List of Hospital-wide/Department Policies & Procedures
Submitted to JCC for Approval on May 8, 2018

1. *a. New Hospital-wide Policies and Procedures*		
Policy Number	**Title**	**Comment(s)/Reason(s) for Development**
LHHPP 31-05	**Preventive Maintenance Plan**	Created to ensure that equipment used in delivering patient care and services comply with safety standards.
LHHPP 72-01 C27	**Care of the Persistently Non-adherent Tuberculosis Patient Placed on Civil Detention**	Created to provide guidelines for admitting and caring for a tuberculosis patient placed on a civil detention order.
2. a. Revised Hospital-wide Policies and Procedures		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
LHHPP 21-05	**Medical Record Documentation**	Revised to add Medication Regimen Review as part of the resident's clinical health record.
LHHPP 22-01	**Abuse Prevention, Identification, Reporting, Investigation and Response**	Revised to update and clarify forms of reportable abuse and new reporting protocol timelines.
LHHPP 50-11	**Procurement Card**	Revised to reflect current citywide process.
LHHPP 60-12	**Review of Sentinel Events (Applicable to Acute Care Units Only) (Re-titled)**	Revised policy statement to clarify that reportable sentinel events are only applicable to acute care units.
LHHPP 70-01 C7	**Power Outage Response Plan**	Revised to streamline and update emergency preparedness procedures in case of power outage.
b. Revised Department Policies and Procedures		
Department: Nursing		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
C 4.0	**Notification and Documentation of Change in Resident Status**	• Policy #5 – generalized statement to just notifying family or surrogate decision maker for change of condition, not indicating who exactly would do the notification • Moved SBAR Appendix into Procedure A
3. *a. Hospital-wide Policies and Procedures for Deletion*		
Policy Number	**Title**	**Comment(s)/Reason(s) for Deletion**
None.		
b. Department Policies and Procedures for Deletion		
Policy Number	**Title**	**Comment(s)/Reason(s) for Revision**
None.		

Informational: A revision to LHHPP 45-01 Gift Fund Management will be submitted for approval at the June 19, 2018, Health Commission meeting.

PREVENTIVE MAINTENANCE PLAN

POLICY:

1. The facility shall develop and implement a preventive maintenance plan that provides an acceptable level of equipment safety and quality for the well-being of residents/patients, staff and visitors.

2. Equipment covered under this policy includes facility equipment that supports the physical environment of the hospital (e.g. elevators, generators, air handlers, medical gas systems, air compressors and vacuum systems, etc.), medical and non-medical equipment or devices intended for diagnostic, therapeutic or monitoring care for residents/patients (e.g. IV infusion equipment, laboratory equipment, rehabilitation gym equipment, blood pressure machines, hospital beds, etc.) and departmental specific equipment (e.g. floor cleaning machines, powered delivery carts, cooking equipment, etc.)

3. All equipment shall be inspected and tested for performance and safety prior to initial use, after major repairs or upgrades, and annually thereafter, or according to manufacturer's recommendations.

4. The facility utilizes hospital personnel, contracted services or a combination of hospital services and contracted services for performing equipment preventive maintenance.

5. The exclusions to this policy include office furniture and hospital furniture or equipment that are not listed in department inventory lists.

6. New equipment covered under this policy shall be evaluated for preventive maintenance by Facility Services and/or Central Processing Department (CPD) prior to purchase.

Note: Maintenance of Information Technology devices are not covered under this policy. Please refer to Information Systems Policies and Procedures Section 20 and 40.

PURPOSE:

To ensure that medical and non-medical equipment used in delivering resident/patient care and services comply with appropriate safety and operational standards.

PROCEDURE:

1. Preventive Maintenance Program

   a. The majority of testing and maintenance of the hospital's medical and non-medical resident/patient care related equipment is conducted by Facility Services personnel and contracted services.

i. Refer to the Facility Services Policy and Procedure EM-1 Equipment Management Program for a description of procedures carried out.

ii. Refer to the Central Processing Department (CPD) Policy and Procedure Section 3.21 Biomedical Technical Assistance for preventive maintenance process and B5 on Equipment Maintenance for a list of bio-medical equipment that are maintained by the contracted vendor(s).

b. The testing and maintenance of equipment that either supports the physical environment of the hospital or departmental specific equipment, is conducted by Facility Services personnel or by contracted services under the oversight of the respective Department Manager

c. Activities and associated frequencies for maintaining, inspecting and testing shall be documented.

2. The following departments/services have been identified with responsibilities for implementing the preventive maintenance plan:

   a. Central Processing Department

   b. Clinical Support (Laboratory, Radiology, and Respiratory Therapy)

   c. Environmental Services

   d. Facility Services

   e. Food and Nutrition Services

   f. Information Technology

   g. Nursing

   h. Outpatient Clinic (includes Dental services)

   i. Pharmacy

   j. Rehabilitation Services

   k. Vocational Rehabilitation

   l. Wellness and Activity Therapy

   m. Workplace Safety and Emergency Management

3. Inventory and Asset Tags

    a. A written inventory shall be maintained by the above departments that utilize equipment in delivering resident/patient care services.

    b. Each piece of inventoried equipment shall be labelled with an asset tag.

    c. The asset tag shall begin with an alpha followed by numerical digits, or have a "No Maintenance Required" tag.

    d. The following tags indicate the department or vendor/supplier that is responsible for performing preventive maintenance work; and the criteria for determining which category if it is assigned:

        i. "A" – Contracted house-wide bio-medical service under the oversight of Director of CPD

        ii. "B" and "Q" – Information Technology department

        iii. "C" – Facility Services

        iv. "D" – Individualized contracted vendor/supplier agreement under the oversight of the respective Department Manager. Any item that requires qualified and trained service personnel to perform the maintenance per the manufacturer's installation, operation, and maintenance (IOM) manual.

        v. "No Maintenance Required" – Any item that does not specify preventive maintenance required in the owner/user's manual.

4. When staff identifies hospital equipment without an asset tag, carry out the following steps:

    a. CPD shall be contacted to determine if preventive maintenance work is under the purview of the house-wide contracted bio-medical service vendor.

        i. If the equipment/device is listed on the vendor's list, the appropriate A-tag shall be affixed on the equipment/device with the correct date of the next scheduled preventive maintenance.

        ii. If the equipment/device is not on the vendor's list but falls under the "A" tag designation, an A-tag shall be affixed to the equipment/device with the correct date of the next scheduled preventive maintenance and added to the vendor's contract.

b. If the equipment/device is not under the purview of the house-wide contracted bio-medical service vendor, CPD shall contact Facility Services to determine if Facility Services is able to perform preventive maintenance work on the device/equipment.

   i. If Facility Services can perform the preventive maintenance work, the appropriate C-tag shall be affixed on the equipment/device with the correct date of the next scheduled preventive maintenance work.

c. If Facility Services is unable to perform the preventative maintenance work due to specialize training and qualifications required by the manufacturer, a D-tag shall be affixed to the equipment/device.

   i. The respective Department Manager shall be responsible for contracting out the preventive maintenance of this equipment with a certified maintenance vendor.

5. Departmental Responsibilities

   a. Department managers are responsible for performing the following:

      i. Ensuring equipment used for meeting resident/patient or departmental needs for both day-to-day operations and in an emergency/disaster situation is identified by an asset tag.

      ii. Verifying that equipment used in their respective units is properly maintained as evidenced by a preventive maintenance sticker that has not gone past the expiration date.

      iii. Equipment that is not included in Procedure 1a or 1b shall be identified as described in Procedure 3.d.v.

      iv. Performing periodic rounds to ensure that equipment used in the department has a preventive maintenance sticker that has not gone past the expiration date.

      v. Notify CPD if equipment used by the department does not have an asset tag.

      vi. Notify CPD, Facility Services, or the individualized contracted vendor if equipment used by the department is missing a preventive maintenance sticker or has a preventive maintenance sticker that has gone past the expiration date.

   b. New equipment that is purchased shall be added to the appropriate department inventory list, tested prior to initial use and maintained according to this policy and procedure.

c. Equipment that is no longer in use shall be removed from inventory list and discarded according to City and County policy and procedure.

d. Department Managers or designees are responsible for submitting quarterly reports on preventive maintenance to the Performance Improvement and Patient Safety Committee to assess departmental compliance with facility procedures.

ATTACHMENT:
None.

REFERENCE:
Facility Services P & P EM-1 Equipment Management Program
CPD P & P Section 3.21 Biomedical Technical Assistance
CPD P & P Section B5 Equipment Maintenance
State Operations Manual Appendix A- Survey Protocol, Regulations and Interpretative Guidelines for Hospitals, Section A-0724 Issued: 02-12-14
HWPP 31-03 Clinical Product and Device Evaluation

Original adoption: 18/05/08 (Year/Month/Day)

CARE OF THE PERSISTENTLY NON-ADHERENT TUBERCULOSIS PATIENT PLACED ON CIVIL DETENTION

BACKGROUND:

The Health Officer has authority under state law to detain a patient for the purposes of diagnosis, treatment, and/or isolation of tuberculosis infection. The California Department of Public Health (CDPH) and the California Tuberculosis Controllers Association (CTCA) have established guidelines for the civil detention of persistently non-adherent tuberculosis patients in California. When the Health Officer issues a civil detention order, the order must describe less restrictive alternatives attempted and only if those alternatives fail, and public safety is put at risk by a patient's continued non-adherence with less restrictive alternatives, may detention be considered appropriate. Detention is a very costly intervention and shall only be used when less costly interventions have been unsuccessful.

The San Francisco Department of Public Health (SFDPH) shall initiate civil detention at SFDPH facilities after other less restrictive means to ensure compliance with examination/isolation/quarantine protocols have been exhausted, and it is determined that placement within a SFDPH facility is needed to ensure compliance with support from the San Francisco Sheriff's Department (SFSD) and to avert a health threat to the public.

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall admit and provide care to a person who has been placed on a civil detention order for persistently being non-adherent with their tuberculosis (TB) treatment, failed to complete their TB treatment when placed in a less restrictive environment, and poses a health threat to the public.

2. The decision on the appropriateness of admitting a resident under a civil detention order shall be made by the Chief Executive Officer (CEO), Chief Medical Officer (CMO), and Chief Nursing Officer (CNO) based on the facility's ability to provide quality care to the resident. The resident may or may not meet skilled nursing facility (SNF) level of care criteria.

3. These residents shall be admitted Monday to Friday excluding holidays secondary to the extra coordination between services that is required, and the limited availability of resources during those times.

4. LHH shall utilize the CDPH/CTCA joint guidelines when appropriate in providing care for the TB resident who is under a civil detention order.

5. LHH staff shall work collaboratively with staff from the San Francisco TB Clinic to plan the resident's admission, on-going care, and discharge plans.

6. The conditions of civil detention shall be as therapeutic as possible and be designed to protect the rights of the individual, while at the same time balanced with the legal, ethical, and moral responsibilities of a health care provider to protect the public from TB.

