4.2. LHH shall coordinate emergency response with the Department of Public Health (DPH) and, communicate status and resource needs or requests throughout any major event to the Department Operations Center (DOC).

PURPOSE:

1. ~~The purpose of this plan is to~~ serve as a guide for a rapid, effective, and coordinated ~~emergency response to any event resulting in a disruption of normal operations at LHH.~~
~~in an effort~~

4.2. ~~The purpose of an effective response will be~~ to provide continued, quality service to residents, maintain essential internal and external communications, manage the use of resources; facilitate recovery efforts; and reduce the impact of the ~~emergency~~ event.

PROCEDURE:

1. Activating the Hospital Incident Command System (HICS)

~~a. Assigning the Role of Incident Commander~~

a. If an emergency situation affects the normal operation of the facility, the employee who discovers the situation shall immediately report it to his or her supervisor. The supervisor shall notify the Chief Executive Officer (CEO) or Administrator on Duty (AOD) of the major event that adversely affects the facility's ability to deliver care in the usual and customary manner, or to an accepted standard.

b. The CEO or AOD shall activate HICS and either assume or designate the role of Incident Commander.

c. If the CEO or AOD cannot be reached, the Operations Nurse Managers~~supervisor~~ shall assume the role of Acting Incident Commander and assign someone to notify the following in the order listed:

i. Chief Operations Officer (COO)

ii. Medical Director

iii. Chief Nursing Officer (CNO)

iv. Quality Management Director
Operations Nurse Manager

d. The first person to be reached on the above list shall assume or delegate the position of Incident Commander. Staff qualified to serve as the Incident Commander are those who have completed minimum training, which includes ICS 100, 200, 700 as well as additional HICS training, and whom are deemed by the CEO or AOD to be qualified to manage the specific incident. A list of staff with this level of training ~~is included in Appendix A~~ can be found in Section A3 Emergency Resources and Maps and shall be updated quarterly by the Emergency Management Coordinator.

~~d.e.~~ If ~~no qualified~~ the designated Incident Commander is not on site when HICS is initiated, the ~~AOD shall designate an~~ Operations Nurse Manager shall serve as Acting Incident Commander who shall serve until ~~a qualified staff member~~ the designated Incident Commander arrives to relieve them.

e.f. HICS roles are activated at the discretion of the Incident Commander for emergency incidents or planned events with the number of positions activated scalable to the situation. The Incident Commander is the only position ALWAYS activated.

g. An incident may be initiated from LHH or the hospital may be informed of a city-wide incident through external notification by EMS Duty Officer or DPH Departmental Operation Center.

h. Whenever HICS is activated, all department and neighborhood managers or designees shall assess the status of their area using the Department Operating Status Report (DOSR), (see Appendix A), which shall be faxed to the Command Center at 415-504-8313, or delivered to the nearest DOSR collection bin within 15 minutes of HICS activation. The DOSR collection bins are in the following locations:

i. B102

ii. Clinic Registration Area

iii. Cadet's desk at the Pavilion main entrance

iv. Nursing Office

2. Notifications and Internal Communications

a. Whether an incident is internal or external to LHH, the sequence of notifications in Table 1 shall ~~occur~~ be followed once HICS is ~~initiated~~ activated.

<u>Table 1: NOTIFICATION PROCESS</u>		
<u>PERSON INITIATING</u>	<u>CONTACT PERSONS</u>	<u>COMMUNICATION</u>
<u>Incident Commander</u>	<u>Nursing Office Staff at 4-2999</u>	<u>State message to be announced such as "Attention: HICS has been activated due to _____.</u> <u>Complete your DOSRs now.</u>
<u>Nursing Office Staff</u>	<u>Facility Occupants</u>	<u>Announce on the overhead Public Address (PA) system as directed by the Incident Commander</u>
<u>Incident Commander</u>	<u>S.F. Sheriff Duty Officer</u> <u>On-Call Medical Staff</u>	<u>Inform of situation.</u>
<u>Incident Commander</u>	<u>Executive Staff</u>	<u>Using DPH Alert system (Everbridge), notify the executive team that HICS has been activated and why.</u>
<u>Executive Staff</u>	<u>Department Managers</u>	<u>Follow Department Emergency Plan</u>

~~i. Staff call back is initiated at the direction of the Incident Commander. Staff are called back by their manager or designee as needed and may be expected to work 12 hour shifts with the staff on duty as the first shift.~~

~~ii.i. A variety of back-up communication methods are employed available at the direction discretion of the Incident Commander: based upon what is functional (e.g. pages, group phone messages, email, and use of 800 MHz radios for communication between radio holders.)~~

- ~~• Additional notifications may be sent from the command center to all employees or groups of employees using the DPH Alert system.~~
- ~~• Radios are available in the HICS cabinet command center, Nursing Office, and offices for the CEO, COO, Sheriff, Emergency Management Coordinator, and Health at Home.~~
- ~~• A Mayor's Emergency Telephone System (METS) phone is available in the command center for direct contact with city emergency services officials. The METS system is also connected to the State of California's satellite telephone system for direct communication with the Governor's Office of Emergency Services in Sacramento, as well as the emergency operations centers of surrounding counties.~~
- ~~• Messengers are shall be used if all communication devices have failed, or as needed to augment communication devices.~~

- iii.ii. External notification is made by the Incident Commander or designee to the EMS Duty Officer, DPH Departmental Operation Center and other key contacts listed in Table 3. Communication shall be maintained with the DPH Departmental Operation Center (DOC) throughout large scale incidents in order to verify status, prioritize, share resources, and coordinate city-wide.

Table 4 INTEROPERABLE COMMUNICATION DEVICES In the rare event that all or most systems are down, messengers shall be used to augment technology	
System or Device	Use
METS phone (Mayors Emergency Telephone System)	Red phone available in the B102 Command Center for direct contact with city emergency services officials. METS system is also connected to the State of California's satellite telephone system for direct communication with the Governor's Office of Emergency Services in Sacramento, as well as the emergency operations centers of surrounding counties.
800-MHz radios (See Appendix L)	For communications with DPH partners and hospitals.
Dept. issued cell phones	Carried by Facility Services staff and EVS Supervisory staff
Spectralink cell phones	Carried primarily by nursing staff on neighborhoods and by the Nursing Operations Manager; linked to call light, bed alarm, duress alarm, and wander system alarms.
Pagers	Carried primarily by management and medical staff; most with texting capability.
Email	Used by many staff hospital and DPH-wide; DPH and UCSF directories provide quick access to DPH and UCSF staff emails. Supervisory and support staff have key emergency response staff group lists set up within their email system address books.
Overhead paging system	Linked to phone system and operated from the telecommunications office or by Nursing Operations in the absence of the operator.
DPH-issued devices, such as BlackBerry SmartPhones	Carried primarily by executive staff; allows email access and instant messaging.
California Health Alert Network (CAHAN)	Provides health alerts to registered participants, including over 100 LHH staff and hospital and DPH representatives city and state-wide. The LHH Emergency Preparedness Coordinator functions as a CAHAN site administrator; includes the ability to send alerts internally, monitor responses, and reset log-ins and passwords for LHH staff.

Table 1 IMMEDIATE NOTIFICATION PROCESS		
PERSON INITIATING	CONTACT PERSONS	COMMUNICATION
Incident Commander	Nursing Office Staff	Call 4-2999 State message to be announced such as "Attention all staff: Activate Code Yellow. HICS has been activated" and repeat x3 Nursing Office Staff announces directly on the Public Address (PA) system
Incident Commander	Emergency Management Coordinator	1. Inform of situation.

	S.F. Sheriff Duty Officer On-Call Medical Staff	
Incident Commander Notifies directly or through delegate	Executive Staff	Inform of situation Notify to activate subordinate staff notification and departmental call back procedures if necessary. Progress of departmental call back procedures shall be reported to Command Center.
Executive Staff / designated managers	Departmental subordinate Employees per dept. plan	Notify to activate subordinate staff notification and activate departmental call back procedures. Call back log must be kept to track progress and report to Command Center.

~~3. Set Up Of Other Areas, As Needed~~

- ~~i. Once the Command Center is established, additional response staging areas may be established at the discretion of the Incident Commander, according to the incident.~~
- ~~ii. A Labor Pool may be called for when additional staff are needed for the emergency response and may consist of volunteers and staff on site or called in. The first choice for the labor pool site is the Community Center.~~
- ~~iii. Triage may be called for when a number of people are injured or there are a number of incoming patients from other hospitals or persons from the community seeking help. The plan calls for three triage teams; one at the outpatient clinic and two mobile teams. Additional triage areas may be set up on a neighborhood(s) when injuries occur in these areas, or identified by the Incident Commander.~~
- ~~iv. Refer to Table 2 for the locations and staffing plan for the labor pool, triage and treatment areas, shelter and holding and temporary morgue.~~

Table 2

~~OVERVIEW OF EMERGENCY SITE SET UP~~

~~See also Appendix H: Hazard Specific Plans-Medical Surge Quick Reference and Appendix J: Job Action Sheets~~

Function	Location	Staffing
Labor Pool	Community Center Pavilion bldg. 1st floor Alternate Location TBD by Incident Commander	Charge Persons: Labor Pool Unit Leader Staffing: All unassigned employees (Appendix D, Departmental Procedures)
Triage 1) Stationary 2) Mobile 3) Mobile 4) Neighborhood	Outpatient Clinic Mobile Teams meet at outpatient clinic and are dispatched to sites as needed i.e. Mobile Team 1 to South Residence and Pavilion Residency; Mobile team 2 to North Residence	Triage MD or RN skilled in triage (as assigned by the Medical Care Branch Director) 1 RN per team to treat residents 1 clerk per team (to complete triage tag, attach to right wrist, complete log, operate radio) 1 messenger per team Sheriff or Cadets to direct arriving external casualties to Triage location

	Alternate Location TBD by Incident Commander	In addition, neighborhood staff shall check every person in their area and triage, provide minor treatment, and report status to Incident Command.
Treatment	Outpatient Clinic Pavilion bldg. 1 st floor Alternate Location TBD by Incident Commander	Charge Person: MD or senior RN, as assigned Staff: 1 RN (treats/ dispatches) —— 1 clerk (completes log) —— 1 clerk (operates radio) —— 1 messenger —— 1 pharmacist to deliver disaster drug supply —— 1 respiratory therapist —— 1 EKG tech —— 1 lab tech
Shelter and Holding	Wellness Center Pavilion bldg. Ground floor Alternate Location TBD by Incident Commander	Charge: as assigned Staffing: as assigned
Morgue Area	Both existing morgues; SRB1 Clean Linen Storage Room, South bldg. 1 st floor Alternate Location TBD by Incident Commander	Transporters and messengers from labor pool, as assigned

a. External Communication

- i. ~~External notification is made by the Incident Commander or designee to the EMS Duty Officer, DPH Departmental Operation Center and other key contacts listed in Table 3.~~

EXTERNAL NOTIFICATIONS—Table 3		
Incident Commander	EMS Duty Officer 415-327-9144	Request that DPH activate their DOC (for disaster initiated at LHH)
Incident Commander/ designee	DPH Departmental Operation Center (DOC) Main: 415-503-4722 Line 2: 415-503-4719 Line 3: 415-503-4716 Fax: 415-255-3054	—— Additional Information Located at 1380 Howard—4 th and 5 th floors Primary Site Authorized Activators include LHH's CEO.
Public Health Emergency Preparedness and Response (PHEPR)	Naveena Bobba John Brown Tomas Aragon Medical & Health Operational Area Coordinator (MHOAC)	Office: 558-5939 Cell: 518-8772 Office: 487-5034 Cell: 640-8307 Office: 554-2898 Cell: 787-2583 Available 24/7; Updates to above contacts are placed in the HICS cabinets in the front of the Confidential Call Back Lists binder.
Citywide Emergency Operations Center (EOC)	Contact through DPH DOC, above	1011 Turk—Restricted access; LHH is not expected to report to the EOC
Mayors Emergency Telephones System	Direct line from red "METS" phone in B102 Command Center. Dial "0" for Public Safety. See also: METS directory in the HICS cabinet.	
Other key contacts	Refer to METS Directory & Confidential Call Back Lists in HICS Cabinets in B102 & Nursing Office	

3.4. Off-Duty Staff Response

- a. All staff are mandated disaster service workers ~~as indicated on their identification badge.~~
- b. Off duty staff are expected to:
 - i. First assure their own safety and that of their family
 - ii. Wait to be called back to work or report for the next scheduled shift unless ~~you are~~ required to report immediately per the departmental emergency plan.
 - iii. Listen to the radio in case the phone lines are down (Radio stations KNBR 680, KGO 810, or KCBS 740)
- c. Staff are advised to ~~proceed safely and~~ check road conditions and radio announcements before traveling. The city may also assist staff to and from their assigned locations in the event that roads and bridges are compromised, as announced on radio and other means available.
- d. The Incident Commander shall activate staff to HICS positions according to the needs of the response. ~~Additional staff may also be called to either their regular duties or to the labor pool by their managers.~~
- ~~e.~~ Additional staff may be called to either their regular duties or to the labor pool. Each department manager/-designee leads the call back process and response according to their Departmental Procedure (see Appendix D). If the department manager or designed is not available, the Incident Commander may initiate call back of any staff deemed necessary for the response.
- ~~f.e.~~ Any messages or text pages must direct the recipient to call back to affirm receipt of the message and all calls must be logged to show progress and to report out to the Incident Commander. Progress can be recorded directly on the call back list in the columns provided.
- ~~g.~~ All department and neighborhood managers or designees assess the status of their area using the Department Operating Status Report (DOSR), (see Appendix F), which shall be delivered to the nearest DOSR collection bin within 15 minutes of HICS activation. The DOSR collection bins are in the following locations:
 - i. ~~B102~~
 - ii. ~~Clinic Registration Area~~
 - iii. ~~Cadet's desk at the Pavilion main entrance~~
 - iv. ~~Nursing Office~~

5. Use of Volunteers

- a. LHH has a pool of volunteers who provide various levels of day to day assistance through the Volunteer Coordinators. Volunteers frequently assist with resident transport and this is their anticipated primary role during an incident or event.
- b. Calls to volunteers shall be made as needed through the Volunteer Coordinators.
- c. New volunteers who offer assistance during an emergency incident shall be screened according to the usual volunteer screening processes and may only work in roles usually assigned to volunteers.

