Annual Departmental and Hospital-wide Policies and Procedures Review Submitted to the Joint Conference Committee (JCC) for Approval on September 11, 2018

The annual Laguna Honda Hospital (LHH) policy and procedure review meeting was held on August 28, 2018 to review hospital-wide and departmental policies and procedures that were newly developed, revised or deleted over the past year. This includes policies and procedures that were previously submitted and approved by the JCC on 11/14/2017, 01/09/2018, 03/13/2018, 05/08/2018, and 07/10/2018.

Policy and Procedure changes that have not been previously submitted and approved by the JCC are listed and summarized below:

Hospital-wide Policies and Procedures

Revised Policies

Policies	Comments
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response	Revised to add a grid for quick reference of the new federal regulations for reporting crimes and/or allegations of abuse.
LHHPP 27-05 Tracheostomy Management	Revised to specify two resources available for assistance with tracheostomy management (Ear, Nose and Throat specialist (ENT) and/or Tracheostomy Team); revised to state that the ENT shall make recommendations for management instead of the Trach Team.
LHHPP 65-01 Procedures for Grant Application, Acceptance and Expenditure	Revised to provide clarity on the various levels of grant application and acceptance that require approval from the Board of Supervisors; revised to identify the information required for accept and expend documentation and details pertaining to the responsibilities of the grantee(s) and the Accounting Department.
LHHPP 70-01 A3 Emergency Resources and Maps	Revised to reflect updated resources and map.
LHHPP 70-01 B3 Resident Evacuation Plan	Revised to add new procedures for the decision to evacuate and for employee training; added Appendix A for Alternate Care Sites.
LHHPP 70-01 C4 Medical Surge Plan	Revised to reflect updated procedures.
LHHPP 70-01 C8 Water Service Disruption Response Plan	Revised to reflect updated procedures.
LHHPP 72-01 A7 Reportable Communicable Diseases	Revised to reflect updated contacts; updated Appendix A with the latest version of Reportable Diseases and Conditions for SFDPH.
LHHPP 72-01 A9 Contact/Exposure Investigation	Revised to pertain to residents only; employee aspects of contact and exposure investigation are referenced in a separate policy.
LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions	Updated list of diseases/conditions to include bed bugs, cyclosporiasis, MERS Co-V (Middle Eastern Respiratory Syndrome Coronavirus), and Zika virus.
LHHPP 72-01 C24 Employee Influenza Vaccination(s) Policy and Use of Surgical Masks When	Revised Employee Health Services hours to Monday – Friday 7:00 am to 4:30 pm.

Vaccination(s) is Declined	
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis	Revised to add description of positive induration.
LHHPP 72-01 E3 Barber and Beauticians	Revised to specify the types of disinfectant to be used; added a new procedure for cutting hair with lice infestation.
LHHPP 73-02 Asbestos and Lead Management Plan (re-titled)	Re-titled to include lead management; revised policy to conform to Cal OSHA, EPA, and Bay Area Air Quality Management District regulations.
LHHPP 73-05 Workplace Violence Prevention Program	Revised to add procedure for Campus Safety and Security (CSS) Committee; and clarified procedure on Education of the Workplace Violence Prevention Program.
LHHPP 76-02 Smoke and Tobacco Free Environment	Revised to change to a smoke free facility and designate a smoking area for residents on campus; staff, vendors, and visitors will need to go off campus to smoke.

Department: Admissions & Eligibility

No changes were made.

Department: Central Processing Department

No changes were made.

Department: Clinical Laboratory Services

No changes were made.

Department: Clinical Nutrition Services & Diet Manual

<u>Revised Policies</u>

Policies	Comments
Diet Manual	Major changes made: •The Clinical Nutrition neighborhood assignments and phone/pager list updated. •Language added to the introduction page that helps support our nutritional analysis. It helps to provide supporting language that explains why we are unable to provide adequate analysis of some nutrients. •The front page of each diet includes the basic principles, indication, adequacy/ approximate composition of calories, protein, carbohydrate & fat with suggested meal plan. Every diet's nutritional composition has been updated with the current nutritional analysis that was completed for our 28 day menu cycle. •The following diets have been eliminated because they are obsolete. All protein restricted diets (40 gm, 50gm, 60 gm) are eliminated and we will keep only the Renal 60 (60 gm protein, 2gm sodium & 2-3gm potassium restricted). And the 100 gram fat

	test diet. •Added a description for the 7 major food allergies/intolerances with reference to the Academy of Nutrition and Dietetics Nutrition Care Manual.
1.11 Nutritionally Adequate Meals	Revised to add language related to adequacy of nutrients & diet manual
1.12 Registration of Dietitians	Updated it to include the CDR website referenced and the CMS guideline reference for “qualified dietitian” and “sufficient staffing”

Deleted Policies

Policies	Comments
1.14 Charging for Enteral Feedings	Delete
1.20 Charting Deficiencies	Delete
1.26 Test Routines	Delete

Department: Environmental Services

No changes were made.

Department: Facility Services

Revised Policies

Policies	Comments
DP-01 Format of Manual	Revised to reflect updated procedures.
DP-02 Organizational Chart	Revised to reflect updated procedures.
DP-03 Watch Engineer Responsibility and Response Time	Revised to reflect updated procedures.
DP-04 Facility Services Employee Cellular Phone and Pagers	Revised to reflect updated procedures.
DP-07 Work Clothes	Revised to reflect updated procedures.
DP-08 Stationary Engineers Assigned Areas	Revised to reflect updated procedures.
DP-13 Work Site orientation for New Employees	Revised to reflect updated procedures.
DP-14 In-Service Training	Revised to reflect updated procedures.
DP-17 Patient’s Smoking Precautions	Revised to reflect updated procedures.
DP-26 Request for Housekeeping Services	Revised to reflect updated procedures.
DP-27 Employee Health/Sick Leave Policy/Call-In Sick Log	Revised to reflect updated procedures.
DP-29 Keys, Key Security, and Security	Revised to reflect updated procedures.
DP-30 Responding to Locked Wards	Revised to reflect updated procedures.
DP-31 Body Substance Isolation Policy	Revised to reflect updated procedures.

Deleted Policies

Policies	Comments
DP-6 Resetting Time Clocks	Obsolete
DP-11 Reporting Vehicle Accidents	Duplicate of LHHPP 75-09
DP-15 Unusual Occurrence Reporting	Duplicate of LHHPP 60-04
DP-18 Smoking Policy	Duplicate of LHHPP 76-02
DP-19 Building Lock-up Procedure	Duplicate of LHHPP 75-02
DP-20 Patients Found Off Grounds	Duplicate of LHHPP 24-04
DP-21 Public Access	Included in LHHPP 75-02
DP-22 Major Medical Emergencies	Duplicate of LHHPP 73-01
DP-23 Resident Abuse	Duplicate of LHHPP 22-01
DP-24 Interaction with the Media	Duplicate of LHHPP 01-08
DP-25 Distribution of Literature	Duplicate of LHHPP 01-05
DP-28 Parking Restriction	Duplicate of LHHPP 90-04

Department: Food Services

Revised Policies

Policies	Comments
1.1 Food from Home or Outside Sources Served Directly to Residents	Revised to reflect updated procedures.
1.4 Quality Assurance	Revised to reflect updated procedures.

Deleted Policies

Policies	Comments
1.120 Isolation Trays	No longer relevant.
1.125 Communication with Nutrition Services Department	No longer relevant.
1.85 Congregated Meals for Residents, Social Dining Program	No longer relevant.

Department: Health Information Services

No changes were made.

Department: Medical Staff

No changes were made.

Department: Nursing Services

Revised Policies

Policies	Comments
D2 2.0 Bathing Alternatives/Bed Bath	• Added Policy #1 Laguna Honda Hospital shall recognize and integrate resident's past experiences in all aspects of resident's care • Included "frequency" as an example for individualizing bath preferences • Added "licensed nurse" for whom to report change in resident preferences • Attachment reviewed with no changes

Department: Outpatient Clinics

No changes were made.

Department: Pharmacy Services

Revised Policies

Policies	Comments
01.05.00 Request for Time Off	Revised policy statement to allow for no more than one clinical pharmacist to take scheduled time-off during the same period.
02.02.00 Controlled Substances	Revised to include quarterly inventory reconciliation required for schedule II medications in compliance with new California Board of Pharmacy requirement.
03.01.00 Pharmacy Quality Assessment and Improvement	Revised to reflect which committees the pharmacy QA is reported to; corrected the name of PIPS.
03.01.02 Med Pass Observation	Revised to reflect Pharmacy Supervisor role replacing clinical pharmacist in this process.
03.03.00 Infection Control	Revised Compounding Section to include references to specific compounding policies for details.

Department: Radiology

No changes were made.

Department: Rehabilitation Services

Revised Policies

Policies	Comments
20-01 Responsibility and Accountability of the Rehabilitation Services	Removed redundancies re: role of Chief of Rehabilitation and physiatrists that are present in other P&Ps. Clarified the relationship of Rehabilitation Services and physiatrists with general skilled nursing units.
30-01 Scope of Rehabilitation Services to Be Provided	Minor wording changes.
30-02 Physical Medicine and Rehabilitation Services	Minor wording changes.
30-05 Neuropsychology Services	Clarified that Neuropsychology services are available by referral (as opposed to be at all of the PCT meetings). Minor wording

	changes.
30-07 Scope of Rehab Services: Activity Therapy Services	Minor wording changes.
40-01 Rehabilitation Services for Rehabilitation Unit Patients	Minor wording changes.
40-02 Rehabilitation Services for General SNF Unit Patients	Minor wording changes.
40-04 Rehabilitation Services and Medical Record	Removed redundancies, minor wording changes.
40-08 Rehabilitation Assessment and Interdisciplinary Care Planning	Minor wording changes.
50-02 Admission and Eligibility Criteria for SNF-Level Rehabilitation	Minor wording changes.
50-03 Verbal Orders	Minor wording changes.
50-04 Sources and Forms Used for Referral of Patients	Minor wording changes.
70-02 Occupational Therapy Staff	Added information about healthworkers since this is newly added classification in our department
70-06 Custom Wheelchairs	Wording changes; added information to include a funding source for custom wheelchairs
70-08 Connectivity Clinic	Changed "Connectivity Clinic" to "Psychosocial Occupational Therapy Groups" to reflect current title of groups. Also, added information that documentation is now in the medical record (LHH GetCare, not LCR).
80-02 Physical Therapy Staff	Added information about healthworkers since this is newly added classification in our department
90-07 Establishment and Treatment Programs and Documentation: Audiology	Procedure #4: added "Primary Care Physician. Change impacted cerumen to be removed by ENT to "If impacted cerumen is noted, removal prior to the assessment for a hearing aid will be recommended."
90-08 Hearing Aid Evaluation and Dispensing	Procedure #4: Change "ENT" to primary care and/or ENT physician . . ."
100-01 Electrodiagnostic Studies	Minor word changes
Appendix A Guidelines for Completion of MR505	Clarified that this form can no longer be used for physiatry referrals; physiatry referrals must be made electronically
Appendix B Chief of Rehabilitation Services	Minor wording changes.
Appendix B Internist	Clarified that physician may either be an Internist or Family Practitioner
Appendix B Staff Physiatrist	Removed "performing electrodiagnostics studies" as not all physiatrists perform these studies (privileging issue); minor wording changes.

Department: Respiratory Services

Deleted Policies

Policies	Comments
A.01 Mission Statement and Goals	Duplicate of LHHPP 01-00 Value, Mission and Vision Statements

of Laguna Honda Hospital	

Department: Social Services

Revised Policies

Policies	Comments
7.4 Recording	Added sentence to Procedure 1: "If resident is coded as short stay resident, the assessment must be in the record within two (2) working days of admission. Added sentence to Procedure 3: "If resident is coded as a short stay resident, the Discharge Assessment (MR 711) must be completed within seven (7) days of admission.
7.7 Discharge Planning and Implementation	Added additional wording to Procedure 1: "… (two working days for short stay residents)… (seven days for short stay residents)" Added a new Procedure #3: "A Resident Discharge Information sheet including projected discharge date and equipment needed will be placed in resident's room with resident's permission and updated as needed." Number order changed due to new procedures. Added 3 sentences to Procedure 7: "Coordinate home evaluation with resident/caregiver, OT and PT. Email the Rehab team and A&E via "DPH-LHH Discharge Address" list when discharge date and location is established to start DME ordering process. Hospital beds and hoyer lifts require a minimum one month notification." Added 1 sentence to Procedure 8: "A copy will be faxed to the Ombudsman program at 415-751-9789 and if any changes are made to the notice, all recipients will be updated. Added a new Procedure 9: "A Discharge Checklist will be placed in left side of medical record for all team members to review and initial to ensure resident is ready to go." Added a few words and one sentence to Procedure 10: "...a finalized version…" "A copy of the written discharge instructions (MR 313A Post-Discharge Plan of Care/Home Instructions) will be given to the resident and/or resident representative and box will be checked off on the MR 705.
7.18 Discharge Database Information	Added additional wording to Policy: "(7 days for short stay residents)"

	Added additional wording to Procedure 2: "(7 days for short stay residents)"

Department: Spiritual Care

Revised Policies

Policies	Comments
A 3.0 Roman Catholic Program	Updated to show current Mass schedule.
B 3.0 SCD NODA Volunteer Program	Updated language to show current program.
C 3.0 SCD Spiritual Care Referrals	Updated to show current contacts.

Department: Vocational Rehabilitation

Revised Policies

Policies	Comments
VR 2.0 Scope of Services	Removed from section I: assistance with career exploration, assistance with job search Removed from section 2: volunteer opportunities in the community, Updated from section 3: Position of escort/guide Change: documentation in SFGetCare progress notes
VR 3.0 Referral and Assessment	Updated to reflect SFGetCare documentation
VR 4.0 Documentation	Updated to reflect SFGetCare documentation

Department: Volunteer Services

No changes were made.

Department: Wellness & Activity Therapy

Revised Policies

Policies	Comments
A2 Scope of Services	Updated references.
A3 Staffing Plan	Updated references.
A5 Continuing Education	Deleted one procedure.
A6 Overtime Utilization and Monitoring	Departmental overtime process update.
A8 Equipment & Program Supplies	Revised procedures.
A9 Call-in procedures	Revised grammar.
A11 Assignment Bidding Process	Revised grammar.
A12 Emergency Response Plan	Updated procedures.
D1 Medical Record Documentation	Updated references.
D2 Tracking of Resident	Updated references.

Participation	
D4 Quarterly Progress Note Format	Updated references.
P4 Special Events Coordinator	Updated procedures and references.
P5 Animal Assisted Therapy	Updated procedures and references.
P7 Community Outings	Updated procedures and references.

Deleted Policies

Policies	Comments
A7 Neighborhood and Shoptime	No longer applicable.

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, 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 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.

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 "the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. 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.

   "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."

   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" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."

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

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

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

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 emotional distress."

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

4. 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."

5. Mistreatment means inappropriate treatment or exploitation of a resident

6. 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 will, or the will of 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. 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. 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;

- 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, 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, abuse and neglect prevention in-services.

c. Information on 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 safety management and response 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 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.

   ii. If the criminal incident resulted in serious bodily injury to the resident, 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.

   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 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. 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 CEO or designee, Medical Social Services Worker, Ombudsman, SFSD,QM staff and CDPH of events involving allegations of abuse that are not substantiated and do not result in serious bodily injury.

iv. During regular business hours, Monday to Friday from 8:00 am to 5:00 pm excluding holidays and weekends, the reporting function to CDPH is performed by Quality/Risk Management Nurses.

v. 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.

g. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of, 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.

j. The results of the investigation shall be reported to CDPH within five working days of the incident. If the alleged violation is verified, appropriate corrective actions shall be taken.

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

Federal Regulation (F-Tags)	**42 Code of Federal Regulation (CFR) 483.12(b)(5) and Section 1150B of the Social Security Act**	**42 CFR 483.12(c)**
	F608 Reporting Crimes	**F609 Reporting Allegations of Abuse, Neglect, Exploitation or Mistreatment**
What to Report	Any reasonable suspicion of a crime against a resident	All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property
Who to Report Abuse Allegations or Crime Suspicion To	Every Employee (Mandated Reporter) should report their observation/information to their Manager/ Supervisor. Can also report to Quality Management during business hours or to the Nursing Office via Nursing Operations Manager or Supervisor after business hours (including weekends and holidays). **Please report immediately.**	
Who Will Report to CDPH	Quality Management Nurse during business hours Nursing Operations Manager or Supervisor during non-business hours	

	(including weekends and holidays)	
Who Will Report to Ombudsman and SFSD	Nurse Manager, Nursing Director or Clinical Staff	
When to Report to CDPH, Ombudsman and SFSD	Within two (2) hours of forming the suspicion of crime	Within two (2) hours of knowledge of the allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property

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 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 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 carry out the investigation.

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.

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 submitted to QM. (Refer to LHH designated site for copies of electronic forms related to the allegation of abuse investigation).

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.

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

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

f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the investigating director/manager conducting the inquiry shall complete the

Investigation of Alleged Abuse form and submit the form, along with any attachments to QM. Final conclusion shall be determined by the Nursing Director.

g. In cases of injury on unknown origin, the investigation supervisor/manager shall complete the Investigation of Alleged Abuse form and submit the form, along with any documents, to QM.

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.

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 this incident (excessive noise, crowded room).

   viii. Ability to modify environment.

   ix. Likelihood of a repeat incident.

   x. What Interventions 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: Investigation of Alleged Abuse
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, 18/09/11 (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 shall 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 shall 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

TRACHEOSTOMY MANAGEMENT

POLICY:

~~1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) to ensure adequate safety and care of all residents with tracheostomies.~~

Tracheostomy management shall be carried out by physicians and nurses on the neighborhood. The interdisciplinary Tracheostomy Team and/or the Ear, Nose and Throat specialist (ENT) are available by consultation to provide assistance with tracheostomy management. ~~in conjunction with an interdisciplinary tracheostomy team composed of a nurse, physician, respiratory therapist, and speech pathologist, composed of a nurse, physician, respiratory care practitioner, and speech pathologist. If indicatedThe, ENT is available, by physician consultation, to evaluate residents admitted to Laguna Honda with tracheostomies.~~

~~2. The Tracheostomy Team will evaluate residents admitted to Laguna Honda with tracheostomies, provide follow-up monitoring as indicated, make recommendations, and provide education/training, as needed.~~

PURPOSE:

1. To ensure safety, continuity and standardization of care to Laguna Honda residents with ~~a~~ tracheostomies~~y~~.

2. To provide a venue for collaboration among disciplines of nurses, physicians, respiratory therapists, and speech pathologists to facilitate resident care.

3. To educate hospital staff, residents, and their families regarding tracheostomy care.

PROCEDURE:

1. Initial Referral ~~to Tracheostomy Team~~to ~~the~~ ENT and/or Tracheostomy Team

~~Two resources exist fo~~T~~r~~he ~~the~~ resident care team (RCT) has two resources available for~~to~~ assistance with tracheostomy management. One or both of the following referrals may be made for evaluation and treatment recommendations. Of note, initial tracheostomy tube changes, known complicated cuffed tracheostomy tube changes and non-standard tracheostomy tube changes must be referred to the ENT as noted below (sections 4.a., 5.c. and 7.a.).

a. ~~Upon admission, t~~The attending physician ~~will~~ may refer ~~any~~ residents with ~~a~~ tracheostom~~y~~ies to the ~~the Tracheostomy Team~~ENT via e-referral and/~~-~~or the Tracheostomy Team ~~for review and evaluation~~ via the "Tracheostomy Care Order Form" (MR 167). The Tracheostomy Team consists of a physician, nurse, speech

pathologist and respiratory therapist. If the primary physician determines the referral/s is/are not indicated, the reason will be documented in the Physician pProgress nNote.

b. Referral shall be made on the "Tracheostomy Care Order Form" (MR 167) and placed in the Rehabilitation Services mail box in the hospital's mailroom (H-2 Corridor on the second floor), or delivered to the Rehabilitation Services secretary in the Pavilion Building, Room PG-132. (N.B.: This form also can be used to order routine tracheostomy care, see Section C.)If indicated, the ENT shall recommend follow-up with other members of the team. The primary physician shall make the referral for the recommended follow-up on theThe -"Tracheostomy Care Order Form" (MR 167) shouldallto be placed -in the Rehabilitation Services mailbox in the hospital'sss' mailroom (H-2 Corridor on the second floor), faxed or delivered to the Rehabilitation Services PG-132. (N.B.: This form is also used to order routine tracheostomy care, see Section 3C).

c. If indicatedthe resident is referred to the ENT, the ENT may recommend that the Tracheostomy Team be involved with follow-up care.

with members of the Tracheostomy Team.

c.d. If a consultation request is considered urgent, the charge nurse or attending physician will contact Respiratory Therapy via pager, in addition to completing the Tracheostomy Care Order form, marking the form "Urgent." Respiratory Therapy will, in turn, contact thea physician on the Tracheostomy Team, if necessary.

d.e. The Tracheostomy Team is available Monday through Friday (except holidays) during the day shift only.

2. Referral to Speech PathologySpeaking Valves (e.g. Passy Muir valve)

a. Residents admitted with a speaking valve (i.e., e.g., Passey Muir valve [(PMV]) will alsoshall be referred to Speech Pathology per HWPP 27-01. The1 fo referral should be generated at or shortly after admission to allow the screening r screening evaluation to take place within 72 hours of admissionLHHPP 20-52.

b. The screening evaluation will be performed by both Speech Pathology and Respiratory Therapy.

a.c. The results of the screening evaluation shallwill be documented in the Speech Pathology section of the electronic medical record.

3. Routine Tracheostomy Care

a. The attending physician may order routine tracheostomy care by the nursing staff via the Tracheostomy Care Order Form (MR 167) by checking the box

"Tracheostomy Care per Nursing Protocol." A copy will be placed in the medical record.

b. When indicated, oxygen flow and mist interface will be ordered by the attending physician on the standard physician's order form (MR 101) and the Respiratory Therapy Requisition form (RT 100).

c. Nursing will perform routine tracheostomy care per Nursing P&P I 3.0, Tracheostomy Care.

d. The attending physician may ~~order~~ refer residents to Respiratory Therapy, if indicated, via the Respiratory Therapy Requisition form (RT 100).

~~d.~~e. An extra tracheostomy tube of the same size and type (e.g. cuffless or cuffed) shall be available at bedside.

4. Cuffless Tracheostomy Tubes

a. For the initial change of a cuffless tracheostomy tube, ~~T~~the attending physician shall ~~will obtain an~~submit an electronic referral to the ENT. ~~consultation (via MR 101) for the initial cuffless tracheostomy tube change.~~ For an urgent appointment, ~~submit after~~following submission of the referral, ~~and call the~~~~contact~~ the Medical Clinic ~~staff~~shall be contacted ~~Surgical Clinic and mark urgent on the ENT consultation form.~~ for appointment availability. (Note: If an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy.)~~.~~

b. If no problems occur with the initial tracheostomy change, trained licensed nurses may carry out subsequent replacements of the tracheostomy tube. The cuffless tracheostomy tube should be replaced monthly, or as directed per physician order. Unless otherwise indicated, all tracheostomy tubes should be changed with the same tube type and size.

c. ~~The~~ ~~If referred to Tracheostomy Team~~~~ENTENT~~The ~~,~~ENT may ~~will~~ make recommendations regarding tracheostomy management (e.g., downsizing, changing from cuffed to cuffless, etc.).

~~c.~~d. Known complicated cuffless tracheostomy tube changes shall be performed by ENT.~~, as well as the need for ENT referral.~~

5. Cuffed Tracheostomy Tubes

a. The attending physician will document in the medical record if a patient is admitted with a cuffed tracheotomy tube and will write specific orders regarding cuff inflation/deflation via the standard physician's order form.

b. If cuff inflation/deflation is ordered by the physician, Respiratory Therapy shall be consulted to review inflation/deflation procedures/precautions.

c. For the initial change of a cuffed tracheostomy tube, the attending physician shall submit an electronic referral to the ENT. For an urgent appointment, ~~after~~ following submission of the referral, ~~and~~ the Medical Clinic shall be contacted for appointment availability. (Note: If an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy.)

d. ~~The attending physician will obtain an ENT consultation (via MR 101) for the first all cuffed tracheostomy tube change.s; a~~All ~~cuffed tracheostomy~~subsequent cuffed tracheostomy tube changes shall~~ould~~ be performed by ~~the ENT~~ ~~physician~~~~or the~~ Respiratory ~~Care Practitioner~~Therapy. The cuffed~~less~~ tracheostomy tube sh~~ould~~all be replaced monthly, or as directed per physician order. Unless otherwise indicated, all tracheostomy tubes should be changed with the same tube type and size.

~~Cuffed tracheostomy tubes should be replaced monthly (or at the interval ordered by the physician) by the ENT physician.~~

~~c.~~e. Known complicated cuffed tracheostomy tube changes shall be performed by the ENT.

6. Tracheostomy Team Evaluation/Follow-up

~~a.~~ Upon receipt of referral, ~~a members of~~ the Tracheostomy Team ~~will~~ shall ~~initiate a review of the resident's medical record, contact appropriate professionals from the acute hospital for pertinent tracheostomy information, etc., and present the information to the Tracheostomy Team. Preliminary recommendations will be charted in the integrated progress notes section of the resident's medical record~~~~follow up with the appropriate evaluation~~evaluate the ~~patient~~resident's needs and document recommendations in the residen~~patient~~t's medical record. ~~(e.g., PMV and treatment).~~ Recommendations ~~will~~shall be charted in the integrated progress notes section of the resident's medical record for review by the RCT.~~.~~

~~b.~~a.

~~c. Tracheostomy Team members will evaluate the resident using the "Team Oriented Tracheostomy Evaluation" (MR 525) as a guideline. The evaluation will be placed in the Rehabilitation section of the resident's medical record.~~

~~The eEvaluationn results and recommendations will be reviewed by the resident care team (RCT). with the attending physician, and with the Unit neighborhood nursing staff. Members of the Tracheostomy Team will be available to consult with the resident and family upon request of the RCT.~~

b. At the request of the RCT~~IDT~~, ~~T~~the Tracheostomy Team will be available to:

i. ~~-~~A~~a~~ssist the ~~interdisiciplinary team~~RCT to~~in~~ establis~~h~~h~~hing~~ and meet~~ing~~ goals for each resident (e.g., downsizing tracheostomy, changing from cuffed to cuffless tracheostom~~ies~~y ~~tubes~~, decannulation, etc.). ~~The level of involvement of the Tracheostomy Team will be determined by the Resident Care Team.~~

~~i.~~

~~ii.~~

ii. ~~The Tracheostomy Team, in consultation with the attending physician, will~~ D~~d~~etermine a ~~follow-up,~~ monitoring ~~,~~ and/or re-evaluation schedule for each resident, on a case-by-case basis.

iii. Provide education and training to the staff relating to the use and purpose of tracheostomy equipment.

iv. Provide education and training to the resident and family, if needed.