7. A resident placed under a Health Officer's Civil Detention Order shall not be detained for more than 60 days without a court order authorizing detention.

8. The facility shall obtain a subsequent court review; within 90 days of the initial court order, and thereafter within 90 days of each subsequent court review; if the resident requires on-going detention to complete his/her TB treatment and continues to pose a health threat to the public

PURPOSE:

1. The purpose of this policy is to provide guidelines for the following considerations:

    a. Decision-making for appropriateness of resident placement at LHH,
    b. Placement in a negative pressure respiratory isolation room,
    c. Discontinuation from respiratory isolation,
    d. Supervision by personnel from the San Francisco Sheriff's Department,
    e. Resident's rights,
    f. Collaboration with staff from the TB Clinic on resident care management,
    g. Resident need for a higher level of care,
    h. Resident need for a lower level of care,
    i. Discharge Planning, and
    j. Release from civil detention.

PROCEDURE:

1. The San Francisco Health Officer identifies a person in the community who has violated an examination or isolation order, or has persistently been non-adherent to tuberculosis treatment and poses a health threat to the public. The Health Officer prepares and issues a "Civil Order of Detention and Completion Treatment for TB" to the patient and the TB Clinic refers the patient for placement at LHH.

2. The CEO, CMO, and CNO reviews the information submitted by the TB Clinic and if deemed appropriate for SNF placement, agrees to accept the resident for placement at LHH.

3. The resident shall be admitted to an isolation or non-isolation room based on recommendations from the San Francisco TB Controller, or another designee of the Health Officer.

4. Refer to LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement if resident is placed in an isolation room.

5. The resident who is placed under a Civil Detention order shall be monitored by staff from SFSD, who shall be stationed outside of the resident's room, and shall accompany the resident whenever s/he participates in activities held outside of the resident's room if the resident is not in respiratory isolation.

6. The San Francisco TB Clinic shall be consulted for TB medication treatment orders and the frequency of acid fast bacilli (AFB) sputum smears and cultures to determine the infectiousness of the resident.

7. The required SNF admission and continuing care orders and processes shall be completed in the same manner as other LHH resident admissions.

8. The required SNF comprehensive assessment, care planning, resident care conference meetings, informed consent and documentation processes shall be completed according to LHH policies and procedures.

9. If the resident requests release from detention, the request shall be communicated to the TB Clinic, Quality Management Department and the Deputy City Attorney to enact the following:

    a. An application for a court order authorizing continued detention shall be made within 72 hours after the request.

    b. Resident detention shall not continue for more than 5 business days in the absence of a court order authorizing detention.

10. The resident with a civil detention order with or without a court order may be detained only until s/he completes treatment and cannot be forced to take medications.

11. Weekly reviews on the resident's progress with TB treatment and patient's expressed interests for activities or schedule at LHH shall be conducted by staff from Nursing, Medicine, and other members of the Resident Care Team, Infection Control, TB Clinic, Deputy City Attorney and other members of the administrative team. The frequency of reviews may be decreased when deemed appropriate based on the consensus of the entire team.

12. Weekly reviews shall be conducted to determine appropriateness of continued placement at LHH. The frequency of reviews may be decreased when deemed appropriate.

13. Discharge planning back to the community shall be initiated in accordance with LHHPP 20-01. The Health Officer or the TB Controller shall determine when the resident has completed his/her course of TB treatment and civil detention is no longer necessary.

14. If civil detention is no longer required, the resident shall be discharged in conjunction with advice from the TB Clinic to the appropriate level of care.

ATTACHMENT:
Appendix A: CDPH/CTCA Joint Guidelines for the Civil Detention of Persistently Non-Adherent Tuberculosis Patients in California

REFERENCE:
LHHPP 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
Standards from the TB Clinic pertaining to the following:

- Conditions/Caveats to Placement
- Risk Table
- Criteria for Infectiousness and Placement in High and Lower Risk Settings

Original adoption: 18/05/08 (Year/Month/Day)

CDPH/CTCA Joint Guidelines

Guidelines for the Civil Detention of Persistently Non-Adherent Tuberculosis Patients in California

Table of Contents

Preface 2

Background 2

Guiding Principles and Legal Requirements 3

Comprehensive Patient Assessments 4

Detention Facility Services 4

Criteria for Early Release 5

Written Agreements 6

References 8

Preface

The following Guidelines have been developed by the California Department of Public Health (CDPH), Center for Infectious Diseases, Tuberculosis Control Branch (TBCB), and the California TB Controllers Association (CTCA). These Guidelines provide statewide recommendations for tuberculosis (TB) control in California. If these Guidelines are altered for local use, then the logo should be removed and adaptation from this source document acknowledged.

No set of guidelines can cover all individual situations that can and will arise. When questions arise on individual situations not covered by these guidelines, consult with your local TB Controller or the CDPH, TBCB. As mandated by state law (Health and Safety Code, Section 121361), all decisions regarding the discharge or transfer of TB patients from health care facilities (HCFs) must be made by the local health officer (LHO) or designee of the jurisdiction in which the facility is located.

Background

These guidelines refer primarily to the detention of non-infectious TB patients for the purpose of completing an adequate course of therapy. However, detention may be necessary for certain patients for the period during which they are infectious. Respiratory isolation may not be possible in all long-term detention sites. Therefore, detention in facilities other than long-term detention sites may be necessary when appropriate respiratory isolation facilities are not available at the long-term detention site.

Before detention is implemented, reasonable attempts should be made to address concomitant problems such as mental illness, homelessness, and substance abuse that may be contributing factors to non-adherence. If all appropriate and available less restrictive alternatives have been attempted and failed, or if the public safety is put at risk by delayed action, detention is appropriate. These concomitant problems, however, will continue to need attention during the period of detention. Consideration should be given to placing patients in detention sites equipped to deal with their major problems (e.g., mental illness and substance abuse) as well as provide treatment for TB if such facilities are otherwise appropriate.

Detention is a very costly intervention and should only be used when less costly interventions have been unsuccessful. While all local health jurisdictions should make certain less restrictive alternatives (e.g., incentives, enablers, directly observed therapy) are available, the availability of resources for providing other less restrictive alternatives (e.g., social work interventions, psychiatric evaluation and treatment, drug and alcohol rehabilitation) will vary from health jurisdiction to health jurisdiction. It is important however, to give consideration to all available alternatives.

While detention is inherently restrictive, the goal should be to ensure the completion of TB treatment and the protection of the public health, not the punishment of the patient.

- All patients may not need the same level of security, and detention may not be

needed for the entire period of treatment. Appropriate detention options should be considered.

- There should be procedural safeguards against unnecessary infringement on the rights of patients whose liberty has been restricted as provided by State Law.

Guiding Principles and Legal Requirements

The following guiding principles in the detention of persistently non-adherent TB patients are designed to protect the rights of the individual, but are also balanced with the legal, ethical, and moral responsibilities of public health officials to protect the public from TB.

- Public health officials should make every reasonable attempt to assure that TB patients complete a prescribed course of therapy.
- The decision to detain should be based on a comprehensive and individualized assessment of the patient, including:
  - His or her medical condition
  - Course treatment
  - Risk of transmission if therapy is not completed
  - Barriers which prevent him or her from completing therapy
- The conditions of civil detention should be as therapeutic as possible.
- Detention sites, whether they be regional or local, should address the following needs of the patient:
  - Physical
  - Emotional
  - Social
  - Medical

In addition to the principles stated above, the following laws should guide detention.

- Health and Safety Code (H&SC) Section 121367 requires that orders for detention include:
  - An individualized assessment of the person's circumstances or behavior constituting the basis for the issuance of the order and the less restrictive alternatives that were attempted and were unsuccessful: **OR**
  - The less restrictive alternatives which were considered and rejected, and the reasons the alternatives were rejected.
- H&SC Section 121366 requires that:
  - If a detained person has requested release, "the local health officer shall make an application for court order authorizing continued detention within 72 hours after the request."

- If a detained person requests to be released, detention shall not continue for more than five business days in the absence of a court order authorizing detention.
- "In no event, shall any person be detained for more than 60 days without a court order authorizing detention."
- "The local health officer seek further court review of the detention within 90 days of the initial court order authorizing detention and thereafter within 90 days of each subsequent court review."

- Patients may be detained only until they complete treatment (H&SC 121368.c) but may not be forced to take medications (H&SC 121365.b). They should not be subjected to surgery without informed consent.

Comprehensive Patient Assessments

A comprehensive assessment of each patient's circumstances should include:

1. The patient's understanding (or lack thereof) of TB and why adherence to therapy is important.
2. History of non-adherence to treatment
3. Attitudes toward adherence to treatment
4. Mental health and psycho-social history, cognitive status
5. Medical history, including:
   - The risk to the patient and the community if treatment is not completed as recommended in the CDPH/CTCA, "Guidelines for the Treatment of Active Tuberculosis in California" (2003); and
   - The concomitant conditions which may influence response and adherence to treatment.
6. Drug or alcohol dependence
7. Living conditions (e.g., number of members in the household, availability of food, etc.)
8. Homelessness or lack of stable housing
9. Social-cultural considerations (ethnicity, customs, etc.)
10. Language

Detention Facility Services

Detention sites, whether they be regional or local, working in cooperation with the health officer of the jurisdiction which ordered the detention, should provide the following

services:

1. Directly Observed Therapy (DOT)
2. Case Management
3. Discharge planning in cooperation with health officials in the jurisdiction to which the patient will be released
4. Twenty-four hour security
5. Recreation facilities
6. Mental health counseling
7. Substance abuse counseling
8. Access to spiritual counseling
9. Reasonable accommodation of the patient's social-cultural needs
10. Visiting privileges
11. Reasonable accommodation of persons with disabilities
12. Services in the patient's native language

In addition, the detention facility should

13. Be properly licensed to provide these services
14. Have the ability to bill third parties (if appropriate)

Criteria for Early Release

Generally, patients will be released when they have completed therapy and are cured. The local health officer may determine that early release is appropriate and either directly revoke the order for detention or request release from the courts depending on circumstances.

The following criteria *(2)* for release from detention before completion of therapy should be considered where appropriate:

1. The patient has demonstrated sufficient progress to make it reasonable to conclude that completion of therapy and cure can be achieved outside detention. This may involve providing differing levels of security for various patients.
2. The patient demonstrates a willingness to continue TB treatment.
3. The patient demonstrates an understanding of the nature of TB and the importance of completion of treatment and is willing to adhere to a DOT program.

4. Progress has been made in treating the concomitant conditions (i.e., mental illness, substance abuse, homelessness) which made adherence to TB treatment difficult.
5. A plan for the outpatient treatment of these concomitant problems has been developed as part of the plan for the completion of therapy.
6. Reasonable evidence exists that public health workers will be able to locate the patient in the community when necessary.
7. The patient understands that he or she will be detained again if he or she is not adherent to the treatment plan.