~~Volunteers who hold professional licenses (e.g. physicians, nurses, etc.) who choose to assist within their scope of practice are subject to license verification and clearance, and may not be used in a licensed professional capacity until license verification and clearance is completed.~~

6. Equipment and Supplies

Equipment and supplies to support a safe and effective staff response are ~~inventoried quarterly maintained~~ by ~~the Emergency Preparedness Coordinator or designee~~ the Department of Workplace Safety and Environmental Management (WSEM), Materials Management, Nutrition Services, and the Pharmacy. ~~Minimum supplies and equipment include, but are not limited to the following items: Table 2 lists critical equipment and supplies along with their storage locations.~~

Table 2: Emergency Equipment and Supply Locations

<u>EMERGENCY EQUIPMENT/SUPPLY</u>	<u>STORAGE LOCATION</u>
<u>Seven days' worth of food for 2000 people</u>	<u>Kitchen</u>
<u>600,000 gallons potable water</u>	<u>Water tanks east of facility</u>
<u>266 gallons of bottled water</u>	<u>Kitchen</u>
<u>Par level of linen</u>	<u>Clean linen storage room in S1</u>
<u>Evacuation equipment</u>	<u>H2 emergency storage</u>
<u>Respirators and cartridges</u>	<u>H2 emergency storage</u>
<u>Emergency lighting</u>	<u>H2 emergency storage and each neighborhood/department</u>
<u>Personal patient care supplies</u>	<u>H2 Central Supply/Warehouse</u>
<u>Tent</u>	<u>Container in gravel parking lot</u>
<u>Cots (55)</u>	<u>Container in gravel parking lot</u>

- ~~h. HICS cabinet Emergency Supplies and Equipment list. (Includes location and amount of personal protective equipment, evacuation devices and other supplies.~~
- ~~i. Hospital equipment with locator devices list. (Includes items such as wheelchairs, I.V. pumps, vital signs machines, EKG machines and other resident care equipment.)~~
- ~~j. A 7-day food supply for 1400 people and water to augment the 600,000 gallons of water in towers behind the 5th floor parking lot.~~
- ~~k. A par level of linen maintained by the Environmental Services Department.~~
- ~~l. A cache of antibiotics for LHH Pharmacy available for delivery from DPH storage sites. (Refer to Appendix H: Hazard Specific Plans Emergency Responder Dispensing Plan.)~~
- ~~m. Par levels of medical and personal patient care supplies are available through most vendors.~~

~~7. Evacuation~~

- ~~8.~~
- ~~a. In the rare event that evacuation becomes necessary, the Incident Commander is responsible for initiating evacuation procedures to another area of the hospital or to an area external to LHH (See LHH 70-05: Resident Evacuation Plan).~~
- ~~9.~~
- ~~a. Elevators are not used unless cleared for safety by Facility Services.~~
- ~~10.~~
- ~~a. Evacuation to external sites is made in collaboration with the city DOC. The nearest Red Cross shelter is A.P. Gianini Middle School, 3151 Ortega (cross streets: 37th and 38th avenues), San Francisco, CA 94122 and the phone number is (415) 759-2770.~~
- ~~11.~~
- ~~a. If vehicles are needed, refer to Appendix L: Laguna Honda City Vehicles.~~

~~4. System Recovery~~

- ~~g. Recovery and demobilization planning is initiated at the start of an incident through the Planning Section Demobilization Unit Leader (see Appendix J).~~
- ~~h. The Demobilization Unit Leader stays abreast of the incident status and time lines and submits a Demobilization Plan to the Planning Chief for approval.~~
- ~~i. The Demobilization Plan is developed in coordination with Logistics and the Safety Officer and specifies the anticipated time that units, branches, and strike teams shall be demobilized. Cleaning and return of equipment are part of the safety and logistics aspects addressed in the plan.~~

5. ~~Appendices (including Departmental Plans)~~

- ~~g. The Appendices contain essential key information for an effective emergency response and provide useful information and tools to be used as needed, depending upon the incident.~~
- ~~h. Staff is encouraged to review the content of appendices in preparation for events and utilize these resources extensively.~~
- ~~i. Department Managers shall review their respective Department specific procedures, at a minimum on an annual basis, and revise them as procedures are modified.~~
- ~~j. Department managers are also responsible for notifying the Emergency Preparedness Coordinator when section(s) of the Appendices are changed, especially if the changes may impact the operations of another department.~~
- ~~k. Additional appendices shall be added as new emergency or hazard specific responses or standards are developed.~~
- ~~l. The overall emergency response plan shall be reviewed and kept current to community standards, at a minimum, on an annual basis.~~

ATTACHMENT:

~~Appendix A: HICS Organizational Chart, Staff qualified to fill HICS roles~~ Department Operating Status Report (DOSR)

~~Appendix B Approved for Deletion on May 9, 2017~~

~~Appendix C Continuity Of Operations Plan (COOP) — Prioritizing Essential Services~~

~~Appendix D Department Specific Procedures~~

~~Appendix E Evacuation Alternate Care Site Options~~

~~Appendix F Forms~~

~~Appendix G Glossary~~

~~Appendix H Hazard Specific Plans~~

~~1. Emergency Responder Dispensing Plan (Mass Prophylaxis)~~

~~2. Earthquake~~

~~3. Fire Plan~~

~~4. Medical Surge~~

~~5. Power Outage~~

~~6. Water Disruption~~

~~Appendix I Incident Command System~~

~~Appendix J Job Action Sheets~~

~~Appendix K Triage Tags and Algorithm~~

~~Appendix L Lists~~

~~1. Radios~~

~~2. Vehicles~~

~~Appendix M Map of Campus~~

REFERENCE:

~~LHH 70-02 Emergency Preparedness~~

~~LHH 71-02 Fire Response Plan~~

~~LHH 70-05 Resident Evacuation Plan~~

~~LHH Facilities PP LS-12 Fire Watch~~

~~LHH Facilities PP US-2 Emergency Power Generation System~~

~~ASPR, Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness, January, 2012. Accessed~~

~~at <http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf> on July 6, 2012.~~

Regulatory References: California Occupational Safety and Health Standards, California Code of Regulations (CCR), Title 8, Section 3220; and Licensing and Certification of Health Facilities, California Code of Regulations (CCR), Title 22, Sections 70741 and 72551; and the Standardized Emergency Management System (SEMS), CCR Title 19, Division 2.

Revised: 14/11/25, 17/05/09, 18/03/13 (Year/Month/Day)

Original Adoption: 13/05/28

DEPARTMENT OPERATING STATUS REPORT**COMPLETE THIS FORM IMMEDIATELY FOR ALL DISASTER / EMERGENCY NOTIFICATIONS & PROVIDE TO THE COMMAND CENTER**

Date: _____ Time notified of emergency/disaster activation _____ : _____ Time report completed _____ : _____ Time report received at Command Center _____ :

Department: _____ Location: _____ Telephone: _____

Contact Person _____ Title _____ Contact by phone _____ Pager _____

If no residents in your area, skip to Section 2 SECTION 1 – RESIDENTS	SECTION 2 – STAFFING	Resident Units, Clinic, Rehab Only SECTION 3 – CRITICAL RESOURCES
Current Census in Department: Number of residents accounted for Have any residents been injured? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list on the back of this form names of any injured or missing residents. Indicate type of injury or location/ likely whereabouts as applicable. Any anticipated Resident condition changes or problems resulting from this event? <input type="checkbox"/> Yes <input type="checkbox"/> No # of Patients eligible for discharge # of Patients eligible for Transfer	Current Staffing in department (on duty) RN# LVN# CNA/PCA# HHA# MD# EVS# Unit Clerk# FSW# HIS# AT# SW# Other staff: (List title and number of staff) Total Staff: Any injuries to staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", list number of injuries by severity: Minor Delayed Immediate Expired Number of staff available for Labor Pool:	Open/Available Beds # Open/Available Negative Pressure Rooms# Open/Available Gurneys # Open/Available Wheelchairs # Available Portable O2 # Full #Partially Full Other Available Space, Equipment and Supplies

Please use back of form for additional information as needed

SECTION 4 – DEPARTMENT STATUS	SECTION 5 – ESSENTIAL SERVICES	SECTION 6 – NEEDS ASSESSMENT
Please survey your department and complete the following: <input type="checkbox"/> Yes <input type="checkbox"/> No Are any hallways or exits blocked? <input type="checkbox"/> Yes <input type="checkbox"/> No Are water lines ruptured or leaking? <input type="checkbox"/> Yes <input type="checkbox"/> No Are gas lines ruptured or leaking? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there structural damage? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any hazardous material spills? Additional info:	Please answer all questions: <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have working telephones? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Are medical gases (O2) working? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there running water? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No Are your computers working? <input type="checkbox"/> Yes <input type="checkbox"/> No Are sewage systems intact? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have power? What areas are without power?	Please check all that apply: <input type="checkbox"/> Yes <input type="checkbox"/> No Do you need extra staff? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you need medical equipment / supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you need clean-up assistance? If yes to any, specify number and type needed:

FIRE RESPONSE PLAN

POLICY:

The care and safety of our residents is the primary mission of Laguna Honda Hospital and Rehabilitation Center (LHH).

PURPOSE:

The purpose of this policy is to set forth procedures for responding to a fire with the primary objectives of life safety, continuity of operations, and preservation of property.

PROCEDURE:

1. When You See Smoke or Fire

- a. Follow the R.A.C.E. acronym below for basic fire response steps:
 - i. **Rescue** persons in immediate danger while announcing “Code Red” to nearby staff.
 - ii. **Alarm** by continuing to shout “Code Red” to nearby staff and by activating the alarm using the nearest manual pull station.
 - Any person may activate the Fire Plan by pulling a manual pull station. –In addition, the fire detection system may be automatically activated via heat sensors and particle (smoke) detectors.
 - When the alarm activates, chimes will ring and strobes will flash in the building.
 - Once activated, the fire alarm automatically alerts the San Francisco Fire Department, which will respond immediately.

Dial 4-2999. Provide the following information:

- Location of fire
- What is burning
- Your name

Do not hang up until the operator repeats back the information and asks you any clarifying questions they may have.

Report as above even if the fire appears to have been put out. Fire can appear under control and then flare up unexpectedly and therefore must be cleared by the fire department.