~~iii. Regardless of the schedule decided upon, a physician may request assistance of the Tracheostomy Team at any time.~~

~~7. Upon request, members of the Tracheostomy Team will review related physiology, tracheostomy, tracheostomy tubes (cuffed and cuffless), inner cannulas, and this hospital-wide Tracheostomy Management policy with the Nursing and Medical Staff.~~

~~a. Members of the Tracheostomy Team will provide information regarding the resident's tracheostomy to the resident and families, when indicated, in terms that are understandable.~~

~~8.~~7. Non-standard Tracheostomy Tubes ~~for Special Needs~~ (e.g., extra-long tracheostomy tubes):

a. If a resident ~~has a~~is admitted with a non-standard tracheostomy tube, the resident shall be referred to ENT for evaluation and the initial tracheostomy change. The ENT/RCT will determine which discipline will manage subsequent changes.

ATTACHMENTS:

~~Appendix A: Team Oriented Tracheostomy Evaluation (MR 525) July 3, 2008~~

~~Appendix B: Tracheostomy Care Order Form (MR 167) January 2008~~

REFERENCES:

None

Tracheostomy Care Order Form (MR 167) January 2008

HWPP 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir

Revised: 09/09/30, 10/04/27, 18/0~~9~~6/11~~04~~5/~~14~~ (Year/Month/Day)

Original adoption: 08/11/25

PROCEDURES FOR GRANT APPLICATION, ACCEPTANCE AND EXPENDITURE

POLICY:

Laguna Honda staff will coordinate grant applications, proposals, acceptances, and expenditures with the Accounting Department and the DPH Grants Office, which provide advisory information and technical assistance throughout the grant process.

PURPOSE:

To assure that all grant-related documents meet the specific requirements of the DPH Grants Office as well as the specific requirements of the Board of Supervisors, Controller's Office, and City Attorney.

PROCEDURE:

1. Prior to any significant interaction with a grantor agency, Laguna Honda staff will consult the Department of Public Health (DPH) Grants Handbook. Staff may contact the DPH Grants Office for questions and consultation.

2. All grant applications shall be approved by the Director of Public Health

3. Grants applications equal or greater than five million dollars ($5,000,000) require Board of Supervisor approval.

4. All grants, no matter the amount, must go through an Accept and Expend process directed by the DPH Grants Office.

   a. Grants equal to or greater than one hundred thousand dollars ($100,000) require approval from the Board of Supervisors.

   b. Grants less than one hundred thousand dollars ($100,000) require approval from the Controller's Office.

   c. Once the grant is awarded, the Accept and Expend process takes two to four months. It is not possible to automatically begin using funds from the award.

5. Staff assemble documents making up the Accept and Expend Package and submit to the DPH Grants Office.

   a. Grants Resolution Information Form including disability checklist
   b. Grant Line-Item Budget and Grant Budget Justification
   c. Grant Application
   d. Grant Award Letter from funding agency

   e. Ethics form 126 (if applicable)
   f. Contracts, leases/agreements (if applicable)

6. For grants requiring Board of Supervisor approval, staff, in consultation with the Deputy City Attorney, will draft an "Accept and Expend" resolution for submission to the Board of Supervisors through the DPH Grants Office.

7. After approval, the grant process owner consults with the Accounting Department to set up the grant in the City's Financial System following the Controller's Accounting Policies and Procedures, and identify program managers and roles for requisition and purchase order approval.

8. Grant related activities resulting in expenditures proceed per grant guidelines.

9. Program managers have the responsibility of making sure the expenditures are compliant with grantor's requirements.

10. Program managers are responsible to obtain written consent from the grantor on any expenditure substitutions.

    a. For changes in the total award, the program manager will be referred to the DPH Grants Office.

11. For reimbursement based grants, the program managers are responsible to submit information for billing to the Accounting Department.

12. Operation and program manager complete monitoring and reporting requirements as specified by the grantor agency.

    a. Copies of all reports shall be forwarded to the Accounting Department

13. Program managers are responsible to provide and support any audit needs related to the grant.

14. The Accounting Department reconciles grant budget and actuals, including revenue and expenditures, and reports to the Controller's Office on a quarterly basis.

ATTACHMENT:
None

REFERENCE:
San Francisco Department of Public Health Grants Handbook
https://www.sfdph.org/dph/files/PoliciesProcedures/GAD4_GrantsPolicy.pdf
City and County of San Francisco – Office of the Controller Accounting Policies and

Procedures
San Francisco Administrative Code 10.170-1

~~**POLICY:**~~

~~Laguna Honda staff will coordinate grant applications, proposals, acceptances, and expenditures with the DPH Grants Office, which provides advisory information and technical assistance throughout the grant process.~~

~~**PURPOSE:**~~

~~To assure that all grant-related documents meet the specific requirements of the DPH Grants Office as well as the specific requirements of the Health Commission, Board of Supervisors, Controller, and City Attorney.~~

~~**PROCEDURE:**~~

1. ~~Prior to any significant interaction with a grantor agency Laguna Honda staff will contact the hospital's Director of Administrative Operations to coordinate with the DPH Grants Office.~~

2. ~~Prior to acceptance of an award from any grantor agency:~~

   a. ~~Laguna Honda staff in consultation with the Deputy City Attorney will draft an "accept and expend" resolution for submission by the Health Commission to the Board of Supervisors.~~

   b. ~~In addition to the "accept and expend" resolution, the Health Commission review and approval package, will include the following:~~

      i. ~~Notice of the grant award~~

      ii. ~~Copy of the grant agreement, including:~~

         1. ~~The formal contract, including the agency's standard boilerplate, if any;~~
         2. ~~Objectives and deliverables;~~
         3. ~~Budget;~~
         4. ~~Budget justification~~

      ~~Resolutions approving acceptance and expenditure of grant funds cannot be authorized without the above documents or their equivalents. Therefore, it is necessary to wait for receipt of an agreement from the grantor before submission of the "accept and expend" resolution.~~

~~**ATTACHMENT:**~~
~~None~~

~~**REFERENCE:**~~
~~DPH Grants Handbook: http://dphnet.dph.sf.ca.us/Grant/GrantsHandbook2011.pdf~~

Revised: 02/10/31, 12/09/25, 18/09/11 (Year/Month/Day)
Original adoption: 98/04/01

EMERGENCY RESOURCES AND MAPS

Staff Trained and Eligible to be Assigned HIMT Roles 2

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Staff Trained and Eligible to be Assigned HICS Roles*

Arnaldo	Ritchele
Antoc	Maria
Banaria	Nora
Banchero-Hasson	Monica
Bindoy	Leanne
Blanco	Irin
Cantor	Mark
Carton-Wade	Jennifer
Cecconi	Loretta
Chan	Idy
Chan	Sherry
Cozzi	Gary
Dayrit	Elizabeth
Doyle	Jan
Duong	Susan
Durand	Kate
Fernandes	Cherrylyn
Ferrer	Valerie
Fishman	Amie
Fouts	Michelle
Frazier	William
Garcia	Emeterio
Garrick	Rodney
German	Mercedes
Gomez	Regina
Grimes	John
Guina	Edward
Hirose	Mivic
Ivanco	Olga
Jackson	Chauncey
Johnson	Yeva
Kenyon	Diana
Lee	Christina
Lee	Sheri
Lee	Vincent

Ma	Chia Yu
McShane	Michael
Michaud	Andre
Nakai	Russell
Ng	Sandy
Nguyen	Quoc
Radoc	Ronald
Riley	Colleen
Rodriguez	Amparo
Rosen	Susan
Schindler	Elizabeth
Shaikh	Shaheenara
Spencer-Davies	Jacky
Talai	Nawzaneen
Tan	Teresa
Tesorero	Maria Luna
Thanh	Olivia
Valencia	Madonna
Yarbrough	Jason

* Department, shift, and contact information are available in the Incident Commander binder in the command center

Emergency 800 MHz Radios

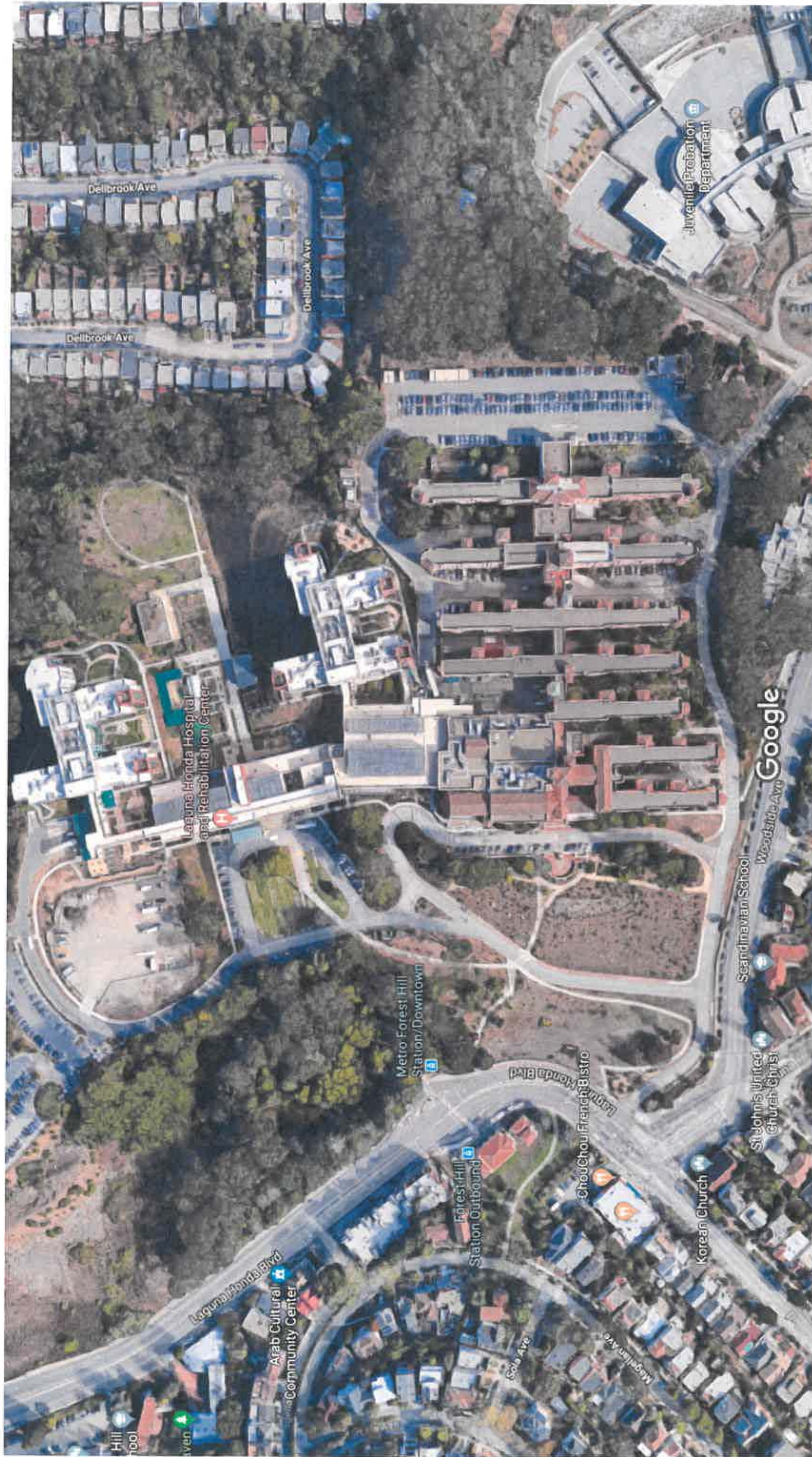
Radio #	Location	Staff Assigned
119-3	1st Floor Administration Building Executive Administration Suite	CEO
137	4th Floor Administration Building A401 Command Center	CMO
138	1st Floor Pavilion Building Nursing Office	CNO
173	5th Floor Administration Building Health At Home (on site at LHH – F5)	Nurse Manager, HAH
190	4th Floor Administration Building LHH IH Office	Industrial Hygienist WSEM
191	1st Floor Administration Building Executive Administration Suite	COO
255	4th Floor Administration Building LHH WSEM Director's Office	WSEM Director
269	4th Floor Administration Building A401 Command Center	HICS Team
271	4th Floor Administration Building A401 Command Center	HICS Team
270	2nd Floor Administration Building LHH Facility Services	Diana Kenyon
272	2nd Floor Administration Building LHH Facility Services	Diana Kenyon

Vehicle List

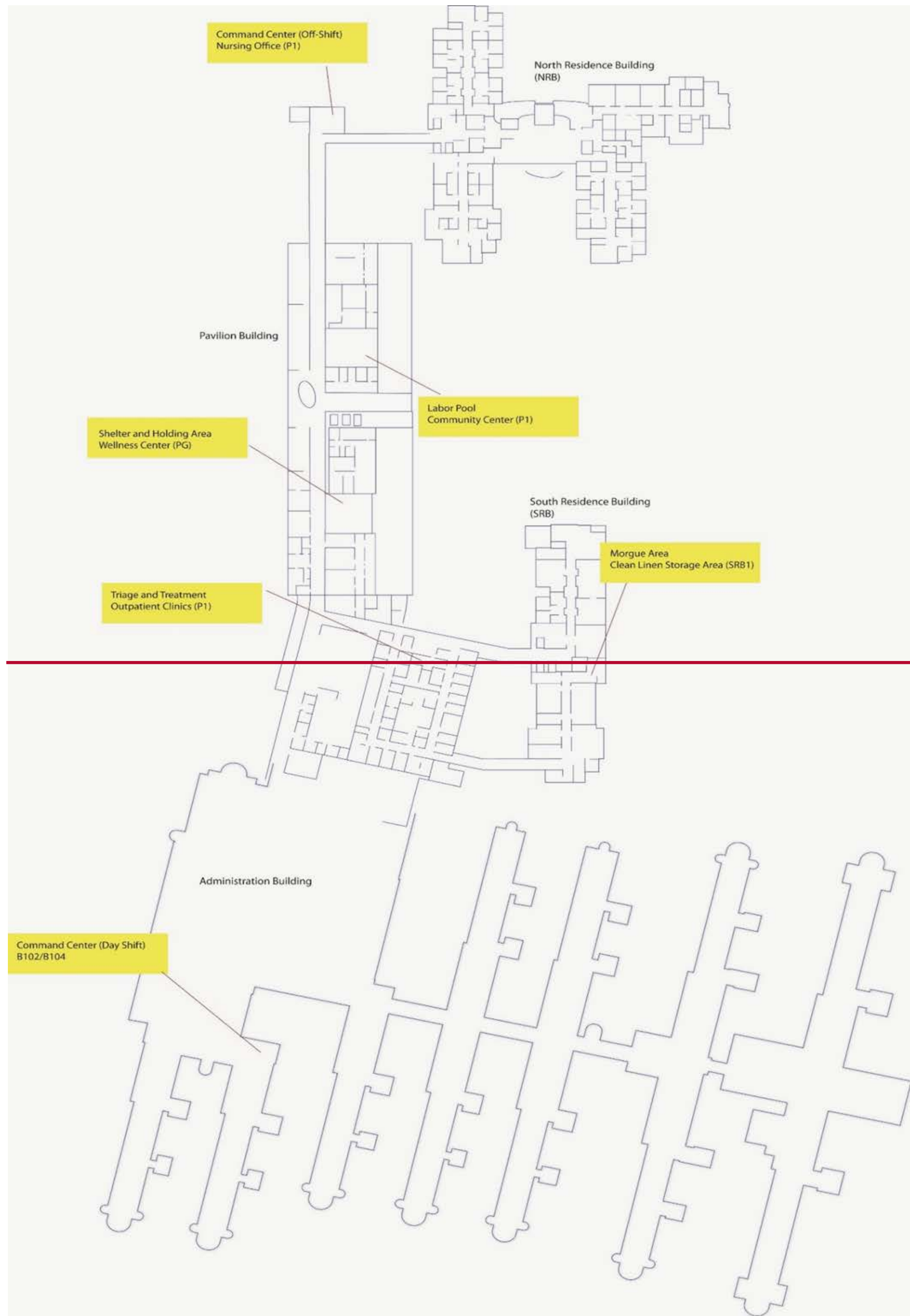
TAG	VEHICLE #	VIN # s	MAKE	MODEL	YR	FUEL	L. PLATE	USE	ASSIGNED	capacity
1	555-00001	3FRWF6FL8BV592094	Ford	F650	2011	Diesel	1365853	Resident Transport.	Activity Dpt.	10 W/CH
2	555-00003	3FRWF6FL1BV592096	Ford	F650	2011	Diesel	1365855	Resident Transport.	Activity Dpt.	10 W/CH
3	555-00004	3FRWF6FLXBV592095	Ford	F650	2011	Diesel	1365854	Resident Transport.	Activity Dpt.	10 W/CH
4	555-105	2FMZA51656BA58080	Ford van	Freestar	2006	Gasoline	1227591	Official Staff use	-	7
5	555-106	1HGFA46507L000253	Honda	Civic	2006	CNG	1251056	Official Staff use	-	5
10	555-504	1FTSX20565EA23417	Ford Tck.	F250	2005	Gasoline	1191893	Facility Services	Engineering	Lift Gate
11	555-505	1FTYR14U75PA67978	Ford Tck.	Ranger	2005	Gasoline	1202139	Outside watch	Engineering	5
12	555-506	1FTYR14U47PA73045	Ford Tck.	Ranger	2005	Gasoline	1268066	Official Staff use	Messenger	5
13	555-522	2FDPF17M34CA36027	Ford Tck.	F150	2004	Gasoline	1179634	Fleet Maintenance	Ricardo C.	-
14	555-600	1FMNE31M62HB64380	Ford Van	E350	2002	CNG	1147190	Official Staff use	-	10
15	555-601	1FBSS31M02HB75170	Ford Van	E350	2002	CNG	1147195	Official Staff use	-	10
16	555-602	2FTJW35H3LCA41626	Ford	F350	1989	Gasoline	1004749	Facility Services	Crafts	-
17	555-604	1FTSS34LX6DB25937	Ford Van	E350	2006	Gasoline	1249367	Resident Transport.	Activity Dpt.	8 or3 w/ch
18	555-605	1FBNE31L7YHB72237	Ford Van	E350	2000	Gasoline	1077827	Resident Transport.	Plnt. Svcs.	Lift + 4
19	555-608	1GBJG31J0V1107824	Chevrolet	3500	2000	Gasoline	1117249	EVS	EVS	Lift Gate
21	555-655	1FDWF36S7XEC19467	Ford	F350	1999	Gasoline	1021507	Gardener	Gardener	-
23	555-806	1BAGJCPA0YF092466	BlueBird	CSRE	2000	Diesel	1037333	Day Trip Bus	Activity Dpt.	-
25	555-906	MOHP4GX052585	JohnDeer	-	2007	Gasoline	N/A	Gardener	Gardener	-
26	220-046	1FABP215320104761	Ford	Think/Neigh	2002	Electric	1147477	Materials Mgmt.	Materials Mgmt.	2
30	555-01029	1FTNE24M72HB75172	Ford	E250	2002	CNG	1147293	Clinics	Crafts	2
31	555-00039	1FTYR14UX5PA67991	Ford	Ranger	2005	Gasoline	1211400	Clinics	Crafts	2
32	555-01038	1FTNE24M62HB79911	Ford	E250	2002	CNG	1147298	Clinics	Crafts	2
	555-00005	JTDKN3DU0D1719743	Toyota	Prius	2013	Hybrid	1430024	Administration	COO	5
	555-00006	NMOGE9F77G1263046	Ford	Transit Connect XL	2016	Gasoline	1495926	Nursing	Resident transport	Lift + 4
	555-00007	JTDKN3DU8F0432501	Toyota	Prius	2015	Hybrid	1452892	Administration	Mivic Hirose	5
	555-00008	JTDKN3DUXF1914090	Toyota	Prius	2015	Hybrid	1452891	Administration	Pool	5
	555-00009	1FDFE4FS8FDA12387	Ford	E450	2016	Gasoline	1473555	Shuttle Service	Muni Transport	13 + WC
	555-00010	1FDFE5FS6FDA12386	Ford	E450	2016	Gasoline	1473596	Shuttle Service	Muni Transport	13
	555-00011		Ford	F550	2015	Gasoline	1474007	Bus	Activity Dpt.	23 + WC

MapSite Map of Campus with Primary Area Designators

Additional schematic maps of each floor are available from Facility Services and the HICS Cabinets


Dellbrook Ave
Dellbrook Ave
Dellbrook Ave
Juvenile Probation Department
Laguna Honda Hospital and Rehabilitation Center
Google
Woodside Ave
Scandinavian School
Metro Forest Hill Station/Downtown
Laguna Honda Blvd
Forest Hill Station Outbound
Korean Church
Laguna Honda Blvd
Arab Cultural and Community Center

Additional schematic maps of each floor are available from Facility Services and in the Command Center.


Command Center (Off-Shift)
Nursing Office (P1)
North Residence Building
(NRB)
Pavilion Building
Labor Pool
Community Center (P1)
Shelter and Holding Area
Wellness Center (PG)
South Residence Building
(SRB)
Morgue Area
Clean Linen Storage Area (SRB1)
Triage and Treatment
Outpatient Clinics (P1)
Administration Building
Command Center (Day Shift)
B102/B104

Revised: 13/05/28, 18/09/11 (Year/Month/Day)

RESIDENT EVACUATION PLAN

POLICY:

In order to provide care for residents in a safe location, Laguna Honda Hospital has a plan for a partial or full evacuation in the event of an emergency.

PURPOSE:

The purpose of this policy is to set forth procedures for moving residents to a safe location for their continued care in the event of a disaster or other circumstance that renders any portion of the hospital unsafe for such care.

PROCEDURE:

1. Decision to Evacuate

Any time any resident care area of the hospital becomes unsafe for residents, HICS will be activated they will be moved out of the area and into an alternate care site. Alternate care sites will be selected by the HICS Team.

~~1.~~2. Horizontal Evacuation

~~Any time any resident care area of the hospital becomes unsafe for residents, they will be moved out of the area.~~ Whenever possible, ~~this~~ evacuation will be done horizontally ~~beyond at least 1-2 fire doors~~. The Nurse Manager or designee will coordinate this process using the following procedure.

a. Move ambulatory residents.
b. Move semi-ambulatory residents and those in wheelchairs.
c. Move residents who are bed-ridden using evacuation devices or emergency carriers.
d. Check the area to ensure that all residents have been moved out of the unsafe area.
e. If medical records are being stored in an area that has been deemed to be unsafe, move these with the residents if possible to do so safely.
f. Account for all residents, staff, and visitors.
g. If anyone is missing, attempt to locate them and notify the command center, the Nursing Office, and the Sheriff's Department.

~~2.~~3. Vertical Evacuation

a. If horizontal evacuation is insufficient to locate residents in an area that is safe for their care, vertical evacuation will be initiated. If elevators are operational and safe

to use, vertical evacuation will be completed using a combination of stairs and elevators. In the event of a fire, earthquake, or other disaster that may compromise the safety of the elevators, elevators will not be used and the procedures for stair evacuation will be followed.

b. Upon making the decision to evacuate, the command center will designate a destination location(s) within the facility to which residents will be relocated and staff from the labor pool will be used to set up the area for resident care.

~~3.~~4. Vertical Evacuation Using Elevators

a. Elevators will be controlled by staff from the labor pool with a key to override the elevators. These staff members will remain in the elevators and use each elevator to clear one floor at a time. The order in which neighborhoods will be evacuated will be determined by the Incident Commander and will depend on the type and specific location of the emergency.

b. Ambulatory Residents

i. Ambulatory residents who are able to walk up and down stairs will be escorted to an exit stairwell by a member of the Nursing staff, who will walk up or down the stairs with groups of 3-5 residents.
ii. The Nursing staff will go back to the neighborhood to continue evacuation.
iii. Additional staff members from the labor pool will be waiting in the stairwell on the same floor as the designated relocation area and will escort residents in groups of 5-10 from the stairwell to the relocation area.

c. Residents in Wheelchairs

i. Residents in wheelchairs will be brought to the great room and then to the elevator in groups of 4-6. The Charge Nurse will coordinate this process.
ii. If time is of the essence, some of the non-ambulatory residents may be taken down the stairs after the ambulatory residents using evacuation devices, such as Stretchairs. They will then be carried by waiting staff to the relocation area.
iii. Additional staff will be available on the same floor as the designated relocation area and will direct/escort residents to the relocation area as needed.

d. Bed-bound Residents

~~i. Bed-bound residents will be brought to the great room in their beds.~~
~~ii.~~i. After the residents in wheelchairs have been evacuated, residents in beds may be brought to the elevators. This will be coordinated by the charge nurse.
~~iii.~~ii. If time is of the essence, bed-bound residents may be brought down the stairs using evacuation devices or carriers.

~~iv.~~iii. Labor pool staff will bring residents to the designated care area.

e. Wheelchair Retrieval

Once necessary evacuation of residents has been completed, staff will use the elevators to retrieve any wheelchairs left behind if the Incident Commander determines it is safe to do so.

~~4.~~5. Vertical Evacuation Using Stairs Only

a. Ambulatory Residents

i. Ambulatory residents who are able to walk up and down stairs will be escorted to the exit stairwell by a member of the Nursing staff, who will walk up or down the stairs with groups of 3-5 residents.
ii. The Nursing staff will go back to the neighborhood to continue evacuation.
iii. Additional staff members from the labor pool will be waiting in the stairwell on the same floor as the designated relocation area and will escort residents in groups of 5-10 from the stairwell to the relocation area.

b. Non-ambulatory Residents

i. Non-ambulatory residents will be brought down the stairs using evacuation devices such as Stretchairs, Stryker chairs, and Paraslydes after the ambulatory residents have evacuated. See Appendix B for information about available devices.
ii. If time is of the essence or there are not enough evacuation devices, staff will use blanket carries to bring residents down the stairs and to the relocation area. See Appendix C for instructions on make-shift evacuation devices.
iii. As many staff members as possible will be provided from the labor pool for this task, which will be coordinated by the Nurse Manager and/or Charge Nurse.

c. Wheelchair Retrieval

Once necessary evacuation of residents has been completed, staff will retrieve any wheelchairs left behind if the Incident Commander determines it is safe to do so.

~~5.~~6. Accounting for Residents

a. Labor pool staff will greet residents at the designated relocation area and account for all residents arriving in the area and report to the Command Center.

b. The Command Center will work with Nurse Mangers to account for any missing residents.

7. Employee Training

a. All Laguna Staff shall be made aware of general evacuation procedures in orientation and annual emergency preparedness in-services.

b. Nursing, Rehab, and Activity Therapy staff shall be trained on the use of evacuation devices on initial hire and annually.