Written Agreements

If regional detention sites are established for use by two or more health jurisdictions, the participating health jurisdictions should enter into written agreements which should be reviewed by the respective county/city councils of each jurisdiction and which include at least the following:

1. Procedures for detention and admission to the detention site. These procedures should:
   - Be guided by the Guiding Principles above (see **Guiding Principles and Legal Requirements, A)**
   - Include the Comprehensive Patient Assessments described above (see **Comprehensive Patient Assessments, A**)
   - Be consistent with the CDPH-CTCA, "Guidelines for the Assessment of Tuberculosis Patients Infectiousness and Placement into High and Lower Risk Settings (2009) *(2)*
2. Agreement as to when patients will be considered infectious and non-infectious
3. The services, which will be provided at the detention, site – every effort should be made to include all the services described above (see **Detention Facility Services**)
4. Charges which will be made for those services
5. Invoicing procedures
6. Methods and timing of payment
7. Criteria and procedures for discharge, including who has the authority to approve the discharge
8. Rights of the patients
9. Responsibilities of the health jurisdiction seeking detention

10. Responsibilities of the health jurisdiction in which the site is located

11. Procedures for obtaining proper judicial review of detention at intervals set by law

12. Procedures and responsibilities for transporting patients:

    - To and from the detention site
    - To and from court when needed
    - To and from medical care if needed

    NOTE: Each local health jurisdiction and each regional detention site may have differing requirements necessitating the issuance of service orders and/or letters of intent in addition to the formal written agreements described above.

The local health officer ordering detention should retain primary responsibility for the management of the tuberculosis patient being detained in a facility located outside the health officer's jurisdiction. The TB Controller or his/her designee should maintain frequent contact with the provider of treatment to:

- Monitor the patient's progress
- Gather information for the judicial review process
- Determine the earliest time for the appropriate release of the patient from detention
- Oversee discharge planning
- Gather information on the disposition of the case and complete follow-up Reports of a Verified Case of Tuberculosis (RVCT)
- Minimize the workload of and expense to the jurisdiction in which the regional site is located

References

1. CDPH-CTCA Guidelines for the Treatment of Active Tuberculosis (2003)

2. CDPH/CTCA Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings (2009)

3. Public Health Institute – TB and the Law Project California Tuberculosis Control Law 2003

MEDICAL RECORD DOCUMENTATION

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that:

1. Medical record systems are maintained in paper-based and computer-based formats;

2. A medical record is created for each resident/patient assessed or treated;

3. All medical record entries are legible;

4. The clinical staff are responsible for documentation of the clinical course of the resident/patient;

5. Medical records are legal documents which are the property of LHH and are under the custodianship of the Health Information Services Department (HIS);

6. Medical record documentation is complete and timely to ensure quality of care and continuity of treatment;

7. Medical record documentation includes pertinent facts, findings and observations about an individual's health history, past and present illnesses, exams, tests, treatment and outcomes. It chronologically documents the care provided to the resident/patient and also provides documentation of each resident/patient's medical conditions and treatment for medical, legal and financial purposes;

8. Medical record documentation supports the medical necessity of tests and services for which LHH is seeking reimbursement from government and non-government payers as required by federal and state laws, rules and regulations.

PURPOSE:

The purpose of this policy is to establish guidelines for medical record documentation of healthcare services provided at LHH. These guidelines are in accordance with Medical Staff by laws, the Center for Medicare and Medicaid Services (CMS), Title 22 - California Code of Regulations.

SCOPE:

This policy applies to all entities providing healthcare services at LHH.

PROCEDURE:

1. Initiating a Medical Record

a. A medical record is initiated for all resident/patients assessed or treated. For those resident/patients admitted to LHH, this includes the following clinical information:

   i. A complete history and physical examination;

   ii. Initial diagnostic impression;

   iii. Diagnostic reports (such as consultation, clinical laboratory, electrocardiogram, x-ray and others);

   iv. Records of medical and/or surgical treatment;

   v. Records of pathologic findings;

   vi. Progress notes; and

   vii. Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, resident/patient's condition on discharge, and discharge instructions as pertinent.

b. Entries are made in the medical record by individuals having direct primary knowledge of the healthcare services provided to the resident/patient. Such individuals include:

   i. Licensed practitioners;

   ii. Other credentialed health professionals; and/or

   iii. Physicians in post graduate residency programs, nursing staff and allied health professions students.

2. The Hybrid Medical Record

a. LHH maintains paper-based and computer based medical records. This hybrid computer based medical record is united by an enterprise-wide resident/patient identification system that is numerical. Clinical and administrative users of these systems recognize that they may have to use both paper-based and computer-based medical records (e.g. reports/notes and measurements entered into the electronic health record) to review all of the data necessary to perform their duties because all findings and reports associated with resident care are purposely not duplicated in multiple component systems.

b. The hybrid medical record system utilizes an electronic signature application for transcribed medical reports dictated or typed by the clinical staff.

c. The hybrid medical record is managed through a formal process by the LHH HIS Committee (refer to Appendix A – Guidelines for transitioning from paper-based to the electronic medical record system).

3. Medical Record Documentation Required for Services Rendered

a. The following general principles apply to the documentation of each resident/patient treatment encounter by a licensed independent practitioner in order to substantiate the need for the services provided.

i. The resident/patient's medical record clearly, accurately and legibly conveys that:

- the services have been provided;
- the services were appropriate for the resident/patient's condition, and
- the services meet reasonable standards for medical care.

b. The presenting problem is clear. There is a complete notation of the resident/patient's complaint(s), condition and/or reason(s) for the healthcare visit.

c. Physical exam findings and prior diagnostic test results are recorded. The reasons for ordering diagnostic and other ancillary services should be easily determined, if not specifically described in the record.

d. Assessment, clinical impression or diagnosis is recorded.

e. A plan of care and/or a description of the care rendered during the encounter are documented.

f. The resident/patient's progress, response to changes in treatment, and any revision to the diagnosis is documented.

g. Health risk factors specific to the resident/patient are documented.

h. The date and time, and the legible identifier (Name, signature and title).

i. Each entry shall be able to "stand alone" and support the test, and/or service being reported.

4. Physician's Orders

a. The presence of an order is required to substantiate the medical necessity for laboratory, radiology and other diagnostic services. Orders may be written by a

physician or affiliated staff who are working under approved standardized procedures.

b. Requisitions for Laboratory tests, Radiology, and other Diagnostic or Therapeutic Services shall include:

   i. The diagnosis (es) or finding(s) that best justifies the need for the service(s). This may be the same reason for the hospital admission or clinic visit.

   ii. The ordering/referring physician's signature, title, and CHN ID number.

5. Responsibilities of the Treating Physician

a. It shall be clearly documented that the attending physician actually provided the services and/or is physically present during the portion of the service.

b. Documentation for all minor procedures, surgeries, and interpretation of diagnostic tests shall follow the guidelines for documentation of evaluation and management services developed by the American Medical Association.

c. It is the responsibility of the attending physician to supervise the practice of medical students and physicians involved in postgraduate residency programs and to approve the diagnostic and treatment regimens developed by them for resident/patients at Laguna Honda.

6. Authentication

a. All medical record entries shall be timed and dated. Documentation of physicians involved in a postgraduate residency program is authenticated with signature, and title. Documentation of nurses and other health professionals is authenticated with signature and credential designation. All documentation entered by students shall be co-signed by the supervising attending physician, nurse, or other health professional.

7. Correcting and Amending Entries

a. The Paper Record

   i. Correcting an erroneous entry: Any corrections should be made by drawing one line through the erroneous entry, writing "error" in the margin and initialing it. Do not erase or otherwise obliterate the erroneous entry; it should remain legible.

   ii. Late Entries and Addenda: All entries in the record should be written at the time of the event. If it is necessary to make a late entry or addendum to include important clinical information in the record, follow these guidelines:

- Label the entry as a late entry or an addendum.
- Date and time the entry when it was written (do not back date the entry).
- Sign the entry.
- Enter the late entry or addendum in the Progress Notes or Nurses' Notes. Do not utilize the flow sheet or graphic records for late entries.
- The late entry or addendum should not obliterate any earlier entry.

b. If the electronic health record system is not available for charting, to avoid late entries, the clinician shall document their note(s) on a paper-based record.

~~b.~~c. The Electronic Record: Refer to LHHPP 21-07 Handling Misfiled Electronic Health Records.

ATTACHMENT:
Appendix A: Guidelines for transitioning from paper-based to the electronic medical record system

REFERENCE:
LHHPP 21-07 Handling Misfiled Electronic Health Records NPP G1.0 Vital Signs
NPP G4.0 Measuring the Resident's Height and Weight
San Francisco Department of Public Health Use of Scribes for Electronic Charting in San Francisco Health Network Electronic Health Records Policy and Procedure

Revised: 13/01/29, 15/03/24, 15/09/08, 17/09/12, 18/05/08 (Year/Month/Day)
Original adoption: 09/04/14

Appendix A:

Guidelines for transitioning from paper-based to the electronic medical record system

The hybrid medical record is managed through a formal process by the Laguna Honda Hospital (LHH) Health Information System (HIS) Committee using the following guidelines:

1. The transition and expansion of the electronic medical record shall be systematically planned and managed administratively, financially, organizationally and culturally.

2. There shall be a formal process for approving electronic medical record software and hardware to ensure that the system can adequately support the facility's operational needs.

3. The same Federal and State confidentiality, privacy and security regulations that govern the paper based medical record are also applicable to the electronic medical record.

4. The LHH HIS Committee, which reports to the Medical Executive Committee, will establish an interdisciplinary sub-committee when needed to guide the organization to effectively transition from a paper based medical record system to an electronic medical record system.

5. The designated sub-committee will develop and publish procedures relevant to the medical record component being transitioned from the paper based format to the electronic format and notify clinical and administrative users of the change in workflow.

6. The following, describes the hybrid medical record system currently in use:

The Skilled Nursing Facility (SNF) neighborhoods have adopted eClinical Works (eCW) for physician documentation in the clinics and SNF bedside visits. Psychiatry and substance abuse treatment notes are via AVATAR. Designated documentation from Nursing, Clinical Nutrition, Social Services, Activity and Rehabilitation Therapy are in SFGetCare. This document provides an outline of where information is found for LHH residents.

Type of Documentation	Location
Physician bedside visit progress note SNF	eCW effective May 2015, locked notes also appear in LCR
Consents	Paper chart and eCW
Physician Quarterly Psychotropic Drug Assessment	Paper chart
Annual, Admission H&P, Discharge Physician Notes	eCW effective May 2015 and/or LCR

Medication orders (oral, ophthalmic, ENT, Injection)	eCW effective May 2015
Medication orders topical ointments, creams, shampoos, wound care products	Paper chart
Complete medication list with original order dates	Paper Medication Administration Record
Medication Regimen Review	Electronic form in an interdisciplinary shared database
Nursing, Clinical Nutrition, Social Services, Activity and Rehabilitation Therapy Charting	Paper chart and SFGetCare
Minimum Data Set	Paper chart and accessible on the ADL system
Care Plans	Paper chart
Psychiatry	Avatar, some appear in LCR and behavioral health folder within eCW
Substance Abuse	Avatar
Pre-Admission Screening Resident Review (PASRR) and Level II Evaluations	Paper chart prior to the upload in eCW, effective May 2017
Inventory of Resident Personal Belongings	Paper chart
Notice of Proposed Transfer/Discharge	Paper chart

7. The LHH HIS Committee shall evaluate the effectiveness and adequacy of each electronic medical record component implemented, improving processes as necessary, with the goal of transitioning the facility to a paperless environment.