Nursing Office shall announce "Attention, Attention. Code Red (location) on the overhead paging system," and will call 911.

iii. **Contain the smoke and/or fire by closing all windows and doors.**

- Move residents needing oxygen to a safe area to administer it.
- Licensed staff turns off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.
- Turn off electrical equipment in the area.

iv. **Extinguish the fire only when it is safe to do so. Otherwise Evacuate.** Extinguishers are located in corridors and units throughout the facility. Extinguishers are used according to the P.A.S.S. acronym:

- **P**ull the pin
- **A**im at the base of the fire
- **S**queeze the handle
- **S**weep side to side

b. If evacuation of residents is necessary, follow the procedures in LHHPP 70-05 Resident Evacuation Plan

2. Fire Response in the ~~New~~ Hospital Buildings

a. **Resident Safety**

When a fire occurs in any of the new hospital buildings (North Residence, South Residence, or Pavilion), the following steps shall be taken to protect resident safety:

- i. Move residents needing oxygen to a safe area to administer it.
- ii. Turn off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.

iii. Turn off electrical equipment in the area.

b. Fire Door Closure

Upon alarm activation, all fire/smoke doors held open by electromagnets will immediately close. Staff shall ensure that automatic doors have closed.

- i. Passage through activated fire doors is acceptable after visual check through window and/ or light touch to assure the area is free of smoke, flames, or excessive heat.
- ii. Fire alarm activation in the Pavilion Building triggers four automatic accordion fire doors on the Esplanade to close. Any staff member on the Esplanade during accordion door activation is expected to assist residents or visitors who are unsure of what to do. Accordion doors retract if an obstacle is encountered and then re-close automatically. The doors can be opened by pressing a clearly marked green bar after safety on the other side of the door is verified by visual check through the accordion door window.
- iii. The Rehabilitation Department (Pavilion ground floor), Art Studio (Pavilion 1st floor, and Pharmacy (Pavilion 2nd floor) have roll down fire screens in addition to fire doors. The roll down doors must be kept clear of obstructions.

c. Stairwell Doors

- i. Activation of the fire alarm by a smoke detector will cause exit doors in the neighborhoods of the affected building to automatically unlock to allow for evacuation.
- ii. The doors will not automatically unlock during a drill or if the fire alarm is activated using a manual pull station; a heat or smoke sensor must also be activated.
- iii. Precautions must be taken to prevent –residents from inadvertently exiting unaccompanied by staff, as follows:
 - In case of fire activity in the North Mezzanine secure neighborhood, North 1, 2, 3 and 4 will send one staff member to North Mezzanine to monitor the fire stairwell doors to assure resident safety as follows:
 - **N1:** send staff to monitor NM **Cypress** household door
 - **N2:** send staff to monitor NM **Redwood** household door
 - **N3:** send staff to monitor NM **Cedar** household door

- **N4:** send staff to monitor NM **Juniper** household door
- On all other units, staff must go to the stairwell doors to redirect residents.
- Relock each of the stairwell doors after the "all clear" is announced over the public address system. Stairwell doors can also be unlocked from the master lock outside of the medication room on each neighborhood/unit.

d. Elevators

- i. Elevators are equipped with fire screens and systems to bring the elevator to the lowest safe floor automatically in case of fire in the building.
- ii. To exit the elevator once it reaches the lowest safe floor, press the clearly marked button in the center of the roll down fire screen.
- iii. Never use elevators during a fire.
- iv. Elevators will be placed back in service by the Fire Department or the Watch Engineer once "all clear" has been declared.

e. Evacuation of Hazardous Area

- i. An evacuation of a unit or department area shall take place if the fire cannot be safely extinguished or if smoke or other damage renders the area unsafe for residents.
- ii. Residents shall be moved to a safe area 1-2 fire doors away from the fire on the same floor if possible (horizontal evacuation).
- iii. Initiate horizontal evacuation in the following order:
 - Ambulatory residents
 - Semi-ambulatory residents and those in wheelchairs
 - Residents who are more dependent/in bed.
- iv. During horizontal evacuation, the Nurse Manager or designee shall:
 - Coordinate the movement of residents.
 - Perform a check of the unit to verify that all persons have been moved out of the hazardous area.
 - Remove medical records from the hazardous area if safe to do so.

- Account for residents, staff, and visitors and take steps to locate anyone missing.
- v. When vertical evacuation is necessary for the safety of residents, follow the procedures in LHHPP 70-05 Resident Evacuation Plan.

3. Fire Response in the ~~Old~~ Administration Building

When ~~a fire occurs~~ the fire alarm sounds in the ~~old~~ administration building, the basic R.A.C.E. procedure shall be followed, but then all occupants must evacuate the building.

a. Staff Evacuation Procedures

- i. When the alarm sounds, building occupants will calmly secure work areas and exit the building via the nearest fire exit. If you are not on ground level, use stairs to reach the nearest exit. Elevators must not be used in a fire.
- ii. Once you have exited the building, proceed to the front of the building near the flagpole. If the fire prevents access to this area, the 5th floor parking lot will be the alternate meeting area.
- iii. At least three staff members from each of the wings/building areas that are normally occupied are pre-assigned to participate on an Evacuation Team and will keep a red vest and clipboard with a list of staff in their work area.
- iv. The Evacuation Team members will put on their red vests, collect their clipboard with attendance sheets, and sweep their assigned areas, knocking on all doors to make sure that all occupants have evacuated.
- v. Evacuation Team members will proceed to the meeting area in front of the building where they will take attendance using the lists of staff for each area.
- vi. Evacuation Team members will also compile a list of people present at the meeting location whose names are not on the list of building occupants. Attendance sheets will be turned over to the Incident Commander.
- vi.vii. If a determination is made by SFFD, SFSD, Engineering, or WSEM that there is no fire in the administration building either because the alarm was triggered in error or only in the Pavilion building, "All Clear" will be announced and occupants may re-enter the building.
- vii.viii. If there is an actual fire in the administration building, Building occupants will not return to the building until the SFFD and or the Incident Commander declare "All Clear."

4. HICS Activation in Response to a Fire

a. Designation of an Incident Commander

- i. As soon as possible after alarm activation, the Nursing Office will notify the Executive Administrator or the Administrator on Duty (AOD) of the Code Red.
- ii. The AOD and the Nursing Officer will:
 - Determine the extent of the fire
 - Activate HICS if a fire leads to a disruption in normal operations
 - Designate the Incident Commander

b. Incident Commander Responsibilities:

- i. Learn from the Nursing Office staff/telecommunications operator the LOCATION and NATURE of the fire. Verify that Nursing Office staff/telecommunications operator telephoned SFFD to confirm the automated alarm.
- ii. Ascertain the following from the Fireground Officer (watch engineer initially, then senior fire fighter once SFFD arrives)
 - Immediate danger to residents or staff
 - Arrival of SFFD at scene
 - Any need to consider additional evacuation
 - Resources required
- iii. Coordinate the hospital's response to the fire emergency, including activation of other HICS roles as necessary.
- iv. Upon receiving clearance from the Fire Department or watch engineer, authorize the announcement of "CODE RED ALL CLEAR (location)" by Nursing Office staff/ telecommunications operator.
- v. Authorize initialization of clean up and restoration of the affected area as required. This work should include removal of fire debris and immediate restoration of the rooms (unless arson is suspected, in which case crime scene must be preserved).

- vi. Manage the post fire clean-up operation by providing specific direction and resources. Assure the incident is completely documented for required reporting.
- vii. Schedule a post-fire debriefing as necessary.
- viii. Contact the Nursing Directors and Nurse Managers as needed to arrange for alternate accommodations for residents who may be temporarily displaced due to fire.

ATTACHMENT:

Appendix A: Nursing Operations Procedure
Appendix B: Watch Engineer Procedure
Appendix C: Sheriff's Department Procedure

REFERENCE:

LHHPP 70-05 Resident Evacuation Plan

Revised: 09/08/24, 11/09/27, 13/05/28, 14/07/29, 14/09/09, 18/03/13 (Year/Month/Day)
(Previously numbered as LHHPP 71-02)

Appendix A: Nursing Operations Fire Response Procedures

1. Upon Notification of a Code Red on the Emergency Phone Line:

- a. NOTIFY the fire department of the fire and location by telephone call to 911.
- b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED (location)"
- c. Page the Emergency Response Group (Stationary Engineers, SFSD, Emergency Management Coordinator, Nursing Program Directors, Nursing Operations Managers).
- d. If a live fire is discovered, notify the following:
 - i. Executive Administrator
 - ii. AOD (Administrator on Duty).
 - iii. Chief Operation Officer
 - iv. Chief Medical Officer
 - v. Chief Nursing Officer
 - vi. Emergency Management Coordinator
- e. Keep telephone lines open to the incident.
- f. Log all activity relative to the alarm for review by supervisor.
- g. When instructed by senior SFSD firefighter and approved by Incident Commander, announce three times over paging system: "CODE RED (location) IS ALL CLEAR."

2. Upon alarm activation without a phone call from the affected area:

- a. Expect to receive a call from SFSD regarding the location of the alarm activation. If you do not receive a call, call SFSD at 4-2319 to confirm location of the alarm.
- b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED (location)"

2.3. Upon Notification of a Code Red Drill:

- a. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED DRILL (location)"

- b. Page the Emergency Response Group (Stationary Engineers, SFSD, Emergency Management Coordinator, Nursing Program Directors, Nursing Operations Managers).
- c. When notified that the drill is all clear by the unit being drilled, or by Engineering staff, announce three times over the paging system: "CODE RED DRILL (location) IS ALL CLEAR."

Appendix B: Watch Engineer Fire Response Procedures

1. ~~When a fire occurs~~Upon activation of the fire alarm system, the Watch Engineer on duty shall:
 - a. Immediately respond to the ~~fire~~location of the alarm and become the Fireground Officer ~~if there is an actual fire. –Confirm the LOCATION, NATURE, and EXTENT of fire with the Nursing Operations office.–~~
 - b. Initial response to fire shall include the following:
 - i. Activate nearest fire alarm pull station if not already done.
 - ii. Tell others to close doors and windows.
 - iii. Tell others to turn off Oxygen cylinders and wall gases.
 - iv. Extinguish fire, if small.
 - v. Direct firefighting until SFFD arrives.
 - vi. If false alarm, locate source detector and possible causes.
 - ~~b.c.~~ _____ If hazardous materials are involved, inform the ~~operator~~SFSD to notify 911 responders.
 - ~~c.d.~~ _____ If necessary, go directly to the location of the emergency shut-off breaker of the intake/exhaust fan(s) and shut them off. Immediately return to the fireground.
 - ~~d.~~ Initial response to fire shall include the following:
 - i. ~~Activate nearest fire alarm pull station if not already done.~~
 - ii. ~~Tell others to close doors and windows.~~
 - iii. ~~Tell others to turn off Oxygen cylinders and wall gases.~~
 - iv. ~~Extinguish fire, if small.~~
 - v. ~~Direct firefighting until SFFD arrives.~~
 - vi. ~~If false alarm, locate source detector and possible causes.~~

~~Determine whether adjacent areas must be evacuated and advise Incident Commander.~~
 - e. If HICS has been activated, c~~C~~arry out the Incident Command directives.
 - f. Determine whether adjacent areas are at risk and advise Incident Commander. When SFFD arrives, relinquish authority to the senior firefighter and inform Incident Commander of that person's name.
 - g. When the SFFD authorizes a "Code red (location) all clear".
 - i. Notify the Incident Command Center and Nursing Operations of all clear authorization.

- ii. Reset the alarm system.
- iii. Reset the elevators if not damaged by fire.
- iv. Report completion of re-setting to the Command Center.

h. Secure fire sprinkler valves, if fire sprinklers activated and once fire is extinguished. All watch engineers are responsible for knowing where shut-off valves are located. Make immediate arrangements to have sprinkler heads replaced and system recharged.

h.i. –Initiate clean up and restoration of the affected area as required.

i. –Initiate clean up and restoration of the affected area as required–
j. –

Appendix C: San Francisco Sherriff Department Fire Response Procedures

1. Upon fire alarm activation of notification of fire:

- a. SFSD staff shall gather information on the fire alarm panel including what caused the alarm and the location.
- a.b. SFSD staff shall call the Nursing Office at 4-2999 and provide information gathered and This information will be broadcast this information over the radio to all SFSD units.
- b.c. A Deputy shawill respond to the location of the alarm.
- c.d. Another Deputy shawill respond to the Pavilion lobby to confirm the location of the fire and to stand by to direct or escort responding SFFD personnel.
- d.e. SFSD supervisor, in conjunction with the LHH AOD or Incident Commander, will determine if any evacuation procedures or other duties are required until the arrival of SFFD.

2. Documentation:

- a. In the event of an actual fire emergency, SFSD deputy will complete an incident report. It will include the name of the SFFD Officer who authorized the Code Red all clear announcement. This report will be completed before the end of the shift. A request for a copy of this report may be made to SFSD Public Information Officer at City Hall by the hospital's Chief Operating Officer and/or Fire Safety Officer.