ATTACHMENT:

Appendix A: Alternate Care Sites
Appendix BA: Evacuation Devices
Appendix CB: Emergency Carriers

REFERENCE:
None.70-01B1 Emergency Response Plan

Revised: 18/09/11N/A (Year/Month/Day)
Original Adoption: 14/07/29

Appendix A: Alternate Care Sites

LOCATION	Electricity (E power available)	Water	Ease of Transporting Patient (1=Easy, 3=Hardest)	Ease of Transporting Equipment (1=Easy, 3=Hard)	Quality of Space (1=Good, 3=Poor)	Lighting (Y=Yes, N=No)	Protection from Weather	Restrooms (Y=Yes, N=No, L=Limited)	Bed Capacity, est.	Ability to Quarantine	Med Gas Availability	Surface
Clinic, P1	Y, E	Y	1	1	1	Y	Y	Y	12	Y	Y	terrazo
Rehab Center, PG	Y no E	Y	1	1	1	Y	Y	Y	30	N	N	terrazo
Simon Auditorium, Admin 1	minimal no E	N	1	1	1	Y	Y	Y	60	N	N	concrete
Wellness Hub, H3	minimal no E	N	2	2	1	Y	Y	Y	50	N	N	carpet
Moran Hall, H3	minimal no E	N	2	2	1	Y	Y	Y	50	N	N	concrete, carpet
Esplanade, including Kanaley, P1	minimal no E	Y	1	1	1	Y	Y	Y	40	minimal	N	terrazo
Cafeteria, P1	minimal no E	Y	1	1	1	Y	Y	Y	25	N	N	terrazo
Outside - Main Entrance (front of Pavilion)	N	N	3	3	1	minimal	N	L inside	100	N	N	grass, blacktop, variable
NW Parking Lot	N	N	3	3	3	minimal	N	N	100	N	N	blacktop

APPENDIX BA: Evacuation Devices

Several devices are available to safely evacuate residents, injured staff, or visitors. Call the Command Center at 4-4636 (4- INFO) to deploy staff to bring the evacuation devices to the evacuation site.

a. **Reeves Stretchairs** (approximately 60) are stored in the emergency storage room in H2 and can be made available from the 1st floor Pavilion Communityby request from the Command Center. Each Stretchair has a cover with a shoulder strap to facilitate easy transport of several devices at once. Open the Stretchair and place under the victim either on a flat surface (bed or floor) or on a chair. To use on a flat surface, roll the victim to one side and place the Stretchair beneath them, with the top aligned with the victims shoulder. Roll the victim to the opposite side and ease the Stretchair beneath them. Secure the shoulder and crotch/ hip straps. To use on a chair, place on a chair with the crotch strap near the edge of the seat and place the victim on the device by having the victim stand up momentarily and then sit down on the Stretchair or transfer the victim via a standing pivot with 1 or 2 assistants or via a mechanical lifting device. Assure that the top of the Stretchair is level with the victims' shoulders. Lift on the count of three ("1-2-3 lift") with 2-4 rescuers each firmly grasping one or two handles, depending upon the weight of the victim and the strength of the rescuers. The Reeves Stretchair is rated up to 1000 lbs.; however you must never lift more than you can easily manage

b. **Medivac chairs** (approximately 30) are also stored in the emergency storage room in H2 and can be made available by request from the Command Centeravailable in Central Supply as back up devices. They are rated at 450 lbs and they do not have a strap. Place under the victim as described above.

c. **Paraslydes** (15) are available through the Command Center and can be used to evacuate down stairs. Pictoral directions appear on the device. Place the victim (500 lb weight limit) on the stair litter by rolling them to the side and placing the device beneath them. Roll the victim onto the device and center them on the device by sliding their shoulders, then legs, then hips to the middle of the litter. Fold the device around the victim and secure the straps, criss-crossing the chest straps. Use 2-4 rescuers to slide the Paraslyde to the stairwell and ease the device safely and slowly down the stairs. An additional harness is provided if needed for added control for lighter rescuers to ease a heavy victim down stairs.

d. **Stryker Evacuation Chairs** (47) are available through the Command Center for evacuation down stairs (weight limit 500 lbs). Pictoral directions appear on the back of the chair. Fold the chair out as pictured, by squeezing the red bar to raise the handle and by squeezing the lower red bar while pulling out the stair track. Transfer the victim onto the chair and fasten the waist, chest, and ankle straps. Wheel the

victim to the stairs. Tip the chair back to allow it to descend on the gliders down the stairs with 1 or 2 rescuers holding the handles to safely guide the chair down.

APPENDIX CB: Emergency Carriers

Use as a second choice if evacuation devices are not immediately available.

a. Cradle drop and blanket pull – 1 person (heavy resident)

   i. Double a blanket lengthwise on floor parallel to bed. Slide arm nearest resident's head under the neck and grasp shoulder. Slide free arm under knees and grasp firmly. Place knee or thigh, depending on height of bed, against bed close to resident's thigh. Keep both feet flat on floor about six (6) inches from bed. Pull resident from bed; no lifting is necessary. Pull with both hands, push with knee or thigh against bed. The moment resident starts to leave bed, drop on knee nearest the head. When the resident is clear of bed, the extended knee supports knees of resident and the arm under neck supports arm and shoulders of resident. The cradle formed by the knee and arm protects the back. Let the resident slide gently to the blanket and pull blanket from the room.
   ii. Rescuer cannot maintain the balance necessary if rescuer pulls the resident's buttocks instead of the knees or thighs out on rescuer's knee. This removal is for residents too heavy for one person to carry, for low beds and for bed fires.

b. Swing – 2 persons

   i. Carriers grasp wrists under the resident's knees and behind the resident's back. Resident's arms are along the two carriers' shoulders. Carry resident from room to safe place.

c. Extremity – 2 persons

   i. (To carry a person through a burning exit). One carrier grabs resident around knees (carrier's body between the resident's knees). Second carrier grabs resident under the arms and across upper abdomen. Carry resident from room. Use wet cover if possible.

d. Using a gurney – 3 persons

   i. Gurney placed parallel to bed. Three carriers to lift, one at shoulder level and upper back, one below waist and below hip, one at knee and at ankle. Lift resident and place on gurney. Wheel to safety.

e. Without a gurney, using a blanket – 3 persons

i. First person spreads blanket on floor at right angles to bed. Resident is placed on blanket. First person positions at the head of the resident, placing own hands on blanket above the resident's elbows. Second and third persons position on the sides of the resident, placing their hands above and below the resident's knees.

MEDICAL SURGE EMERGENCY QUICK REFERENCE RESPONSE GUIDE

ANTICIPATED IMPACT

Moderate to Significant

1. Disruption of normal operations and services.
2. Influx of stable acute hospital level patients from SFGH or other hospitals
3. Influx of community residents who may be been impacted by an event and who are seeking basic first aid or guidance in the event of a large scale incident.
4. Need to provide shelter for community residents / others not able to return to their homes.
5. Possible partial or total evacuation of the hospital

MISSION

To provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within Laguna Honda. This encompasses the ability to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised.

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	Receive alerts: from CAHAN and DPH/ DEM Disseminate official notifications through Public Information Officer (PIO) Use public address system, email, pages/ page group, 800 MHz radios, community meetings and other venues to disseminate information as directed by PIO with approval of Incident Commander Initiate call back lists if directed by Incident Commander Keep Hospital Incident Command and DPH Incident Command apprised of status and resources needed or available
Account for persons	Charge Nurse and Department Managers: □ Account for all persons in the neighborhood or department and provide a status report to the Hospital Command Center (HCC) (Appendix F of Emergency Plan) □ If any resident, staff, or visitor is missing, provide the name promptly to HCC. □ Notify HCC of any inaccessible room that not yet been searched. Labor Pool Unit Director (Logistics Section, Support Branch): □ If incident commander directs search procedures, automatically send 2-person teams to search all areas for missing persons (other than the neighborhoods and departments already searched, per above) Ground Floor 1st Floor 2nd Floor Other Wellness Center Cafeteria Service Kitchen Admin. Bldg. flrs 1-8 Pool Area Clinic Pharmacy* Facility Trailers Lobby Telecom offices* Engineering rooms Roof Areas Admissions Offices* Facilities rooms Medical Conf. Rm. Campus Grounds Rehabilitation Dept* Linen storage rm. Hallways All stairwells Animal Farm Work rm. Bathrooms Hallways

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

MEDICAL SURGE EMERGENCY QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS
	Greenhouse — Conf. rms (2) — Bathrooms Orchard Area — Radiology* — Harmony Park Sutro Meadow — Lab* Art Studio Beauty/ Barber shops Community Center Library Activities Dept.* Nursing Office Hallway & Bathrooms (*Indicates Departmental areas: include if not already searched and status report provided.) ☐ Utilize facility maps along with above as needed to guide search. ☐ Labor Pool Unit Director informs and coordinates with Sheriff's office and Facilities staff directly or through Incident Command as these departments departmental procedures with overlapping responsibilities and may be needed to guide or assist search efforts.
Evacuate Safely if so-directed	1. Highest ranking on-site manager or Administrator on Duty (AOD) or Executive Administrator directs evacuation and specifies movement to another area of the hospital or outside location. ☐ 1st choice is to move to a safe area on the same floor (past 1-2 fire doors if a fire is occurring or imminent): "Horizontal Evacuation" ☐ 2nd choice is to move to a safe area on another floor, preferably down 1-2 floors: "Vertical Evacuation". ☐ 3rd choice is to move to a safe area outside or off site (rare) ☐ General evacuation off site is arranged through the DPH Command Center and City and County of San Francisco Office of Emergency Services 2. Team designated by Incident Commander (or Labor Pool Director if activated) walks the tentative evacuation route to assure evacuation is possible: ☐ DO NOT USE ELEVATORS DURING EVACUATION unless cleared for safety and so-directed by incident command (some incidences do not affect elevators) ☐ Cautiously move obstructions along route if safe to do so. ☐ Stay in contact with command center and request Labor Pool assistance as needed ☐ Re-route evacuation as needed and inform command center 3. Neighborhood nursing staff with interdepartmental others and/ or labor pool ☐ **1st**: Move residents / injured others away from affected unsafe areas first and call Hospital Incident Command for evacuation devices and staff support as needed.

MEDICAL SURGE EMERGENCY QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS
	□ **2nd**: Move ambulatory residents to designated safe area with at least one staff following to assure that residents are not left without guidance. □ **3rd**: Then move residents who require wheelchairs for transport. Return wheelchairs for use by others as needed and as feasible. □ **4th**: Move dependent residents. Generally residents are not moved in their beds as this blocks egress and access by emergency personnel. However, moving in beds to relocate to a safe area on the same floor is reasonable. □ Evacuation Devices are available in the Community Center (60 Reeves Stretchairs) or from storage areas as listed on the Inventory of Emergency Supplies in the HICS cabinets (i.e. 15 Paraslydes and 3 Stryker Evacuation Chairs). □ Alternative evacuation methods such as blanket carries are utilized when other safer devices are not available or are not feasible to use in the situation.
Triage injured and incoming persons including worried well from the community, or community residents seeking first aid	1. Incident Commander initiates triage through the Nursing Care Branch Director and Medical Branch Director 2. Nursing Care Branch & Medical Branch Directors / designees recruit staff from Clinic, neighborhoods and/ or labor pool to report to Clinic to fill positions for 3 teams including 1 Stationary Team at the Clinic and 2 Mobile Teams □ Triage MD or RN skilled in triage in charge □ 1 RN per team to treat residents □ 1 clerk per team (completes triage tag, attaches to right wrist, completes log, operates radio) □ 1 messenger per team □ Sheriff(s) or Cadet(s) to direct arriving external casualties to Triage location. 3. Mobile Teams meet at outpatient clinic and are dispatched to sites as needed (i.e. Mobile Team 1 to South and Pavilion Residences; Mobile team 2 to North Residence). Alternate Location TBD by Incident Commander. 4. Routine Clinic appointments are postponed to accommodate Triage activities.
Treat persons referred for basic first aid care by triage teams	Treatment services are activated in the same manner as Triage, described above, by the Incident Commander through the Nursing Care and Medical Branch Directors who recruit from neighborhoods, clinic, and labor pool to staff as follows. Charge Person: MD or senior RN, as assigned Staff: 1 RN (treats/ dispatches) — 1 pharmacist to deliver disaster drug supply 1 clerk (completes log) — 1 respiratory therapist 1 clerk (operates radio) — 1 EKG tech 1 messenger — 1 lab tech

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

MEDICAL SURGE EMERGENCY QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS
	Location: Outpatient Clinic Pavilion Bldng. 1st floor Alternate Location TBD by Incident Commander
Accommodate an Influx of stable adult patients from SFGH and other hospitals	Laguna Honda anticipates being able to provide at least 50 beds, cots, or gurneys for patients (includes available beds on units, 15 cots, 2 gurneys per unit for a total of 26, and 6 beds or gurneys in the clinic). Surge may expand beyond the above through resource requests for additional beds and personnel. Service to incoming acute patients is planned to be centralized on the Pavilion Mezzanine (PM) Rehabilitation and Acute Units for a total of 60 beds plus temporary alternative beds set up in available spaces for current PM residents. Process is initiated at the direction of the Incident Commander through the Nursing Care Branch Director and under the leadership of the Medical Branch Director. Charge: Nurse Manager / Charge Nurse/ designee works with unit physicians to: 1) discharge Laguna Honda's current acute residents to their usual unit 2) relocate rehabilitation patients to available beds on other units 3) have additional beds/ cots/ gurneys set up in the Meadow and Ocean rooms as needed to accommodate remaining rehab residents Staffing: Staff from admissions, nursing, medicine, pharmacy, medical records, social services and other areas as directed are deployed via the command center to Pavilion Mezzanine to fast track admission and care for influx of acute adult patients. Utilize Clinic, neighborhood living rooms and / or Great Rooms as necessary to set up additional beds preferably for existing residents to keep influx of new acute patients together on PM to the extent feasible. Account for census through Invision data base (record overflow as outpatients) or utilize down time procedures for census / other processes if computer systems are unavailable. Location: Pavilion Mezzanine and other areas as needed such as Clinic, Neighborhood Living Rooms and Great Rooms
Provide Shelter and Holding Areas for persons unable to return to usual residence / area	Charge: as assigned by command center Staffing: as assigned by command center Location: Wellness Center Pavilion Bldng. Ground floor Alternate Location TBD by Incident Commander
Provide an emergency Morgue Area if needed for mass fatalities	Transporters and messengers from labor pool, as assigned by command center Location: SRB1 Clean Linen Storage Room, South Bldg. 1st floor Alternate Location TBD by Incident Commander

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

GOAL	ACTIONS
OTHER REFERENCES	

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

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

Appendix H of 70-03: Emergency Responder Dispensing Plan

MEDICAL SURGE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to providing safe, quality care to its residents in the event of a city-wide or regional medical surge. Laguna Honda is also prepared to participate in a system-wide response to medical surge by receiving appropriate patients from other healthcare facilities who need decompression to manage the surge.To provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within Laguna Honda. This encompasses the ability to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised.

PURPOSE:

To provide adequate medical evaluation andcontinued quality care duringand participate in a system-wide response to incidents that result in a medical surge exceeding exceed the limitscapacity of the normal medical infrastructure within Laguna Honda. This encompasses the ability to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised.

DEFINITIONS:

Anticipated Impact (Moderate to Significant)

- Disruption of normal operations and services.
- Influx of stable acute hospital level patients from SFGH or other hospitals
- Influx of community residents who may be been impacted by an event and who are seeking basic first aid or guidance in the event of a large scale incident.
- Need to provide shelter for community residents / others not able to return to their homes.
- Possible partial or total evacuation of the hospital

PROCEDURE:

1. Any time the SF healthcare system is challenged by an increase in emergency calls or healthcare utilization that goes beyond the capacity to provide adequate care, Laguna Honda shall implement this Medical Surge Plan.

2. The most important goal is the safe care of Laguna Honda residents. Therefore, if a medical surge occurs as a result of a disease epidemic that is affecting Laguna Honda residents, then triage and care of these residents is the number one priority and the procedures outlined in LHHPP 70-01 C6 Pandemic Flu Plan or disease specific procedures in LHHPP 72 Infection Control shall be followed.

3. When a medical surge occurs specifically at ZSFG:

   a. Laguna Honda will assist in accordance with LHHPP 20-11 Laguna Honda Hospital's Response to ZSFG Condition Code Yellow and Red Alerts.
   b. The CEO/AOD shall activate HICS if Laguna Honda resident care operations are affected by the response.

4. When a medical surge occurs throughout the San Francisco healthcare system:

   a. Laguna Honda will participate in a coordinated response with the possibility of receiving patients from hospitals outside of the SF Health Network using the protocols that are in place in LHHPP 20-11 to determine bed availability and ensure appropriate level of care.

   b. HICS shall be activated to manage a response to a city-wide surge.

   c. The HICS team shall coordinate activities and communication with hospitals and DPH through the DPH Department Operations Center (DOC) or City Emergency Operations Center (EOC).

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

5. In the case of a city-wide disaster such as earthquake, there may be a widespread need for first aid treatment throughout the city. If members of the community show up at Laguna Honda for first aid:Communicate to stakeholders

   a. HICS shall be activated to triage and treat these patients.

b. Triage and treatment shall be provided in the medical clinic if the number of patients is manageable.
c. For triage and treatment of large numbers of first aid patients, a tent can be set up in the gravel parking lot. The tent is stored in storage container #6 in the parking lot and can be assembled if necessary.by

Receive alerts: from CAHAN and DPH/ DEM
Disseminate official notifications through Public Information Officer (PIO)
Use public address system, email, pages/ page group, 800 MHz radios, community meetings and other venues to disseminate information as directed by PIO with approval of Incident Commander
Initiate call back lists if directed by Incident Commander
Keep Hospital Incident Command and DPH Incident Command apprised of status and resources needed or available

Account for persons

Evacuate Safely if so-directed

Triage injured and incoming persons including worried well from the community, or community residents seeking first aid

Treat persons referred for basic first aid care by triage teams

Accommodate an Influx of stable adult patients from SFGH and other hospitals

Provide Shelter and Holding Areas for persons unable to return to usual residence / area

Provide an emergency Morgue Area if needed for mass fatalities

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity Of Operations Plan (COOP)
LHHPP 70-01 C5 Emergency Responder Dispensing Plan
LHHPP 70-01 C6 Pandemic Influenza Plan
LHHPP 20-11 Laguna Honda Hospital's Response to ZSFG Condition Code Yellow and Red Alerts
LHHPP 72 Infection Control

Revised: 18/09/11 (Year/Month/Day)

WATER DISRUPTION EMERGENCY QUICK REFERENCE RESPONSE GUIDE

ANTICIPATED IMPACT

Moderate to Significant

1. Disruption of normal operations and services
2. Potential stress and / or injuries
3. Potential contamination and resulting illness
4. Potential impact on multiple systems including electrical power
5. Influx of stable patients from SFGH, worried well from the community, or community residents seeking first aid in the event of a large scale water disruption
6. Possible partial or total evacuation of the hospital

MISSION

To effectively and efficiently manage the effects of a loss of water service

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	Receive alerts: from CAHAN and DPH/ DEM Anticipate and receive official “Do Not Drink” or “Do Not Use” notification from above 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
Conserve water and restore water supply	If “Do Not Use Water” notification issued, disconnect from water main to prevent burn or poisoning from water use Do not flush toilets Use alcohol gel for hand washing Use environmental wipes for tables Use waterless bathing products for resident hygiene as much as possible Disconnect ice machines and use ice, once cleared for safety and as directed by incident commander Minimize environmental cleaning as directed by command center/ infection control branch director to maintain infection control and safety Turn off irrigation systems If “Do Not Drink” notification, only, proceed with below
Identify and obtain alternate sources of potable water Estimated potable water needs: 1 gallon per person per day for drinking, cooking, and food preparation based upon WHO recommendations. Amount per	600,000 gallon water tanks behind 5th floor parking lot (seismic anchoring in place; valves to disconnect from city water system, if needed) 1400 gallons of Arrowhead water delivered monthly with emergency operations MOU in place (average amount on hand 700 gallons) 190 gallons in kitchen (60 cases of 24 ½ liter bottles) **Subtotal: 601,590 gallons of available potable water**

WATER DISRUPTION EMERGENCY QUICK REFERENCE RESPONSE GUIDE

GOAL	ACTIONS
day estimated at **1480 gallons per day** for a full census of 780 plus 700 staff (each 12 hr. shift) Water for 3 days = 4440 gallons Water for 5 days = 7400 gallons Water for 7 days = 10,360 gal.	Excluding ice machines and including the following: 164 gallons of juice, soda, and flavored water in kitchen (includes 20 cases of frozen 4 oz. juice, 94/ case; 25 cases of 24 12 oz. soda; 20 cases of 24 miscellaneous juice and flavored water, usually 12 oz. each)
Provide alternate means for sanitary waste disposal	**First Choice:** Flush toilets with bucket of water, if advised by command center. Pools have a total of 32, 450 gallons of water. A pump is available to fill buckets on a cart that can be transported for cleaning or flushing purposes, if deemed necessary and safe by incident command in collaboration with Infection Control **Second Choice** to above, if directed by Incident Command: Use plastic bags under seat in toilets to contain waste and dispose of in biohazard containers; add kitty litter to absorb fluid and odor if available (red bags are not mandatory but may be advised by incident command per hazardous materials team recommendations) Obtain additional plastic bags from CSR. Contact EVS for back up supply after CSR supply is depleted Use commodes and bedpans with liners and empty into biohazard waste bags Utilize disposable toilet products if available until supply is depleted (i.e. "wag bag" waste kit or "gocleanwaste" kits) Dispose of used bags as directed by Infection Control
Maintain resident care, hygiene and infection control measures	Hand washing and resident hygiene with waterless products as above Follow infection control advisories issued from the command center Consider sources of non-potable water, such as pools: 32,450 gallons total (24,150 in the larger 1st pool and 8300 in the 2nd pool)
Monitor boilers & steam systems	Use non-steam cooking methods, if advised by command center
Maintain fire safety	Confer with SFFD If fire watch advised, deploy staff to each unit and floor Monitor for evidence of smoke or fire and respond per usual protocol Utilize extinguishers alone if water unavailable (6 per unit; 5 in Pavilion Mezzanine and additional in corridors / departments)
Restore normal hospital operations as soon as possible.	Notify staff when "all clear"

OTHER REFERENCES

Laguna Honda Hospital Wide Policy and Procedure 70-02, 70-03, and Water Disruption Appendix

Facility Services Policy and Procedure US-6: Utility Systems – Plumbing Systems

Facility Services Policy and Procedure LS-12: Life Safety Management – Fire Watch

Facility Services Policy and Procedure US-7: Domestic Water System

GOAL	ACTIONS
Nutrition Services Emergency Food Plan	

WATER DISRUPTION PLAN

POLICY:

To effectively and efficiently manage the effects of a loss of water serviceLaguna Honda Hospital is committed to providing residents and staff with a sufficient supply of water throughout any emergency event that disrupts the water supply.

PURPOSE:

To effectively manage a disruption in water service.

DEFINITIONS:

Anticipated Impact (Moderate to Significant)

- Disruption of normal operations and services
- Potential stress and / or injuries
- Potential contamination and resulting illness
- Potential impact on multiple systems including electrical power
- Influx of stable patients from SFGH, worried well from the community, or community residents seeking first aid in the event of a large scale water disruption
- Possible partial or total evacuation of the hospital

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 shall be responsible for managing the response to the disruption in water service with the following basic objectives:

    a. Ensure an adequate water supply for the safety of residents and staff

    b. Minimize damage to property

c. Facilitate the recovery of water service and return to normal operations

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 disruption 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 provision of an adequate water supply 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 disruption of water service, to report adverse effects, 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. Identify sources of potable water

   Estimated potable water needs: 1 gallon per person per day for drinking, cooking, and food preparation based upon WHO recommendations. Amount required per day estimated at 1,780 gallons per day for a full census of 780 plus 1,000 staff.

   Water for 3 days = 5,340 gallons
   Water for 5 days = 8,900 gallons
   Water for 7 days = 12,460 gal.

   a. There are two 300,000 gallon water tanks east of the east parking lot (seismic anchoring in place; valves to disconnect from city water system, if needed)

   b. Bottled water is delivered weekly for office water coolers such that there is between 1200 and 1700 gallons on hand at any given time. We also have an emergency operations MOU in place with the vendor.

   c. 190 gallons stored in the kitchen (60 cases of 24 ½ liter bottles)

d. 164 gallons of juice, soda, and flavored water in kitchen (includes 20 cases of frozen 4 oz. juice, 94/ case; 25 cases of 24 12 oz. soda; 20 cases of 24 miscellaneous juice and flavored water, usually 12 oz. each).

5. CConserve potable water and restore water supplyuntil service is restored:

If "Do Not Use Water" notification issued, disconnect from water main to prevent burns or poisoning from water use

a. Do not flush toilets more than necessary.

b. Use alcohol gelhand sanitizer for hand washing.

c. Turn off irrigation systems. Use environmental wipes for tables

d. Use waterless bathing products for resident hygiene as much as possible.

e. Disconnect ice machines.
and use ice, once cleared for safety and as directed by incident commander

f. Minimize environmental cleaning as directed by command center/ infection control branch director to maintain infection control and safety and use wipes as much as possible for disinfecting surfaces.

g. Use alternate methods for sanitary sewage disposal:

i. Flush toilets with buckets of pool water. Pools have a total of 32,450 gallons of water. A pump is available to fill buckets on a cart that can be transported for cleaning or flushing purposes.
i. If pool water runs out, use commodes and bedpans with liners or plastic bags under toilet seats and empty into waste bags. Follow instruction from command center for bag disposal procedures.
ii.

Turn off irrigation systems

If "Do Not Drink" notification, only, proceed with below

h. If the sprinkler system loses pressure, Facility Services shall activate Facility Services P&P LS-12 Fire Watch.

Identify and obtain alternate sources of potable water

Estimated potable water needs: 1 gallon per person per day for drinking, cooking, and food preparation based upon WHO recommendations. Amount per day

estimated at 1480 gallons per day for a full census of 780 plus 700 staff (each 12 hr. shift)

Water for 3 days = 4440 gallons Water for 5 days = 7400 gallons Water for 7 days = 10,360 gal.

- 600,000 gallon water tanks behind 5th floor parking lot (seismic anchoring in place; valves to disconnect from city water system, if needed)
- 1400 gallons of Arrowhead water delivered monthly with emergency operations MOU in place (average amount on hand 700 gallons)
- 190 gallons in kitchen (60 cases of 24 ½ liter bottles)

Subtotal: 601,590 gallons of available potable water

- Excluding ice machines and including the following:
- 164 gallons of juice, soda, and flavored water in kitchen (includes 20 cases of frozen 4 oz. juice, 94/ case; 25 cases of 24 12 oz. soda; 20 cases of 24 miscellaneous juice and flavored water, usually 12 oz. each)

Provide alternate means for sanitary waste disposal

- First Choice: Flush toilets with bucket of water, if advised by command center. Pools have a total of 32,450 gallons of water. A pump is available to fill buckets on a cart that can be transported for cleaning or flushing purposes, if deemed necessary and safe by incident command in collaboration with Infection Control.
- Second Choice to above, if directed by Incident Command:
  - Use plastic bags under seat in toilets to contain waste and dispose of in biohazard containers; add kitty litter to absorb fluid and odor if available (red bags are not mandatory but may be advised by incident command per hazardous materials team recommendations)
  - Obtain additional plastic bags from CSR. Contact EVS for back up supply after CSR supply is depleted
  - Use commodes and bedpans with liners and empty into biohazard waste bags
  - Utilize disposable toilet products if available until supply is depleted (i.e. "wag bag" waste kit or "gocleanwaste" kits)

Dispose of used bags as directed by Infection Control

Maintain resident care, hygiene and infection control measures

Hand washing and resident hygiene with waterless products as above

Follow infection control advisories issued from the command center

Consider sources of non-potable water, such as pools: 32,450 gallons total (24,150 in the larger 1st pool and 8300 in the 2nd pool)

Monitor boilers & steam systems

Use non-steam cooking methods, if advised by command center

Maintain fire safety

Confer with SFFD

If fire watch advised, deploy staff to each unit and floor

Monitor for evidence of smoke or fire and respond per usual protocol

Utilize extinguishers alone if water unavailable (6 per unit; 5 in Pavilion Mezzanine and additional in corridors / departments)

Restore normal hospital operations as soon as possible.