ABUSE AND NEGLECT PREVENTION, IDENTIFICATION, INVESTIGATION, PROTECTION, REPORTING AND RESPONSE

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall promote an environment that enhances resident well-being and protects residents from abuse, neglect, exploitation of residents, ~~and~~ misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

POLICY:

1. LHH employees and volunteers shall strive to protect ~~all~~ residents from physical, psychological, fiduciary and verbal abuse and neglect.

2. LHH employees and volunteers shall comply with their obligation under law to refrain from acts of abuse or neglect and to report observed or suspected incidents of abuse and neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition.

3. LHH employees and volunteers shall respond to these incidents in a timely manner and report the incident to their direct supervisor, nurse manager or supervisor.

4. LHH Department Managers are responsible for monitoring staff compliance with this policy and LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.

5. The facility shall not employ or otherwise engage individuals who:

    a. have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

    b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and/or

    c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

6. Retaliation against any persons who lawfully reports a reasonable suspicion of resident abuse, causes a lawful report to be made, or takes steps in furtherance of making a lawful report is strictly prohibited.

PURPOSE:

1. To protect the resident from abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.
1.
2. To report incidents or alleged violations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms without fear of retaliation and in a timely manner.

3. To promptly investigate allegations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms

4. To provide clinical intervention to prevent and minimize abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms

5. To meet reporting requirements as mandated by federal and state laws and regulations.

DEFINITION:

1. "Abuse" is defined at 42 CFR §483.5 as means "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish." (42 CFR 488.301) Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psycho-social well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology." All residents, even those in a coma, may experience physical harm, pain or mental anguish. Abuse can include verbal, sexual, physical, financial and mental abuse.

   "Willful," as defined at 42 CFR §483.5 and as used in the definition of "abuse" "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."
   1.

   a. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

~~b. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.~~ "Sexual abuse" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."

~~c.~~b. Physical abuse, includes but is not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

~~d.~~c. Financial abuse includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.

~~e.~~d. Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.

~~2.~~ 2. "Neglect" as defined at 42 CFR §483.5 means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or ~~mental~~ emotional distress."~~illness." (42 CFR 488.301)~~

~~3.~~2. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion.

~~4.~~3. Misappropriation of resident property means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent." ~~(42 CFR 488.301)~~

~~5.~~4. Mistreatment means inappropriate treatment or exploitation of a resident

~~6.~~5. Involuntary seclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/ his room (with or without roommates) against the resident's~~s'~~ will, or the will of ~~legal~~ resident representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs.

~~7.~~6. Injury of unknown source/origin is an injury when the source of the injury was not observed by any person, or the source of injury could not be explained by a resident, and when the extent of the injury, location of the injury or the number of injuries observed at one particular point in time or the incidents of injuries over time are suspicious in nature.

~~8.~~7. Serious bodily injury [as defined in Section 6703 (b) (3) of the Affordable Care Act] is defined as an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

PROCEDURE:

1. **Screening of Potential Employees**

   a. Criminal Background Checks

      i. Applicants for employment at LHH must submit to fingerprinting by federal authorities and must have a clear background check prior to processing of any appointments for hire at LHH. This is required in addition to the existing bi-annual fingerprinting and background check process in the State of California for initial certification and continued CNA certification as a condition of employment.

   b. Experience and References

      i. Applicants for employment shall provide a photocopy of certification and verification (including references) of qualifying experience. The facility will make reasonable efforts to verify previous employment and to obtain information from previous and/or current employers.

2. **Education**

   a. Employee and Volunteer Education

      i. New employees/volunteers, including transfers or inter- facility reassignments to LHH, shall, as a condition of employment, review and sign a statement acknowledging the prohibition against the abuse of elder and dependent adults and the obligation to report such abuse. A copy of the signed statement "Dependent Adult/Elder Abuse Prohibition and Reporting Requirement" shall be kept in the employee's/ volunteer's personnel file.

      ii. New employees/volunteers, including transfers or inter- facility reassignments to LHH, shall, as a condition of employment, participate in "The Abuse Prohibition/Prevention Program", which includes the following:

         - Facility orientation program on residents' rights, including confidentiality, preservation of dignity, recognizing and reporting of abuse without fear of retaliation, lost/stolen property, and misappropriation of resident funds;

         - ~~SMART~~ Safety management and response technique training provided to new LHH staff;

         - Review of the following policies and procedures that support the overall program:

            - LHHPP 22-03 Resident Rights

    - LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
    - LHHPP 22-07 Physical Restraints Including Siderails
    - LHHPP 22-08 Threats of Physical Violence to Residents
    - LHHPP 24-06 Resident Complaints/Grievances
    - LHHPP 22-10 Management of Aggression and Hostility
    - LHHPP 73-05 Workplace Violence Prevention Program

  - Annual in-service education provided by the Nurse Educators to all employees, which includes a review of residents' rights, abuse and neglect prohibition/prevention, and resident and employee freedom from retaliation when reporting abuse allegations.

  - Nurse Educators provide additional abuse and neglect prevention training to nursing staff, including recognition of potential signs of abuse including catastrophic reactions in residents, and recognition of factors that may contribute to abuse such as employee stress and burnout.

b. Employees are obliged to report any reasonable suspicion of abuse against a resident to a law enforcement agency. Employees shall be notified of their reporting obligations during the new employee orientation and annually during residents' rights, ~~and~~ abuse and neglect prevention in-services. Employees shall be notified of their reporting obligations to report any reasonable suspicion of a crime against a resident to a law enforcement agency during the new employee orientation and annually during residents' rights, ~~and~~ abuse and neglect prevention in-services.

c. Information on employee rights~~, including employee rights~~, including the right to file a complaint with the State Survey Agency if anyone at the facility retaliates against an employee who files a report of a reasonable suspicion of a crime committed against a resident of the facility to a law enforcement agency, shall be posted in the Human Resources Department. Posting will also encourage the employee to file a complaint with the Human Resources Department in the event of retaliation.

d. Resident Education

   i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting

advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.

ii. A listing of Residents' rights shall be posted on each unit.

3. Prevention

a. Staff and families are provided with information on how and whom they may report concerns, incidents and grievances (see Employee and Volunteer Education).

b. Staff shall be trained in s~~S~~afety ~~Management~~ management and ~~Response~~ response ~~Technique (SMART)~~ techniques, which includes components on dealing with residents' aggressive behavior and catastrophic reactions.

c. Staff conduct resident assessments, develop care plans, and monitor residents needs and behaviors that may lead to neglect or abuse (see "Resident Assessment and Care Planning").

4. Identification: Signs of Possible Abuse, Neglect or Exploitation

a. The following signs may alert LHH staff to possible resident abuse and indicate the need for immediate and further investigation:

i. Statements from a resident alleging abuse, neglect or exploitation (including unreasonable confinement) by staff or another resident;
ii. Sounds that suggest physical or verbal abuse, neglect or exploitation;

iii. Repeated resident "accidents," unexplained contusions or abrasions, injuries or bruises of unknown origin in a suspicious location;

iv. Illogical accounts given by resident or staff member of how an injury occurred;

v. Changes in resident personality or behavior, such as from pleasant to angry or from even-tempered to dejected or depressed; from easy-going to anxious, especially around a certain person, and especially if reluctant to give information;

vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;

vii. Resident-to-resident altercations.

5. Protection: Staff/Volunteer Intervention

a. In the event that an employee/volunteer

i. Observes abuse,

ii. Suspects that abuse has occurred,

iii. Observes resident–to-resident altercation,

iv. Identifies an injury of unknown source/ origin,

v. Learns about an allegation of abuse, neglect or exploitation of any LHH resident, and/or is the first person to learn of a resident-to-resident altercation, that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.

b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:

i. In the event of alleged employee to resident abuse, neglect or exploitation, the responsible manager shall reassign the employee who is being investigated to non-patient care duties or place the employee on administrative leave if non-patient care duties are not available at the point the manager was notified of the allegation. These measures shall be in place until the investigation is completed.

ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.

c. The responsible manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.

d. Upon receiving a report of alleged abuse, neglect or exploitation, the attending or on-call physician shall promptly perform a physical exam. The physician shall record in the progress notes of the resident's medical record the history of abuse as relayed, any findings of physical examination and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.

e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.

f. The employee and/or responsible managers, supervisors, physicians and others shall complete all required forms. See "Reporting Protocol".

6. Reporting Protocol

a. The facility mandates all staff to report suspected abuse to the local Ombudsman office as required by State law.

b. The facility also requires the employee, manager, agent or contractor of the facility to report to the San Francisco Sheriff's Department (SFSD) any reasonable suspicion of a crime committed against a resident of LHH.

i. Examples of crimes that are reportable include but are not limited to the following:
- Murder;
- Manslaughter;
- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery
- Drug diversion for personal use or gain;
- Identity theft; and
- Fraud and forgery.

i.ii. If the criminal incident resulted in serious bodily injury to the resident, the Sheriff's Department SFSD, Chief Executive Officer (CEO) or designee, Ombudsman, Quality Management (QM) staff and the State Survey Agency (i.e. California Department of Public Health - CDPH) must be notified immediately, no later than 2 hours after the suspicion is formed.

ii.iii. Criminal incidents not resulting in serious bodily injury to the resident be reported to the CEO or designee, Ombudsman, SFSD, QM staff and CDPH Sheriff's Department within 24 hours of the time the suspicion is formed.

c. The nurse manager, charge nurse, and nursing supervisor shall communicate to inform one another of the alleged abuse. The nurse manager, charge nurse, and nursing supervisor shall:

i. Immediately notify the attending or on-call physician of the alleged abuse;

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker;

ii. Notify within 2 hours to the CEO or designee, CDPH, Ombudsman, SFSD, and QM staff of events involving alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

iii. Notify within 24 hours to the Administrator CEO or designee, Medical Social Services Worker, Ombudsman, SFSD, and QM staff and CDPH by phone or e-mail; of events involving allegations of abuse that are not substantiated and do not result in serious bodily injury.

iv. Notify within 24 hours the Long Term Care Ombudsman office;

v. Notify within 24 hours the State Survey Agency on weekends and holidays. During regular business dayshours, Monday to Friday from 8;:00 am to 5:00 pm excluding holidays and weekends, the reporting function to the State Survey Agency CDPH is performed by Quality/Risk Management Nurses.

v.vi. After regular business hours, weekends and on holidays, the reporting function is performed by the Nursing Operations Manager.

d. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

e. If an abuse allegation involves a LHH staff person, the nursing supervisor shall notify HR and the staff person's immediate supervisor within 24 hours.

f. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician., the San Francisco Sheriff's Department, and the LHH Administrator On Duty.

f.

g. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of staff to resident abuse, resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to the Sheriff's Department. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.

h. In cases of alleged or factual rape the following steps must be taken:

i. Facility staff must immediately notify the San Francisco Sheriff's Department (Ext. 4-2319; 4-2301)

ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

iii. At the San Francisco Rape Treatment Center the resident will be interviewed, specimens will be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.

iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.

v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.