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

Central Processing Department Policy and Procedures

3.21 Biomedical Technical Assistance

Policy:

LHH has contracted with Universal Healthcare Services to provide biomedical services for our medical equipment. This agreement will cover approximately 500 pieces of medical equipment in the hospital with the remaining equipment maintained by Plant Services. The agreement calls for **annual** (non-life safety equipment) or **semi annual** (life safety equipment) preventative maintenance (PM) inspections/checks and repairs as needed throughout the year. Some equipment will be PM only with repairs made by the manufacturer or other arrangements. UHS has established a repair shop in the H2 Materials Management.

1. Locate the Equipment Control number on the piece of equipment that needs service during the 30 days prior to due date.
2. Any equipment that is unable to be located (MIA), UHS tech will utilize the AeroScout system to attempt to locate the missing equipment.
3. When MIA equipment is unable to be located, UHS tech will notify Materials Management and we will send an email to the Nurse Managers to search their units for MIA equipment.
4. UHS will continue to maintain the MIA equipment on the contract for 90 days and continue to search. After 90 days, the equipment will be removed from our contract.
5. UHS will conduct a semi-annual housewide search and inventory all equipment.
6. New equipment is provided an electrical safety check and functional check. Equipment is tagged with an equipment control # label, AeroScout tag affixed, and equipment information provided to Facilities to enter into the AeroScout system.
7. Any broken, malfunctioning, or equipment overdue for PM will be tagged with problem noted and placed in the Nursing soiled utility room. CPD techs will pickup equipment and bring to UHS.

~~1. Locate the Equipment Control number on the piece of equipment that needs service.~~

~~2. Tag the equipment with equipment control #, date, Nursing unit, and what the problem is.~~

~~3. Send the equipment to CSR or place it in your soiled utility room for CSR to pickup.~~

Most recent review: 08/15/17

Revised: [02/01/18](#)

Original adoption:

EQUIPMENT MANAGEMENT PROGRAM

Testing and Maintenance of Patient Care Equipment:

POLICY:

1. The hospital shall maintain an equipment management program designed to manage the clinical and physical risk associated with all patient care equipment -- that is, all electrical, non-electrical, fixed and portable equipment which is used for the diagnosis, treatment, monitoring and care of patients.

PURPOSE:

1. To assure that all patient care equipment performs properly and safely.
- ~~2.~~ The hospital has elected to select for inclusion in the program all patient care and electrical equipment in lieu of selecting limited equipment based on risk management.
- ~~2-3.~~ The equipment management program shall be used to identify and document equipment failures and user errors that have a real or potentially adverse impact on patient and staff safety.

PROCEDURE:

- A. Patient care equipment, both electrically powered and non-electrically powered, ~~a~~ shall be tested by appropriate persons prior to initial use and thereafter as outlined and programmed in the TMS Program to assure proper performance and safety. ~~Specific patient care equipment.~~ Specific patient care equipment, such as patient lifts and beds, shall be inventoried within the TMS system.
- B. Critical care equipment, such as defibrillators shall be tested by ~~UHS specialists~~ a Biomed Contractor. Records for this equipment are kept in ~~LHH Central Supply~~ Central Processing & Distribution (CPD), ~~facilities~~ Facilities AND and Matl Management ~~Materials~~. Non-critical care electrical equipment, such as suction machines and feeding pumps, will be tested by the ~~LHH electricians~~ Biomed Contractor. Non-critical care, non-electrical equipment, such as beds and patient lifts shall be tested by the LHH engineering section. Initial electrical safety checks of all patient care equipment shall be performed by the Biomed Contractor.
- C. Preventive Maintenance scheduling for patient care equipment ~~will~~ shall be handled by the TMS system, under the supervision of the Maintenance Supervisor (for crafts) and Chief Engineer (for engineers). ~~A~~ TMS shall document the completion of preventive maintenance and regular work orders, and shall provide periodic reports of completed PM and W.O.
- D. Records and documentation for critical care electrical equipment are kept at ~~Nursing-Central Supply~~ CPD; records and documentation for non-critical care electrical equipment shall be kept at Facility Services.
- ~~E. — The equipment management program shall be used to identify and document equipment failures and user errors that have a real or potentially adverse impact on patient and staff safety. The Director of Facility Services role on the Safety Committee shall include periodic exception reports regarding equipment failures and user errors, including user training issues. (Refer to Nursing for similar reporting relationships with Safety Committee).~~
- E. Summary data regarding equipment failures, user errors, and relevant published reports of equipment hazards shall be the purview of the Quality ~~Assurance~~ Management Committee. ~~The Safety Committee will be made aware of relevant safety issues. Committee requests for available data shall be honored in a timely manner.~~

HUMAN RESOURCES

INSERVICE CONTINUED EDUCATION AND TRAINING:

POLICY:

~~A systematic program of orientation, o~~On-the-job training, specialized training and regular in-service training shall be ~~developed and implemented for~~ available for all Health Information Services employees.

PURPOSE:

1. Reduce potential liability ~~because of due to~~ error(s).
2. Create a positive motivational environment.
3. Enhance employee productivity and efficiency.
- ~~4.~~ Enhance employee opportunity for promotion.
- ~~5.4.~~ _____

PROCEDURE:

1. Participation in in-service programs that reflect critical issues, such as (fire drills and safety practices) shall be mandatory.
2. Participation in the in-service programs required by Title XXII shall ~~also be~~ mandatory.
3. Employee(s) shall have the option of choosing the available in-service times.
4. Documentation of attendance shall be kept ~~by the technical supervisor of for~~ each employee.
5. Documentation of attendance shall be kept along with a copy of any C.E. certificate by the management and the employee.
- ~~5.6.~~ Management ~~and supervising staff~~ shall participate regularly in professional association meetings, conferences and workshops as approved ~~by the director~~.
- ~~6. Appropriate budgetary support of these activities shall be made available when possible.~~
- ~~Documentation of attendance shall be kept along with a copy of any C.E. certificate by the technical supervisor.~~
7. Each Registered Health Information Technologist (RHIT), Certified Coding Specialist (CCS), Certified Coding Associate (CCA), etc... shall provide a copy of their AHIMA Credential when renewed, with the current cycle date sticker

attached. **Or** provide a copy of the AHIMA Certificate of Completion CE form, for each Credential (RHIT, CCS, CCA, etc.) held, which must be submitted to HIS Management when received, by the end of their CE cycle renewal period. ~~Most recent review: 08/2008, 08/2009, 07/2015~~

~~Revised: 2009/08/10/2009, 2015/07/13/2015, 2018/02/05~~

Original adoption: ~~1986/08/1986~~
~~P.1 of 1~~

POST-MORTEM CARE

POLICY:

1. Following physician pronouncement of death, any nursing staff member may provide respectful, mindful post mortem care which ~~is respectful, mindful, and in~~ is in accordance with resident/families' religious and cultural practices.
2. Death notification of the family or designated significant other is completed by the physician who has pronounced the death; in rare cases notification may be completed by the nurse or social worker.
3. Once the resident's death is pronounced, the licensed Nurse (LN) will notify the family or decision-maker to contact the private prearranged (pre-need) funeral service. If funeral arrangements were not completed, the deceased body will be transported to the LHH morgue during usual business hours (0800 until 2300).
4. Refer to hospital policy LHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates for information about access to death certificates.

Note: If requested, when a resident, living in a semi-private or shared room, is nearing the end of his/her life, every effort will be made to relocate the resident into a private room for private and dignified terminal care.:-

PURPOSE:

To describe the procedures for care of the resident after death.

PROCEDURES:

A. Equipment

1. Each neighborhood will have
 - a. "Post-Mortem care pack" including shroud, tape, tags, body bag if necessary
 - ~~b. Property~~ b. Property envelopes/packing boxes

B. Notifications

1. After the resident has been pronounced by the physician, the licensed nurse will notify:
 - a. RCT members if the physician was unable to contact the family or significant other
 - b. Nurse Manager or Nursing Operations Manager (when not weekday)
 - c. Social Worker
 - d. Clergy if requested by resident or family
 - e. Admissions and Eligibility on weekdays between 0800 and 1630

C. Preparing the body for viewing

1. Be attentive to religious/cultural preferences listed on the Resident Care Plan RCP. Refer to Attachment 1.

Post-Mortem Care

LHH Nursing Policies and Procedures

2. Bathe the body, apply clean dressings (if needed), and comb hair. Align the body on the bed with the head on a pillow. Cover the resident, from chest level to toes, with a clean sheet or bedspread. Put bed in low position and side rails down. Close bedside curtains or door when appropriate for privacy.
3. Remove jewelry if possible unless family/surrogate decision-maker request otherwise. Place wedding ring or other jewelry in a storage envelope with label and locked securely in Nurse Manager Office for safe keeping. Update the Property Inventory. Tape wedding ring on finger if it cannot be removed easily.
4. Leave the resident's hands outside of the bedspread unless visitors prefer that they be tucked under bedclothes.
5. If lips will not stay closed, use a small towel or soft collar under the chin to help close lips, especially if dentures will not stay in place.
6. ~~On South 3, a~~ scarf ~~is sometimes~~ may be placed around neck to hide collar or towel, and quilt or comforter and special pillow case placed for viewing.
7. If eyes will not remain closed, use a tiny dot of Vaseline between lids.
8. Remove medical/hospital equipment ~~in~~ bedside/room.
9. Bring one or two extra chairs for family comfort. Leave tissue box, family photographs and flowers if available and water pitcher and cups.

D. Viewing of the Body

1. If the family requests to view the resident's body, inform the family that the viewing may occur in the resident's room up to 8 hours after the death pronouncement or after transport to the morgue in the viewing room adjacent to the new morgue.
2. If special cultural/religious traditions require extended hours beyond the 8 hours, the unit will communicate with Nurse Manager or Nursing Operations Nurse Manager so that special arrangements are accommodated.
3. If the deceased resident is in an open double or triple room and has roommates, relocate the deceased's body to a private room for privacy for the family/friends if available. Otherwise the deceased can be transported to the morgue; there is a viewing room for family/friends next to the new morgue.
4. When funeral arrangements have been made (as per medical record/care plan), the family or decision maker will be asked to contact mortuary to pick up body from LH and to arrange an appropriate time for the body removal that does not occur during group activities in the Great Room.
5. If funeral arrangement has not been made, the deceased would be transported to the morgue.
6. If family members or friends are unable to come to the unit for viewing in a reasonable timeframe, staff from the unit of the deceased, may assist with viewing in the room adjacent to LHH new morgue. Gurney and other supplies are available in the LHH new morgue if needed to clean the face.

E. Preparation of the Body for Transport to the Morgue or Mortuary

1. Lay the body flat in bed. Do not remove identification band.
2. If there is any drainage from the mouth or rectum, place an abdominal pad over orifice.
3. A shroud will be used to transport the body to the morgue after completing the following:
 - a. Place arms at sides, remove dressings and tubes, and insert clean dentures. If unable to insert dentures, place dentures in well-labeled property envelope (name, hospital number, date of expiration) and tape to shroud over chest.
 - b. Make three tags, each containing the person's name, date and time of death pronounced by Dr. _____. Remark on tag if wedding band is taped to finger and if dentures are in mouth. Stamp addressograph on the reverse side of tags.
 - i. Tie string of one tag on right big toe or to another extremity.
 - ii. Tie second tag to zipper-pull on the outside of the body bag.
 - iii. Secure the 3rd tag to the LHH morgue refrigerated unit if not picked up by funeral director.
 - c. Place shroud under body in diamond fashion, so that the head is at one point and the feet at the opposite point:
 - i. Fold bottom of shroud over feet.
 - ii. Then fold both sides towards the center of the body. Tape shroud closed.
 - iii. Fold top corner loosely over the face. Tape shroud closed.
4. Once the funeral home attendant arrives to pick up the body, accompany the funeral ~~home attendant~~home attendant to the room.
5. From 2300 to 0800, the deceased body will remain in their room and will not be transported to the LHH morgue. If absolutely necessary to transport the body to the morgue during that time, because of roommate discomfort or awareness, contact Nursing Operations Manager to assign 2-3 staff members from other units to assist the sending unit staff.
6. If the body is to be transported to LHH morgue, at least 3-4 staff members are required to safely transfer the body from the gurney to the refrigerated unit while maintaining the dignity of the deceased.
7. After the body has been transported, strip and wash the resident's bedside, unless it is at night and the cleaning of the bedside unit would disturb other residents.