Notify staff when "all clear"

6. When water service is restored:

   a. The Facility Services Department shall check all building systems, including sprinklers to ensure adequate pressure and water flow.

   b. The command center shall notify building occupants that the service is restored and normal operations can resume.

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

  - Receive alerts: from CAHAN and DPH/ DEM

  - Anticipate and receive official "Do Not Drink" or "Do Not Use" notification from above

  - 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

- Conserve water and restore water supply

  - If "Do Not Use Water" notification issued, disconnect from water main to prevent burns or poisoning from water use

  - Do not flush toilets

  - Use alcohol gel for hand washing

  - Use environmental wipes for tables

  - Use waterless bathing products for resident hygiene as much as possible

  - Disconnect ice machines and use ice, once cleared for safety and as directed by incident commander

  - Minimize environmental cleaning as directed by command center/ infection control branch director to maintain infection control and safety

  - Turn off irrigation systems

  - If "Do Not Drink" notification, only, proceed with below

- Identify and obtain alternate sources of potable water

Estimated potable water needs: 1 gallon per person per day for drinking, cooking, and food preparation based upon WHO recommendations. Amount per day

estimated at 1480 gallons per day for a full census of 780 plus 700 staff (each 12 hr. shift)

Water for 3 days = 4440 gallons Water for 5 days = 7400 gallons Water for 7 days = 10,360 gal.

- 600,000 gallon water tanks behind 5th floor parking lot (seismic anchoring in place; valves to disconnect from city water system, if needed)
- 1400 gallons of Arrowhead water delivered monthly with emergency operations MOU in place (average amount on hand 700 gallons)
- 190 gallons in kitchen (60 cases of 24 ½ liter bottles)
- Subtotal: 601,590 gallons of available potable water
- Excluding ice machines and including the following:
  - 164 gallons of juice, soda, and flavored water in kitchen (includes 20 cases of frozen 4 oz. juice, 94/ case; 25 cases of 24 12 oz. soda; 20 cases of 24 miscellaneous juice and flavored water, usually 12 oz. each)

- Provide alternate means for sanitary waste disposal
  - First Choice: Flush toilets with bucket of water, if advised by command center. Pools have a total of 32,450 gallons of water. A pump is available to fill buckets on a cart that can be transported for cleaning or flushing purposes, if deemed necessary and safe by incident command in collaboration with Infection Control.
  - Second Choice to above, if directed by Incident Command:
    - Use plastic bags under seat in toilets to contain waste and dispose of in biohazard containers; add kitty litter to absorb fluid and odor if available (red bags are not mandatory but may be advised by incident command per hazardous materials team recommendations)
    - Obtain additional plastic bags from CSR. Contact EVS for back up supply after CSR supply is depleted
    - Use commodes and bedpans with liners and empty into biohazard waste bags

- Utilize disposable toilet products if available until supply is depleted (i.e. "wag bag" waste kit or "gocleanwaste" kits)
- Dispose of used bags as directed by Infection Control

- Maintain resident care, hygiene and infection control measures
  - Hand washing and resident hygiene with waterless products as above
  - Follow infection control advisories issued from the command center
  - Consider sources of non-potable water, such as pools: 32,450 gallons total (24,150 in the larger 1st pool and 8300 in the 2nd pool)
- Monitor boilers & steam systems
  - Use non-steam cooking methods, if advised by command center
- Maintain fire safety
  - Confer with SFFD
  - If fire watch advised, deploy staff to each unit and floor
  - Monitor for evidence of smoke or fire and respond per usual protocol
  - Utilize extinguishers alone if water unavailable (6 per unit; 5 in Pavilion Mezzanine and additional in corridors / departments)
- Restore normal hospital operations as soon as possible.
  - Notify staff when "all clear"

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 A2 Emergency Preparedness
LHHPP 70-01 B1 Emergency Response Plan
Facility Services P&P US-6: Utility Systems – Plumbing Systems

Facility Services P&P LS-12: Life Safety Management – Fire Watch
Facility Services P&P US-7: Domestic Water System
Nutrition Food Services 1.03 Emergency FoodDisaster Plan

Revised: 18/09/11 (Year/Month/Day)
Original adoption:

REPORTABLE COMMUNICABLE DISEASES

POLICY:

Diseases designated as reportable that have been identified in hospitalized patients, nursing home residents, and health care providers shall be reported to the local health department as defined.

PURPOSE:

To comply with mandated reporting requirements governing California health care facilities, participate in identifying communicable diseases, and control the spread of infectious outbreaks.

PROCEDURE:

1. Notification

    a. The Infection Control Nurse (ICN) shall submit the names of residents and or health care workers who contract any of the special diseases listed under Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions to the California Department of Public Health, Division of Communicable Diseases.

    b. The ICN shall also report the names of residents and or health care workers suspected of contracting a newly identified communicable disease by the California Department of Public Health (CDPH), that is not yet listed on the most recent Title 17 list of reportable diseases (e.g. Middle East Respiratory Syndrome), to the local health department and the CDPH, Division of Communicable Diseases.

    c. The ICN is responsible for notifying the Chair of the Infection Control Committee, Chief Medical Officer, Chief Nursing Officer, Executive Administrator and the Risk Management Nurse when reporting under Procedure 1a and 1b is necessary.

    d. The Risk Management Nurse is responsible for notifying the California Department of Public Health when required by regulation.

2. Maintaining the List of Reportable Communicable Diseases

    a. The list of reportable communicable diseases is attached as the source list of reportable communicable diseases. See Appendix A.

    b. The Infection Control Nurse is responsible for verifying on an annual basis that the attached list is current.

3. Public Health Communicable Disease Emergencies and Evening, Weekend, and Holiday Reporting

a. Reporting of non-urgent communicable diseases shall be made during regular business hours (8 am – 5 pm), Monday – Friday (Phone: 415-554-2830, Fax: 415-554-2848).

b. Urgent reports of communicable diseases may also be received at 415-554-2830 after hours and on weekends and holidays. Follow the prompts to contact the on-call physician, who will be paged by the answering service.

In the event of an occupational exposure to possible Human Immunodeficiency Virus (HIV), call the National Clinicians' Post-Exposure Prophylaxis Hotline at 1-888-HIV-4911 (1-888-448-4911). The Hotline was created to provide timely and accurate information to clinicians who are caring for occupationally exposed health care workers. It is available 24 hours/day, 7 days a week.

In an emergency situation, at least one of the public health communicable disease physicians will be available to offer assistance:

Communicable Disease Physician	Contact Information
Juliet Stoltey, MD~~Cora Hoover, MD, MPH~~ CD Controller~~Director, Community Health~~ Epidemiology & Disease Ctrl S. F. Dept. of Public Health OR CHEDC on-call physician	415-554-2830 [work] 415-327-5697 [pager]
Chris Keh, MD ~~Director,~~ Tuberculosis (TB) Controller, TB Prevention and Control Program Disease Prevention and Control Population Health Division S. F. Dept. of Public Health	415-206-8524 [work] 415-748-8000 [cellular]
San Francisco City Clinic STD Section S. F. Dept. of Public Health	415-487-5530
Sarah Doernberg, MD Infectious Diseases, UCSF - SFGH ID Fellow – SFGH	415-206-4700 [work] 415-443-2847 (BUGS) [pager]
California Dept. of Public Health Division of Communicable Disease Ctrl	916-558-1784

ATTACHMENT:
Appendix A: Reportable Diseases and Conditions, City and County of San Francisco and San Francisco Department of Public Health. Revised ~~August 2016~~July 2018.

REFERENCE:
None.

Revised: 14/11/25, 16/07/12, 17/09/12, 18/09/11 (Year/Month/Day)
Original adoption: Est. 05/11/01

Appendix A:

REPORTABLE DISEASES AND CONDITIONS

City and County of San Francisco San Francisco Department of Public Health

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643 and §2800-2812.
Every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, must report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
§2500 (c) The Administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.

WHOM TO REPORT TO

REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO COMMUNICABLE DISEASE CONTROL UNIT UNLESS OTHERWISE INDICATED

COMMUNICABLE DISEASE CONTROL UNIT
PHONE: (415) 554-2830
FAX: (415) 554-2848 M-F 8AM TO 5PM
For urgent reports after hours, call 415-554-2830, and follow the instructions on the voicemail to page the on-call MD.

HIV REPORTING
PHONE: (415) 437-6335

STD REPORTING
PHONE: (415) 487-5530 FAX: (415) 431-4628

TUBERCULOSIS REPORTING
PHONE: (415) 206-8524 FAX: (415) 206-4565

ANIMAL CARE & CONTROL
ANIMAL BITES (Mammals Only)
PHONE: (415) 554-9422 FAX: (415) 864-2866

ENVIRONMENTAL HEALTH SERVICES FOR PESTICIDE
PHONE: (415) 252-3862 FAX: (415) 252-3818

DISEASE OR CONDITION / URGENCY REPORTING REQUIREMENTS

URGENCY REPORTING KEY

▲ Report immediately by telephone **1** Report within one working day of identification **7** Report within seven calendar days by FAX, phone or mail

- **1** Amebiasis
- **7** Anaplasmosis
- **7** Animal bites (mammals only) *to Animal Care*
- **▲** Anthrax*, human or animal
- **1** Babesiosis
- **▲** Botulism* (Infant, Foodborne, Wound, Other)
- **7** Brucellosis, animal (except infections due to *Brucella canis*)
- **▲** Brucellosis*, human
- **1** Campylobacteriosis
- -- Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) *(Report w/in 30 days to California Cancer Registry)*
- **7** Chancroid *to STD*
- **1** Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
- **1** Chikungunya Virus Infection
- **7** *Chlamydia trachomatis* infections *to STD*
- **▲** Cholera
- **▲** Ciguatera Fish Poisoning
- **7** Coccidioidomycosis
- **7** Creutzfeldt-Jakob Disease (CJD)
- **1** Cryptosporidiosis
- **7** Cyclosporiasis
- **7** Cysticercosis
- **▲** Dengue Virus Infection
- **▲** Diphtheria
- **7** Disorders Characterized by Lapses of Consciousness
- **▲** Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- **7** Ehrlichiosis
- **1** Encephalitis, infectious (specify etiology)
- **▲** *Escherichia coli* shiga toxin producing (STEC) including *E. coli* O157
- **▲** Flavivirus infection of undetermined species
- **▲** Foodborne illness (2 or more cases from different households)
- **7** Giardiasis
- **7** Gonococcal infections (Including disseminated) to STD
- **1** *Haemophilus influenzae*, invasive disease, all sero-types (in persons less than five years of age.)
- **1** Hantavirus infections
- **▲** Hemolytic Uremic Syndrome
- **1** Hepatitis A, acute infection
- **7** Hepatitis B (specify acute case or chronic)
- **7** Hepatitis C (specify acute case or chronic)
- **7** Hepatitis D (Delta) (specify acute case or chronic)
- **7** Hepatitis E, acute infection
- **1** Human Immunodefiency Virus (HIV), *Acute infection to HIV Reporting*
- **7** Human Immunodeficiency Virus (HIV) Infection, stage 3 (AIDS) *to HIV Reporting*
- **7** Influenza, deaths in laboratory-confirmed cases for age 0-64 years
- **▲** Influenza, novel strains (human)
- **7** Legionellosis
- **7** Leprosy (Hansen Disease)
- **7** Leptospirosis
- **1** Listeriosis
- **7** Lyme Disease
- **7** Lymphogranuloma Venereum (LGV) *to STD*
- **1** Malaria
- **▲** Measles (Rubeola)
- **1** Meningitis (specify etiology)
- **▲** Meningococcal infections
- **7** Mumps
- **▲** Novel Virus Infection with Pandemic Potential
- **▲** Paralytic Shellfish Poisoning
- -- Parkinson's Disease, *Report w/in 90 days to California Parkinson's Disease Registry (CPDR)*
- **1** Pertussis (Whooping Cough)
- **7** Pesticide-related illness or injury (known or suspected cases) to *Environmental Health Services*
- **▲** Plague*, human or animal
- **1** Poliovirus infection
- **1** Psittacosis
- **1** Q Fever
- **▲** Rabies, human or animal
- **1** Relapsing Fever
- **7** Respiratory Syncytial Virus (only report death in patient less than five years of age)
- **7** Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- **7** Rocky Mountain Spotted Fever
- **7** Rubella (German Measles)
- **7** Rubella Congenital Syndrome
- **1** Salmonellosis (other than Typhoid Fever)
- **▲** Scombroid Fish Poisoning
- **▲** Shiga toxin (detected in feces)
- **1** Shigellosis
- **▲** Smallpox* (Variola)
- **1** Streptococcal infections, outbreaks of any type and individual cases in food handlers and dairy workers only
- **1** Syphilis *to STD Reporting*
- **7** Taeniasis
- **7** Tetanus
- **7** Transmissible Spongiform Encephalopathies (TSE)
- **1** Trichinosis
- **1** Tuberculosis to *Tuberculosis Reporting*
- **7** Tularemia, animal
- **▲** Tularemia*, human
- **1** Typhoid Fever (cases and carriers)
- **1** *Vibrio* infections
- **▲** Viral Hemorrhagic Fevers*, human or animal (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
- **1** West Nile Virus (WNV) Infection
- **▲** Yellow Fever
- **1** Yersiniosis
- **▲** Zika Virus Infection
- **▲** **ANY UNUSUAL DISEASES**
- **▲** **NEW DISEASE OR SYNDROME NOT PREVIOUSLY RECOGNIZED**
- **▲** **OUTBREAKS OF ANY DISEASE**

For updates go to https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Public-Health-Reporting.aspx

* Potential Bioterrorism Agents

July 2018

State of California—Health and Human Services Agency
Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: ______

Patient's Last Name | Social Security Number

First Name / Middle Name (or initial) | DOB: MONTH DAY YEAR | Age

Address: Number, Street | Apt./Unit Number

City / Town | State | ZIP Code | Country of Birth

Phone Number
Area Code | Primary Phone Number
Area Code | Secondary Phone Number

Gender (Please Check One)
☐ Male ☐ Genderqueer/Gender Non-Binary
☐ Female ☐ Not Listed (Specify): ______
☐ Trans Male
☐ Trans Female
☐ Unknown

Pregnant? Y ☐ N ☐ UNK ☐
Estimated Delivery Date: DD MM YY

Patient's Occupation/Setting
☐ Food service ☐ Day care ☐ Health care ☐ School
☐ Correctional facility ☐ Other ______

Ethnicity (✓one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino

Race (✓one)
☐ African-American/Black
☐ Asian/Pacific Islander (✓one)
☐ Asian-Indian ☐ Japanese
☐ Cambodian ☐ Korean
☐ Chinese ☐ Laotian
☐ Filipino ☐ Samoan
☐ Guamanian ☐ Vietnamese
☐ Hawaiian ☐ Other ______
☐ Native American/Alaskan Native
☐ White
☐ Other: ______
☐ Unknown

DATE OF ONSET Month Day Year

DATE DIAGNOSED Month Day Year

DATE OF DEATH Month Day Year

Reporting Health Care Provider | Medical Record Number
Reporting Health Care Facility
Address
City | State | ZIP Code
Telephone Number ( ) | Fax ( )
Submitted by | Date Submitted (Month/Day/Year)

Report all non STD, non-TB, non-HIV to:
Communicable Disease Control Unit
San Francisco Dept of Public Health
25 Van Ness Ave, Suite 500
San Francisco, CA 94102
CD Phone: (415) 554-2830
CD Fax: (415) 554-2848
STD Fax: (415) 431-4628
TB Fax: (415) 206-4565
HIV Phone: (415) 437-6335

SEXUALLY TRANSMITTED DISEASES (STD)

Syphilis
☐ Primary (lesion present) ☐ Late latent > 1 year
☐ Secondary ☐ Late (tertiary)
☐ Early latent <1 year ☐ Congenital
☐ Latent (unknown duration)
☐ Neurosyphilis Y ☐ N ☐ UNK ☐ Ocular Syphilis Y ☐ N ☐ UNK ☐

Syphilis Test Results
☐ RPR Titer: ______
☐ VDRL Titer: ______
☐ CSF-VDRL ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
Other: ______

☐ Chlamydia ☐ Gonorrhea ☐ LGV (Suspect)
Specimen Source
☐ Pharyngeal ☐ Urine
☐ Rectal ☐ Vaginal
☐ Urethral/Cervical ☐ Other: ______

Gender(s) of Sex Partners last 12 months
Please check all that apply:
☐ Male ☐ Female ☐ Trans Male ☐ Trans Female
☐ Unknown ☐ Genderqueer/Gender Non-Binary

STD TREATMENT INFORMATION On PrEP for HIV prevention Y ☐ N ☐ UNK ☐
☐ **Treated** (Drugs, Dosage, Route): ______ Month Day Year
☐ Treated in office ☐ Given prescription
☐ Unable to contact patient
☐ Refused treatment
☐ Referred to: ______

VIRAL HEPATITIS

		Pos	Neg	Pend	Not Done
☐ Hep A	anti-HAV IgM	☐	☐	☐	☐
☐ Hep B	HBsAg	☐	☐	☐	☐
☐ Acute	anti-HBc	☐	☐	☐	☐
☐ Chronic	anti-HBc IgM	☐	☐	☐	☐
	anti-HBs	☐	☐	☐	☐
☐ Hep C	anti-HCV	☐	☐	☐	☐
☐ Acute ☐ Chronic	PCR-HCV	☐	☐	☐	☐
☐ Hep D (Delta)	anti-Delta	☐	☐	☐	☐
☐ Other: ______		☐	☐	☐	☐

Suspected Exposure Type
☐ Blood transfusion ☐ Other needle exposure ☐ Sexual contact ☐ Household contact
☐ Child care ☐ Other: ______

TUBERCULOSIS (TB)

Status
☐ Active Disease ☐ LTBI
☐ Confirmed
☐ Suspected

Site(s)
☐ Pulmonary
☐ Extra-Pulmonary

NAAT/PCR
☐ Positive
☐ Negative
☐ RIF resistance detected
☐ RIF resistance NOT detected

TB Testing
☐ IGRA
☐ PPD/TST
Date Performed Month Day Year
Results: ______

Chest X-Ray
Date Performed Month Day Year
☐ Normal ☐ Attach all results to CMR
☐ Cavitary ☐ Abnormal/Noncavitary

Bacteriology/Pathology
Accession number ______
Date Specimen Collected Month Day Year
Source: ______
Smear: ☐ Pos ☐ Neg ☐ Pending
Culture: ☐ Pos ☐ Neg ☐ Pending
☐ Pathology suggests TB
Other test(s) ______

TB TREATMENT INFORMATION
☐ **Current Treatment**
☐ INH ☐ RIF ☐ PZA
☐ EMB ☐ Other: ______
Date Treatment Initiated Month Day Year
☐ **Untreated**
☐ Will treat
☐ Unable to contact patient
☐ Refused treatment
☐ Referred to: ______

REMARKS

PM 110 (SF7/18)

REPORTABLE DISEASES AND CONDITIONS

City and County of San Francisco San Francisco Department of Public Health

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643 and §2800-2812.

Every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, must report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

§2500 (c) The Administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.

WHOM TO REPORT TO

REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO COMMUNICABLE DISEASE CONTROL UNIT UNLESS OTHERWISE INDICATED

COMMUNICABLE DISEASE CONTROL UNIT **PHONE: (415) 554-2830** **FAX: (415) 554-2848 M-F 8AM to 5PM** For urgent reports after hours, call 415-554-2830, and follow the instructions on the voicemail to page the on-call MD.	**HIV REPORTING** **PHONE: (415) 437-6335** **STD REPORTING** **PHONE: (415) 487-5530 FAX: (415) 431-4628** **TUBERCULOSIS REPORTING** **PHONE: (415) 206-8524 FAX: (415) 206-4565**	**ANIMAL CARE & CONTROL** **ANIMAL BITES (Mammals Only)** **PHONE: (415) 554-9422 FAX: (415) 864-2866** **ENVIRONMENTAL HEALTH SERVICES FOR PESTICIDE** **PHONE: (415) 252-3862 FAX: (415) 252-3818**

DISEASE OR CONDITION / URGENCY REPORTING REQUIREMENTS

URGENCY REPORTING KEY

▲ Report immediately by telephone — 1 Report within one working day of identification — 7 Report within seven calendar days by FAX, phone or mail

- 1 Amebiasis
- 7 Anaplasmosis
- 7 Animal bites (mammals only) *to Animal Care*
- ▲ Anthrax*, human or animal
- 1 Babesiosis
- ▲ Botulism* (Infant, Foodborne, Wound, Other)
- 7 Brucellosis, animal (except infections due to *Brucella canis*)
- ▲ Brucellosis*, human
- 1 Campylobacteriosis
- 7 Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix)
- 7 Chancroid *to STD*
- 1 Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
- 1 Chikungunya Virus Infection
- 7 *Chlamydia trachomatis* infections *to STD*
- ▲ Cholera
- ▲ Ciguatera Fish Poisoning
- 7 Coccidioidomycosis
- 7 Creutzfeldt-Jakob Disease (CJD)
- 1 Cryptosporidiosis
- 7 Cyclosporiasis
- 7 Cysticercosis
- ▲ Dengue Virus Infection
- ▲ Diphtheria
- 7 Disorders Characterized by Lapses of Consciousness
- ▲ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- 7 Ehrlichiosis
- 1 Encephalitis, infectious (specify etiology)
- ▲ *Escherichia coli* shiga toxin producing (STEC) including *E. coli* O157
- ▲ Flavivirus infection of undetermined species
- ▲ Foodborne illness (2 or more cases from different households)
- 7 Giardiasis
- 7 Gonococcal infections (Including disseminated) to STD
- 1 Haemophilus influenza, *invasive disease, all sero-types (in persons less than five years of age)*
- 1 Hantavirus infections
- ▲ Hemolytic Uremic Syndrome
- 1 Hepatitis A, acute infection
- 7 Hepatitis B (specify acute case or chronic)
- 7 Hepatitis C (specify acute case or chronic)
- 7 Hepatitis D (Delta) (specify acute case or chronic)
- 7 Hepatitis E, acute infection
- 1 Human Immunodeficiency Virus (HIV), *Acute Infection to HIV*
- 7 Human Immunodeficiency Virus (HIV) Infection, stage 3 (AIDS) *to HIV Reporting*
- 7 Influenza, deaths in laboratory-confirmed cases for age 0-64 years
- ▲ Influenza, novel strains (human)
- 7 Legionellosis
- 7 Leprosy (Hansen Disease)
- 7 Leptospirosis
- 1 Listeriosis
- 7 Lyme Disease
- 7 Lymphogranuloma Venereum (LGV) *to STD*
- 1 Malaria
- ▲ Measles (Rubeola)
- 1 Meningitis (specify etiology)
- ▲ Meningococcal infections
- 7 Mumps
- ▲ Novel Virus Infection with Pandemic Potential
- ▲ Paralytic Shellfish Poisoning
- 1 Pertussis (Whooping Cough)
- 7 Pesticide-related illness or injury (known or suspected cases) to *Environmental Health Services*
- ▲ Plague*, human or animal
- 1 Poliovirus infection
- 1 Psittacosis
- 1 Q Fever
- ▲ Rabies, human or animal
- 1 Relapsing Fever
- 7 Respiratory Syncytial Virus (only report death in patient less than five years of age)
- 7 Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- 7 Rocky Mountain Spotted Fever
- 7 Rubella (German Measles)
- 7 Rubella Congenital Syndrome
- 1 Salmonellosis (other than Typhoid Fever)
- ▲ Scombroid Fish Poisoning
- ▲ Shiga toxin (detected in feces)
- 1 Shigellosis
- ▲ Smallpox* (Variola)
- 1 Streptococcal infections, outbreaks of any type and individual cases in food handlers and dairy workers only
- 1 Syphilis *to STD Reporting*
- 7 Taeniasis
- 7 Tetanus
- 7 Transmissable Spongiform Encephalopathies (TSE)
- 1 Trichinosis
- 1 Tuberculosis *to Tuberculosis*
- 7 Tularemia, animal
- ▲ Tularemia*, human
- 1 Typhoid Fever (cases and carriers)
- 1 *Vibrio* infections
- ▲ Viral Hemorrhagic Fevers*, human or animal (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
- 1 West Nile Virus (WNV) Infection
- ▲ Yellow Fever
- 1 Yersiniosis
- ▲ Zika Virus Infection
- ▲ **ANY UNUSUAL DISEASES**
- ▲ **NEW DISEASE OR SYNDROME NOT PREVIOUSLY RECOGNIZED**
- ▲ **OUTBREAKS OF ANY DISEASE**

*Potential Bioterrorism Agents

Effective May 24, 2016 Revised August 2016

CONTACT/EXPOSURE INVESTIGATION

POLICY:

1. Laguna Honda Hospital implements protocols for contact and exposure investigation.

2. The Infection Control Nurse (ICN) is responsible for conducting contact/exposure investigation when a resident(s) ~~or staff are~~is suspected to have been in contact or exposed to a communicable disease.

PURPOSE:

To evaluate and manage ~~individuals~~ residents who have been exposed to infectious diseases while in the facility.

PROCEDURE:

1. Contact investigations are conducted to evaluate contacts for immunity, prophylaxis~~, work restrictions~~, isolation or precautions, as indicated by specific diseases to prevent secondary cases.

2. In some infectious disease circumstances, prompt prophylaxis is required and more immediate notification may be necessary. The Infection Control team will make this determination at the time. Under these circumstances, all components of this policy may not be possible and phone calls, verbal instructions, etc., will be substituted.

3. Contact investigations are initiated for exposures to cases of:

    a. Active pulmonary tuberculosis

    b. Rubella (German measles)

    c. Rubeola (measles)

    d. Varicella (chicken pox)/ disseminated varicella

    e. Meningococcemia/ meningococcal meningitis

    f. Pertussis

    g. Invasive H. influenza disease

    h. Norwegian scabies

    i. Any other communicable diseases as needed

4. The ICN initiates the protocol for contact investigations as follows:

   a. Confirms the diagnosis and defines the disease-specific exposure based on current Centers for Disease Control (CDC) criteria.

Note: If it is determined that no exposures occurred, the person(s) suspecting the exposure is notified.

   b. Reviews the infectious resident's chart and/or interviews the source to determine who was exposed. Possibilities include:

      i. Persons within departments with whom the resident had contact

      ii. Other residents with whom the source had contact

      iii. Family members and community contacts whom the source exposed

   c. Interviews employee and/ or the manager to determine if the contact/source is an employee.

   d. Informs the Chair of the Infection Control Committee, the Employee Health Service, the Industrial Hygienist from the department of Workplace Safety and Emergency Management (WSEM), and the appropriate public health communicable disease division.

   e. Notifies the department directors/managers involved, provides the exposure definition, dates of exposure, and name of the index case/source when appropriate.

   f. Determines if other residents were exposed (by applying the exposure definition).