~~i.~~ This policy designates the Director of QM as the primary mandated reporter for LHH. The Director of QM or designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriff's Department, and CDPH. ~~the California State Licensing and Certification Office.~~

~~j.~~i. The results of the investigation shall be reported to ~~the State Survey and Certification Agency~~CDPH within five working days of the incident. If the alleged violation is verified, appropriate corrective actions ~~must~~ shall be taken.

~~k.~~j. The respective department head, in consultation with HR, shall report cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards.

7. Investigation

a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, neglect or exploitation shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).

b. If an abuse, neglect or exploitation allegation involves a LHH employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or place the employee on administrative leave, pending completion of the investigation. The interim reassignment or administrative leave will be in place until the Nursing and HR Departments complete their investigations and confer on their findings. The employee shall be formally notified of the outcome of the investigation and future employee assignment.

c. If an abuse allegation, neglect or exploitation involves a LHH employee and the ~~preliminary~~ conclusion to the investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by HR. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:

   i. Severity of the allegation,

   ii. Circumstances of the case per the investigation, and

   iii. Prior disciplinary and employment history.

d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to the LHH HR. The LHH HR shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse ~~in the Summary of Alleged Abuse Preliminary Report form that abuse~~ is substantiated.

e. LHH HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.

~~f.~~ If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact the Sheriff's Department. The nursing supervisor or manager shall initiate action to protect the resident and the Sheriff's Department and or San Francisco Police Department shall ~~jointly~~ carry out the investigation. ~~and initiate action to protect the resident.~~

f.

g. The nurse manager or nursing supervisor shall inform the resident and responsible party of the findings of the investigation and provide a feedback to the employee who reported the criminal incident or abuse allegation.

8. Forms Completion and Submission

a. The Charge Nurse or reporting employee shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.

~~a.~~b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the Nurse Manager/designee or Operations Nurse Manager or be designated to the Medical Social Worker to complete form SOC 341 during regular business hours and~~. Both reports must be~~ submitted to QM. (Refer to LHH designated site for copies of electronic forms related to the allegation of ~~Abuse~~ abuse ~~Investigation~~ investigation).

~~b.~~c. The investigating supervisor/manager conducting the investigation into resident abuse, neglect or exploitation shall verify that the Unusual Occurrence and Report of Suspected Dependent Adult/Elder Abuse forms have been completed and submitted to QM.

~~c.~~d. The SOC 341 shall be faxed to 415-751-9789 by the reporting employee and the fax verification submitted to QM.

~~d.~~e. In cases of resident-to-resident altercation, the investigating supervisor/manager shall complete the ~~""Abuse Preliminary Inquiry Form-Resident to Resident"~~ Investigation of Alleged Abuse form and submit the form, along with any attachments, to QM.

~~e.~~f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the investigating director/ manager conducting the inquiry shall complete ~~an "Abuse Preliminary Inquiry Form-Staff to Resident" form or "Abuse Visitor to Resident Abuse Investigation"~~ the Investigation of Alleged Abuse form and submit the form, along with any attachments to QM. Final conclusion ~~is~~ shall be determined by the Nursing Director.

~~f.~~g. In cases of injury on unknown origin, the investigation supervisor/manager shall complete the ~~"Abuse Preliminary Inquiry Form - Injury of Unknown Origin"~~Investigation of Alleged Abuse form and submit the form, along with any documents, to QM.

~~g.~~h. QM staff shall submit form SOC 341 to the Ombudsman Office via fax (415-751-9789) when fax verification by the reporting employee is not received by the QM staff.

~~h.~~i. QM staff shall provide a copy of the form SOC 341 to the Sheriff's Department.

9. Resident Assessment and Care Planning

a. In cases of allegations of abuse, neglect or exploitation or resident-to-resident altercation, the nurse manager or charge nurse, with input from other RCT members, shall take the lead in assessing and updating the residents care plan(s). Considerations for care planning may include the following:

i. Short-term and long-term measures to provide the resident with a safe and secure environment.

ii. Measures to mitigate the psychological impact of the incident.

iii. Identify Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.

iv. Physiologic factor(s) involved in this incident. (Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived? Was the resident in pain? Did the resident have signs of an infection or delirium?

v. Treatment that may have contributed to his/her behavior.

vi. Need for psychiatric evaluation.

vii. Environmental stimulus/factor(s) contributing to ~~in~~ this incident (excessive noise, crowded room).

viii. Ability to modify environment.

ix. Likelihood of a repeat incident.

x. What Interventions ~~to~~ can be implemented to minimize the risk of recurrence.

xi. Need relocation or transfer to another level of care.

ATTACHMENT:
Appendix One: Sample Guidance for "Conducting A Thorough Investigation"

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-07 Physical Restraints Including Siderails
LHHPP 22-08 Threats of Violence to Residents by an External Party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-06 Resident Complaints/Grievances
LHHPP 76-04 Workplace Violence Prevention Program
LHHPP B 3.0 Nursing Policy - Resident Funds
Form: "Dependent Adult/Elder Abuse Prohibition and Reporting Requirement"
Form: ~~Preliminary Investigation of Alleged Staff to Resident~~ Investigation of Alleged Abuse
~~Form: Preliminary Investigation of Resident to Staff Aggressive Behavior~~
~~Form: Preliminary Investigation of Resident to Resident Incident~~
Elder Justice Act of 2009

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05, 07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 17/09/12, 18/05/08 (Year/Month/Day)
Original adoption: 05/20/92

APPENDIX ONE:

The following guidance represents the components of an investigation that would constitute a thorough investigation. Documentation of all aspects of the investigation is essential in order to provide evidence that all allegations were thoroughly investigated.

GUIDANCE TO CONDUCTING A THOROUGH INVESTIGATION

1. Identify the type of reportable incident (injury of unknown source or alleged abuse).

2. If abuse is alleged, identify the type of abuse (i.e. physical, verbal, sexual, mental, neglect, involuntary seclusion, misappropriation of resident property).

3. If the reportable incident is an injury of unknown source:

    a. Describe the injury.

    b. Document the size, location, color, pattern and number of injuries.

    c. What treatment was required and provided?

    d. Document if the resident has had similar injuries.

    e. Identify any diagnoses or medications that have the potential for placing the resident at risk for injury.

4. Consider and document the time of the last observation of the resident prior to the reportable incident. What was the resident's condition prior to the reportable incident? What was the resident's condition after the reportable incident?

5. If the reportable incident is a case of suspected abuse:

    a. Examine the resident for any signs of injury.

    b. Was there a change in the resident's "usual" demeanor?

    c. Accurately describe the first signs of injury or any change in the resident.

    d. Photograph any actual injury in a manner that will show a close-up view of the injury and will not include the resident's face or other identifying features. The staff taking the photographs should sign and date the photographs and document the name of the resident on the photograph.

6. Interview the person reporting the incident.

    a. Was the incident reported timely?

b. What allegedly occurred?

c. When and where did the alleged incident occur?

d. If abuse is alleged, has an individual been identified as the abuser?

7. Develop a list of known and possible witnesses to the reportable incident.

8. Interview staff, residents, and/or visitors, or anyone who has or might have knowledge of the incident under investigation.

   a. Interview staff assigned to the resident at the time of the alleged incident.

   b. In addition, consider all possible witnesses such as housekeeping and dietary staff.

   c. Interview staff on other shifts that may have seen or heard something, such as 24 to 48 hours prior to the identification of the reportable incident.

   d. Attempt to narrow down the time of the alleged incident.

   e. Interview the resident in the same room, or residents in the immediate vicinity where the reportable incident occurred.

   f. Consider who may have seen or heard something and what they think could have happened.

   g. Observe and document any unusual demeanor of the person being interviewed

9. Identify the cognitive status of the victim(s) and resident(s) determined to be witnesses.

   a. Are they alert and oriented and able to answer questions appropriately?

   b. Can staff confirm the resident's ability to be an accurate reporter of the events?

   c. If so, document the interview with the staff related to the reliability of the resident.

   d. Review a copy of the resident's current MDS and the current plan of care, if applicable to the incident.

   e. If the witness (resident or roommate) is not alert and oriented, but the facility is utilizing the resident's statement in the investigation, explain why the resident is considered an accurate reporter (i.e., he/she has a history of consistently providing accurate information).

10. Review and have documentation of the alleged abuser(s) schedule for the 48-hour period prior to and the day of the reportable incident.

a. When and where was the alleged abuser(s) working at the time of the incident? Be specific as to the hall, section, and room numbers. Review and compare the assignment and the witness statements for accuracy of pertinent dates, times, location, and persons present.

11. Review the alleged abuser(s) personnel record for a history of previous disciplinary actions, previous employment evaluations, background investigation, in-service record, and the status of the certification or license. Interview co-workers and/or residents to gain knowledge of their experiences with the alleged abuser(s).

12. Document any action(s) taken by the facility to protect the resident and to prevent possible retaliation during the investigation (maintain punch card reports to show alleged abuser(s) was suspended during the investigation).

13. Document any knowledge of bias between alleged abuser(s) and witnesses. What is the relationship between the witnesses and the alleged abuser(s) (i.e. professionals, friends, relatives, and enemies)? Is there a reason the witness would wrongfully accuse the alleged abuser?

14. Were agency personnel involved? Identify the name of the agency, the contact person, and the names, address, and phone number of the agency staff employee(s).

15. If the allegation involves alleged sexual abuse, did a nurse immediately examine the resident? Did the nurse document the findings? Document if a physician examined the resident and maintain a copy of the examination. Document specifically what immediate action was taken by the staff at the time of the alleged abuse, i.e., facility secured, notification of administrator, physician, responsible party, law enforcement, evidence secured (resident's clothing not removed, resident not bathed).

16. If the allegation involves neglect, attempt to identify the staff involved. How were they involved and what was the outcome to the resident? Maintain physical evidence related to the care of the resident in use on the day of the incident (i.e., written plan of care, communication tools used to direct care such as signs above the head of the bed, personal care records, CNA assignments sheets, facility communication sheets). Signed and dated copies of any forms or documents used in the care of the resident at the time of the incident. If applicable, review facility procedures if the incident may be related to unsafe technique. Review and maintain the manufacturer's recommendations related to the use of special equipment. Review and identify any nurse's notes or other facility records that may contain information relative to the incident. What interventions were in place prior to the reportable incident?
17. If the allegation involves misappropriation of resident property, clearly identify the missing items and their approximate value. Document the immediate action taken, i.e. notification of law enforcement, and responsible party. Obtain copies of bills, charge slips, vendor receipts.