F. Release of Body to the Funeral/Mortuary Services

1. If Nursing receives information about pre-need or prearranged Funeral plans, the nurse will notify the MSW for follow-up. If confirmed, the MSW will provide copies to A&E and place a copy in resident's chart.
2. The resident with "Pre-Need" or prior funeral arrangements will have their medical record flagged as followed:

Post-Mortem Care

LHH Nursing Policies and Procedures

- a. A&E will fill in the "Pre-Need" field in Invision and flag the A&E file by writing or stamping "PRE-NEED" on the front of A&E file.
- b. Nursing or Social Worker will place the "PRE-NEED" in the Advanced Directives section in the resident's/patient's medical chart and will document in the front card of the RCP under preferences.
- c. "Pre-Need" (prior to funeral arrangements) form will be stamped "Do Not Remove".
3. During business hours 0800 to 1630, funeral home/mortuary attendant will go to A & E to sign on death registry for body pickup.
4. During non-business hours, weekends and holidays, funeral home/mortuary attendant will go to Operations Nursing Office to sign on death registry prior to body pickup.
5. For pickup by funeral home/~~mortuary attendant~~mortuary attendant, a form with family signature releasing the body to the mortuary is to be submitted.
6. Staff from the unit of the deceased, are required to go to the morgue to unlock door for morgue attendant.

G. Disposition of Properties

1. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
2. Assemble resident's property. Obtain a packing box and storage envelopes as needed. Check the resident's bedside stand and wardrobe. Assure that property is safely stored in the designated storage room (K-5).
3. Update property checklist:
 - a. Make certain property sheet is stamped with resident's name, neighborhood number, and hospital number.
 - b. Write on the original form in the "Remarks" section: date, time, pronounced expired by Dr._____. Itemize property and its disposition to either Admissions and Eligibility or the Nursing Neighborhood Station.
 - c. Make a photocopy. Place original property sheet in resident's chart and securely attach the photocopy to the property.
 - d. Store valuables or money in an envelope with label and locked securely in Nurse Manager Office.
4. Check with the Nurse Manager or Charge Nurse if there are any other properties stored in the Nurse Manager's office or storage room.
5. Responsible party can sign the property sheet and take the valuables before they leave after viewing the body or may return during the following few days.

H. Documentation

1. Electronic Health Record ~~Interdisciplinary Notes~~
 - a. a.—Document resident's condition/decline prior to the death, the time of death, the name of the physician who pronounced the death, and disposition of the body.

Post-Mortem Care

LHH Nursing Policies and Procedures

~~a.b.~~ Record whether or not family or decision maker were notified of death by the physician.

- b. Document information regarding resident's dentures, ring(s), and other property.
- c. Record if this will be a coroner's case.
- d. Document the time when the body was picked up by the ~~_morgue or mortuary~~ to brought to the LHH morgue.

- 2. Complete Chronological Record of Admissions, Transfers, and Discharges
- 3. Property Sheet (See also Section G)
Itemize list of property and information regarding disposition of property and valuables, including any rings and dentures. Make duplicate copy to attach to property.
- 4. Invision/LCR: Update census.
- 6. Resident Trust's Funds: Refer to LHHPP 50-02 Resident Trust Fund

ATTACHMENT:

Attachment 1 - Understanding Cultural and Religious Preferences for Care of the Dying and the Deceased

CROSS REFERENCES:

LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of
Change in Condition
LHHPP 50-02 Resident Trust Fund
LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death Certificates
MSPP C01-01 Patient Expiration
MSPP C01-02 Autopsy Policy & Procedures
MSPP C01-03 Organ Tissue Donation Request

Revised: 8/2003; 3/2009, 10/2010, 3/27/2012, 09/08/2015

Reviewed: _____

Approved: _____

Attachment 1 Understanding Cultural and Religious Practices/Preferences for Care of the Dying and the Deceased – Attachment 1

~~During In-resident~~ Resident Care Conference or in one to one conversations with resident, ~~and~~ family or legal decision makers inquire about ~~ask~~ the following:

1. Are there any religious or cultural practices we should know about in order to honor you or your loved one dying? For example:
 - a. Religious/spiritual services (anointing of the sick, chanting)
 - b. Cleaning or preparation of the body
 - c. Gender of caregiver who is caring for the body
 - d. Particular or special clothing that the resident should wear
 - e. Timeliness of burial

New: 09/08/2015

Reviewed: _____

Approved: _____

Vital Signs

VITAL SIGNS

POLICY:

1. Any nursing staff member except Home Health Aide may perform vital signs (V/S) measurements.
2. Vital signs include blood pressure (BP), pulse rate (PR), respiratory rate (RR), temperature (T), and oxygen saturation (O2 sat), ~~and pain intensity.~~
3. Orthostatic VS, are measured as per policies and procedures, as per physician's order, and whenever clinically indicated based on the assessment of the licensed nurse.
4. For residents whose reimbursement for SNF care is Medicare, V/S should be taken and recorded at least daily. In long-term care neighborhoods, V/~~S are~~S are checked monthly at a minimum, unless otherwise ordered~~..~~
5. Residents receiving certain cardiovascular or antihypertensive medications are monitored as per Medication Administration procedure.
6. Residents in isolation rooms will have designated automated V/S machine and tympanic thermometer available. When available, individual BP cuffs are kept at the resident's bedside.
7. The use of individualized BP cuffs is encouraged. When ~~not able to use~~ an individualized BP cuff is not available, use the multi-use BP cuffs, and clean the cuff in between resident use with facility approved disinfectant.

PURPOSE:

To outline frequency of vital sign measurement and nursing responsibilities.

PROCEDURES:

A. Equipment

Automated V/S Machine
Individual BP cuffs or Multi-Use Cuffs
Manual Sphygmomanometer
Tympanic thermometer

B. Frequency of Monitoring V/S

- a. Admission for all SNF Neighborhoods: V/S are taken upon admission to any neighborhood in LHH with at a minimum of every 8 hours for the first three (3) days, unless otherwise ordered. Orthostatic BP/PR is done once as part of the admission nursing assessment to evaluate for hypotension and whenever clinically indicated.
- b. Acute Units :
 - ❑ Pavilion Mezzanine Acute (Medical): upon admission and every four (4) hours, or more frequently as clinically indicated.

Vital Signs

- Pavilion Mezzanine Acute (Rehab): upon admission and then daily or as clinically indicated.
- c. Discharge: before discharge from Pavilion Mezzanine Acute or to outside acute facility or hospital.
- d. Relocation from one neighborhood to another within LHH: every 8 hours for the first 3 days of relocation or as clinically indicated.
- e. Receiving course of antibiotics: every 8 hours at a minimum for the entire course of the antibiotics.
- f. Unanticipated change in resident condition or potential/actual decline: check V/S once per shift at a minimum for 3 days as often as clinically indicated depending on the nature of the change.
- g. Fall incident: check V/S once per shift at a minimum for 3 days or as clinically indicated.
- h. New wounds or worsening of skin ulcers/wounds - check V/S once per shift at a minimum for 3 days and as clinically indicated.

C. Reporting

1. CNA or PCA should report immediately to the licensed nurse in charge of the resident if:
 - a. BP is less than 90/50 or greater than 160/90
 - b. PR less than 50 or greater than 100
 - c. RR less than 14 or greater than 25
 - d. T over 100 degrees F
 - e. O2 sat of less than 90
 - ~~f. Pain score is greater than 0~~
 - g.f. Orthostatic V/S changes
2. Licensed Nurse (LN) is to assess resident immediately and notify physician as needed further medical evaluation.

D. Documentation:

1. Record V/S (BP, PR, RR, T, & O2 sat) ~~and pain level in~~ the electronic health record (EHR.) ~~medical record.~~
2. A LN reviews the V/S. After a LN reviews the vital signs, if stable and within baseline, the CNA, or PCA, or the unit clerk may chart them on the electronic documentation system. In the event of power failure or computer downtime, documentation may be done on the graphic sheet of resident's medical record. All manually entered V/S should be transferred to the electronic system as soon as the power is restored or once the computer is working.
3. The CNA or PCA ~~may can~~ record pain score as verbalized by the resident or as observed using the Pain Assessment in Advanced Dementia Scale (PAINAD) on the electronic documentation system. The CNA or PCA informs the licensed nurse for further pain assessment.

ATTACHMENT 1: Automated Vital Signs Machine Operating Guidelines

ATTACHMENT 2: Quick Reference Guide for Electronic Documentation

REFERENCES:

Lippincott, Williams, and Wilkins, Lippincott Manual of Nursing Practice, 4th Edition, 2010
Elkin, Perry & Potter, Nursing Interventions & Clinical Skills, 4th edition, 2007
Sorrentino, Mosby's Nursing Assistants, 6th edition, 2004

CROSS REFERENCES:

LHH Policies and Procedures: 25-06 Pain Assessment and Management

Nursing Policies and Procedures: C 1.0 Admission and Readmission Procedures

Nursing Policies and Procedures: C 1.2 Relocation Procedure

Nursing Policies and Procedures: C 1.3 Discharge Procedure

Nursing Policies and Procedures: G 2.0 Neurological Status Assessment

Nursing Policies and Procedures: C 3.0 Documentation of Resident Care by Licensed Nurse

Nursing Policies and Procedures: C 3.2 Documentation of Resident Care by Nursing Assistant

Nursing Policies and Procedures: J 1.0 Medication Administration

Revised: 1/2006, 10/2010, 07/31/2012; 11/10/2015. 12/04/17

Reviewed: 11/10/2015

Approved: _____

Attachment 1: Automated Vital Signs Machine Operating Guidelines

Definition:

Automated vital sign machine is a lightweight, portable monitor that measures blood pressure (BP), pulse rate (PR), and blood level oxygen of oxygen saturation (O2 sat). Although the vital signs machine can also be obtained orally, we will continue to use the tympanic thermometer in order to obtain a resident's temperature.

Operating the Automated V/S Machine:

1. Measuring Blood Pressure and Pulse Rate:
 - a. Press the on/off button to activate the V/S machine.
 - b. Apply BP cuff to one of arm. Make sure that the BP cuff size is correct based on the width of the resident's arm.
 - c. Press the start/stop button to inflate the pressure cuff. The cuff automatically inflates and as the pressure cuff gradually deflates it measures BP.
 - d. BP and PR reading will show on the display monitor of the machine.
 - e. V/S machine alarm will beep if the cuff has a pressure leak. Check the hose and cuff for any leak or loose connections. You may silence the alarm while checking the connections.
 - f. For Code Blue Response: press the cycle button repeatedly until "STAT" shows on the display monitor. Blood pressure and pulse rate will be measured faster and will give second BP/PR readings automatically.
2. Measuring Oxygen Saturation:
 - a. Place the finger probe on the ring finger of the resident. If BP is also being taken, place the finger probe on the arm that does not have pressure cuff on.
 - b. O2 sat reading will show on the display monitor of the machine.
3. Display Monitor Screen:
 - a. Automated V/S machine can display previous V/S readings
 - b. Previous readings can be removed by pressing and holding down the "history" button until the memory is cleared.

Maintaining Battery of the Automated V/S Machine:

1. You must charge the machine at all times to preserve battery life span. A fully charged automated V/S machine can be used for up to 8 hours.
2. If "low battery" indicator lights up, there is less than 45 minutes of battery life left. If "low battery" indicator flashes, it means automated V/S machine will shut off in about 5 minutes.
3. CNA or PCA to inform licensed nurse if machine is not functioning. Licensed Nurse to Call Plant Services for any repair or services as needed.

REFERENCE:

Lippincott, Williams, and Wilkins, Lippincott Manual of Nursing Practice, 4th Edition, 2010

New Document: 10/19/2010

Reviewed: 11/2015 – No changes.