NOTE: In the event of a complicated or extensive contact investigation involving many resident units or services, as determined by the Infection Control Professional, a multi-disciplinary team will be assembled to determine the specific course of action.

5. Contact Investigation Protocol For Exposed Residents~~ESIDENTS~~:

   a. The ICN develops a contact list of exposed residents and notifies the ~~Medical Director~~Chief Medical Officer and Chief Nursing Officer.

   b. For residents still in the facility, the ICN shall notify the physician ~~is notified~~ of the exposure and required follow-up.

~~For discharged residents, a letter may be sent directly to the resident or to the resident's primary physician informing him/her of the exposure, and include information such as the exposure date(s), circumstances, and required follow-up.~~

c. For cases involving resident exposure to~~ measles, TB, meningococcal meningitis, meningococcemia, mumps, pertussis, and invasive H. influenza~~ Communicable Disease Unit (CDU) reportable infections, a list is forwarded to the appropriate Department of Public Health Communicable Disease Division for assistance in contacting discharged residents. Social Services shall coordinate with Department of Public Health Communicable Disease Division to ensure the resident is notified.

6. Contact i~~I~~nvestigation ~~Protocol For~~for e~~E~~xposed ~~EMPLOYEES:~~employees shall be conducted by Employee Health and WSEM. Please refer to LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan.

~~a. The ICN will send a memo to the affected department directors/managers defining the exposure.~~

~~b. The Director/Manager will determine which employees were exposed and develop an employee Contact List. (All included must meet the exposure definition). The Contact List must be reviewed by the ICN.~~

~~c. The ICN approves or revises the Contact List as necessary and:~~

~~i. Returns Contact List to the Director/Manager~~

~~ii. Forwards a copy of the Contact List to the Employee Health Service~~

~~d. Directors/Managers notify employees of the exposure and any necessary follow-up.~~

~~e. The employee is responsible for following instructions and follow-up as developed by Infection Control protocol and/or Employee Health Service. Employees are responsible for obtaining necessary referral form and returning them to their manager or designated coordinator within the time frame identified. If follow up occurs from a provider other than Employee Health Service, documentation is also to be provided to Employee Health Service.~~

~~f. Employee Health Service notifies unit managers of exposed employees who have not reported for follow-up (at regularly scheduled intervals.)~~

~~g. Employee Health Service notifies the ICN of any suspected secondary cases that require further investigation.~~

h. Employee Health Service reports results of employees' follow-up to the Infection Control Committee on a bi-monthly basis until the Contact Investigation is complete.

7. Upon completion of the Contact Investigation, the Infection Control Committee shallwill determine if the resident/employee exposures could have been prevented. If determined to be avoidable, remediation in the form of a follow-up letter and/or educational program will be instituted.

ATTACHMENT:
None.

REFERENCE:
Centers for Disease Control (CDC)
San Francisco Department of Public Health Communicable Disease Control Program (SFDPH CDCP)
LHHPP 72-01 A8 Outbreak Investigation Protocol
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 14/11/25, 18/09/11 (Year/Month/Day)
Original adoption: Est. 05/11/01

ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

POLICY:

1. Standard Precautions shall always be followed for all residents regardless of diagnosis. (See Infection Control Policy C2, Standard Precautions)

2. LHH clinicians will utilize the following alphabetical list of diseases and conditions to assist with decisions regarding resident care precautions in accordance with Centers for Disease Control and Prevention (CDC) recommendations.

3. Infection Control shall be contacted as indicated in this guideline and as needed in order to collaborate in regard to individualized and additional precautions or isolation recommendations.

PURPOSE:

To reduce the likelihood of disease transmission, clinical staff shall determine and implement appropriate resident care precautions for all residents.

PROCEDURE:

1. For diseases and conditions requiring Standard Precautions, clinical personnel will care for these residents in the same manner as all hospitalized residents, and no sign shall be posted. (See Infection Control Policy C2, Standard Precautions)

2. For infections spread by respiratory secretions but for which Droplet or Airborne Respiratory Precautions are not required, health care providers must wear a mask, in keeping with Standard Precautions.

3. Appropriate signage is required to be posted on or next to the door to the resident's room for isolation or precautions that are in addition to Standard Precautions.

4. Instructions for each type of isolation/precautions are indicated on the signs, and must be adhered to by all persons entering room.

5. Careful consideration must be given to achieve appropriate room placement to prevent the spread of infection. A private room is necessary for most conditions requiring more than Standard Precautions, unless the resident can be placed in a cohort with someone with a like-condition. In many cases a private room must include a private bathroom, particularly when the pathogen is enteric, such as *C. Difficile* or Norovirus.

6. The Infection Control staff is available for questions or clarification of all resident care precaution guidelines.

7. Diseases requiring a report to the Department of Public Health are reported by Infection Control staff during usual business hours. At other times, the physician or nurse will report if required according to the following table to DPH at 415-554-2830 or, for sexually transmitted diseases to STD clinic at 415-487-5555, or for Tuberculosis, to TB Clinic 415-206-8524.

REMEMBER…**Standard Precautions** are used always, **for all residents** and all resident care. The following table is to help determine any additional precautions.

ATTACHMENT:
Alphabetical List of Diseases/Conditions with Required Precautions

REFERENCE:
None.

Revised: 15/11/09, 17/09/12, 18/09/11 (Year, Month, Day)
Original adoption: Est. 05/11/01

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Abscess	Where dressing covers and contains drainage adequately Where there is no dressing or dressing cannot cover or contain drainage	Standard Precautions CONTACT PRECAUTIONS under some circumstances	 Until drainage ceases CONTACT INFECTION CONTROL
Acquired Immune Deficiency Syndrome (AIDS)		Standard Precautions	DPH Reportable disease
Actinomycosis		Standard Precautions	
Adenovirus Infection	In adults In immunocompromised patients - Acute respiratory infection, tonsillitis, pneumonia or kerato-conjunctivitis	Standard Precautions CONTACT PRECAUTIONS AND DROPLET RESPIRATORY ISOLATION	Duration of illness CONTACT INFECTION CONTROL
Amebiasis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Anthrax	Cutaneous or pulmonary	Standard Precautions	CONTACT INFECTION CONTROL IMMEDIATELY In the event of potential aerosolizable spores other precautions also needed. DPH Reportable disease
Arthropod-borne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus)		Standard Precautions	DPH Reportable disease
Arthropod-borne viral fevers (dengue, yellow fever, Colorado tick fever)		Standard Precautions	DPH Reportable disease
Ascariasis		Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Aspergillosis		Standard Precautions	CONTACT INFECTION CONTROL if massive soft tissue infection with copious drainage and repeated irrigations required
Avian influenza (or other “novel” influenza with a high mortality rate as determined by the CDC or other credible guidelines)		AIRBORNE RESPIRATORY ISOLATION **AND** CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease
Babesiosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Bed bugs		Standard Precautions	Isolate/remove all belongings CONTACT INFECTION CONTROL
Blastomycosis		Standard Precautions	
Botulism		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Bronchiolitis	(see RSV)		
Brucellosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Campylobacter gastroenteritis	(See gastroenteritis)		CONTACT INFECTION CONTROL DPH Reportable disease
Candidiasis	All forms, including oral	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Carbapenem-Resistant Enterobacteriaceae (CRE)	E. coli, *Klebsiella*, pneumonia, or *Enterobacter*, all sites	Private room or cohort with CRE infected or colonized resident CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL Assume indefinite colonization; teach resident hand hygiene Private room or cohort Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.
Cat-scratch fever		Standard Precautions	
Cellulitis	Where no drainage or dressing contains drainage adequately. Where dressing cannot cover or contain drainage.	Standard Precautions CONTACT PRECAUTIONS	 CONTACT INFECTION CONTROL
Chancroid	(soft chancre)	Standard Precautions	DPH Reportable disease
Chickenpox	(see Varicella)		
Chlamydia trachomatis	Conjunctivitis, genital, respiratory	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Cholera Gastroenteritis	(see Gastroenteritis)		
Closed cavity infection		Standard Precautions	
Clostridium infections	*C. botulinum*	Standard Precautions	CONTACT INFECTION CONTROL, DPH Reportable Disease (if foodborne or wound)
	C. difficile (see Gastroenteritis)		
	C. perfringens Food poisoning or Gas gangrene	Standard Precautions	CONTACT INFECTION CONTROL

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Coccidioidomycosis (valley fever)		Standard Precautions	CONTACT INFECTION CONTROL
	Causing draining lesions or pneumonia	Standard Precautions	DPH Reportable disease
Colorado Tick Fever		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Conjunctivitis	Acute bacterial, including Chlamydia, Gonococcal	Standard Precautions	
	Acute viral (acute hemorrhagic)	CONTACT PRECAUTIONS	Duration of illness- CONTACT INFECTION CONTROL
Coronavirus	In adults	DROPLET PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL
	Immunocompromised or non-compliant with hygiene	DROPLET PRECAUTION & CONTACT ISOLATION (private room or cohort with similar case(s)	
Coxsackie virus disease		(See Enteroviral infections)	
Creutzfeldt-Jacob disease (CJD)		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
NOTE: Additional precautions are necessary for handling CJD pathological specimens and contaminated items. CONSULT INFECTION CONTROL before invasive procedures.			
Cryptococcosis		Standard Precautions	
Cryptosporidiosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
	For diapered or incontinent residents unable to maintain hygiene	CONTACT PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL
Cyclosporiasis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Cysticerocosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Cytomegalovirus infection immunosuppressed		Standard Precautions	
Decubitus ulcer (see pressure ulcer)			
Dengue		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Diarrhea, acute	Infective etiology suspected. If resident has uncontrolled diarrhea which cannot be contained and continues to grossly contaminate the environment	CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL
Diphtheria	Cutaneous Pharyngeal	DROPLET RESPIRATORY ISOLATION	For both forms, isolate until off antimicrobial treatment and culture-negative. CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Ebola, viral hemorrhagic fever	For persons who screens positive to current Ebola screening: suspected viral hemorrhagic fever with prominent cough, vomiting, diarrhea, or hemorrhage.	Follow Ebola protocol utilizing Ebola Response Standard Operating Procedure including: Screen clinic outpatients and use posters to screen others to identify possible Persons Under Investigation (PUI). **Do not touch PUI.** Have PUI mask and isolate in clinic. Notify 9-1-1 and DPH CDU to arrange for transport to approved Ebola screening hospital (includes ZSFG).	CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease – REPORT IMMEDIATELY to Communicable Disease Unit (CDU) at 415-554-2830.
Echinococcosis	(Hydatid Disease)	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Echovirus	*(See Enteroviral infections)*		
Encephalitis or encephalomyelitis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Endometritis		Standard Precautions	
Enterobiasis (pinworm disease, oxyuriasis)		Standard Precautions	
Enterococcus faecalis or faecium, vancomycin-resistant (VRE)		*(See VRE)*	
Enterocolitis, Clostridium difficile		(See Gastroenteritis and C18 *Clostridium difficile* guideline)	
Enteroviral Infections (i.e. Group A and B Coxsackie viruses and Echo viruses)	Adults Incontinent persons	Standard Precautions CONTACT PRECAUTIONS	 Duration of illness CONTACT INFECTION CONTROL

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Epiglottitis	*Haemophilus influenzae*	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy
Epstein-Barr virus infection including mononucleosis		DROPLET RESPIRATORY ISOLATION	Respiratory secretions may be highly infectious for 7 days after onset of illness
Erythema infectiosum		DROPLET RESPIRATORY ISOLATION	Respiratory secretions may be highly infectious for 7 days after onset of illness
Escherichia coli gastroenteritis	*(See Gastroenteritis)*		
ESBL producing organisms	e.g., E. coli or *Klebsiella* pneumonia, all sites	Standard Precautions	CONTACT INFECTION CONTROL Assume indefinite colonization.
	If resident with ESBL has uncontrolled diarrhea or infected sites with fluids which cannot be contained	CONTACT Precautions Private room or cohort with ESBL infected or colonized residents	Private room or cohort Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results. Continue contact precautions until site of colonization or infection can be appropriately contained and able to maintain hygiene.
Food poisoning	Botulism	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
	Clostridium perfringens or welchi	Standard Precautions	
	Staphylococcal	Standard Precautions	
Furunculosis (*staphylcoccal*)	Adults	Standard Precautions	Duration of illness
Gangrene	Gas gangrene	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Gastroenteritis	Adenovirus *Campylobacter* Cholera	Standard Precautions CONTACT PRECAUTIONS if incontinent and unable to maintain hygiene.	CONTACT INFECTION CONTROL DPH Reportable disease
	Clostridium difficile (C. diff) See also C18 *Clostridium difficile* Guideline	CONTACT PRECAUTIONS ENHANCED with hand washing with soap and water and environmental cleaning with bleach solution. (Alcohol-based hand sanitizers are ineffective against spores) Room placement in private room with private bathroom (or place in cohort with like-cases).	CONTACT INFECTION CONTROL DPH Reportable if outbreak Continue precautions until resident receives 5 days of antimicrobial therapy AND no diarrhea for 48 hours. Inform EVS upon initiation and termination Follow Bleach cleaning policy and procedures including bleach wipes for high touch surfaces.
	Escherichia coli, including Enterohemorrhagic 0157:H7 *Giardia lamblia*	For all of the following except Noroviruses, Standard Precautions; CONTACT PRECAUTIONS if incontinent and unable to maintain hygiene.	If outbreak or if 0157:H7, CONTACT INFECTION CONTROL DPH Reportable disease For all of the following except Rotavirus: CONTACT INFECTION CONTROL DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Gastroenteritis (continued)	Norovirus	CONTACT PRECAUTIONS – ENHANCED (as per *C. diff*)	
	Rotavirus		
	Salmonella species, including *S. typhi*		
	Shigella species		
	Vibrio parahaemolyticus		
	Viral (not covered elsewhere)		
	Yersinia enterocolitica		
German measles (rubella)		DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL DPH Reportable disease
Note: Respiratory secretions are highly infectious until 7 days after onset of rash.			
Giardiasis (see Gastroenteritis, *Giardia lamblia*)			DPH Reportable disease
Gonorrhea		Standard Precautions	
Granuloma inguinale	(donovanosis, granuloma venereum)	Standard Precautions	
Guillain–Barre syndrome		Standard Precautions	
Hand, foot & mouth disease	(See Enteroviral infection)		
Hantavirus	Pulmonary syndrome	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Helicobacter pylori		Standard Precautions	
Hemorrhagic fevers	See Ebola for suspected Ebola, Marburg, Lassa, or Yellow Fever		
Hepatitis, viral infections		Standard Precautions	All hepatitis cases are DPH Reportable Diseases
	Hepatitis A	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Hepatitis A in resident with diarrhea	CONTACT PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL
	Hepatitis B	Standard Precautions	
	Hepatitis C	Standard Precautions	
	Hepatitis E	Standard Precautions	
	Hepatitis, unspecified non-A, non-B	Standard Precautions	
Herpangina	(See Enteroviral infection)		
Herpes simplex infections	*Herpesvirus hominis*		
	Mucocutaneous, recurrent, localized (skin, oral, genital)	Standard Precautions	
	Mucocutaneous, IF disseminated or severe primary infection	CONTACT PRECAUTIONS	Duration of illness – CONTACT INFECTION CONTROL
	Herpes encephalitis	Standard Precautions	CONTACT INFECTION CONTROL
Herpes zoster	(Varicella-zoster, Shingles) Localized zoster	Standard Precautions	
	Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)	AIRBORNE RESPIRATORY ISOLATION	Duration of illness – People susceptible to varicella/chicken pox (employees with no history of chickenpox and no documented positive varicella antibody), pregnant or immunocompromised employees who are antibody negative should not enter the room CONTACT INFECTION CONTROL
Histoplasmosis		Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
HIV (Human immunodeficiency virus)		Standard Precautions	DPH Reportable disease upon initial diagnosis
Hookworm disease	(Anacylostomiasis, Uncinariasis, Necatoriasis)	Standard Precautions	CONTACT INFECTION CONTROL
Impetigo *Staph, strep, or MRSA* Note: may occur in adults usually after other infections		CONTACT PRECAUTIONS	Until 24 hours after initiation of appropriate antimicrobial therapy. CONTACT INFECTION CONTROL
Infectious mononucleosis		Standard Precautions	
Influenza	Confirmed or highly suspected See also C22 Influenza Immunization and 72-05 Employee Influenza Vaccination Policy and Use of Surgical Mask when Vaccination Declined	DROPLET RESPIRATORY ISOLATION, including private room or isolation room (preferred) or in cohort with like cases if private / isolation rooms unavailable. Other precautions, such as preventive antiviral therapy for ill resident and resident contacts, generally advised by Infection Control, based upon current CDC guidelines for each flu season.	Until 7 days after onset of symptoms or until 24 hours after resolution of fever and respiratory symptoms, whichever is longer. May be extended longer in immunocompromised residents. CONTACT INFECTION CONTROL 1 lab confirmed case plus 1 case of influenza – like illness (ILI) in the setting of 2 or more total cases within 72 hours OR 2 or more linked cases of ILI are considered an outbreak in LTC DPH Reportable Disease
Kawasaki syndrome		Standard Precautions	CONTACT INFECTION CONTROL
Lassa fever	See Ebola, viral hemorrhagic fever		
Legionnaire's disease		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Leprosy		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Leptospirosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Lice	(Pediculosis)	CONTACT PRECAUTIONS	Until 24 hours after initiation of pediculosis therapy and no live lice detected.
Note: Always wear personal protective gear (i.e., gloves, gowns) for contact with non-intact skin and rashes, especially in the absence of a diagnosis			
Listeriosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Lyme disease		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Lymphocytic choriomeningitis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Lymphogranuloma venerum		Standard Precautions	DPH Reportable Disease
Malaria		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Marburg virus disease	See Ebola, viral hemorrhagic fever		
Measles (rubeola), all presentations		AIRBORNE RESPIRATORY ISOLATION Persons susceptible to measles should not enter room. Employees born after 1957 will be considered susceptible unless they have had physician diagnosed measles or a measles immunization.	Duration of illness. CONTACT INFECTION CONTROL IMMEDIATELY DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Melioidosis	All forms	Standard Precautions	
Meningitis			CONTACT INFECTION CONTROL for all forms of meningitis
	Aseptic (nonbacterial or viral meningitis)	Standard Precautions	
	Bacterial, including gram-negative enteric	Standard Precautions	
	Fungal	Standard Precautions	
	Haemophilus influenzae, type b known or suspected Common cause of bronchitis in adults	DROPLET initiation of RESPIRATORY ISOLATION	Until 24 hrs. after appropriate antimicrobial therapy
	Note: Respiratory secretions may be highly infectious until resident has been on 24 hours of appropriate antibiotic therapy. Remember, mask for respiratory and oral care. Hand hygiene imperative		
	Listeria monocytogenes	Standard Precautions	
	Neisseria meningitis (meningococcal)	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL DPH Reportable disease
	Pneumococcal	Standard Precautions	
	Tuberculosis	Standard Precautions	Evaluate for current (active) TB and use Airborne Level Respiratory Isolation accordingly. Report to TB Clinic
	Other diagnosed bacterial meningitis	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Meningococcal sepsis)	(Pneumonia, meningitis,	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL DPH Reportable Disease
MERS Co-V (Middle Eastern Respiratory Syndrome Coronavirus)		AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL
Metapneumo Virus		DROPLET PRECAUTIONS	At least 7 days from symptom onset and symptoms resolve
Molluscum contagiosum		Standard Precautions	
Monkey pox		AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Until lesions crusted CONTACT INFECTION CONTROL DPH Reportable Disease
MRSA (methicillin-resistant *Staph aureus*) see *Staphylococcus aureus* diseases			
Mucormycosis		Standard Precautions	
Multidrug-resistant organisms, infection and/or uncontrolled body fluids	(MRSA, VRE, CRE, ESBL, C. DIFF)	CONTACT PRECAUTIONS	Until drainage and/or secretions cease or can be contained CONTACT INFECTION CONTROL
Mumps	(Infectious parotitis)	DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious for 9 days after onset of parotid swelling.	CONTACT INFECTION CONTROL DPH Reportable disease
Mycobacteria, nontuberculosis (atypical)	Pulmonary or wound site	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Mycoplasma pneumonia		DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious. Remember, mask when entering resident's room.	Duration of illness
Necrotizing enterocolitis		Standard Precautions	
Neutropenia	Absolute neutrophil count (ANC) <500 per µL or as defined by residents physician	Neutropenic Precautions, if ordered (The effectiveness of neutropenic precautions is controversial, however some clinicians may put these precautions in place on a case by case basis).	If clinicians choose NOT to place patient on Neutropenic Precautions then utilize Standard Precautions and restrict ill persons from entering room at least until neutropenia is resolved.
Nocardiosis	Draining lesions and other presentations	Standard Precautions	
Norovirus	(see Gastroenteritis, Viral)		
Orf Virus		Standard Precautions	
Parainfluenza Virus (all types)		DROPLET PRECAUTIONS	At least 7 days from symptom onset and symptoms resolve.
Parvovirus B19		DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious for 7 days after onset of illness. Remember, mask when entering resident's room.	
Pediculosis	(see Lice)		
Pertussis	(Whooping cough)	DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious for 5 days after initiation of appropriate antimicrobial therapy.	CONTACT INFECTION CONTROL DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Pinworm infection		Standard Precautions	
Plague	Bubonic	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
	Pneumonic	DROPLET RESPIRATORY ISOLATION	Until three days after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL
	Note: Respiratory secretions may be highly infectious for 5 days after initiation of appropriate antimicrobial therapy.		
Pleurodynia	(See Enteroviral infection)		
Pneumonia	Adenovirus	DROPLET RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Duration of illness
	Bacterial, not listed elsewhere, including gram-negative bacterial (*Enterobacter, Serratia, Acinetobacter sp.*)	Standard Precautions	CONTACT INFECTION CONTROL
	Burkholderia cepacia without cystic fibrosis	Standard Precautions	CONTACT INFECTION CONTROL Avoid placement of cystic fibrosis patients colonized with *B. cepacia* in cohort
	Chlamydia	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
	Fungal	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Haemophilus influenzae in adults	Standard Precautions Note: Respiratory secretions may be highly infectious until resident has been on 24 hrs. of appropriate antimicrobial therapy. Remember, mask for respiratory and oral care.	Until 24 hrs. after initiation of appropriate antimicrobial therapy
	Legionella	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Pneumonia (continued)	Meningococcal pneumonia	DROPLET RESPIRATORY ISOLATION and CONTACT PRECAUTIONS during first 24 hrs. of antibiotic therapy, then Standard Precautions	CONTACT INFECTION CONTROL
		Note: Respiratory secretions may be highly infectious until resident has been on 24 hrs. of appropriate antimicrobial therapy. Remember, mask for respiratory and oral care.	
	Multi-drug resistant bacteria (see Multi-drug resistant organisms)	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Mycoplasma (primary atypical Pneumonia)	DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious. Remember, mask for respiratory and oral care.	
	Pneumocystis carinii (PCP)	Standard Precautions	Avoid placement in the same rooms with immune-compromised resident
	Pseudomonas cepacia (*Burkholderia cepacia*)	Standard Precautions	
	Staphylococcus aureus	Standard Precautions	
	Streptococcus, Group A	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy
	Viral pneumonia	Standard Precautions	
Pneumonia (continued)	Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood and no cough)	AIRBORNE RESPIRATORY ISOLATION	Until a respiratory diagnosis is confirmed and TB is ruled out (see Policy C5, Airborne Respiratory Isolation)
Poliomyelitis		CONTACT PRECAUTIONS AND DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL DPH Reportable Disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Pressure ulcer (decubitus)	Infected, where dressing covers and contains drainage adequately.	Standard Precautions	
	Infected, where there is no dressing or dressing cannot cover or contain drainage.	CONTACT PRECAUTIONS	Until drainage ceases or can be contained CONTACT INFECTION CONTROL
Psittacosis (ornithosis)		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Q fever		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Rabies		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Rat-bite fever	(*Streptobacillus moniliformis* disease, *Spirillum minus* disease)	Standard Precautions	CONTACT INFECTION CONTROL
Relapsing fever		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable disease
Resistant bacterial infection or colonization	(See Multi-drug resistant organisms)		
Respiratory syncytial virus (RSV)		DROPLET CONTACT ISOLATION	At least 8 days from symptom onset and symptoms resolve
	Immunocompromised	DROPLET PRECAUTION & CONTACT ISOLATION (private room or cohort with similar case(s)	Duration of illness. Immunocompromised adults can shed virus for up to 4 weeks.
Reye's syndrome		Standard Precautions	
Rheumatic fever		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Rhinovirus/Enterovirus		DROPLET PRECAUTIONS	At least 7 days from symptom onset and symptoms resolve.
Rickettsial fevers, tick-borne	(non-Rocky Mountain spotted fever, tick-borne typhus fever)	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Rickettsialpox	(Vesicular rickettsiosis)	Standard Precautions	CONTACT INFECTION CONTROL
Ringworm	(Dermatophytosis, dermatomycosis, tinea)	Standard Precautions	
Ritters Disease (see *Staphylococcal* disease, Scalded Skin Syndrome)			
Rocky Mountain spotted fever		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Rotavirus infection	(See Gastroenteritis)		
Rubella	(German measles)	DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL DPH Reportable Disease
Note: Respiratory secretions are highly infectious until 7 days after onset of rash. Remember, mask for respiratory and oral care. Handwashing stressed.			
Salmonellosis	(See Gastroenteritis, *Salmonella* species)		
SARS - Severe acute respiratory syndrome		AIRBORNE RESPIRATORY ISOLATION **AND** CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL DPH Reportable Disease
Scabies Norwegian scabies		CONTACT PRECAUTIONS CONTACT PRECAUTIONS PRIVATE ROOM	Until 24 hrs. after treatment with effective agent. Maintain isolation until negative skin scrapings obtained by qualified individual.
Note: Always wear personal protective gear (e.g., gloves, gowns) for contact with non-intact skin and rashes, especially in the absence of a diagnosis. Also refer to 72-01C12-Scabies Management.			