18. Facility Investigative File: At the onset of the investigation, begin compiling the investigative file, to be maintained as a record. A complete investigative file may contain/but is not limited to the following:

    a. Reporting sheets completed by staff to internally report the incident (i.e. Incident or Unusual Occurrence Reports which are confidential reports under Section 1157 Code), as well as reporting documents such as the Preliminary Investigation forms as evidence of appropriate reporting to the State survey agency.

    b. Witness statements for all witnesses, alleged abuser(s), and resident if applicable. Include written statements not only from everyone involved in the incident but also everyone who participated in any way in the investigation.

    c. Any written documentation related to an actual injury, (i.e., nurses notes, social work notes on the day of the incident and any other related dates), as well as pictures of the actual injury that identify the resident by name only, signed and dated by the staff member taking the photographs.

    d. Related physician's orders, such as an order for a particular transfer device, or for x-rays if there is evidence or suspicion of injury.

    e. The Resident Care Plan signed and dated by staff to show the care plan that was in place at the time of the incident.

    f. Documents that serve as instruction to CNAs related to the care of the resident.

    g. Manufacturer's recommendations related to the use of special equipment.

    h. In-service material with sign-rosters for equipment in use at the time of the injury that may potentially be involved in the cause of the injury (i.e., lift, transfer equipment, etc.). Include in-service and orientation records that show the staff was trained on any equipment related to the injury.

    i. The schedule for all staff on the unit at the time of the injury and 24 to 48 hours prior to the injury.

    j. Assignment sheets for staff caring for the resident at the time of the incident.

    k. Documents that show action taken by the facility to protect the resident.

    l. Name(s) of agency personnel on duty at the time of the incident, if applicable. Include the name of the agency, the contact person, and the names, addresses and phone numbers of all agency staff employee(s).

    m. Documentation of disciplinary action of the alleged abuser(s) at the time of the incident and any other time during their employment with the facility. Include a

copy of the background investigation prior to hire, and the current certification or license.

n. Documentation of any notification/referrals made as a result of the investigation such Board of Nursing or law enforcement.

SUMMARY REPORT OF FACILITY INVESTIGATION

Upon conclusion of the investigation, the facility should prepare a report to include details of the investigation, any actions taken by the facility (i.e., staff training, disciplinary actions, interventions to prevent further injury/alleged abuse), a summary of the findings and a conclusion of the investigation (i.e., was the allegation substantiated or unsubstantiated). Document any notifications/referrals made as a result of the investigation (i.e., law enforcement, Board of Nursing).

REFERENCE SOURCE:

http://www.scdhec.gov/health/cert/investigation.pdf#xml=http://www.scdhec.gov/cgi-bin/texis.exe/Webinator/search/xml.txt?query=conducting+a+thorough+investigation&pr=www&prox=page&rorder=750&rprox=750&rdfreq=250&rwfreq=500&rlead=1000&sufs=1&order=r&cq=&id=460c950b7

PROCUREMENT CARD

POLICY:

Laguna Honda Hospital (LHH) utilizes a procurement cards (P-Card) for the acquisition of materials, supplies, and services that are not readily available through the normal purchasing mechanism due to the unique needs of resident programing, physician credentialing, and disaster response, and on-line business transactions..

PURPOSE:

To ensure a process for the procurement of materials, supplies, and services that is efficient and maintains appropriate internal controls in compliance with City Controller's policy.

CHARACTERISTICS:

1. P-Cards are used to procure non-medical resident related materials, supplies and services within the Activity Therapy, Rehabilitation, Social Services, and Substance Treatment and Recovery Services (STARS) programs. The LHH Gift Fund is the funding source for these programs.

1.2. -P-Cards are used for physician credentialing, hospital certifications, and emergency and disaster response. P-Cards are also used to maintain appropriate balances for the hospital's Fastrak accounts.

2.3. Use of P-Cardss for physician credentialing and disaster response is appropriate only when normal purchasing mechanisms are prohibitive.

PROCEDURE:

1. The Chief Financial Officer (CFO) or designee maintains the role of **Department Coordinator** for the P-Card program. Responsibilities include:

   a. Oversight of the P-Card program for the hospital.

   b. Approves requests for P-Cards from Approving Officials.

   c. Reviews and approves reports for P-Card use and performance.

   c.d. Approves payments to US Bank for P-Card transactions.

   d.e. Liaison with the P-Card Coordinator in the Controller's Office.

2. The Director of Wellness and Therapeutic Activities, Manager of Rehabilitation Programs, Director of Social Services, and the Director of Psychology, and the Chief

Medical Officer or designees maintain the role of **Approving Officials** for the P-Card program within their respective departments. Responsibilities include:

a. Oversight of proper P-Card use within their departments.

b. Make requests to Department Coordinator for P-Cards for employees under their supervision. Notify Department Coordinator of change of employment status of cardholders within their departments.

c. Approve cardholder purchases, and verify that purchases are made for official hospital business.

d. Review and certify the reconciled Cardholder Statements of Account, and ensure that original receipts and documents are in order.

e. Ensure that each cardholder statement of account is accounted for and forward them to the Billing Official.

3. The -Accounting Cashier Supervisor Gift Fund Program Manager maintains the role of **Billing Official**. Responsibilities include:

   a. Receives, reviews, and ensures accuracy of account statements, receipts, and reconciliation reports.

   b. Facilitates monthly P-Card payments to U. S. Bank and charges expenses to proper accounts.

   c. Determines whether proper sales tax has been paid and accrue any use tax.

   d. Prepares reports for the Department Coordinator.

   e. Executes payments to US Bank within the City's Financial System.

4. Assigned staff of the above mentioned programs are **Cardholders**. Responsibilities include:

   a. Review and consent the CCSF P-Card Cardholder Guide.

   b. Maintain security of the account number and P-Card.

   c. Make appropriate purchases while securing the value for the hospital.

   d. Secure itemized original receipt at the point of purchase and verify for accuracy.

   e. Complete expense form.

   f. Reconcile all transactions and forward original receipts and expense forms to Approving Official.

g. Cardholders shall return P-Card to Department Coordinator if position duties change.

5. All staff involved with P-Card, shall complete training developed by the Controller's Office and comply with the standards established in the City and County of San Francisco's policy on Procurement Card.

6. All P-Cards issued to cardholders will have a default credit limit of $1,000.

7. The expenses in support of Activity Therapy~~, Rehabilitation, Social Service~~, and STARS programs may not exceed Gift Fund budget limits established by the Gift Fund Committee and approved by the Health Commission.

8. Potential cardholders/requesters shall complete a Procurement Card Request Form with approval from their department head and the LHH CFO. The requesters shall indicate and sign the request form acknowledging that they have read and understand the P-Card policy.

9. Cardholders shall make purchases in support of department programs.

10. Cardholders shall download and print monthly statements, reconcile all transactions, and forward all documentation including original receipts and expense forms to their respective Approving Officials prior to the 28th of each month. If the 28th falls on a weekend, the original receipts are forwarded to the Approving Official on the previous business day.

11. Approving Officials shall review P-Card documentation and approve Cardholder transactions, then forward P-Card documentation to the Billing Official by the 2nd of the following month unless it falls on the weekend, then the previous business day.
~~11. Approving Officials shall review P-Card documentation and approve Cardholder transactions in U.S. Bank Access Online system.~~

~~12. Approving Officials shall forward P-Card documentation to the Billing Official by the 2nd of the following month unless it falls on the weekend, then the previous business day.~~

12. The Billing Official shall review and reconcile P-Card documentation and direct Accounting staff to set up payment to U.S. Bank in the City's Financial System by the 4th of each month or prior if that date falls on the weekend.
~~13. The Billing Official shall review P-Card documentation and make monthly payments through Accounting staff to U.S. Bank by the 6th of each month or prior if falls on the weekend.~~

13. ~~The Department Coordinator or designee shall approve all entries in City's Financial System.~~The Billing Official forwards P-Card documentation to the Department Coordinator for review and approval by the 6th of the month or prior if that date falls on the weekend.

14. Upon approval by the Department Coordinator, the Billing Official will approve payment to U.S. Bank in the City's Financial System by the 8th of each month or prior if that date falls on the weekend.

~~The Accounting Cashier Supervisor~~

P-Card statements generated on the ***25th*** of each month or previous business day if the 25th falls on a weekend. Card payment due ***14 days*** from the statement date		
Staff/Role	**Description**	**Monthly Due Date**
Cardholder	Downloads statement, reconciles transactions and submits original receipts with expense form to Approving Officer	28th or prior if weekend
Approving Official or Designee	Reviews & approves Cardholder documents and submits them to Billing Officer/Accounting Department	2nd or prior if weekend
Billing Official/Accounting	Reviews and reconciles all documents including on-line bank statements, sets up payment in City's Financial System, and submits to the Department Coordinator	4th or prior if weekend
Department Coordinator or Designee	Reviews all documentation and approves payment.	6th or prior if weekend
Billing Official/Accounting	Approves payment in the City's Financial System	8th or prior if weekend

~~14. shall reconcile the U.S. Bank statements by the 16th of each month.~~
~~15.~~

~~P-Card statements generated on the ***25th*** of each month or previous business day if the 25th falls on a weekend. Card payment due ***14 days*** from the statement date~~		
~~**Staff/Role**~~	~~**Description**~~	~~**Monthly Due Date**~~
~~Cardholder~~	~~Downloads statement, reconciles transactions and submits original receipts with expense form to Approving Officer~~	~~28th or prior if weekend~~
~~Approving Officer or Designee~~	~~Reviews & approves Cardholder documents and submits them to Billing Officer/Accounting Department~~	~~2nd or prior if weekend~~
~~Billing Officer/Accounting~~	~~Review, process, and approve payment to U.S. Bank in City's Financial System~~	~~6th or prior if weekend~~
~~Accounting Cashier Supervisor~~	~~Reconciliation of bank statements~~	~~16th or prior if weekend~~

~~16.~~15. A P-Card is issued to the Medical Staff Secretary to transact on-line physician credentialing charges. The Medical Staff Secretary assumes the role and

responsibilities of the card holder. The Medical Director assumes the role of Approving Official.

16. Medicare/Medi-Cal certification and Fastrak account payments are transactions for which an Accounting staff member is assigned the role of Cardholder.

    a. Hospital staff responsible for Medicare/Medi-Cal Certification contact the Accounting staff member to facilitate on-line payment and assumes the role of Approving Officials for the transactions.

    a.b. The Program Manager, Gift Fund monitors the hospital's Fastrak account in which automatic payments are set up using the purchase card issued to the Accounting Staff member. When the automatic payments are generated, The Program Manager, Gift Fund contacts the Accounting Department staff member to facilitate payment on the account. The Director of Environmental Services assumes the role and responsibility or the Approving Official for Fastrak payments.

        i. Departments having been issued transponders maintain Fastrak usage logs which are check against monthly Fastrak statements.

    c. The Accounting staff member fulfils the responsibilities of the Cardholder and forwards all documentation to the Approving Official who in turns submits approved documents to the Billing Official, all within the established timelines.