Attachment 2: QUICK REFERENCE GUIDE FOR ELECTRONIC DOCUMENTATION

How to access Invision - LCR:

1. Log on to Invision - LCR
2. Click **Inpt Units**
3. Click the **unit where resident is located**.
4. Click **resident's name**.
5. Click **InPt Fxns**.
6. Follow step-by-step procedures (A) for documenting Vital Signs or (B) for documenting Heights and Weights
7. Follow step-by-step procedures (C) for revising or changing Vital Signs or (B) for revising or changing Heights and Weights

A. For Documenting Vital Signs:

1. Click **Inpt Documentation**
2. Click **Vital Signs**
3. Click **Chart VS**
4. **Answer all applicable fields** carefully. If needed to covert values, click **Calculator**
5. To document **Orthostatics**, click the **Additional VS tab** and fill in the appropriate fields
6. Click **OK**
7. Click **Log Off**

B. For Documenting Heights and Weights:

1. Click **Ht/Wt/Preg/Lact**.
2. Click **Chart Ht/Wt/Preg/Lact**
3. In **Create New Assessment**, enter Time, Date information
4. Click **Begin**
5. **Answer all applicable fields** carefully. If needed to covert values, click **Calculator**
6. Click **Update/Complete**
7. Click **Log Off**

C. For Revising or Changing Vital Signs:

1. Click **Inpt Documentation**
2. Click **Vital Signs**
3. Click **Revise**
4. **Locate the date / time and select the VS to be changed**.
5. Click to highlight the selection (s)
6. Click **Revise** at the bottom of the screen
7. Click **Revise / Result** or **Mark as Error**
8. **Type the necessary changes and fill "Reason for marking as error"**

9. Click **OK**
10. Screen will display "**Function has been completed**"
11. Click **Log Off**

D. For Revising or Changing Heights and Weights:

1. Click **Ht/Wt/Preg/Lact.**
2. Click **Chart**
3. Click **Change/Delete/Existing Assessment** button
4. Click existing assessment to be revised
5. Click **Change**
6. Click item that needs to be revised
7. Click **Chart Detail**
8. **Enter the revision**
9. Click Update/Complete
10. Screen will display "**Function has been completed**"
11. Click **Log Off**

New Document: 07/31/2012

Reviewed: 11/10/2015 – No changes.

ASSESSMENT, PREVENTION, AND MANAGEMENT OF PRESSURE ULCER/PRESSURE INJURY

POLICY:

1. The Registered Nurse (RN) is responsible for assessing each resident for presence and risk of pressure ulcer (PU)/pressure injury (PI) on admission and/or following any significant/clinical change in condition that may increase the resident's risk of developing a pressure ulcer/pressure injury.
2. Upon resident's intra-facility (within Laguna Honda) relocation, including Pavilion Acute, and/or vice-versa, the sending licensed nurse is responsible for conducting skin checks and complete skin section (see LHH Body Diagram form) for any presence of pressure injury/complex wound.
3. The sending RN from SNF and/or Pavilion Acute and the receiving RN from SNF and/or Pavilion Acute will perform skin assessment of the resident.
4. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and complete skin section of the Inter-facility transfer record (MR 113B).
5. Upon identification of PU(s), two RNs are required to verify and accurately stage the ulcer(s).
6. The RNs, Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA), and Home Health Aides (HHA) are responsible, within his/her scope of practice, for observing and reporting changes in residents' skin status and implementing pressure injury prevention and/or treatment.

PURPOSE:

To provide guidelines to nursing in prevention and management of pressure injury.

PROCEDURE:

1. **Prevention of Pressure Ulcer/Pressure Injury for Resident at Risk (Refer also to Impaired Skin Integrity, Potential risk r/t Braden Score ≤ 18 Care plan-Appendix)**
 - a. Skin care: nursing assistants should keep the resident clean and dry and minimize exposure to moisture and associated irritants from incontinence, perspiration or wound drainage as much as possible. Handle skin gently and minimize friction (refer to Appendix B for LHH Skin Care products).
 - b. Skin check: nursing assistants are to thoroughly check the resident's skin at least once daily, paying particular attention to bony prominences and are to report changes to the charge nurse or the designee. This may be incorporated into the resident's daily hygiene care.
 - c. Positioning: position using the 30-degree rule — no greater than 30 degrees on either side, or the head of the bed should not be elevated more than 30 degrees when possible. Avoid positioning directly on trochanter or existing ulcer.
 - d. Repositioning: reposition residents who are immobile, at least every 2 hours or per care plan. Repositioning clock or written schedule (depending on the resident's needs) may be utilized to monitor repositioning.

- e. Caution when moving resident. Avoid shearing/friction by using lifting devices such a trapeze or bed linen to move (rather than drag) residents who cannot assist during transfers and position changes.
- f. Positioning devices: use wedge, pillows, and pads to keep bony prominences from direct contact with one another.
- g. Support surfaces: nursing will apply a pressure-relieving support surface (bed/wheelchair) per protocol and/or specialized mattress when needed after evaluation by wound care CNS or designee. If re-evaluation is needed inform wound care CNS or designee. (Refer to LHPP 24-03 Specialized Bed And Support Surface Equipment).
- h. Protective devices:
 - i. Protectors for ankle and elbow to minimize friction.
 - ii. Heel protectors/devices or pillows under the length of the lower legs to suspend the heels. Do not put the pillow directly under the knees.
 - iii. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet.
 - iv. Foam arm rest covers (available in central supply room) for wheelchair arms can be used.
- i. Careful placement in chairs: position chair-bound resident in good postural alignment, distribution of weight, balance and pressure relief.
 - i. Refer to occupational therapy for evaluation of appropriate seating device.
 - ii. Avoid sitting directly on the pressure ulcer/pressure injury.
 - iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.
 - iv. Rest elbows, forearms and wrists on arm supports. Use foam armrest supports on wheelchair.
 - v. Instruct or assist resident to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes, if they are able.
 - vi. Document the use of positioning devices and repositioning schedule (as tolerated) in the resident care plan.

2. Assessment of Pressure Ulcer/Pressure Injury

The licensed nurse shall complete the Braden scale to identify residents at risk of developing PU/PI. The Braden scale shall be completed on admission, weekly thereafter for 3 consecutive weeks; then quarterly and annually following the Minimum Data Set schedule; and when there is a significant decline or change of condition.

- a. The charge nurse or the designee will inform the RCT of any resident identified at risk for pressure ulcers/pressure injuries, and develop an initial care plan. The RCT will review and contribute to the care plan as needed.
- b. The charge nurse or the designee will ensure that the plan of care is reviewed with nursing staff and ensure through direct supervision that the plan of care is being implemented.
- c. The RN will assess the ulcer(s) when present. The licensed vocational nurse (LVN) may assist in data collection under supervision of RN:
 - i. location
 - ii. size (length, width, depth in cm)

- iii. stage of ulcer(s)
- iv. presence and quality of granulation tissue
- v. whether the wound edge around the ulcer is hard, thick, rolled or white-gray tissue, macerated edge, or open edge (healthy edge)
- vi. presence of pain, exudate, slough, necrotic tissue and odor
- vii. sinus tracts, tunneling, undermining
- viii. periwound for erythema, warmth, maceration, or induration
- ix. signs of wound infection, such as tenderness of surrounding tissue, edema or swelling, purulent drainage or foul odor

Indicators of a deteriorating pressure ulcer/pressure injury include increase in ulcer size, increase in exudate, loss of granulation tissue, purulent drainage and development of slough, necrosis, eschar or odor.

- d. The RN will reassess pressure ulcer(s)/pressure injury(ies), at least weekly, to determine whether the prescribed treatment is working and document on the facility approved wound assessment record (WAR) until healed. A clean pressure ulcer/pressure injury should show evidence of some healing within two weeks.
- e. The RN will reevaluate the treatment plan weekly or as soon as there is any evidence of deterioration in the condition of the resident or the wound. If the ulcer fails to respond to treatment, refer the resident to the physician/wound care Clinical Nurse Specialist (CNS).

3. Management of Pressure Ulcer/Pressure Injury

- a. Following detection of a pressure ulcer/pressure injury, the charge nurse or designee will promptly:
 - i. notify the neighborhood physician (or if immediate treatment is needed, on-call physician) and a treatment plan shall be implemented within eight (8) hours;
 - ii. notify wound care Clinical Nurse Specialist~~NS~~
 - iii. notify the dietitian within 24 hours (call Dietary office)
 - iv. notify the resident and / or Surrogate Decision Maker (SDM) within forty-eight hours
 - v. complete facility approved WAR
 - ~~vi.~~ develop a plan of care for prevention and treatment of the ulcer(s)
 - ~~vi.~~vii. complete an Unusual Occurrence form
 - ~~vii.~~viii. schedule Resident Care Conference
- b. Develop/revise plan of care for prevention and treatment of the ulcer(s).
- c. The RN will assess pressure ulcer(s)/pressure injury(ies) weekly. The LVN may assist in gathering data under supervision of the RN.
- d. The RN will reevaluate the treatment plan if the ulcer(s) fails to show evidence of healing within two weeks, or when the ulcer shows signs of deterioration.
- e. The Attending Physician in conjunction with the RN will evaluate non-healing and worsening ulcers and refer to the Plastic Clinic/Wound Care CNS.

4. Documentation of Pressure Ulcer/Pressure Injury

- a. Admission: Complete Braden Scale Form (MR# 367) and body diagram skin assessment on the Nursing Admission Assessment form (MR #321).

- b. Intra-facility relocation: document condition of skin and complete the facility approved LHH Body Diagram form.
- c. Annually: document condition of skin as part of Minimum Data Set (MDS). Complete the facility approved pressure ulcer/pressure injury risk assessment tool.
- d. Discharge to outside facility or intra-facility acute unit: document condition of skin and pressure ulcer(s)/pressure injury(ies) and complete the body diagram with the approved inter-facility transfer/ LHH body diagram form.
- e. Document the required Pressure Ulcer/Pressure Injury Risk assessment tool on admission, followed by weekly x3, quarterly, annually, and/or following a decline/significant change of condition.
- f. Resident Assessment Instrument (RAI): When a pressure ulcer/pressure injury is triggered as a Care Area Assessments (CAA) Problem Area, the MDS Coordinator will:
 - i. Utilize the CAA guidelines to identify additional areas needing assessment.
 - ii. Document the assessment in the CAA notes, including the decision to care plan or not.
 - iii. Review the RAI policy and consult with the physician and RCT to determine if a significant change in condition MDS assessment must be completed when a residents develops a stage 2 or higher pressure ulcer/pressure injury.
- g. Resident Care Plan: If the resident is identified as being at risk for pressure ulcers/pressure injuries as determined using the facility approved pressure ulcer/pressure injury risk assessment tool, or has a pressure ulcer/pressure injury, a comprehensive, interdisciplinary care plan is developed that:
 - i. identifies problems (i.e., PU risk factors and/or presence of ulcer),
 - ii. develops individualized goal(s),
 - iii. develops interventions to address prevention or treatment.
- h. SNF and Acute care units: Wound assessments are done weekly and/or when there is a decline in the condition of the wound. These assessments are documented on the facility approved WAR.
- i. DNCR notes: Nursing Assistants are to document any changes in skin condition they observed on the DNCR record, including the name of the licensed nurse notified.
- j. Weekly or monthly nursing summaries: Summaries include assessment of any new resident's risk factors for developing pressure ulcer(s) /pressure injury(ies) as well as evaluation of the effectiveness of implemented treatment/interventions and revision of care plan as needed.
- k. Notification: Document all notification to the physician, wound care CNS, dietitian and family or SDM when a pressure ulcer/pressure injury is detected and when the ulcer shows no evidence of healing.
- l. Resident education / counseling: Resident teaching or counseling related to prevention/management of pressure ulcers/pressure injuries is to be documented in the progress notes/WAR, and/or resident care plan.

APPENDICES:

Appendix 1: Definition of Pressure Ulcer and Intervention
Appendix 2: Staging of Pressure Ulcer
Appendix 3: LHH Skin Care Formulary
Appendix 4: LHH Wound Care Formulary

REFERENCES:

Acute & Chronic Wounds: Current Management Concepts, Elsevier, 4th edition, 2012
Evidence-Based Pressure Ulcer Prevention: A Study Guide for Nurses, HC Pro, 2008 Sizewise

CROSS-REFERENCES:

LHHPP File: 24-15 Prevention and Management of Pressure Ulcer

Nursing P&P C 1.0 Admission and Readmission Procedures
Nursing P&P C 1.2 Nursing Guidelines for Relocation between Laguna Honda SNF Neighborhoods
Nursing P&P C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
Nursing P&P C 4.0 Notification and Documentation of Change in Resident's Status

Document originated: 2001/11

Revised: 2005/02; 2008/03; 2015/12/04; 2017/11/04

Reviewed: 2017/11/04

Approved: 2017/11/04

APPLICATIONS: HEAT OR COLD THERAPY

Commented [A1]: Reviewed by NPP-C no changes made 8/14/15

POLICY:

1. The licensed nurse may apply dry heat for comfort unless medically contraindicated, e.g., history of burns or radiation therapy, heat intolerance, impaired circulation, or decreased sensation to heat.
2. The licensed nurse may apply cold to reduce edema not associated with volume overload, control superficial bleeding, reduce feverish symptom, and to relieve musculoskeletal pain unless medically contraindicated, e.g. peripheral vascular disease, cold intolerance, or decreased sensation to cold.
3. Therapy aides may apply dry or moist heat to relieve musculoskeletal pain or tension prior to a treatment. (Refer to Restorative Policy)
- 3.4. Resident's response to heat or cold applications will be evaluated and complications reported promptly to the physician.