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Scalded skin syndrome	See *Staphylococcal* disease, scalded skin syndrome		
Schistosomiasis (bilharziasis)		Standard Precautions	CONTACT INFECTION CONTROL
Shigellosis	(See Gastroenteritis, *Shigella* species)		CONTACT INFECTION CONTROL DPH Reportable disease
Shingles (zoster, varicella zoster)			
	Localized zoster	Standard Precautions	
	Disseminated zoster (many lesions; <u>not unilateral</u> appearance; spread over multiple body surfaces)	AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Duration of illness. People susceptible to varicella/chicken pox (employees with no hx of chicken pox and no documented positive varicella antibody, pregnant or immunocompromised employees who are antibody negative) should not enter room. Maintain isolation until lesions dried and crusted.
Smallpox	Suspected or confirmed smallpox	AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL Maintain isolation until lesions dried and crusted. DPH Reportable Disease
Sporotrichosis		Standard Precautions	
Spirillum minus disease	(see Rat-bite fever)		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Staphylococcal aureus diseases	Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately	Standard Precautions	
	Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage	CONTACT PRECAUTIONS	Until drainage ceases or can be contained
	MRSA (Methicillin-resistant *S. aureus*) in body site / fluid where drainage is adequately contained	Standard Precautions HAND HYGIENE IS CRITICAL Ensure hands are clean prior to entering each resident's room or bedside. Wash hands promptly after contact with residents and residents' immediate environment. Avoid touching equipment and surfaces with potentially contaminated hands.	
	MRSA (Methicillin-resistant *S. aureus*) in body site / fluid where drainage cannot be controlled or adequately contained	CONTACT PRECAUTIONS	Until drainage and/or secretions cease or can be contained, CONTACT INFECTION CONTROL
	Staphylococcal pneumonia	Standard Precautions	
	Scalded skin syndrome (Ritter's disease)	CONTACT PRECAUTIONS	Duration of illness
	Toxic shock syndrome	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Streptobacillus moniliformis disease	(See rat-bite fever)		
Streptococcal disease, Group A			

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage Endometritis (puerperal sepsis) Pneumonia	Standard Precautions Note: HANDWASHING IS CRITICAL CONTACT PRECAUTIONS Standard Precautions (See Pneumonia)	Report to DPH when outbreak or single case in food handlers or dairy workers. Until drainage ceases or can be contained, CONSULT INFECTION CONTROL
Strongyloidiasis		Standard Precautions	
Syphilis	Skin and mucous membrane, including congenital, primary, secondary, latent (tertiary), and seropositivity without lesions	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease to STD clinic
Tapeworm disease	Including *Hymenolepis nana, Taenia solium* (pork), and others	Standard Precautions	DPH Reportable Disease
Tetanus		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Tinea	(Athlete's foot, ringworm)	Standard Precautions	
Toxoplasmosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Toxic shock syndrome	(See *Staphylococcal* disease)		
Trachoma, acute		Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Trench mouth	(Vincent's angina)	Standard Precautions	
Trichinosis		Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Trichomoniasis		Standard Precautions	
Trichuriasis	(Whipworm disease)	Standard Precautions	DPH Reportable Disease
Tuberculosis (TB)	*Mycobacterium* tuberculosis	Varies based upon location of disease, clinical symptoms, stage or treatment; as follows:	CONTACT INFECTION CONTROL DPH Reportable disease (TB Control)
	Pulmonary, confirmed or suspected, AFB smear positive, including laryngeal disease	AIRBORNE RESPIRATORY ISOLATION	Discontinue isolation only when TB resident on effective therapy (usually two weeks after start of appropriate therapy; extended if subclinical drug regimen), improving clinically, and resident has three consecutive negative sputum smears, collected on different days, or TB is ruled out.
	Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood)	AIRBORNE RESPIRATORY ISOLATION	Until a respiratory diagnosis is confirmed
	Extra pulmonary TB, no draining lesion, including scrofula (TB infection of lymph nodes in the neck)	Standard Precautions	CONTACT INFECTION CONTROL

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
	Extra pulmonary TB meningitis	Standard Precautions Note: Resident should also be evaluated for current (active) pulmonary TB. If evidence exists, Airborne precautions necessary (see Tuberculosis)	
	Skin-test positive, with no evidence of current pulmonary disease	Consider TB Clinic referral if any suspicion especially for immunocompromised (symptoms may be masked) Airborne Respiratory Isolation while ruling out pulmonary TB; Standard Precautions once cleared	
Tularemia	Including draining lesions and pulmonary presentations	Standard Precautions	CONTACT INFECTION CONTROL DPH Reportable Disease
Typhoid fever	(*Salmonella typhi*, See Gastroenteritis)		
Typhus (Louse-borne typhus)	*Rickettsia typhi*	Standard precautions	DPH Reportable Disease
Urinary Tract Infections (UTI)	UTI; including pyelonephritis, with or without urinary catheter	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Vancomycin resistant *Enterococcus* (VRE)	*Enterococcus faecalis* or *faecium* If resident with VRE has uncontrolled diarrhea or infected sites with fluids which cannot be contained	Standard Precautions CONTACT PRECAUTIONS Private room or cohort with VRE infected or colonized residents	CONTACT INFECTION CONTROL Assume indefinite colonization. Private room or cohort Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.
Vancomycin-resistant *S. aureus* (VRSA) or Vancomycin-intermediately resistant *S. aureus* (VISA)		CONTACT PRECAUTIONS	Duration varies; CONTACT INFECTION CONTROL

Note: Infection Control must notify Public Health authorities for any suspected case IMMEDIATELY

Infection	Condition	Type of Precautions	Notes / Reporting Required
Varicella (Chickenpox)	Confirmed or suspected case Susceptible persons exposed to chickenpox	AIRBORNE RESPIRATORY ISOLATION And CONTACT PRECAUTIONS AIRBORNE RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL Maintain isolation until lesions are crusted. Susceptible persons should not enter the room Susceptible persons exposed to chickenpox must be isolated days 10 through 21 post exposure. Report Varicella-related deaths to DPH
Vibrio parahaemolyticus (See Gastroenteritis)			
Vincent's angina	(see Trench mouth)		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Viral disease, respiratory (See Respiratory Infectious disease, acute)			
	Diseases not covered elsewhere	Standard Precautions	
	(See Respiratory infectious disease, acute)	Note: Respiratory secretions may be highly infectious for duration of illness. Remember, mask for respiratory and oral care.	
Whooping cough	(Pertussis)	DROPLET RESPIRATORY ISOLATION	Until 5 days after initiation of appropriate antimicrobial therapy. CONTACT INFECTION CONTROL DPH Reportable disease
Wound Infections	Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage	CONTACT PRECAUTIONS	Until drainage ceases or can be contained – CONTACT INFECTION CONTROL
Yersinia enterocolitica	(See Gastroenteritis)		
Zika virus	Standard Precautions		CONTACT INFECTION CONTROL DPH Reportable disease
Zoster (Shingles, varicella zoster)	Localized zoster	Standard Precautions	Duration of illness
	Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)	AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Duration of illness. People susceptible to varicella (chicken pox) should not enter room. Maintain isolation until lesions dried and crusted.
Zygomycosis (*Phycomycosis mucormycosis*)	Standard Precautions		

EMPLOYEE INFLUENZA VACCINATION(S) POLICY AND USE OF SURGICAL MASKS WHEN VACCINATION(S) IS DECLINED

POLICY:

1. All Laguna Honda Hospital and Rehabilitation Center (LHH) staff shall receive the influenza vaccine(s), unless medically contraindicated, during the influenza season as defined by the Centers for Disease Control for the northern hemisphere for the current year in order to protect the health and wellbeing of LHH residents who are particularly vulnerable to exposure.

2. Managers are responsible for enforcing and monitoring the use of a surgical mask by employees who decline the influenza vaccine.

3. Repeated failure by an employee to comply with mandatory masking during the influenza season shall result in disciplinary action according to Human Resources Department procedures.

PURPOSE:

The purpose of this policy is to:

1. Provide explicit standards for all LHH staff regarding required influenza vaccine(s) for the influenza season, to protect residents and staff from exposure to the influenza virus.

2. Ensure LHH managers, supervisors, directors, department heads, section leaders and staff are informed of required influenza policies and procedures. This communication shall be conveyed by e-mail, intranet website postings, phone messages, all staff meetings, memoranda, messages from CEO, etc.

3. Ensure that policies and procedures are in place, and have been provided to management and staff for those individuals who decline the Influenza vaccine requirement.

4. Ensure that the declination process for those staff declining Influenza vaccine(s) is completed by a specific date.

5. Ensure that staff who decline the influenza vaccine are required to wear a surgical mask for the duration of the influenza season in the hospital building except staff break rooms.

6. Staff working in isolation rooms shall follow the standard of masking required for the specific resident involved.

7. Ensure that Employee Health Services, Infection Control Committee, and Hospital Administration designate November 1 through April 30 each fiscal year as the dates when the mandatory masking requirement shall begin and end, subject to the status of the influenza season within the community.

8. Enforce the influenza vaccine(s) requirement of LHH staff in order to protect the health and safety of patients/residents, staff and visitors.

BACKGROUND:

1. Influenza is a serious respiratory disease that kills approximately 36,000 persons in the United States every year.

2. Hospitalized patients are particularly vulnerable to disease exposures.

3. Patient/resident safety is the underlying goal of all influenza policies.

4. Health care worker safety is inextricably linked to patient/resident safety.

5. The influenza virus may be shed for up to 48 hours before the health care worker feels sick or exhibits classic symptoms. Up to 30% of people with influenza have no symptoms, allowing inadvertent and unknowing transmission to patients and coworkers.

PROCEDURE:

1. When the recommended influenza vaccine(s) becomes available to LHH, employees shall be able to obtain the influenza vaccine(s) from Employee Health Services. The influenza vaccine(s) shall be available free of charge.

2. Employee Health Services shall make every reasonable attempt to reach out to LHH employees and accommodate their work schedule.

3. The employee shall present their identification (ID) badge, review the Vaccine Information Statements (VIS) issued and updated by the Centers for Disease Control, and indicate their consent to the influenza vaccine(s) on the VIS form prior to receiving the influenza vaccine(s). Pregnant staff are asked to consult their physician prior to being vaccinated. Mercury free vaccines are to be provided to all pregnant staff.

4. Employees who have not received the influenza vaccine(s) elsewhere, and decline influenza vaccine(s) offered at LHH, shall be required to wear a surgical mask for the duration of the influenza season when in the hospital building except staff break rooms. Staff is expected to manage their mask use to conform to health and safety standards to protect patients/residents, visitors and co-workers.

5. Unvaccinated employees who are non-compliant with mandatory masking shall receive a verbal warning from their supervisor/manager the first time s/he is observed without a mask or improperly donning the mask. Managers shall report further instances of non-compliance to the Human Resources Department for further corrective disciplinary action.

6. Vaccinated staff shall be given a sticker on their ID Badge. A list of all staff who have been vaccinated shall be available at the nursing office and the Employee Health Services M-F 7:030 a.m. - 4:300 p.m.

7. Should a public health disaster be declared, in State of California and/or Federal Government, the above procedures outlined in this policy and procedure may be changed.

8. For those LHH staff incurring days off work due to influenza illness, accrued sick leave shall be used pending adjudication, if indicated, of any claim of workplace acquired illness.

9. LHH staff shall report suspected influenza-like illness to the appropriate unit managers and follow the Respiratory Viral Illness Screening For Staff And Return to Work Algorithm (refer to Appendix A).

10. Employee Health Services and Infection Control Committee shall revise policies as needed according to current evidence based recommendations.

ATTACHMENT:
Appendix A: Screening for Staff and Guidance for Return to Work Algorithm

REFERENCE:
Department of Public Health Uniform Disciplinary Guidelines, Reissued March 2015

Revised: 13/01/29, 14/11/25, 17/01/10, 17/09/12, 18/09/11 (Year/Month/Day)
Original adoption: 09/12/15

APPENDIX A:

RESPIRATORY VIRAL ILLNESS (including Influenza) SCREENING FOR STAFF

Symptoms	Stay At Home	Return to Work
FEVER • Fever (T38C or 100.4F)	T > 38C or 100.4F	• No fever for 24 hours[1]
RESPIRATORY SYMPTOMS WITHOUT FEVER • Cough • Sore throat • Nasal Congestion / Runny Nose • Myalgia (body aches)	Two or more symptoms [2]	• 24 hours after onset of symptoms AND • No fever [1] AND • Symptoms have significantly improved
RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza) • Fever (T38C or 100.4F) • Cough • Sore throat • Nasal Congestion / Runny Nose • Myalgia (body aches)	T > 38C or 100.4F and at least one symptom	• At least 5 days after onset of symptoms[3] AND • No fever for 24 hours[1] AND • Symptoms have significantly improved

AND GUIDANCE FOR RETURN TO WORK

1. Assumes the individual has not taken fever-reducing medication (e.g. Tylenol, Motrin).

2. If you have received the seasonal influenza vaccine, you may work with minimal symptoms if you adhere to excellent hand hygiene and wear a mask when performing direct patient care activities.

3. For the purposes of counting the days, the onset of symptoms happens on Day 0. Day 1 begins the next calendar day. e.g. Symptoms begin on Sunday; Sunday is day zero; Monday is day one; and Friday is day five. You can return to work **if well.**

Questions about the process should be directed to the LHH Infection Control Department at ext. 4-2345.

GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall adopt the prevention and control of tuberculosis (TB) guidelines that were developed by the California Department of Health Services Licensing and Certification Program, the Tuberculosis Control and Infectious Diseases Branches of the Division of Communicable Disease Control and the California Tuberculosis Controllers Association (CDPH –CTCA Joint Guidelines) to minimize resident and health care worker exposure to tuberculosis.

Website address: http://www.cdph.ca.gov/programs/hai/Documents/Guidelines-Prevent-Control-TB-California-LT-HCF-2013.pdf

DEFINITION:

Health care workers (HCW) are defined as persons working at LHH, paid and unpaid.

PURPOSE:

The purpose of these guidelines are multi-fold and include the following:

1. Design and implement a program for screening residents and health care workers for TB;

2. Reduce the transmission of TB through prompt detection and management of active tuberculosis disease;

3. Establish a process for requesting consultation from the local health department in the investigation and management of active TB disease; and

4. Comply with Federal, State and City regulations.

PROCEDURE:

1. Tuberculosis Skin Test (TST)

    a. Resident TST

        i. The TST is performed using the Mantoux method of intradermally injecting five (0.1cc) tuberculin units of purified protein derivation (PPD) into the volar aspect of the forearm.

        ii. A two-step TST shall be administered to residents who have never been tested, or if more than 12 months have elapsed since the last documented negative TST. The second TST shall be administered within 1 to 3 weeks after the first

if the first TST is interpreted as negative. The results of the second TST shall be the reported result.

iii. In uninfected residents, a positive result on any future TST shall be interpreted as a skin test conversion.

iv. New residents with positive TST results shall be referred to their attending physician for treatment recommendations.

- Induration of >5mm is considered positive in:
  - Human immunodeficiency virus (HIV)-infected persons
  - Recent contacts of TB case patients
  - Persons with fibrotic changes on chest radiograph consistent with prior TB
  - Patients with organ transplants and other immuno-suppressed patients
- Induration of >10mm is considered positive in:
  - Residents of nursing homes and other long-term facilities for the elderly

~~iv.~~v. Residents with a positive TST and prior BCG vaccine shall be considered to have latent tuberculosis infection (LTBI).

b. Health Care Worker TST

i. The TST is performed using the Mantoux method of intradermally injecting five (0.1cc) tuberculin units of PPD into the volar aspect of the forearm.

ii. A two-step TST shall be administered to HCWs who have never been tested, or if more than 12 months have elapsed since the last documented negative TST. The second TST shall be administered within 1 to 3 weeks after the first if the first TST is interpreted as negative. The results of the second TST shall be the reported result.

iii. In uninfected HCWs, a positive result on any future TST shall be interpreted as a skin test conversion.

iv. New HCWs with positive TST results shall be referred to their healthcare provider or the local health department for treatment recommendations.

v. HCWs with a positive TST and prior BCG vaccine shall be considered to have latent tuberculosis infection (LTBI).

2. Screening Residents

a. New Admission and Annual Screening

i. Residents with no known or suspected TB shall be screened upon admission with a two-step TST and annual PPD test.

ii. Residents who have received the bacilli Calmette-Guerin (BCG) vaccine shall be included in the TST screening program.

iii. Residents who are known or suspected to have TB and are hospitalized or are residents of other healthcare facilities, may only be admitted with written approval of the local health department/ TB Clinic, or when they are no longer infectious according to the criteria described in the CDPH–CTCA Joint Guidelines.

iv. A resident who has a documented history of positive TST or Interferon Gamma Release Assay (IGRA), or history of active TB disease, shall be screened for TB disease on admission with a symptom screen *(bloody sputum, hoarseness lasting 3 weeks or more, persistent cough lasting 3 weeks or more, unexplained excessive fatigue, unexplained persistent fever lasting 3 weeks or more, unexplained excessive night sweats, unexplained weight loss)* and chest x-ray (CXR), unless one was already done in the United States within 90 days prior to admission.

v. Residents who have documented history of positive TST or IGRA, or history of active TB disease shall be screened annually and if a change in condition suspicious of TB disease occurs. TB screening will include a symptom screen and CXR, if indicated.

- If the result of the CXR is abnormal, the in-coming resident shall be referred to the healthcare provider for evaluation. The resident shall not be admitted until s/he receives medical clearance from the local health department/ TB Clinic.

- If the resident has been admitted to the facility and has an abnormal CXR, the resident shall be placed in respiratory isolation. The case must be reported to the San Francisco TB Clinic within 1 business day. Per TB clinic recommendations, three sputum specimens shall be obtained for AFB smear and culture and treatment with an appropriate four drug TB regimen shall be initiated.

vi. Room Placement

- If the resident is “suspected” to have active TB disease per the physician’s clinical judgement, the resident must be placed in respiratory isolation per Cal OSHA ATD standard.

- If the physician is ruling out disease that s/he does not think is "probable", then sputum induction can be done in the resident's room without violating the Cal OSHA ATD standard.

b. Resident Conversions

i. Residents who convert from a negative to positive TST/IGRA result must have a symptom screen done on the same day. Asymptomatic residents shall have a CXR within 24 hours or by the next business day. Symptomatic residents shall be transferred to isolation and have a STAT CXR.

ii. If CXR result is negative, LTBI treatment will be offered and a symptoms screen will be performed annually.

iii. If CXR result is abnormal, the resident shall be placed in respiratory isolation. The case must be reported to TB Clinic within 1 working day. Per TB Clinic recommendations, three sputum specimens shall be obtained for AFB smear and culture and treatment with an appropriate four drug TB regimen shall be initiated. Respiratory isolation may be discontinued after 3 negative AFB smears are obtained, five days of TB treatment is completed, and if the resident is no longer symptomatic. A physician's order shall be obtained to discontinue respiratory isolation.

iv. Conversion cases shall be reported to infection control by nursing. If indicated, roommates and close contacts shall be screened for active TB.

v. If an active TB case is identified, a contact investigation for residents and staff shall be conducted per LHHPP 72-01 Infection Control Manual, A9 Contact/Exposure Investigation.

c. Re-admission Screening

i. Residents who are re-admitted to the facility within 90 days of discharge requires a TB symptom screen.

ii. Residents who have been discharged for longer than 90 days and are re-admitted require a TB screen based on prior TST status.

3. Screening HCWs

a. New Hire and Annual Screening

i. HCWs shall be screened for tuberculosis within 90 days prior to work, and annually thereafter.

ii. HCWs with no known or suspected TB shall be screened prior to work with a two-step TST and annual PPD test.

iii. HCWs who have received the bacilli Calmette-Guerin (BCG) vaccine shall be included in the TST screening program.

iv. HCWs with documented history of positive TST/IGRA, or history of active TB must have a TB symptom screen and CXR performed unless the HCW provides a written report of a negative CXR done in the United States performed within the past 90 days.

v. HCWs with TB symptoms *(bloody sputum, hoarseness lasting 3 weeks or more, persistent cough lasting 3 weeks or more, unexplained excessive fatigue, unexplained persistent fever lasting 3 weeks or more, unexplained excessive night sweats, unexplained weight loss)* must have a new CXR performed as soon as possible to rule out active TB disease.

vi. If results of the CXR is abnormal, the HCW must be promptly referred to their healthcare provider for evaluation and may not be permitted to work until s/he is determined not to have infectious TB. Written medical clearance must be provided.

vii. HCWs with a positive TST/IGRA, normal CXR and no history of treatment for latent TB infection shall be encouraged to see their healthcare provider prior to employment for evaluation and treatment recommendations.

viii. HCWs with a history of active TB disease must provide documentation of completion of an adequate course of treatment and have medical clearance prior to work.

ix. HCWs will receive a notification from the LHH Clinic when his or her annual PPD test or TB screening is due. A list of staff who are due for completing this annual requirement will be sent by the designated LHH Clinic nurse to department managers each month. Department managers are responsible for follow up on annual health requirement non-compliances reported to them. HCWs who are non-compliant for their annual PPD test or TB screening will be followed up according to Human Resources protocols.

b. HCW Conversions

i. HCWs who convert from a negative to positive TST/IGRA result during employment must have a TB symptom screen and a CXR within one week and be promptly referred to a healthcare provider or the local health department for treatment recommendations.

ii. Symptomatic HCWs must be excluded from work until active TB disease is ruled out and written medical clearance is provided.

c. Post-Exposure Screening

i. HCWs who have been exposed to a confirmed case of active pulmonary TB must receive a symptom-screen questionnaire.

ii. Symptomatic HCWs must have a CXR immediately and referred for medical evaluation.

iii. If a HCW is asymptomatic and has a negative TST/IGRA within the past 3 months of exposure to a confirmed case of active pulmonary TB, the HCW shall be tested in 8-10 weeks following exposure.

iv. If a HCW is asymptomatic and has a negative TST/IGRA greater than 3 months of exposure to a confirmed case of active pulmonary TB, the HCW shall be (TST/IGRA) tested as soon as possible, and the test repeated in 8-10 weeks following the last exposure.

4. Reporting of Positive TSTs

a. Residents or HCWs who test positive following initial negative results upon admission or hire are classified as converters and shall be reported to the local health department.

b. HCW TST conversions shall also be recorded on the OSHA 300 log.

c. The local health department or CDPH shall be consulted as necessary when there are questions related to implementation of the written guidelines.

5. Record Keeping and Retention

a. Effective January 2016, resident admission and annual TST result or TB symptom screen shall be entered and maintained in his or her electronic health record. Nurses will enter PPD results and physicians will enter TB symptom review.

b. Paid HCW health records shall be maintained for the duration of employment plus 30 years.

c. Unpaid HCW health records shall be maintained for the duration of service plus 7 years.

6. Training and Education

   a. HCWs shall be trained annually in methods to identify, prevent and control the transmission of TB.

   b. Training shall be conducted by a health care professional based on current literature and include the topics required by Cal/OSHA.

   c. Training records shall be maintained for a minimum of 3 years from the date the training occurred.

7. Quality Assurance and Performance Improvement

   a. Resident TB screening data for one neighborhood in each building (North and South towers) will be reviewed annually. If 90% or more of the screenings are not completed, TB screening data for all other neighborhoods will be reviewed.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A9 Contact/ Exposure Investigation
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan
CDPH-CTCA Joint Guidelines for Prevention and Control of Tuberculosis in California Long Term Health Care Facilities
SFDPH Communicable Disease Control and Prevention, TB Control, Information for Medical Providers available http://sfcdcp.org/tbinfoforproviders.html

Revised: 15/11/09, 16/03/08, 16/07/12, 17/09/12, 18/09/11 (Year/Month/Day)
Original adoption: est. 05/11/01

BARBER AND BEAUTICIANS

POLICY:

The beauticians shall follow the standards set by their respective professional board requirements, the LHH Nursing Department, and the Infection Control Committee.

PURPOSE:

To maintain effective infection prevention and control practices that support a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

PROCEDURE:

1. Beauticians are to wear appropriate washable uniform or smock and to keep their person and clothing clean when attending residents.

2. Employees are to follow the 72-01 B2 Hand Hygiene policy before and after attending each resident. Employees can wear a disposable apron as desired and can wear gloves while working with the residents, however, the gloves must be removed, hands cleaned, and gloves changed between residents.

3. Cut hair is to be removed from floors frequently, using dust-less method.

4. Freshly laundered towels or individual sanitary neck strips are to be used for each resident.

5. Clean towels are to be stored in a closed or covered area, used for only one resident and deposited in a closed receptacle until laundered.

6. Closed sanitary receptacles are to be used for waste materials.

7. All supplies or instruments which come in direct contact with residents are to be disinfected using the Oster ~~Spray~~ Blade Wash and~~and~~ Barbicide. ~~Alcohol solution is used to disinfect scissors and razors.~~Ship-Shape Comb and Brush Cleaner is used to disinfect combs and brushes.

8. Beauticians are to thoroughly wash all instruments with soap and water then disinfect in fresh Barbicide solution immediately after use on each resident.

9. Containers for disinfection are to be labeled, have covers, and be of sufficient size to accommodate all instruments.

10. ~~All instruments~~Brushes and combs disinfected in a chemical solution are to be rinsed with water and dried prior to resident use.

11. Hair and debris are to be removed from exterior clipper surfaces with a brush used only for that purpose prior to disinfection of the blades. The blades shall be removed, thoroughly washed and then disinfected.

12. All liquids, creams and other preparations are to be kept in properly labeled, clean, and closed containers. When only a portion of a preparation is used on a resident, it is to be removed using a tongue blade in such a way as not to contaminate the remaining portion.

13. Residents must not be served in the beauty salon when neck or scalp contains draining lesions, except on the order of the resident's physician.

14. If a resident is suspected to have a lice infestation, care is to be withheld and the Nurse Manager or charge nurse notified immediately.

~~14.~~15. If a resident with a lice infestation is to have their hair cut, nursing department is responsible for cutting the hair with disposable scissors and hair clippers in the resident's room. After use, the disposable equipment is to be discarded per the 72-01 C17 Pediculosis (Lice) Management policy.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, B1 Standard Precautions
LHHPP 72-01 Infection Control Manual, B2 Hand Hygiene

Revised: 16/01/12, 18/09/11 (Year/Month/Day)
Original adoption: Est. 05/11/01

ASBESTOS AND LEAD MANAGEMENT OPERATIONS AND MAINTENANCE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna HondaLHH) is committed to a policy of safe and effective management of building materials containing asbestos and/or lead to minimize exposure of Laguna HondaLHH employees and other building occupants to airborne asbestos fibers and lead dust. containing materials in its buildings. No employees are to perform asbestos abatement or cleanup of asbestos containing materials. Only licensed contractors will perform this work.

PURPOSE:

1. To establish and administer an effective operations and maintenance plan for Laguna HondaLHH pursuant to Cal OSHA, EPA, and Bay Area Air Quality Management District regulations.
2. To establish a process for renovation or demolition of areas of the Administration building that may contain asbestos and/or lead.
3. To implement procedures for Laguna HondaLHH Facility Services employees to follow when performing short duration maintenance and repair tasks for which a negative exposure assessment has been completed.

The Asbestos Operations and Maintenance Plan has been established to ensure that all employees are aware that Laguna Honda contains asbestos containing materials and that they will not disturb or remove such materials.

PROCEDURE:

1. Facilities Director Responsibilities

a. Posts and maintains asbestos warning and work permit signs in the building, when necessary.

b. Hires licensed asbestos contractors to perform asbestos abatement and removal when required.

c. Ensures that contractors comply with applicable regulations regarding asbestos abatement and removal.