17. Declared Emergency and Natural Disasters

    a. Emergency purchases during Declared Emergencies and Natural Disaster. Refer to San Francisco Administrative Code Section 21.15 and Section 6.60 for emergency procurement procedures and who can declare emergency. Disaster P-Cards do NOT replace the City's existing Emergency Purchasing Procedures, but will supplement the procedures.

    b. A P-Card is issued to the Director of Emergency Response and Workplace Safety. The default credit limit for that card is $5000. Prior to an emergency being declared, the CFO will request pre-approval of a credit limit increases in the event of an emergency. When an emergency is declared, the department will take the following steps to increase P-Card credit limit should the need of credit limit increase arise:

        i. The CFO or designee will contact the Citywide P-Card Administrator to request an emergency increase to the P-Card credit limit.

        ii. The City Controller's Office will contact U.S. Bank to increase the credit limit.

    c. The Director of Emergency Response and Workplace Safety CFO or designee will coordinate all purchases in response to an emergency or disaster.

d. The Director of Emergency Response and Workplace Safety~~CFO~~ is responsible for reconciling all transactions and forwarding original receipts and expense forms to the CFO~~Executive Administrator~~ for verification.

e. All Documentation related to emergency and disaster purchases are forwarded to the Office of the Controller for financial processing.

ATTACHMENT:
Attachment A: Procurement Card Request Form

REFERENCE:
LHHPP 45-01 Gift Fund Management
CCSF Procurement Card Policy and Procedures
CCSF Purchasing Cardholder Guide
San Francisco Administrative Code Section 21.15 and Section 6.60

Revised: 18/05/08 (Year/Month/Day)
Original adoption: 16/11/08 ~~(Year/Month/Day)~~

Attachment A: Procurement Card Request Form

Procurement Card Request Form

Name		DSW #	
Department	Department of Public Health	Department Code	DPH
Division	Laguna Honda Hospital	Division Code	HLH
Program			
Job Title		Job Class #	
Address	375 Laguna Honda Boulevard	Room #	
City	San Francisco	State/Zip Code	California, 94116
Work E-mail		Work Phone	
Approving Officer of Designee			

☐ I have read and understand the hospital policy and procedure of the use of Procurement Cards

Name ____________ Signature ____________

Department Head ____________ Signature ____________ Chia Yu Ma, Chief Financial Officer ____________ Signature ____________

REVIEW OF SENTINEL EVENTS (APPLICABLE TO ACUTE CARE UNITS ONLY)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) ~~employees~~ shall report and investigate ~~all~~ sentinel events to improve safety and learn from those events occurring on the acute care units~~.~~ The definition of a sentinel event shall be applied to only to incidents that occur on the acute care units at ~~Laguna Honda~~LHH.

Refer to Policies and Procedures on Patient Safety Committees and Plans (LHHPP File: 60-13), Risk Management Program (LHHPP File 60-08), Unusual Occurrences (LHHPP File: 60-04), Incidents Reportable to the State of California (LHHPP File: 60-03) for serious events occurring on the Skilled Nursing Facility.

PURPOSE:

1. To facilitate the investigation of sentinel events, including performance of a root cause analysis, to ensure that appropriate corrective actions are taken to minimize recurrences and protect residents.

2. To have a positive impact in improving patient~~/resident~~ care; treatment and services; and minimize the risk of future adverse events.

3. To focus the attention of the organization that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures/gaps in processes, or organizational culture).

4. To increase general knowledge about sentinel events, their contributing factors and strategies for prevention.

DEFINITIONS:

1. Division Heads: Individuals responsible for the following divisions within the hospital include: Nursing Services, Medical Services, Clinical Services, Operations, Finance, Information Services, and Human Resources.

2. Joint Conference Committee: A subcommittee appointed by the Health Commission, which serves as the Governing Body, to oversee administration of Laguna Honda Hospital and Rehabilitation Center.

3. Medical Peer Review/Credentials Committee: A committee of the Medical Staff that comprises certain physician members of the Medical Executive Committee.

4. Performance Improvement and Patient Safety (PIPS) Committee: A committee of the Medical Staff, with interdisciplinary membership representing medicine, psychiatry,

rehabilitation, nursing, administration, pharmacy, infection control, nutrition services, health information services, activity therapy, social services, Deputy City Attorney and the quality improvement coordinator.

5. Root Cause Analysis: A systematic process used to identify the causal factors that contributed to the event or problem. The root cause analysis focuses primarily on systems and processes, while understanding how individual performance contributed and is influenced by system factors. It is used to identify opportunities for improvement in systems and/or processes with the goal of reducing the likelihood of recurrence of comparable or related events.

6. Sentinel Event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

   a. Death

   b. Permanent harm

   c. Severe temporary harm* (critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

7. Other Reviewable Events

   a. An event is also considered sentinel if it is one of the following:

      i. Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge

      ii. Abduction of any patient receiving care, treatment, and services

      iii. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting, leading to death, permanent harm, or severe temporary harm to the patient

      iv. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)

      Acts of major security issues or violence such as rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any person while on site at the hospital.

v. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure

vi. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery

PROCEDURE:

1. Sentinel Event Notification

a. During regular business hours, Laguna HondaLHH employees will report sentinel events to their Division Heads. The Division Head will immediately notify the Administrator on Duty (AOD), the Executive Administrator, the Chief Nursing Officer, the Chief Medical Officer, the Director of Quality Management, the Deputy City Attorney (DCA) and the Risk Management Nurse (RMN) or designee.

b. After regular business hours, Laguna HondaLHH employees will report sentinel events to their Division Heads, if available, or if not available, to the AOD. If the employee notifies the Division Head, the Division Head will notify the AOD who will immediately notify the individuals listed above. If the AOD is notified directly by the employee, the AOD will notify the individuals listed above, as well as the division head.

The Chief Medical Officer or designee will determine whether the event will be treated as sentinel based on the information provided by the preliminary investigation.

c. The RMN or designee will evaluate the incident and, if applicable, timely report the event to the California Department of Public Health (CDPH) as per regulation.

2. Sentinel Event Process

a. The Division Head(s) or designee(s) will complete the initial sentinel event investigation in consultation with the Deputy City Attorney. The RMN or designee, under the auspices of the PIPS Committee, will appoint an investigation team to gather facts and to perform a root cause analysis. The investigation team will include the Deputy City Attorney and the Director of Quality Management in addition to appropriate clinical and administrative staff, as necessary. The initial meeting will convene no later than three (3) business days after the sentinel event. The team will investigate the sentinel event to identify the facts, systems issues and processes that affect the care, services or safety of residents, visitors or staff, to decide preventability and to propose corrective action. Within 10 days of the initial meeting, the RMN or designee will provide documentation of the investigation and plan of correction to the Executive Administrator, through the Chair of the PIPS Committee.

b. The investigation team, in consultation with the RMN or designee, shall develop the plan of correction, identify individual(s) responsible for corrective action, and will submit its findings and recommendations to the PIPS Committee. The RMN or designee will distribute the plan to the division or department head of the person assigned to carry out the activities and processes toward resolution. The RMN or designee may inform or consult with other ~~Laguna Honda~~LHH administrative, executive or medical committees. The RMN or designee will monitor the implementation of the plan of correction at least weekly until completed and will report findings to PIPS Committee until resolved. The investigation team may meet more frequently, as necessary, to assure that the plan of correction is implemented and resolves the issues. If the PIPS Committee determines of the plan of correction does not obtain the desired outcomes within specified time frames, the RMN or designee will report the matter to the Executive Administrator.

c. The RMN or designee will report to the Director of Quality Management any changes in the status of the affected party. Throughout this process and within the appropriate time frame, the Director of Quality Management will ensure that ~~Laguna Honda~~LHH reports the event to external and/or regulatory agencies.

3. Reporting

a. The RMN or designee will present the results of all investigations, interviews and plans of correction to the Chair of the PIPS Committee. The Chair of the PIPS Committee or designee will report findings to the Medical and Hospital Executive Committees and the Joint Conference Committee. These reports will identify systems problems and opportunities for improvement. If the findings identify an individual responsible for the sentinel event, the PIPS Committee will refer these findings to the appropriate department or to the Medical Peer Review / Credentials Committee for further investigation and appropriate corrective action.

4. Record Maintenance

a. The RMN or designee will maintain a confidential file for all documented discussions, meetings and investigations regarding the event in a central repository along with the approved Plan of Correction and outcome data.

ATTACHMENT:
None.

REFERENCE:
LHHPP File: 60-03 Incidents Reportable to the State of California
Joint Commission Standards on Sentinel Events (CAMH~~LTC~~ Update 1, ~~March~~ July ~~2012~~2017)

Revised: 00/03/15; 02/03/14, 07/12/17, 08/01/08, 15/01/13, 16/03/08, 16/07/12, 18/05/08 (Year/Month/Day)
Original adoption: 97/11/10

POWER OUTAGE QUICK REFERENCE RESPONSE GUIDE

ANTICIPATED IMPACT

Moderate to Significant

1. Disruption of normal operations and services in one or more areas, possibly for an extended period of time
2. Potential injuries and stress to residents, visitors, and staff
3. Loss of safety and security systems necessitating increased monitoring, support and activation of down time procedures
4. Potential loss of related utility systems such as oxygen, suction, HVAC, and negative pressure isolation
5. Possible evacuation in adverse conditions with little lighting
6. Possible influx of patients and community if power is partially or completely restored but is still down in other areas outside of Laguna Honda

Elevators in all buildings are on generator power and would continue to function unless there is seismic activity. (Refer to Earthquake Quick Reference Response Guide)

MISSION

Take appropriate action during a power outage to reduce injury and loss of life and facilitate recovery. Maintain or restore generator power from two (2) emergency generators to power all outlets and switches with red cover plates and essential systems, including medication systems and elevators.