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PURPOSE:

To describe procedure for the safe use of heat or cold for symptom relief.

PROCEDURE:

A. Equipment

For Cold/Heat Application: Obtain prepackaged cold and heat packs from CSR.

B. Heat or Cold Applications

1. Follow manufacturer's instructions for use of pre-packaged heat or cold packs.
2. Heat or cold application shall be is limited to no more than 20 minutes/application. Monitor resident after application for any discomfort, if present, remove application.
3. The resident should never lie on the pack, as the body weight could break the pack and potentially cause a burn (heat).
4. Wrap the pack with towel or pillow case to prevent direct skin contact with heat or cold source. Increasing the towel thickness will reduce the heat/cold and delays heat/cold penetration.
5. Inspect skin for redness or injury after application, or if resident reports skin discomfort.

C. Documentation

1. Document application of heat or cold therapy on the Treatment Administration Record (TAR) as nursing order.
2. Describe resident's tolerance of treatment and overall effectiveness of procedure in electronic health recordintegrated progress notes.
3. Include heat/cold application interventions in the appropriate care plan.

Applications: Heat or Cold Therapy

File K 4.0 [January 2018](#) ~~July 22, 2014~~, Revised
LHH Nursing Policies and Procedures

REFERENCES:

Best Practices: Evidence –Based Nursing Procedures, 2nd edition Springhouse Corporation,
Lippincott, Williams & Wilkins, [2007](#).

Commented [ah2]: please update with current reference (which don't have) and could someone kindly scan for any needed corrections? My review of the literature uncovered hypothermia protocols post arrest and warming procedures, not on point with this NPP. Thank you very much. Anne

CROSS-REFERENCES:

NPP K 2.0 Wound Assessments and Management
[INCLUDE RESTORATIVE](#)

Revised: 8/2000, 8/2008, 07/31/2012; 07/22/2014, [01/2018](#)

Reviewed: 07/22/2014

Approved: 07/22/2014

Protocol for the Prevention, Assessment and Management of Dehydration **GUIDELINE FOR PREVENTION, ASSESSMENT AND MANAGEMENT OF RESIDENTS AT RISK FOR DEHYDRATION**

A. Definition: Standard of Care:

- An abnormal depletion of body fluids, due to inadequate water intake to meet a body's metabolic requirements (adapted from Merriam Webster Medical Dictionary, <https://medlineplus.gov/mplusdictionary.html>)
- According to the CDC, there is no recommendation for the amount of water adults should drink daily.
- **Note:** when a person is at the end of life and in the process of dying, decreased fluid and food intake is expected and aggressive intervention is contraindicated, food and fluids are offered for pleasure and as desired.

~~LHH residents are assessed on an ongoing basis for adequate fluid intake and output, and for other signs of dehydration unless care planned otherwise or not clinically appropriate.~~

~~During heat wave conditions, all Laguna Honda Hospital and Rehabilitation Center residents will be assessed for heat related effects. Refer to LHHPP 24-17 Heat Wave.~~

B. Risk Factors for Dehydration

- Heat wave conditions
- Air conditioning malfunction
- Medications/Supplements: diuretics, anti-hypertensive agents, antihistamines, chemotherapy agents, osmotic laxatives, protein-dense nutritional supplements/formula
- Medical problems: uncontrolled DM, fever/infection, GI infections, other causes of diarrhea, vomiting, salt wasting syndrome, hyponatremia.
- Age related changes: decreased thirst sensation, inability to independently drink fluids, intentional decrease in fluids due to toileting concerns.
- Inadequate intake
- Dysphagia
- Others: alcohol intoxication

C. Interventions to Prevent, Assess or Manage Dehydration Rationale:

~~The elderly are at risk for dehydration because of decreased thirst sensation, an inability to independently drink fluids, or a reluctance to request fluids because of increased toileting need.~~
Prevention

- Resident-specific fluid needs are determined by the Dietitian and documented on the Nutrition Screening and Assessment form, along with the amount of fluids served with meals daily.
- Nursing staff as clinically indicated, and as ordered by physician will:
 - offer fluids between meals and at bedtime, smaller amounts provided frequently may be preferred
 - encourage full glass/cup of fluid with oral medication administration
 - administer free water flushes, per MD order, for residents receiving enteral nutrition
 - Assisting the resident to drink as needed.
 - Offering foods with high water content (fruits, vegetables, soups, cream cereals, Jell-O, ice cream, popsicles).
 -

- o Keeping (preferred) fluids within easy reach.
- o monitor fluid intake on trays and between meals
- o implement bladder training/toileting plan for residents restricting their fluid intake to minimize urinary urgency/incontinence

Assessment

- Monitor for early warning signs of inadequate fluid intake: change of condition, increased confusion, decreased appetite, tiredness, complaints of thirst or requests for water/ice chips, weight loss, drinking less than ~ 800 cc per day, urinating less than the usual amount.
- Recognize late signs impending dehydration: dry mouth or cracked lips, concentrated or scanty urine, elevated serum sodium, hemoconcentration and other abnormal laboratory findings.
- Monitor intake and/or output and weight as nursing orders.

Management

- Keeping preferred fluids at bedside.

Providing fluids in social situations.

- Report findings to physician for orders to correct dehydration
- Anticipate need to establish IV access for IV fluids and/or oral rehydration
- Initiate safety measures given increased fall and confusion risks
- Initiate/update care plan for dehydration risk/management
 - o The care plan will include the goals state - of fluid intake recommended by the RD, and urinary output to be maintained at resident's baseline.
 - o Resident's fluid intake and output is recorded each shift by the nursing assistant.
 - o Fluid balance will be analyzed by LN until no longer at risk for dehydration, or plan of care has changed.
 - o Consult with RD for additional fluid replacement on meal tray and provide alternative oral replacement as per MDS.
 - o Discuss with MD need for additional hydration, i.e., IV fluids or, if appropriate, enteral tube free water supplementation.
 - o Measure weight weekly until condition has improved or plan of care has been reviewed / revised.
 - o Consider underlying causes of dehydration and need for nursing or possible medical intervention, e.g. uncontrolled BG, hot weather, nausea / vomiting.

S-

Risk Factors for Dehydration and Assessment of Fluid Intake

~~Residents on diuretic therapy and those with uncontrolled DM (polyuria), infections, fever, diarrhea, sore mouth or throat, and nausea/vomiting are at increased risk of dehydration, as are all residents during periods of hot weather.~~

~~Fluid needs specific to each resident are assessed and determined by the Dietitian and documented on the Nutrition Screening and Assessment form, along with the amount of fluids served with meals daily.~~

~~Early warning signs of inadequate fluid intake include change of condition including but not limited to increased confusion, decreased appetite, tiredness, complaints of thirst or requests for~~

~~water/ice chips, weight loss, drinking less than 800 cc per day, urinating less than the usual amount.~~

~~Late signs of inadequate fluid intake and impending signs of dehydration include dry mouth or cracked lips, concentrated or scanty urine, elevated serum sodium, hemoconcentration and other abnormal laboratory findings.~~

~~Nursing staff, along with other RCT members, evaluate a resident's risk for dehydration and care plan accordingly.~~

~~D. Nursing Interventions to Minimize Risk of Inadequate Fluid Intake~~

~~All residents, except for those residents with fluid restrictions, are encouraged to drink all fluids served with their meal trays and to drink additional fluids between meals and with medications.~~

~~Nursing assistants will observe resident's fluid intake on an ongoing basis and report poor or diminished fluid intake and output or other changes in the resident's routine/behaviors to the resident's licensed nurse for further assessment by the LN.~~

~~Refer to LHHPP 24-17 Heat Wave for clinical intervention(s) during a heat wave.~~

~~E. Care Planning Considerations for Residents at Risk for Dehydration~~

~~Measuring intake and/or output may be initiated by the licensed nurse and does not require a physician's order.~~

~~If Nursing and/or the RCT determines that the resident's care plan includes "at risk for dehydration" or "at risk for heat-related illness", the following measures will be implemented:~~

~~The care plan will include the goals of fluid intake recommended by the RD, and urinary output to be maintained at resident's baseline.~~

~~Resident's fluid intake and output is recorded each shift by the nursing assistant.~~

~~Fluid balance will be analyzed by LN until no longer at risk for dehydration, or plan of care has changed.~~

~~Consult with RD for additional fluid replacement on meal tray and provide alternative oral replacement as per MDS.~~

~~Discuss with MD need for additional hydration, i.e., IV fluids or, if appropriate, enteral tube free water supplementation.~~

~~Measure weight weekly until condition has improved or plan of care has been reviewed / revised.~~

~~Consider underlying causes of dehydration for nursing or possible medical intervention, e.g. uncontrolled BG, hot weather, nausea / vomiting.~~

~~F. Suggestions for enhancing fluid intake include~~

~~Offering smaller amounts of water, juice (unless diabetic), ice chips more frequently throughout the day.~~

~~Assisting the resident to drink as needed.~~

~~Offering foods with high water content (fruits, vegetables, soups, cream cereals, Jell-O, ice cream, popsicles).~~

~~Keeping fluids within easy reach.~~

~~Keeping preferred fluids at bedside.~~

~~Providing fluids in social situations.~~

G. Evaluation

- ~~1. LN will document in the integrated progress notes and/or nursing summary whether the care plan goal (s) was met.~~
- ~~2. If goal(s) was met, return to routine monitoring, and consider the need for a resident care plan for "at risk of dehydration."~~
- ~~3. If goal(s) was not met, the care plan will be reviewed with the dietitian and physician, and modified as necessary according to resident's clinical situation.~~

Reference:

~~CDC. Get the Facts: Drinking Water and Intake (accessed 12/27/17;
<https://www.cdc.gov/nutrition/data-statistics/plain-water-the-healthier-choice.html>)
National Institute on Aging. Getting Enough Fluids. (accessed 12/27/17;
<https://www.nia.nih.gov/health/getting-enough-fluids>) — PubMed Dehydration (updated August 15, 2014)
<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001977/>~~

Cross Reference:

~~LHHPP 24-17 Heat Wave~~

~~Origination: 3/2008~~

~~Revised: 01/29/2013; **01/2018**~~

~~Approved: 01/29/2013~~

~~Reviewed: **11/10/2015 – No change.** **01/29/2013**~~

~~Approved: 01/29/2013~~

POLICY AND PROCEDURE FOR AUTOMATIC STOP ORDERS

Policy:

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

Purpose:

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

- A. The Stop Order Policy is applicable to all medication as specified below.
- B. The attending physician will be notified of stop orders before the medication order expires so that the medications are renewed if necessary to assure continuity of treatment.
- C. Such notification will be documented by the licensed nurse in compliance with the medical records policy.
- D. The Stop Order Policy will be available electronically on the Pharmacy Policy and Procedure Page.

Procedures:

Medication Categories with a Specific Stop Order include the following:

- 1) Schedule II Medications - Stop order in seven (7) days unless the prescription is written for 30 days or specified maintenance in the order.
Examples include:
Codeine
Fentanyl patches (Duragesic)
Hydrocodone and acetaminophen (NorCo, Vicodin)
Hydromorphone (Dilaudid)
Methadone
Methylphenidate (Ritalin)
Morphine (Oramorph SR, MS Contin, Roxanol)
Oxycodone
Oxycodone & acetaminophen (Percocet)
Oxycodone & aspirin (Percodan)
Tincture of Opium
- 2) Anticoagulants:

Unfractionated Heparin - 48 hours
Low molecular weight Heparin - twenty (20) syringes per dispensing and a maximum of two (2) dispensings
Warfarin - 7 days

NOTE: If the prescriber does not renew a warfarin or low molecular weight heparin order, he/she will be contacted to renew or discontinue it. If the prescriber is not readily available, warfarin/low molecular weight

heparin may continue for up to 14 days or until contacted (it shall not be discontinued without a specific "D/C" order from the physician).

3) As Needed Psychotropic Orders

a) Antipsychotic as needed orders shall have a 14 day automatic stop in compliance with CMS requirements. Continuation of the as needed antipsychotic order for an additional 14 days shall require a renewal order and documentation of an assessment of the medication by the prescriber.

b) Non-Antipsychotic Psychotropic as needed orders shall have a 14 day automatic stop for the initial order in compliance with CMS requirements. Continuation of the as needed psychotropic order shall require a renewal order and documentation of an assessment of the medication by the prescriber. The prescriber must specify days supply and number of refills.