2.1. Work Permit EvaluationAsbestos and Lead-Containing Materials

a. The hospital buildings (Pavilion, North Tower and South Tower) at ~~Laguna Honda~~LHH are LEED certified and were built without the use of any materials containing lead or asbestos.

b. ~~Performing~~ Any construction, alterations, installations~~ or~~, maintenance, or repair work in the Administration building at LHH ~~requires~~ has the potential to disturb ~~an assessment of the work to determine if~~ asbestos and/or lead.

i. The Administration Building was surveyed for asbestos by three different consulting companies between 1990 and 2006. A list of known asbestos containing construction material and presumed asbestos-containing construction material based on these surveys is included in Appendix A.

ii. All painted surfaces in the Administration building are assumed to contain lead.

2. Procedures for Work Order Maintenance and Repair Activities

a. Work orders for maintenance and repairs that involve minimal disturbance of building materials, and for which a negative exposure assessment (NEA) has been completed, may be assigned to ~~Laguna Honda~~LHH Facility Services staff who have been trained according to paragraph 6a. These staff may complete the work following the standard procedures in Appendix B.

b. Projects that are larger in scope or of longer duration than the tasks described above, which are assigned to contract employees, or which do not have a completed NEA, require additional hazard assessment to determine whether they can be done by on-site Facility Services staff, or whether they must be done by an accredited abatement worker. An example of this would be replacement of vinyl flooring, typically done by a contracted DPW floor installer.

i. Hazard assessments, including sampling of building materials will be completed by a WSEM employee, who is an accredited Asbestos Building Inspector and a CDPH-certified Lead Inspector/Assessor.

ii. If materials to be disturbed are found not to contain asbestos or lead, the project can proceed in house with ~~Laguna Honda~~LHH employees and/or contractors.

iii. If materials to be disturbed are found to contain asbestos, procedures for renovation and large-scale maintenance shall be followed.

3. Procedures for Building Renovations and Large-Scale Maintenance

a. ~~The assessment will be done by an accredited Asbestos Building Inspector, and will generally result in one of the following determinations and actions:~~When a

project involves the potential disturbance of asbestos and/or lead and is not covered by a standard procedure in Appendix B, the Facility Services Director will notify DPW that a contractor with appropriate accreditation for lead and/or asbestos work will be needed to perform the work.

b. DPW will select an environmental consultant who is a CAC and Lead Inspector/Assessor from their list of approved consultants.

c. DPW will arrange for a pre-job walk that will include representatives from the consultant, DPW, WSEM, and Facility Services.

d. The environmental consultant will collect and analyze samples of building materials and develop a detailed work plan based on information provided at the pre-job walk and the results of sampling. The work plan will include specifics regarding the scope of the job and methods to complete the work safely and in accordance with regulations.

e. The work plan shall be reviewed and approved by DPW, Facility Services, and WSEM.

f. DPW will schedule a bid walk with potential contractors, the environmental consultant, and a representative from Facility Services. A representative from WSEM may also choose, but is not required, to attend.

g. The work plan may be revised based on discussions during the bid walk and any changes must again be approved by DPW, Facility Services, and WSEM.

h. DPW will schedule the work and pre-construction meeting, if necessary.

i. The work will be performed by the contractor with the environmental consultant monitoring the contractor's work to ensure it is done according to the work plan. The consultant shall stop work at any time if the contractor is not in compliance with the work plan such that their workers or building occupants are placed in danger.

j. WSEM is responsible for oversight of the environmental consultant and may stop work if they determine that the consultant is not adequately enforcing the work plan or regulatory standards.

k. Facility Services will ensure that all work is completed satisfactorily according to the scope.

4. Procedures for Addressing Unexpected Asbestos or Lead Encountered by Contractors

a. Any time that a determination is made that ~~neither asbestos or~~neither asbestos nor lead is ~~not~~ present in the vicinity of ~~the~~ work being done by outside contractors, ~~and no special precautions are needed for asbestos.~~ LHH will provide an Asbestos Information Notice to the contractor, advising them to stop work and contact the Facilities Director if they feel at any point that they may have encountered asbestos or lead.

b. ~~Asbestos is present~~If asbestos or lead is encountered in the vicinity of the work, but disturbance is not expected ~~and~~, the contractor shall observe specified work procedures to minimize the possibility of disturbance of lead or asbestos-containing construction materials (ACCM). LHH will specify changes to the contractor's scope of work, if necessary, to minimize the disturbance of asbestos. LHH will verify that the contractor's modified work scope is acceptable and monitor the contractor's work to assure that the ~~ACCM~~material remains undisturbed.

c. If a~~A~~sbestos is present in the vicinity of the work and it may be disturbed, ~~.~~ a~~A~~sbestos abatement must be completed before the proposed work can be performed. LHH will arrange for the specified asbestos abatement according to paragraph 3 above. ~~, if the work is to proceed. If asbestos materials will still be present in the vicinity of the work even after the completion of the asbestos abatement, then LHH may also specify changes to the contractor's scope of work to minimize the disturbance of asbestos. LHH will verify that the contractor's modified work scope is acceptable and monitor the contractor's work to assure that the ACCM remains undisturbed.~~

~~3. Asbestos Abatement~~

~~a. If asbestos abatement work is needed, the work will be performed by a licensed asbestos abatement contractor. An independent industrial hygienist will be hired to provide oversight to the abatement work and provide verification that the asbestos abated has been completed. Abatement contractors will follow applicable waste management and disposal requirements.~~

~~b. California Environmental Protection Agency assigns a unique number to every facility which generates asbestos waste. The generator identification number for LHH is CAD 982482218.~~

~~COMMUNICATION:~~

5. ~~Asbestos Information Notices~~Communication of Asbestos Hazard

~~c. Laguna Honda Hospital will provide notice to all employees and contractors concerning asbestos containing materials within the facility. Asbestos notices will be provided to new employees as part of new employee orientation.~~

4. Labeling and Posting

a.d. Asbestos Warning Signs listing all materials with ACCM or Presumed Asbestos Containing Construction Materials (PACCM) will be posted in the following locations:

i. At the entrance to all mechanical rooms including steam tunnels.
ii. On designated employee bulletin boards where other employment information is posted.
iii.i. In the main entrance Lobby for Laguna HondaLHH Hospital's Administration building.
ii. At the entrance to all mechanical rooms including steam tunnels.
iii. At entrances to locations of asbestos abatement work.

b.e. All painted surfaces in the AdministratinoAdministration building shall be assumed to contain lead paint and Facility Services Staff will be informed of this assumption during their annual training.

6. Education And Training:

a. Facility Servicesies Department

i. AHERA Training for Building Inspector/Management Planner – designated staff only (initial and annual refresher)The Chief Engineer and Building and Grounds Maintenance Supervisor shall complete AHERA training for Contractor/Supervisors in order to oversee the maintenance work done by Facility Services employees.

ii. 16-Hour O&M Training (by outside contract training provider)All Facility Services employees shall be trained annually on the following topics:

- The requirements of the Cal OSHA asbestos and lead standards and the contents of this Management Plan;
- The health effects of asbestos and lead;
- Recognizing asbestos containing building materials;
- Assumption of lead based paint on all painted surfaces in the Administration building;
- The work tasks that might result in exposure to asbestos and/or lead;
- Procedures for performing maintenance tasks causing minimal disturbance of asbestos and/or lead and for which a negative exposure assessment has been completed. This will include hands on practice;
- Information about public health organizations that provide smoking cessation programs;
- Respiratory protection (provided in a separate training session).

b. Environmental Services

i. 1-EVS staff shall receive one hour of Hour Asbestos Awareness Training on initial hire and annually thereafter.

ii. EVS staff shall not disturb asbestos or lead and will be trained to recognize and report damaged material that may contain asbestos.

c. All Other StaffWorkplace Safety and Emergency Management (WSEM)

i. Industrial Hygienists in WSEM shall complete the following classes to maintain AHERA accreditation:

- AHERA Contractor/Supervisor
- AHERA Building Inspector
- AHERA Management/Planner
- AHERA Project Designer

iii.ii. Industrial Hygienists in WSEM shall complete training and examination to maintain certification as a CDPH Lead Inspector/Assessor

b. Asbestos awareness training at new hire orientation.

ATTACHMENT:

Appendix A: Asbestos Containing Construction Materials (ACCM) and Presumed AbestosAsbestos Containing Construction MateralsMaterials (PACCM)

REFERENCE:

CCR Title 8 Section 1529 - Cal OSHA Asbestos in Construction Standard
CCR Title 8 Section 1532.1 Cal OSHA Lead in Construction Standard
40 CFR Part 61 – National Emissions Standard for Hazardous Air Pollutants (NESHAP)
Bay Area Air Quality Management District (BAAQMD) Regulation 11 Rule 2 – Asbestos Demolition, Renovation, and Manufacturing.

~~BUILDING SURVEYS SUMMARY~~

~~1. Assessment of Suspect Asbestos Containing Building Materials~~

~~Performed by Clayton Environmental Consultants, Inc., dated February 9, 1990.~~

~~2. Survey for Asbestos Containing Materials~~

~~Performed by SCA Environmental, Inc.; dated June, 1996.~~

~~3. Hazardous Materials Survey Reports~~

~~Performed by IHI Environmental; Dated January 9, 2006, May 1, 2006, and July 19, 2003.~~

Appendix A:

ASBESTOS CONTAINING CONSTRUCTION MATERIALS (ACCM) AND PRESUMED ABESTOS CONTAINING CONSTRUCTION MATERALS (PACCM) (Updated 8/22/12)

~~Asbestos is only found in the Old Building and the Table below refers to locations in the Old Building only.~~

Materials	Locations
ACCM: Steam & domestic hot water pipe & fitting insulation, and block type insulation on tanks and heat exchangers	Found in mechanical rooms throughout hospital and throughout the buildings. Some piping insulation is concealed in walls and ceiling and in metal cladding.
ACCM: Acoustical Ceiling Plaster	Main hallways on 3rd, 4th, 5th, & 6th Floors
ACCM: Ceiling Tile (transite), screwed-in	Ward G Rooms 301, 401, 501, and 601
ACCM & PACCM: 2' x 2' laid-in ceiling tiles	2nd, 3rd, 4th and 5th Floors of patient's ward C
ACCM: Vinyl floor sheeting, linoleum, vinyl floor tiles, and mastic	Throughout the hospital – consult the survey reports for actual locations
ACCM: Vinyl composite wall Coverings	Various areas of all buildings
ACCM & PACCM: Fire door core insulation	Various areas of all buildings
ACCM: Wall heater transite behind radiators	Throughout building
ACCM: Heater Insulation, behind sheet metal	H-Wing Library
ACCM: Exterior Paint	Ward G exterior
ACCM: Undercoating on Sinks	Throughout building
ACCM: Tar coating, back of splined ceiling tiles	Ward D, Room 314
PACCM: Wall & Ceiling Sheetrock	Throughout building
PACCM: Baseboard glue	Throughout building
PACCM: Insulators/contactors for elevator Control	Elevators & elevator mechanical rooms
PACCM: Ceramic tile grout, mastic and underlying vapor barrier	Throughout building
PACCM: Vapor barrier under concrete floor	Assumed to be present where there are floor drains in concrete floors.

PACCM: Mastic under Formica	Throughout building
PACCM: Asphalt & gravel roofing and vapor barrier under terracotta tiles	On various roofs
PACCM: Caulking & glazing putty on windows and doors	Throughout the exterior
PACCM: Asbestos cement (transite) panels	On bathroom balconies, in Wards

ACCM means any manufactured construction material, including structural, mechanical and building material, which contains more than one-tenth of 1 percent (0.1%) asbestos by weight.

Appendix B: Standard Procedures for Maintenance Tasks Resulting in Minimal Disturbance of Asbestos and/or Lead

Procedures for Small Lead Paint Stabilization Jobs

Laguna HondaLHH Painters in the Facility Services Department may complete small paint stabilization projects on surfaces that may contain lead paint. These projects will not involve removal of more than approximately two square feet of peeling paint and will be completed using the following safe practices.

1. Occupants shall not be permitted to enter the worksite during paint stabilization activities until after work has been completed.

2. The worksite shall be prepared to prevent the release of leaded dust, and contain lead-based paint chips and other debris within the worksite until they can be safely removed. Practices that minimize the spread of leaded dust, paint chips, soil and debris shall be used during worksite preparation.

3. The worksite shall be secured against unauthorized entry, and occupants' belongings protected from contamination by dust-lead hazards and debris during paint stabilization activities. Occupants' belongings in the containment area shall be relocated to a safe and secure area outside the containment area, or covered with an impermeable covering with all seams and edges taped or otherwise sealed.

4. Painters will wear disposable nitrile gloves.

5. Use of a half mask respirator with HEPA filters is recommended during paint stabilization.

6. None of the following prohibited methods will be used for preparing surfaces for painting.

    a. Open flame burning or torching.
    b. Machine sanding or grinding without a high-efficiency particulate air (HEPA) local exhaust control.
    c. Abrasive blasting or sandblasting without HEPA local exhaust control.
    d. Heat guns operating above 1100 degrees Fahrenheit or charring the paint.
    e. Dry sanding or dry scraping, except dry scraping in conjunction with heat guns or within 1.0 ft. (0.30 m.) of electrical outlets, or when treating defective paint spots totaling no more than 2 sq. ft. (0.2 sq. m.) in any one interior room or space, or totaling no more than 20 sq. ft. (2.0 sq. m.) on exterior surfaces.
    f. Paint stripping in a poorly ventilated space using a volatile stripper.

7. Paint stabilization will include the application of fresh, non-lead based paint.

8. Upon completion of work, the entire work area must be vacuumed with a HEPA vacuum.

9. Plastic sheeting/drop cloths that have been cleaned of debris and gloves may be thrown out in the regular trash. Paint chips and contents of HEPA vacuum are hazardous waste and must be sealed in plastic bags, labelled as hazardous lead waste and placed in the hazardous waste storage area.

10. Once clean-up is complete, remove gloves and wash hands.

11. Work clothes should not be worn home.

Procedures for Carpentry Work on Asbestos-Containing or Lead-Painted Surfaces

~~Laguna Honda~~LHH employees other than Painters will not be asked to perform work that requires sanding, scraping, burning, or any other means of intentionally removing paint from surface areas that may contain lead paint. However, in some cases, ~~Laguna Honda~~LHH employees may be required to make repairs on a window or other painted surface that is known or likely to contain lead paint. Such repair may cause inadvertent disturbance, chipping, or flaking of the paint, but is not expected to result in measurable airborne concentrations of lead. In these cases, the employee will follow the procedure below in order to minimize any possible lead exposure.

1. Don disposable, nitrile gloves.

2. Use a vacuum equipped with a HEPA filter to vacuum all painted surfaces that will be disturbed during repair or maintenance.

3. Wipe down surface with a wet rag.

4. Complete work making an effort to leave as much paint intact as possible.

5. Vacuum up any paint chips or dust from work surface and surrounding area using a vacuum equipped with a HEPA filter.

6. Remove and dispose of gloves.

7. Wash hands.

8. Dispose of gloves and rags immediately after use. These can go in the regular trash.

Procedures for Cutting or Drilling Into Asbestos-Containing or Lead-Painted Surfaces

Occasionally, ~~Laguna Honda~~LHH Facility Services employees are required to cut or drill into walls or ceilings in order to complete assigned work. The following procedures must be followed if you will be cutting into a surface that is known or suspected to contain lead based paint.

1. Don disposable, nitrile gloves.

2. For cutting into surfaces, use a saw equipped with a shroud attached to a HEPA vacuum.

3. For drilling into surfaces, use a drill equipped with a shroud attached to a HEPA vacuum or drill through a wet sponge.

4. Use a HEPA vacuum to clean up any dust or debris generated by your work.

5. Wipe around edges of cut surface and any area that was vacuumed with a wet rag.

6. Remove and dispose of gloves.

7. Wash hands.

8. Dispose of gloves and rags immediately after use. These can go in the regular trash.

~~**ATTACHMENT:**~~
~~None~~

~~**REFERENCE:**~~
~~None~~

Revised: 13/05/28, 18/09/11 (Year/Month/Day)

WORKPLACE VIOLENCE PREVENTION PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) is committed to providing a safe and secure environment of care consistent with our mission, the Department of Public Health (DPH) regulations, Title 22, California Occupational Safety and Health Administration (Cal-OSHA) regulations and other applicable local, state and federal laws.

2. ~~Laguna Honda~~LHH employees, residents and visitors are prohibited from bringing weapons to the ~~Laguna Honda~~LHH campus and worksites. Weapons include, but are not limited to, firearms, knives or weapons defined in the California Penal Code Section 12020.

3. ~~Laguna Honda~~The City and County of San Francisco has a zero tolerance policy for assaults, battery or threats or acts of violence by employees in the workplace.~~workplace violence~~. Employees are expected to behave in a professional and courteous manner in the workplace at all times. This includes carrying out their duties on or offsite. A ~~Laguna Honda~~LHH employee who physically or verbally threatens, harasses, or abuses someone in the workplace, or uses hospital resources such as work time, workplace phones, fax machines, mail, e-mail, or other means for such activity, will be subject to corrective or disciplinary action, up to and including dismissal, and may be subject to criminal and/or civil action.

PURPOSE:

To inform the ~~Laguna Honda Hospital and Rehabilitation Center (Laguna Honda)~~LHH community of the hospital's policy towards violence in the workplace, to implement procedures for the prevention of workplace violence, and to provide support for employees who have been subject to a verbal or physical threat and/or violent behavior.

DEFINITIONS:

1. *Violence*: Behavior involving the exercise or exhibition of physical force intended to hurt, damage, or intimidate someone or something.

2. *Threat of Violence*: A statement or conduct that causes a person to fear for his or her safety.

3. *Workplace Violence*: Any act of violence or threat of violence that occurs at the work site, including the following:

   a. Type 1 Violence: Workplace violence committed by a person who has no legitimate business at the work site.

b. Type 2 Violence: Workplace violence directed at employees by residents or visitors.

c. Type 3 Violence: Workplace violence against an employee by another employee or former employee.

d. Type 4 Violence: Workplace violence committed by someone who is not an employee, but has or had a personal relationship with an employee.

PROCEDURE

1. Workplace Violence Prevention Responsibilities

a. Department of Workplace Safety and Emergency Management (WSEM):

WSEM is responsible for the overall administration and maintenance of the workplace violence prevention program, for the tracking and analysis of workplace violence incidents and for eliciting the input of employees in making improvements to the program. WSEM shall also collaborate with the Departments of Education, Medicine, Psychiatry, Social Services, and Nursing to develop and deliver educational programs for staff on strategies for caring for cognitively impaired residents so as to minimize the risk of aggressive behavior in these residents.

b. Resident Care Teams (RCTs):

RCTs are responsible for developing and implementing resident care practices and plans, aimed at prevention of Type 2 violence by minimizing aggressive behavior in ~~Laguna Honda~~LHH residents. RCTs are also responsible for ensuring appropriate assignment and training of staff to care for residents at risk for aggressive behavior.

c. Department of Human Resources (HRS):

HRS is responsible for developing and implementing policies and procedures for preventing of Type 3 violence and for following up with corrective/disciplinary action in the event that such violence does occur.

d. DPH Security Services Department and San Francisco Sheriff's Department (SFSD):

The Security Services Department will develop processes to safeguard all persons, patients, visitors, and employees by addressing threats and aggressive behavior at the earliest stage; define inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.
The DPH Security Director in collaboration with HRS and SFSD provides specialized

personnel protection services, and specialized investigations, including conducting a risk assessment. Risks are assessed based upon all relevant information available and after consultation with experts where appropriate, a risk level will be assigned, and protection plan developed.

SFSD staff also has responsibility for responding to employee calls for law enforcement assistance when experiencing violence or threat of violence. SFSD staff will take the lead in managing Code Silver (Active Shooter) situations that occur on the campus.

e. Campus Safety and Security (CSS) Committee

The LHH CSS Committee is comprised of clinical, administrative, health and safety, and human resources representatives who ensure that the security management program administered by the DPH Security Director and the contracted security provider (SFSD) is aligned with the core values and goals of the organization by providing direction, set strategic goals, determine priority and assess the need for change. The committee ensures coordination, communication and integration of performance improvement for campus security and injury prevention. See 75-01 Security Management Plan.

~~e.~~f. Department Managers and Supervisors:

As per the ~~Laguna Honda~~LHH Injury and Illness Prevention Program, managers and supervisors are responsible for providing a secure work environment for their staff, including the identification of security risks, staff training needs, the development and management of departmental security policies and procedures, and incident reporting, investigation and follow up.

~~f.~~g. All ~~Laguna Honda~~LHH Employees, DPH Employees on Campus, and Tenants:

All ~~Laguna Honda~~LHH employees and building occupants are responsible for reporting hazards and injury or illness incidents per the IIPP, including hazards and incidents related to workplace violence.

2. Staff Incident Response Team (SIRT)

The Staff Incident Response Team (SIRT) is a team of trained staff available for call out by the ~~Laguna Honda~~LHH Administrator on Duty, Division Head/Exec Staff, or Nursing Operations Manager/Supervisor to debrief with personnel after any incident of workplace violence. SIRT membership shall include Psychiatry and Social Services staff and anyone else the SIRT Team Leader would like to include. Supervisory staff with a role in incident investigation will not be part of the SIRT. The SIRT conducts confidential staff defusing as a support service to ~~Laguna Honda~~LHH staff.

3. Reporting and Response

a. Any employee who experiences workplace violence of any type shall report the incident immediately to their manager or supervisor. If the incident involves Type 3 violence perpetrated by a supervisor, the incident may be reported to another supervisor or directly to HRS.

b. Any ~~Laguna Honda~~LHH employee who observes violence in the workplace that involves residents, staff members, volunteers, visitors and/or vendors shall;

   i. If the threat of violence is immediate or life threatening, immediately call the SFSD (ext. 4-2319) or SFPD at 911.

   ii. Inform a manager/supervisor or designee.

   iii. Complete an Unusual Occurrence report.

c. Upon admission to ~~Laguna Honda~~LHH, residents are informed of the policy of non-violence. Residents who violate this policy with aggressive acts toward staff or other residents will be disciplined immediately according to protocols developed by the RCT.

d. Any manager/supervisor who receives a report from an employee of an incident involving violence in the workplace shall investigate and take the following actions:

   i. Immediately complete and submit report to DPH OSH according to injury reporting procedures in the LHH IIPP 73-01.

   ii. Consult with appropriate resources via HRS, WSEM, SFSD, and/or ~~Laguna Honda~~LHH Administrator on Duty (AOD).

   iii. Check in with the threatened person and offer support services periodically following the incident.

e. The AOD who receives a report of violence in the workplace shall ensure that the following actions have been taken:

   i. Notification, if necessary, of the Director of Human Resources, SFSD, or Psychiatry Department Consultant.

   ii. Notification of the SIRT leader for further follow-up as appropriate.

e. The SIRT Leader will:

   i. If appropriate, deploy the SIRT, which will provide ~~Laguna Honda~~LHH employees involved in the incident with initial incident defusing.

ii. Refer employees to The Employee Assistance Program (EAP) as appropriate to provide additional support sessions for ~~Laguna Honda~~LHH employees and their families following a threat or violent behavior incident. EAP is contacted by calling (800) 795-2351.

f. The Deputy Sheriff who receives notification of an act or threat of violence will intervene according to SFSD policy.

7. Response to Threats of Violence from a Third Party

In situations where a resident's family member or other visitor is determined to be a threat to employee safety, the CEO and DPH Security Services sha~~wi~~ll be notified. The following action(s) may be taken depending on the situation and level of threat.

a. A stay-away letter may be issued by the CEO notifying the individual that he/she is not to enter the ~~Laguna Honda~~LHH grounds.

b. Once a stay-away letter has been issued, it is reviewed by the RCT on a quarterly basis to assure accuracy and consistency. If revision is needed, the ~~Laguna Honda~~LHH Deputy City Attorney must be notified.

c. If a visitor poses an imminent or continuing threat to employee safety, a Temporary Restraining Order (TRO) may be secured by Deputy City Attorney. A TRO is a court order signed by a judge, which orders an individual to stop contacting, telephoning, threatening, harassing, or stalking another individual. It can also order an individual to stay a certain distance away from another individual and his/her work place or home.

d. A TRO will remain in force until a hearing is conducted on the matter; at which time a judge can continue, make permanent, or terminate the provisions of the order. The individual requesting a TRO will be asked to sign a declaration and to testify at a court proceeding where the accused will be present.

e. Employees who are being threatened by someone with whom they have a personal relationship should notify the CEO and DPH Security Services and are encouraged to obtain a TRO preventing the threatening individual from entering their workplace.

8. Education

a. All new employees receive training during hospital wide orientation on:

i. ~~Laguna Honda~~LHH IIPP

ii. ~~Laguna Honda Safety Committee~~The details of this Workplace Violence Prevention Program

iii. ~~Safety Management and Response Training (SMART) for the prevention of workplace violence.~~Procedures for reporting incidents of workplace violence

b. All employees with direct resident care responsibilities receive initial and annual non-violent crisis intervention training, including the following topics:

i. Aggression and violence predicting factors
ii. The assault cycle (CPI Crisis Development Model)
iii. Verbal intervention and de-escalation techniques and physical maneuvers to prevent physical harm, including role plays and hands-on practice.
iv. Inappropriateness of use of restraints at ~~Laguna Honda~~LHH

~~b.~~ All other employees also receive annual training on workplace violence ~~and harassment policies.~~ appropriate to their responsibilities.

~~c.~~

~~d.~~c. ~~All clinical employees receive annual SMART update training.~~

~~e.~~d. Clinical staff assigned to work on units with residents at risk for unintentional aggressive behavior due to health conditions affecting the brain shall receive additional education that includes role playing to increase confidence in handling these residents.

~~f.~~e. The Employee Assistance Program staff (800)-759-2351 is also available to provide educational sessions to ~~Laguna Honda~~LHH departments/services regarding recognition and prevention of violence in the workplace.

ATTACHMENT:
None.

REFERENCE:
LHHPP 60-04 Unusual Occurrences
LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 75-01 Security Management Plan
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-04 ~~Stat~~ Calls for SFSD Assistance
~~LHHPP 75-06 Dr. Gray~~75-10 Security Services Standard Operating Procedures
LHHPP 75-11 Public Access and Defined Restricted Areas
LHHPP 75-12 Firearms, Dangerous Weapons and Contraband Policy
LHHPP 75-13 Forensic Residents/Patients
LHHPP 22-08 Threat of violence to residents by an external party
LHHPP 22-10 Management of Resident Aggression
CCR Title 8 Section 3342. ~~Workplace~~ Violence Prevention in Healthc ~~C~~are ~~(proposed)~~

Revised: 05/12/20, 08/09/23, 09/01/13, 10/08/01, 10/11/09, 15/01/13, 16/03/08, 18/09/11 (Year/Month/Day)
Original adoption: 05/12/20

SMOKE and TOBACCO FREE ENVIRONMENT

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) to maintain a smoke and tobacco free environment consistent with City regulation for the protection and preservation of the health of residents, employees, volunteers and visitors.

2. This policy applies to smokable and tobacco products, including e-cigarettes, nicotine, non-nicotine and chewing tobaccos.

3. Buying and selling of smokable and tobacco products between residents is prohibited.

4. The prohibition of smoking on the LHH campus applies to ~~all persons on the Laguna Honda campus~~staff, vendors, and visitors.