GOAL	ACTIONS
Coordinate activities with other hospitals, DPH and the community	Contact the Department of Emergency Management to report issues and coordinate resource requests. DEM coordinates with the Emergency Operations Center (EOC) for a city-wide response. State and Federal agencies are contacted as determined by local DEM and EOC authorities
Communicate to stakeholders	Notify the 24-hour watch engineer who will institute Facility Services policy for power outage, including notification of PG&E, extricating persons trapped in elevators, and checking the building and grounds for function, safety, and hazards (PG&E outage report number for businesses is 1 800 743-5000; status update number is 1 800 743-5002) Initiate Hospital Incident Command System, beginning with notification of the Administrator On Duty (AOD). Notify the Nursing Operations Manager evenings, nights, weekends and holidays. Receive and Initiate alerts: between Laguna Honda and DPH/ DEM and through CAHAN via any working system available: analog (red) phones on each unit, 800 MHz radio, cell phones, computer/ email, messenger Disseminate official notifications through Public Information Officer (PIO) Use public address system, email, pages/ page group, 800 Mhz radios, community meetings and other venues to disseminate information as directed by PIO with approval of Incident Commander Initiate call back lists if directed by Incident Commander Keep Hospital Incident Command and DPH Incident Command apprised of status and resources needed or available Refer ALL media representatives to the Hospital Incident Command Center

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

POWER OUTAGE QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS
Assure safety and well-being of self, residents and others	Proceed carefully due to unseen hazards/ obstructions Obtain flashlights, available from the 1st cabinet in each nurses' station and elsewhere on each neighborhood and in each department Check residents for injuries and fall risk. Prioritize checking all bathrooms: they have no windows and would be very dark, creating a significant fall risk Check every space and every person Account for all persons in your neighborhood or department Complete the Department Operating Status Report, Appendix F of 70-03 Emergency Response Plan and report status to the Hospital Incident Command Center at 4- INFO (44636). This document includes accounting for persons in area, name of anyone missing, number of injuries, hazardous conditions, and resources needed Follow your Department Specific Emergency Response Plan (70-03 Emergency Response Plan, Appendix D)
Mitigate secondary hazards	Follow all directions from the command center and report changes in status Do not use elevators until advised of their safety Keep essential resident care equipment plugged into red outlets Turn off unnecessary lights and equipment as needed to avoid added demand when power is restored Do not turn on non-essential lights or equipment until advised to do so by the command center When cleared to do so, check all equipment and lights in the area you are responsible for and notify the command center of negative effects due to the power outage Notify the Help Desk at 206-5035 or 725-7300 if assistance in needed to restore computer systems Sheriff's Department directs incoming visitors to specific areas and restricts hospital access if directed by Incident Command.
Provide essential services as usual and return to full service as soon as possible	Continue or re-establish usual care according to essential service priorities within the Laguna Honda Continuity Of Operations Plan (COOP)

OTHER REFERENCES

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

POWER OUTAGE QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS

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

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

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

- Emergency Responder Dispensing Plan
- Medical Surge Quick Reference Response Guide
- Power Outage Quick Reference Response Guide
- Water Disruption Quick Reference Response Guide

POWER OUTAGE REPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents in the event of a power outage by using generator power and/or downtime procedures.

PURPOSE:

To take appropriate action during a power outage to prevent injury and loss of life and to facilitate recovery.

PROCEDURE:

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

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

   b. Minimize damage to property

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

POWER OUTAGE QUICK REFERENCE RESPONSE GUIDE

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

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

   b. Initiate emergency call backs if the implementation of any downtime procedures requires extra labor resources not available on site.

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

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

   a. All employees shall contact the command center with questions about the power outage, to report hazards, or to request resources to assist with safe, quality delivery of care.

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

4. Ensure Safety of all Persons and Continue Quality Care of Residents

   a. Neighborhood staff shall account for all residents, staff, and visitors in the neighborhood.

   b. Check for injuries and fall risk. Prioritize checking all bathrooms, which will be very dark, creating a significant fall risk.

   c. Each neighborhood has a supply of emergency lighting equipment, including flashlights and lanterns that may be used to provide care in poorly lit locations.

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

   e. Activate the Continuity of Operations Plan (COOP) 70-01 B2 and follow your department's downtime procedures to continue care without equipment or systems that may be unavailable due to power outage.

5. Mitigate secondary hazards

POWER OUTAGE QUICK REFERENCE RESPONSE GUIDE

a. Follow all directions from the command center and report changes in status

b. Keep essential resident care equipment plugged into red outlets, which are powered by the emergency generators.

c. Turn off unnecessary lights and unplug unnecessary equipment as needed to avoid excess demand when power is restored.

d. SFSD shall notify incoming visitors of the power outage and restrict hospital access if directed by the HICS Team.

6. Once Power Has Been Restored

a. When power is restored, the command center will notify the Nursing office and they shall notify building occupants via overhead page.

b. Check all equipment and lights and notify the command center of negative effects caused by the power outage.

c. Notify the IT Help Desk at 4-3577 or dph.helpdesk@sfdph.org

ATTACHMENT:
None.

REFERENCE:

LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)

Revised: 18/05/08 (Year/Month/Day)
Original adoption:

NOTIFICATION AND DOCUMENTATION OF UNANTICIPATED CHANGE IN RESIDENT STATUS

POLICY:

1. The Licensed Nurse shall will notify the physician whenever there is an unanticipated change in resident's physical, mental, or psychosocial condition indicative of decline resulting from injury, acute medical illness or resulting from the progression of a chronic medical conditions.

2. The Licensed Nurse communicates verbally using SBARN* Method of Communication when notifying the physician.

3. Non-urgent clinical issues, such as unsigned orders, expired medications, non-critical medications will be communicated to the primary care physician during regular business hours using clipboard.

4. When the physician arrives to evaluate the resident, the licensed nurse will be available to provide pertinent assessment information and assist as necessary.

5. When there is a change in resident condition, the family or surrogate decision maker will be notified by the physician or licensed nurse depending on the situation.

PURPOSE:

To inform the physician about changes in resident's condition using a standardized communication method so that the resident receives timely and appropriate treatment interventions.

BACKGROUND:

A **"significant change"** is defined in the RAI/MDS as a decline (or improvement) in a resident's condition that (a) will not normally resolve itself or is not self-limiting; (b) impacts more than one area of the resident's health status; and (c) requires interdisciplinary review and/or revision of the resident care plan.

Reportable significant changes for decline or improvement are listed below but not limited to:

1. Significant change in the resident's physical, mental or psychosocial condition.
2. A significant change or alteration in the treatment or care plan.
3. A decision to transfer or discharge the resident from the facility.
4. Significant change of weight (5 pounds or 5% within 30 days or 10% within the last 180 days).
5. An untoward reaction to medications or treatments.
6. Any life-threatening error in medicine or treatment (any risk to the resident).
7. Any time the facility is unable to timely obtain or administer drugs, equipment, supplies or services as prescribed, under conditions which present a risk to the health, safety or security of the resident.

PROCEDURE:

A. Before contacting the physician, gather the following information:

1. Assess the resident for vital signs, change in mental status, symptoms, and pertinent physical findings.

2. Review the chart/electronic health record for last progress notes, any recent treatment and medication changes, recent lab results, and advanced directives.

3. Have the resident's medical record and MAR available

B. Use SBAR* Method of Communication:

1. **S – SITUATION:** What is the problem or concern regarding resident

   a. **Identify yourself**: state your name, position i.e. job title
   b. **Identify the resident:** "I am calling about….resident name**,** age**,** household room number/ bed number…"
   c. **Describe the situation** you are calling about: "The reason I am calling is……"

2. **B – BACKGROUND:** Brief, related to the point

   a. State the **admission diagnosis and date** of admission
   b. State the **pertinent medical history, recent laboratory results** pertaining to the current problem
   c. State a **brief synopsis of the treatment** to date, code status

3. **A – ASSESSMENT:** What you found and what you think or what is your assessment

   a. **Pertinent subjective information** gathered from resident, family or nursing caregivers. The chart, MAR, medication allergies and other needed documentation are to be available for easy reference.
   b. **Pertinent objective data**
      i. Most recent vital signs including quality of respiration or changes in pulse rhythm, pain assessment, skin color
      ii. New or changed medications significant to current status
      iii. Neurological changes: Mental status – new behaviors
      iv. Any interventions taken and their effectiveness

4. **R – RECOMMENDATION:** State what you would like to see done

   a. Change in treatment? How often?
   b. Diagnostics: Lab/CXR/EKG?
   c. Ask MD: "If resident does not improve, when do you want to be called again?

A. Physician Notification using SBARN* Method of Communication

See attached Appendix A

B.C. Family/Significant Others Notification

For family notifications regarding a serious incident or change in condition, the licensed nurse and physician will discuss the situation and make a decision regarding which of them should notify family/significant other, taking into account any prior relationship with the family /significant other and the risk management implications, refer to LHHPP 24-11.

C.D. Reporting and Documentation

1. Electronic Health RecordIntegrated Progress Notes

   a. Chart the date, time and name of the physician who was notified of the change in resident's condition and each subsequent attempt to notify the physician.
   b. Document notification of the Nurse Manager, Nurse Supervisor, or Program Director.

2. Comprehensive MDS Assessment

   A Significant Change of resident condition requires that a comprehensive MDS Assessment is completed no later than fourteen (14) days after the determination by the Resident Care Team (RCT) members that a significant change has occurred. After completion of MDS assessment, a special Resident Care Team Conference should be scheduled for RCT discussion.

APPENDIX:

Appendix A: Physician Notification Using SBARN* Method of Communication
NONE

REFERENCES:

RAI/MDS Manual
SBAR Tool was developed by Kaiser Permanente
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

CROSS REFERENCE:

LHHPP File # 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of Change in Condition
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
LHHPP 23-02 Completion of RAI
LHHPP 24-24 Nurse-Physician Communication during Quiet Hours 10 PM to 6 AM

Revised: 10/2000, 1/2006, 1/2008, 12/2009, 10/2010; 05/12/2015, 12/2017

Reviewed: 05/12/2015

Approved: 05/12/2015

APPENDIX A

USING SBAR~~N~~* Method of Communication

A. Before contacting the physician, gather ~~complete~~ the following information:

1. Assess the resident for vital signs, change in mental status, symptoms, and pertinent physical findings.

2. Review the chart/electronic health record ~~LCR~~ for last progress notes, any recent treatment and medication changes, recent lab results, and advanced directives.

3. Have the resident's medical record and MAR available

B. Use SBAR~~N~~* Method of Communication:

1. **S – SITUATION:** What is the problem or concern regarding resident

   a. **Identify yourself**: state your name, position i.e. job title
   b. **Identify the resident:** "I am calling about….resident name**,** age**,** household room number/ bed number…"
   c. **Describe the situation** you are calling about: "The reason I am calling is……"

2. **B – BACKGROUND:** Brief, related to the point

   a. State the **admission diagnosis and date** of admission
   b. State the **pertinent medical history, recent laboratory results** pertaining to the current problem
   c. State a **brief synopsis of the treatment** to date, code status

3. **A – ASSESSMENT:** What you found and what you think or what is your assessment

   a. **Pertinent subjective information** gathered from resident, family or nursing caregivers. The chart, MAR, medication allergies and other needed documentation are to be available for easy reference.
   b. **Pertinent objective data**
      i. Most recent vital signs including quality of respiration or changes in pulse rhythm, pain assessment, skin color
      ii. New or changed medications significant to current status
      iii. Neurological changes: Mental status – new behaviors
      iv. Any interventions taken and their effectiveness

4. **R – RECOMMENDATION:** State what you would like to see done

   a. Change in treatment? How often?
   b. Diagnostics: Lab/CXR/EKG?
   c. Ask MD: "If resident does not improve, when do you want to be called again?

5. **N* – NOW:** Urgency of the situation (LN should indicate to physician the need to see patient now)

    a. Is there an urgency for the physician to do further evaluation?
    b. Is there an urgency to transfer resident to the hospital?

    Note: **N*** was added to SBAR by LHH Medical Staff to indicate the urgency of physician evaluation with the N (now)

Revised: 1/2008, 9/2009, 12/2009; 05/27/2014; 05/12/2015

Reviewed: 05/12/2015

Approved: 05/12/2015