~~3~~4) All orders for antibiotics, including those administered by the parenteral, oral, topical, and ophthalmic routes, unless otherwise specified by the prescriber, will have a stop order in seven (7) days. The seven (7) day stop order **EXCLUDES** antiviral, antifungal and antituberculosis agents.

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

~~4~~5) Antiemetics, anti-diarrhea, antihistamines and cough and cold preparations will have an automatic stop order after seven (7) days unless the physician has specified a definite dc order date, or has written the prescription for 30 days with refills or specified maintenance in the order.

~~5~~6) All Non-steroidal anti inflammatory agents (NSAIDS) will have an automatic stop of 7 days unless a specific number of days, for 30 days with refills or specified maintenance in the order. NOTE: This policy does not apply to single daily doses of aspirin.

~~6~~7) Genito-urinary antispasmodics {flavoxate (Urispas), hyoscyamine (Levsin), oxybutynin (Ditropan), propantheline (Pro-Banthine), tolterodine tartrate (Detrol)} will have an automatic stop of 14 days unless the physician has specified a definite dc order date, for 30 days with refills or specified maintenance in the order.

~~7~~8) All other medication classifications will be in effect for 45 days.

New: 4/93

Revised: 1/94; 4/98, 6/98, 11/99, 6/00, 11/00, 04/03, 04/04, 08/05, 05/06, 01/08, 4/11, 2/15, 6/15, 1/18

Reviewed: 04/09, 02/10, 4/12, 8/13, 4/14, 6/16, 8/17

POLICY AND PROCEDURE FOR UNIT AREA INSPECTIONS FOR LABELING, STORAGE AND SUITABILITY OF MEDICATIONS

Policy:

The Pharmacy Service will conduct unit area inspections to see that medications are labeled properly and stored in locked areas under proper temperature controls and that only authorized personnel have access to the keys.

Purpose:

To ensure optimal medication storage and safe keeping on Patient Care Areas.

Procedure:

- A. The pharmacy will check each month the Emergency Container, the Automated Dispensing Cabinet, Other Medication Cabinets, Medication Carts, and Refrigerator for:
 1. Orderliness and accessibility of medications: Medications should be stored properly and in an orderly manner.
 2. Condition and legibility of labels: All medications will be labeled in conformance with state and federal food and drug laws. All drugs obtained by prescription will be labeled in compliance with state and federal laws governing prescription dispensing. (See 5.3 Section B.5.) No person other than the pharmacist will alter any prescription label. Medication labels will be legible.
 3. Condition of container and contents: Containers that are cracked, soiled, or without secure closures will not be used. Contents that are outdated contaminated, or show deterioration will not be used and should be returned to the pharmacy for disposal. Medications of each resident will be kept and stored in their originally received containers and no medications will be transferred to other containers.
 4. Separation of internal, external, and injectable medications: External use medications in liquid, tablet, capsule or powder form will be stored separately from medications for internal use. Test reagents, germicides, disinfectants and other household substances will be stored separately from medications.
 5. Contents of refrigerator: Medication and food will not be stored in the same refrigerator.
 6. Refrigerator temperature: Monitored via wireless refrigerator monitoring system. See HWP
 7. Adequate lighting: Dose preparation and administration areas will be well lighted.
 8. Outdated medications: Outdated medications will be returned to the pharmacy for disposal.

LAGUNA HONDA HOSPITAL PHARMACY
MONTHLY UNIT INSPECTION CHECK LIST

UNIT: _____

DATE: _____

<u>Floor Stock Drugs and Supplies</u>	
	<u>Arrangement is neat, clean and orderly.</u>
	<u>All items are properly labeled.</u>
	<u>Open bottles of blood glucose test strips are dated. (good thru mfg's expiration date)</u>
	<u>Open glucose testing control solutions are dated and discarded after 90 days.</u>
	<u>Internal & external drugs are separated on different shelves in med room.</u>
	<u>Syringes/needles disposed in Sharps container.</u>
	<u>Irrigation solutions are dated when opened.</u>
	<u>All expired items are returned to Pharmacy.</u>
	<u>Promod bottles are dated when opened.</u>

<u>Refrigerated Drugs</u>	
	<u>Refrigerator is Locked.</u>
	<u>Preventive maintenance sticker present & dated.</u>
	<u>Temperature: _____ (36-46F or 2-8C)</u>
	<u>Refrigerator is clean.</u>
	<u>Food is not present in medication refrigerator.</u>
	<u>All drugs are properly labeled.</u>
	<u>All open multi-dose vials are dated & discarded after 28 days.</u>
	<u>PPD vials are dated & discarded after 28 days.</u>
	<u>Insulin vials are dated when opened and discarded after 28 days.</u>
	<u>All expired items are returned to Pharmacy.</u>

<u>Patient Medication Storage& General Observations</u>	
	<u>Cart is locked, clean and well organized. Narcotic lock box in cart only for narcotics.</u>
	<u>Medications are properly labeled.</u>
	<u>Injections are properly labeled including date when vial initially opened.</u>
	<u>All expired items are returned to Pharmacy.</u>
	<u>No staff/patient personal items including purses/backpacks stored in med room or med cart.</u>
	<u>No staff/patient personal items including food, nutritional products stored in med room or cart.</u>
	<u>IV Prep work area within blue lines clean and clear of any items.</u>
	<u>Med cart bin-reminder sign on top of cart/ Poison control center's phone sticker on phones.</u>
	<u>Make sure all pill crushers and cutters have wear mask labels.</u>
	<u>IV bags out of overwrap have sticker with date opened, date expired.</u>
	<u>No external products including wound dressings and lab kits stored in medication carts.</u>

<u>Emergency Drug Box</u>	
	<u>Emergency box has red lock intact.</u>
	<u>Stock is complete and sealed.</u>
	<u>All drugs are fresh, if not state the drugs and exp date : _____</u>
	<u>Morphine inj available in both omnicells North and South building and PM/PMA.</u>
	<u>List of emergency box drugs is in the box pocket.</u>

DATE AND INITIALS OMNICELL FILTER IS CLEANED BY PHARMACY TECHNICIAN: _____

Comments/Questions/Problems on back side

[illegible]

Nurse: _____ Pharmacist : _____

Modifications to Unit Inspection check list

<u>Date</u>	<u>Pharmacist</u>	<u>Modification</u>
<u>11/3/2017</u>	<u>SR</u>	<u>Reviewed and updated: removed reference (on line now) removed mask for pill cutter, wound dressing/lab kits added. External/internal separated of different shelves.</u>
<u>12/23/2017</u>	<u>SR</u>	<u>Added promod, narcotic lock box</u>

POLICY AND PROCEDURE FOR MEDICATION REGIMEN REVIEW

Policy:

The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest, practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The MRR is available for viewing by members of the Resident Care Team electronically in the MRR database. Findings and recommendations are reported to the ~~director of nursing~~Chief Nursing Officer, the attending physician, the ~~Chief Medical director~~Chief Medical Officer and if appropriate the administrator.

Purpose:

To ensure accurate and proper medication administration to residents.

Procedure:

- a) A pharmacist reviews the medication regimen of each resident at least monthly.
 - a) A more frequent review may be deemed necessary, e.g., if the medication regimen is thought to contribute to an acute change in status or adverse consequence.
 - b) Upon admission a preliminary medication regimen review will be conducted and include a medication reconciliation. The review will be documented by an entry in the electronic health record indicating "Medication Reconciliation Completed" date and time stamped with the reviewing pharmacist's name.
- b) In performing medication regimen reviews, the pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards, such as the American Society of Consultant Pharmacists (ASCP) Practice Standards, and clinical standards such as the Agency for Healthcare Research and Quality (AHRQ) Clinical Practice Guidelines and American Medical Directors Association (AMDA) Clinical Practice Guidelines.
- c) The pharmacist identifies irregularities through a variety of sources including: Medication Administration Records (MARs); prescribers' orders; progress notes of prescriber, nurses, and/or consultants; the Resident Assessment Instrument (RAI); laboratory and diagnostic test results; behavior monitoring information; the facility staff; the attending physician, and from interviewing, assessing, and/or observing the resident. The pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following:
 - a) Physician's orders
 - i) Date written

- ii) Clarity of orders
- b) Medication regimen
 - i) Evaluate for possible interactions, incompatibilities, or contraindications, improper dosing and frequency, or other pertinent medication therapy issues.
- c) Diagnosis
 - i) A written diagnosis, indication, or documented objective findings to support each medication order.
 - ii) Pharmacists shall require clarification of orders for medications prescribed for non-FDA approved uses unless the use is recognized as the community standard, accepted clinical practice or there is literature to support use.
- d) Charting
 - i) Compare medications charted to those prescribed, including completeness, dosage, frequency of administration, and route of administration.
- e) Administration
 - i) Pharmacy will conduct an Observation Pass as outlined in policy 03.01.02. Nursing preparation and administration of residents' medications will be observed. .
- f) Laboratory tests
 - i) Laboratory tests should be reviewed for frequency of ordering and possible interference with test results by a medication the resident is taking. Laboratory tests will also be reviewed for abnormal values.
 - ii) Lab tests to monitor the efficacy and/or toxicity of certain medications may be recommended to the physician.
- g) Nurses' Notes
 - i) Clarity and continuity of entries pertaining to regular special care will be assessed in order to obtain a quick insight into condition or of unusual personal characteristics of the resident.
 - ii) Special attention should be noted in regard to accuracy of "prn" entries.
- h) Resident's Current History Entry
 - i) Note the resident's present medical condition as observed by the physician.
- i) The reviewing pharmacist will note to the physician instances of medication incompatibility, duplication of orders, missing diagnoses, incomplete orders, reevaluation of therapy requests, and other pertinent issues.

- d) Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the facility MRR database and reported to the prescriber, Chief Medical Director-Officer and Director-of-Chief Nursing Officer.
 - a) Notification mode is dependent on severity of irregularity.
 - b) The pharmacist will contact the physician directly for problems requiring his/her immediate attention.
 - c) The reviewing pharmacist will date and sign the resident's chart after each review.
 - d) The reviewing pharmacist shall check below their signature the appropriate box to indicate if new irregularities were found.
- e) If a continuing irregularity is deemed to be clinically insignificant, or evidence of a valid clinical reason for rejecting the recommendation is provided, the pharmacist will reconsider whether to report the irregularity again or make a new recommendation.
- e) Recommendations are acted upon and documented by the prescriber and or the facility staff.
 - a) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.
 - b) If there is potential for serious harm and the attending physician does not concur, or the attending physician refuses to document an explanation for disagreeing, the pharmacist contacts the Medical Director-Officer and the Director-of-Chief Nursing Officer
 - c) The Director-of-Chief Nursing Officer or designated licensed nurse addresses and document recommendations that do not require a physician intervention, e.g., monitor blood pressure.
- f) The pharmacist compiles and analyzes data collected during MRR and presents findings to the Pharmacy & Therapeutics Committee, Medical Executive Committee and the Performance Improvement and Patient Safety Committee as a part of the facility continuous-quality improvement assessment and performance improvement (CQI/QAPI) program.

New: 10/91

Revised: 6/99DY, 2/02DY, 04/07dw, 08/11, 8/15, 1/18

REVIEWED: 02/05dw, 02/06, 01/08, 04/09, 5/12, 8/13, 8/14, 6/16, 8/17

POLICY AND PROCEDURE FOR PSYCHOTROPIC MEDICATIONS

Policy:

In accordance with federal and state regulations, the pharmacist will include as part of the monthly medication regimen review, a review of each resident's psychotropic medications.

Purpose:

To ensure rational psychotropic medication use, and to avoid unnecessary medication use.

Procedure:

- A. Medication Regimen Review: Pharmacists will review the medical chart of each resident monthly. Regimen will be reviewed for:
 - 1. Diagnosis and target symptoms for each med.
 - 2. Appropriate (not excessive) dose.
 - 3. Appropriate (not excessive) duration.
 - 4. Adequate monitoring.
 - 5. Appropriate documentation.
 - a. A quarterly review of psychotropic medication regimen shall be completed at least quarterly by the attending physician and/or prescribing psychiatrist.
 - b. As Needed psychotropics shall have clear documentation of an assessment of use, effectiveness and ongoing need in each psychotropic quarterly review. As Needed psychotropics shall be subject to automatic stops per CMS regulations as outlined in policy Stop Orders (01.01.02).
 - c. Informed Consent
- B. Any recommendations related to the psychotropic medication will be conveyed to the physician and nursing staff as per policy on Medication Regimen Review (06.01.00)

Revised: 8/11, 1/18