~~4.~~5. Residents may only smoke in ~~a~~the designated smoking area when on campus.

~~5.~~6. During off campus resident related activities:
   a. Residents are expected to comply with this policy and according to their care plan.
   b. Employees shall comply with this policy when on work time.

DEFINITION:

The campus of Laguna Honda Hospital and Rehabilitation Center refers to areas that include the buildings, grounds, parking spaces bordered by Laguna Honda Boulevard, Woodside, Idora and Clarendon and includes Hospital operated vehicles.

PURPOSE:

1. To promote a smoke and tobacco free environment;

2. To comply with state and/or local regulations which promote a smoke free work environment;

3. To ensure a healthy, comfortable and safe environment; and

4. To provide leadership, guidance and support in the promotion of a healthy lifestyle.

PROCEDURE:

1. Signage

   a. Signs that advise that ~~Laguna Honda~~LHH is a smoke and tobacco free ~~campus~~ facility shall be posted at the hospital's public entrances.

a.b. A temporary designated smoking area has been created on the right side of the horseshoe parking lot when exiting the ground floor lobby of Pavilion building until the permanent designated smoking area is made available.

2. Applicability

a. Resident Notification, Assessment and Care Planning

i. Applicants and referral sources shall be informed by receipt of the referral packet that Laguna HondaLHH campus is a smoke and tobacco free environmentfacility with a designated smoking area.

ii. New residents are given the Smoke and Tobacco Free Environment Policy by Admissions and Eligibility staff at the time of the resident's admission or as soon thereafter as is reasonable.

iii. The resident or surrogate decision-maker acknowledges receipt of the Smoke and Tobacco Free Environment policy and agrees to abide by its requirements by their signature on the Admission packet.

iv. The physician and/or the licensed nurse shall document the resident's smoking and tobacco use history.

v. When indicated, a designated member(s) of the RCT shall provide the resident with smoking cessation education and therapies.

vi. Assessment and education about smoking and smoking cessation shall be documented in the resident's medical records.

vii. Clinical care plan interventions shall be developed for those residents who have violated the smoking policy, and may include,

- Search of person, belongings and resident room for, and confiscation of, smoking materials

- Meeting with RCT members to discuss the violation with resident and outline care plan to prevent further smoking violations, which may include repeat searches, engagement in smoking cessation activities referral to SATS and/or MD.

viii. Those residents who are identified as smokers, who would like to quit smoking shall be offered smoking cessation education and will be evaluated for appropriate therapies with a goal of smoking cessation..

b. Employee and Volunteer Notification

i. Job posting announcements shall include a statement informing applicants that ~~the Laguna Honda~~LHH ~~campus~~ is a smoke and tobacco free ~~environment~~facility.

ii. Employees, volunteers, including trainees and students, shall be notified during orientation that smoking is not permitted on the hospital campus. Staff, vendors, and visitors will need to go off campus to smoke. The designated smoking area is only for resident use.

iii. To facilitate a smoke and tobacco free environment, designated staff shall periodically offer smoking cessation programs for employees.

c. Visitor Notification

i. Visitors, including contractors, vendors and outpatients, shall be informed that ~~the Laguna Honda~~LHH ~~campus~~ is a smoke and tobacco free ~~environment~~ facility through signage at entrances, applicable agreements, and hospital brochures and by staff.

3. Compliance

a. The entire ~~Laguna Honda~~LHH community is responsible for complying with the Smoke and Tobacco Free Environment Policy which may include respectfully informing the smoker that ~~Laguna Honda~~LHH is a smoke and tobacco free ~~campus~~facility with a designated smoking area.

b. The smoke and tobacco free environment policy is part of the new employee orientation and annual in-service.

c. An employee who observes a smoking violation by a resident is to report the incident to the respective neighborhood nurse manager/charge nurse.

d. An employee who observes a smoking violation by a staff member is encouraged to report the incident to the responsible manager for corrective action.

e. The Resident Care Team shall review the care plan of residents who are not complying with the terms of this policy to determine if further interventions can be provided to assist the resident with compliance.

f. An employee who violates this policy may be subject to disciplinary action.

g. Sheriff Officers who observe noncompliance or are contacted to assist with notifying residents, visitors or employees to comply with this policy may cite the noncompliant smoker for violation of municipal or state codes.

h. The smoke patrol and others are to report smoking violations to the Nursing Office.

i. RCT will address resident's non-compliance by assessing and implementing appropriate interventions.

ATTACHMENT:
None

REFERENCE:
LHHPP 35-01 Guidelines for Sales, Distribution of Free Items, and Solicitation on the Campus
CDPH Program Flexibility, Requested 01/13/2014
Smoking Cessation Assessment (MR 161T)

Revised: 98/01/01, 08/10/01, 08/11/25, 10/04/13, 11/11/29, 14/01/28, 15/11/09, 18/09/11 (Year/Month/Day)
Original adoption: 92/10/30

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition - Diet Manual

Updated: ~~August 29th, 2013~~August-, 2018
Reviewed: August 27th, 2014, August14th, 2015

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Contact Information for Clinical Nutrition ~~Services~~ Staff

Name	Position	Desk Phone ext.#	Pager #
Atlas, Zoe	Dietitian	4-3098	1844
Cizas, Grace	Dietitian	4-3097	1843
Cecconi, Loretta	Chief Dietitian	4-3367	2533
Cruz, Monica	Dietitian	4-4031	1860
Dantoc, Judy	Dietitian	4-3389	1859
Kataria, Sheetal	Dietitian	4-3362	1086
• N5~~6~~ (C~~ypress~~edar- 1~~2~~0's& ~~Juniper~~Redwood- ~~3~~40's)			
• N6~~S4~~			
~~Batten, Chrisitne~~	~~Dietitian~~	~~4-3389~~	~~0613~~
• ~~S2~~			
~~Lai, Julie~~	~~Dietitian~~	~~4-3340~~	~~2327~~
• ~~N3~~			
• ~~N6 (Cedar-10's & Redwood-40's)~~			
~~Langvardt, Mary Ann~~	~~Dietitian~~	~~4-3097~~	~~2328~~
• ~~NM~~			
• ~~N4 (Cypress-20's & Juniper-30's)~~			
Moghbel,Neda	Dietitian	4-3385	1919
• N3			
• N5~~1~~ (~~Cedar~~Cypress-2~~1~~0's& ~~Redwood~~ Juniper ~~4~~30's)			
• ~~N5 (Cypress-20's & Juniper 30's)~~			
Podesta, Danielle	Dietitian	4-4589	0514
• S3			
• S6 (Buena Vista-10's & Sierra-40's)			
Shiels, Rebecca	Dietitian	4-3356	7502
• N2			
• NM (Cypress-20's & Juniper-30's)			
~~Siragusa, Gabrielle~~	~~Dietitian~~	~~4-3367~~	~~1705~~
• ~~PM-Rehab SNF/Acute(rms 48-51)~~			
• ~~N4 (Cedar-10's & Redwood-40s)~~			
Wildman, Clair	Dietitian	4-3020	7814
• S5			
• N1 (Cypress – 20's & Juniper – 30's)			

Diet Techs will assist with MDS, screening & QR's as assigned by RD

Name	Position	Desk Phone ext.#	Pager #
~~Guan, YingYing~~Parks, Alicia	~~Dietitian/~~ Diet Tech	~~1935~~1778	4-~~4031~~3340
• ~~N3, N6, S4, S5~~S2, S4, NM, N4 (MDS)			
Subia, Adam	Diet Tech	4-4623	7759
• PM, S5, S6 (MDS) CBORD/Menu Mgmt~~N4, S2, S6~~			
Wan, Elisa	Diet Tech	4-3087	1538
• S3~~, NM~~,N1, N2, N3, N5, N6 (MDS)			

Diet Office 4-5776

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition Department
Diet Manual
~~Laguna Honda Hospital and Rehabilitation Center~~
~~Nutrition Services Department~~
~~Diet Manual~~

~~Introduction~~INTRODCUTION

This Diet Manual was developed for use at Laguna Honda Hospital and Rehabilitation Center with the continuing efforts and combined knowledge of the Registered Dietitians (RDs). It is the objective of the Diet Manual to incorporate current dietary guidelines for U.S. populations with principles of feeding the elderly, as well as the chronically ill or young disabled resident.

As consultant members of the interdisciplinary teams, RDs provide medical nutrition therapy (MNT) to hospital residents; document nutrition assessments, develop care plans, and promote optimal nutritional status throughout the resident's stay at the hospital. The RDs and the dietetic technicians (DTRs) visit residents to assist with food choices and to increase satisfaction with meal service. Through diet modification, individualized counseling and specialized nutrition therapy, the RDs participate in disease management and provide effective, comprehensive resident care. Nutrition education for staff and residents and nutrition counseling for discharge are included in these resident services.

The Laguna Honda ~~diets in this~~Diet -M~~m~~anual serves as a guideline and information tool about diets at Laguna Honda Hospital for providers, nursing and nutrition and foodservice staff within Laguna Honda. The Laguna Honda Diet Manual has been developed by Clinical Nutrition and approved by the medical staff. ~~reference and guide for members of the health care team: to assure that medical nutrition therapy is coordinated with other disciplines in the hospital and in community programs and to collaborate with hospital-wide staff for resident care planning in the area of nutrition.~~

The RD use the Diet Manual to plan regular and therapeutic menus to: 1. adjust diet prescriptions to meet resident food preferences, 2. evaluate a resident's individual nutrient needs, 3. determine nutrient adequacy of the daily diet, – 4. develop resident education materials. The Physicians use this resource to specify appropriate dietary regimens and diet prescriptions. Dietary/Nursing/Ancillary personnel on the interdisciplinary team use the manual in establishing a common language of communication for quality nutrition care.

The Laguna Honda Diet Manual describes the Regular diet, texture modifications, therapeutic diets commonly used and the enteral products currently stocked in the department. Format of each diet is as follows:

I. ~~Basic Principles~~Purpose: denotes characteristics of each diet as a modification of the Regular diet.

II. Indications –lists specific medical concerns for which the diets can be used.

~~III.~~ Adequacy indicates the nutritional adequacy of the diet based on the Dietary Reference Intakes (DRI), *[(DRI for Calcium, Phosphorous Magnesium, Vitamin D and Fluoride(1997); DRI for thiamin, Riboflavin, Niacin, Vitamin B_6, Folate, Vitamin B_{12}, Pantothenic Acid, Biotin and Choline(1998); DRI for Vitamin C, Vitamin E, Selenium, and Carotenoids (2000); DRI for Vitamin A, Vitamin K, Arsenic, Boron, Chromium, Copper, Iodine, Iron, Manganese, Molybdenum, Nickle, Silicon, Vandium and Zinc (2001); DRI for Energy, Carbohydrates, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids (2002/2005); DRI for Calcium and Vitamin D (2011)*] and the Recommended Daily Allowance (RDA), 1989. Due to the lack of manufacturer information, not all vitamins and minerals can be reported. Vitamins and Minerals which do not have DRI/RDAs established, and are not readily available in the USDA or vendor database cannot be evaluated for complete nutritional adequacy in the patient menu. When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team works to individualize nutritional care of the patient considering their food preferences. ~~Diets that do not provide adequate nutrients are noted.~~

III.

IV. Approximate Composition lists approximate calories, protein, carbohydrateand carbohydrate, fat and, as needed, specific nutrients provided in each diet.

IV. Suggested Meal Patterns show basic meal-planning guides with approximate amounts of foods specified according to dietary restrictions. The RD may adjust meal patterns to meet a resident's cultural, ethnic, food likes and dislikes and meal service preferences.

V.

V. There is additional nutritional information in the appendix to further assist the health care staff in the nutritional care of the residents. Clinical Services contacts are listed after the table of contents.

VI. The Clinical Dietetics Staff at Laguna Honda Hospital may be contacted at 682-5776.

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~~VIII.~~VI. ~~Diet Manual~~

~~Quality Nutrition Care for the Elderly~~QUALITY OF CARE FOR THE ELDERLY

Many residents entering Laguna Honda have a history of poor nutritional intake because of -lack of financial resources, inability to prepare or consume a balanced meal or a recent acute illness or injury. Proper nutrition through medical nutrition therapy is a vital factor in their convalescence. The person may improve physically, and often mentally, with a better diet. The registered dietitian plays an active, dynamic role in health maintenance and disease prevention to promote high quality nutrition care that provides positive benefits to the residents.

NUTRIENT RECOMMENDATIONS OF THE ELDERLY~~RDA and Recommended Dietary Intake (RDI)~~
~~Special Nutrient Needs of The Elderly~~

~~The Dietary Guidelines for Americans 2010 is based on the most recent scientific evidence review and focuses on nutrient-dense foods and beverages, and that contributes to achieving and maintaining a healthy weight. The recommendations accommodate the food preferences, cultural traditions, and customs of the many and diverse groups who live in the United States. The RDA (published by the National Academy of Sciences in 1989), and the most recently published RDI (in 2000), are standards of acceptable daily intakes for healthy people under normal conditions. To ensure that the nutritional needs are met, the RDA is set relatively high, with the exception of calories. These recommendations of the estimated nutritional needs throughout the life cycle do not vary significantly from maturity through advanced age, however the nutrient needs of this population are not fully understood. The RDA may not allow for increased nutritional needs due to infection, chronic diseases or ingestion of certain medications.~~ The patient menu was developed in accordance with the most current Recommended Dietary Allowances (RDAs) and Daily Reference Intakes (DRIs) established by the Nutrition Research Council –National Academy of Sciences (Appendix 1). When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team work to individualize nutrition care of the patient considering their food preferences.

~~Generally, the nutritional needs of the resident can be determined by the following: the resident's height, weight, activity level and medical needs using the basal energy expenditure (BEE). Attractiveness and temperature of meals are extremely important since the residents often have poor appetites. The unavoidable effects of aging can cause a loss in the senses, such as taste, smell, hearing, sight and touch. Even favorite foods lose their appeal. This can diminish the enjoyment of meals, as well as increase the risk of compromising the resident's nutritional status. Residents may also have a reduced sense of thirst, creating a risk for dehydration.~~

~~Many studies have found intake of some nutrients and trace elements to be commonly inadequate in the elderly. Most frequently reported as inadequate are intakes of folacin, vitamins D, B_6, and B_{12}, zinc, magnesium, and calcium.~~

~~The resident may have difficulty chewing due to decreased salivation, missing teeth or their natural teeth may be in poor condition. Dentures may fit poorly because of shrinkage of the supporting bone and gums. Various levels of texture modifications are available to meet individual needs, including the special needs of residents with difficulty swallowing, as in Dysphagia.~~

~~Constipation may be a problem because of lack of dietary fiber, water and exercise or as a side effect of~~

medications. The resident in good health should be encouraged to eat whole grain breads and cereals, as well as fruits and vegetables to provide bulk, and to drink 6 to 8 glasses (2000 cc or more) of assorted fluids taken throughout the day.

The resident may have established particular eating habits which could interfere with his/her acceptance of a therapeutic diet or hospital food. Past eating practices and food preferences, as well as ethnic customs and religious beliefs, should be tailored into meal planning for each individual. Our resident menu is a four-week

cycle menu with two hot entrees and many alternates offered each day. The dietary staff will assist the resident in determining the preferred menu items and food substitutes.

Malnutrition is one of the most serious problems facing health professionals working in long term care. Undernutrition adversely affects the quality and length of life, predisposing older adults to an increased risk of illness and infection. Unintentional weight loss has been correlated with increased mortality, compromised

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ability to resist infections, and increased incidence of pressure ulcers. The link between psychiatric well being, food intake and nutritional status is evident in older adults. Depression is common, contributing to the resident's lack of interest in food and to compromised food intake. [1]

During the resident assessment process, the RD identifies specific nutritional risks, including weight loss, poor appetite, medical condition, dehydration, pressure ulcers, feeding dependency, aspiration risk, or chewing & swallowing problems. Working with the interdisciplinary team, the RD develops an appropriate nutrition therapy plan for the resident. The goals of nutrition intervention include the improvement of overall health through optimal nutrition. The decision to implement a therapeutic diet regime should balance both medical and quality-of-life needs.

Therapeutic modifications may be eliminated or liberalized to maximize the resident's satisfaction with their meals. Prolonged restrictive diet orders could contribute to reduced food intake and a decline in nutritional status. The American Dietetic Association has recommended that diets be liberalized for older adults in long-term care. When a medical condition requires a therapeutic diet, the physician and the RD should discuss the level of restriction needed and weigh the benefits and potential impact on the resident's quality of life. When possible, the resident should be involved in these decisions.

Diets requiring texture modifications may eliminate many preferred foods or restrict them to grinding, mashing or a puree ('baby food') consistency. These limitations often cause a resident to reject meals. Except when health or safety is an issue, the resident has the right to be provided food at the highest level of texture tolerated. When possible, it is best to eliminate specific problem foods that may cause eating difficulty. Then the resident can choose foods from the larger variety of regular or soft foods. The more flexible diet should increase meal satisfaction and food intake, improving nutritional status and the overall quality of life. Residents may prefer a social dining environment in which they enjoy the company of friends at meals. A comfortable dining room, away from the bedside, can stimulate the appetite and increase the pleasures of eating.

[1] Position of The American Dietetic Association: *Liberalized diets for older adults in long-term care. J Am Diet Assoc. 1998;98:201.*

Philosophy of Feeding Our Residents

Don't puree the food if chopped will do. Don't chop the food when whole will do,
Do all you can to help them chew! --- Anonymous

Many residents have difficulty eating sufficient nutrients (food and fluids) to maintain their weight for optimal health. A nutritional nourishment may be added to supplement the daily diet if the resident is unable to consume adequate protein and calories. Residents who refuse to eat whole foods and request liquid nutrition substitutes for meals should be encouraged to take frequent small meals, throughout the day. If poor intake continues, a call for a consultation by the RD can assist in the evaluation and assessment of the problem to prevent unnecessary weight loss. The RD can schedule calorie counts to measure intake, provide dietary counseling and plan additional calories and protein into the daily diet as requested by the resident. (See Appendix for nutrition supplements protocol).

LAGUNA HONDA 28-DAY MENU CYCLE DIET ANALYSIS

The complete 28-Day Laguna Honda Diet cycle was analyzed using the nutrition database CBORD. Each meal, for the 28 days, was analyzed for calories, protein, carbohydrates, fats, minerals and vitamins. Totals, averages and standard deviations were determined using Excel. Further information or a hardcopy of the nutrient analysis can be found in the Clinical Nutrition Department or by contacting 759-4589.

NUTRIENT NEEDS OF THE ELDERLY

~~Specific nutrient considerations for the elderly are outlined below.~~

KILOCALORIES

Calorie needs per day are calculated individually for each resident by the RD. The Harris Benedict Equation can be used to calculate a resident's BEE requiremen~~tt for (Appendix)~~. Stress and activity factors are determined by the RD based on resident's medical condition and mobility. The determined stress and activity factor is multiplied by the resident's BEE to obtain total calories per day needed by the resident. ~~The Adequate Intakes (AI) for healthy, older adults for total kilocalories can be found in Appendix 1.A.~~ If residents are obese (BMI>=30.0kg/m2; IBW>=130%) or underweight (BMI<=18.5kg/m2) calories may be adjusted by the RD for weight loss or gain during~~in~~ an appropriate timeframe. Residents with pressure ulcers require increased calories per day for wound healing.

PROTEIN

Protein (grams) is calculated based on the residents' weight (kilograms) and medical condition. The minimum protein requirement is 0.8-1 gram of protein/ kilogram of body weight~~.~~. Appendix 1.A. provides protein RDAs for healthy, older adults. If the resident is stable with normal weight (BMI:19-24.9kg/m2) or overweight (BMI:25-29.9kg/m2) status, the residents actual weight (kg) may be used to determine protein needs. If the resident is obese (BMI>=30.0kg/m2), ~~adjusted~~ actual body weight (kg)~~?~~ may be used to determine appropriate protein needs. Residents, with pressure ulcers, require increased protein needs for wound healing.

CARBOHYDRATE

The diets at Laguna Honda are designed with ~45-65% of total calories coming from carbohydrates. Carbohydrate restrictions, either for weight loss and/or blood glucose control, are determined by the RD and medical team depending on the ~~residents~~residents' medical condition. Appendix 1 A.~~A.~~ provides the RDA for carbohydrates for healthy, older adults.

FAT

Fat intake should be adequate to provide for appetizing meals and satiety. At Laguna Honda, the food service and nutrition department strive to develop diets that meet the goal: ~30% of total kilocalories coming from fat, 10% of calories from saturated fats, less than 300 mg of dietary cholesterol and no trans fat. ~~Appendix 1.A provides the AI percentage range of total fat coming from total calories for healthy, older adults.~~

~~MINERALS AND~~ VITAMINS AND MINERALS

Appendix 1.A., B. ~~,~~and C. provides Mineral and Vitamin RDAs for healthy, older adults.

FLUIDS AND DIETARY FIBER

~~Six to eight glasses of water a day are important to help maintain hydration. Encourage fluids throughout the day. Liquids also aid in good elimination habits and sufficient fiber and fluid is helpful to prevent constipation. Prune juice, bran supplementation, raw and/or cooked fruits and vegetables, whole grain breads should be emphasized when possible.~~ Appendix 1.A. provides AI for total fiber and fluids for healthy, older ~~men and women~~adults.

~~28-DAY CYCLE LAGUNA HONDA DIET ANALYSIS~~

~~The complete 28-Day Laguna Honda Diet cycle was analyzed using the nutrition database CBORD. Each meal, for the 28 days, was analyzed for calories, protein, carbohydrates, fats, minerals and vitamins. Totals, averages and standard deviations were determined using Excel. Further information or a hardcopy of the nutrient analysis can be found in the Clinical Nutrition Department or by contacting 759-4589.~~

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REGULAR DIET

I~~1~~. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

~~Regular foods are selected from all food groups and prepared in a variety of ways~~ The regular diet is designed to achieve or maintain optimal nutritional status in persons who do not require a therapeutic diet. Offers choices that promote intake of whole grains, fresh fruits, and vegetables, soups, fish and poultry, red meat and milk. However there are no restrictions and i~~I~~ndividual ~~tolerances and~~ preferences may necessitate the exclusion of certain food items.

II. ~~-~~INDICATIONS~~S:~~

~~This diet is designed for residents who are not acutely ill, do not need any dietary modifications or restrictions, and who can chew and swallow without difficulty.~~ The regular diet is used to promote health and reduce the risks for the development of major, chronic and nutrition-related diseases.

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to ~~include the recommended servings from the Food Guide Pyramid.~~ meet current DRI/RDAs (Appendix A).

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	~~2200-2600~~1800-2750	95-115	~~100-110~~85-120	240-290
		~~grams~~	~~grams~~	~~grams~~
~~V. % of Calories~~		~~18 %~~	~~43 %~~	~~39 %~~

SUGGESTED MEAL PATTERN:

BREAKFAST

- ~~*~~4 oz. Fruit ~~-~~or Juice
- 1 Serving ~~6 oz.~~ Cereal
- 1 Egg or Alternate
- 1 Slice Toast or Alternate
- 1 Pat Butter / Margarine
- 8 oz. Low ~~f~~Fat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

LUNCH ~~and~~ & DINNER

- 6 oz. Soup or Salad w/ Dressing
- 3 oz. Meat or Alternate
- 2 oz. Gravy
- 3 oz. Starch
- 3 oz. Cooked Vegetable
- 1 Serving Dessert
- 1 Slice Bread, 1 Pat Margarine
- 8 oz. Low ~~f~~Fat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

Reference
Academy of Nutrition and Dietetics. Nutrition Care Manual. General, Healthful Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=6. Accessed July 29, 2018

~~*May Be Supplied As A Neighborhood Nourishment~~

~~Note: For residents who wish to eat a Vegetarian diet, the regular diet can be modified to substitute entrees with foods such as: non-meat entrees and salads, sliced cheese, cottage cheese, yogurt, or egg dishes.~~

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VEGETARIAN DIET

1. BASIC PRINCIPLES:
Vegetarian foods are selected from all food groups and prepared in a variety of ways. Individual tolerances and preferences may necessitate the exclusion of certain food items.
II. INDICATIONS:
For residents who wish to eat a Vegetarian diet, the regular diet can be modified to substitute entrees with foods such as: non-meat entrees and salads, sliced cheese, cottage cheese, yogurt, or egg dishes.
III. ADEQUACY:
This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).
IV. APPROXIMATE COMPOSITION:

	Calories	Protein	Carbohydrate	Fat
Range	2200-2600	100-110 grams	240-290 grams	95-115 grams
% of Calories		18 %	43 %	39 %

BREAKFAST	LUNCH and DINNER
4 oz. Fruit or Juice	6 oz. Soup or Salad w/ Dressing
6 oz. Cereal	3 oz. Meat Alternate
1 Egg or Alternate	2 oz. Gravy
1 Slice Toast or Alternate	3 oz. Starch
1 Pat Butter / Margarine	3 oz. Cooked Vegetable
8 oz. Low Fat Milk	1 Serving Dessert
Coffee, Tea, Decaf	1 Slice Bread, 1 Pat Margarine
Sugar, Salt, Pepper	8 oz. Low Fat Milk
	Coffee, Tea, Decaf
	Sugar, Salt, Pepper

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DENTAL SOFT DIET

I. PURPOSE~~BASIC PRINCIPLES:~~

This diet includes soft textured foods while most raw foods are excluded. Regular foods are selected from all food groups to increase the acceptability of the diet. ~~Roast meats are prepared by chopping or grinding as needed. Soft fresh fruits and cooked vegetables are used in the menus.~~

II. INDICATIONS~~:~~

This diet may be ordered for residents who have difficulty chewing solid foods because of missing teeth, poorly fitting dentures, and mouth pain. The diet is not intended for residents who have identified choking or swallowing problems. ~~The Mechanical Soft Diet or Puree Diets may be used to restrict the diet to semi-soft and puree foods for ease of swallowing.~~

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

~~This diet is nutritionally adequate when planned to include the recommended servings from the Food Guide Pyramid.~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	2300-2500	100-110	250-275	95-105
		~~grams~~	~~grams~~	~~grams~~
~~% of Calories~~		~~18 %~~	~~44 %~~	~~38 %~~

~~V~~V. SUGGESTED MEAL PATTERN:

BREAKFAST
~~*~~4 oz. Fruit or Juice
1 Serving~~6 oz.~~ Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter / Margarine
8 oz. Lowfat Milk
1 Serving Dessert
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH ~~and~~ & DINNER
6 oz. Soup or 6 oz Soft Salad
3 oz. Meat or Chopped Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Slice White or Wheat Bread
1 Pat Butter / Margarine
8 oz. Lowfat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

~~*May Be Supplied As A Neighborhood Nourishment~~

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DDENTAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	Milk, buttermilk, milkshakes, plain or fruited yogurt.	Yogurt with nuts.
Meats, Fish, Poultry,	Tender or chopped meats and poultry, baked, boiled, steamed meat or chicken, such as ground beef, hot dog, cold cuts, Thinly sliced deli meats, ham, beef, turkey. Soft sandwich mixes, chicken nuggets. Baked, steamed or sauté fish & shrimp.	Crispy fried or breaded meats, fish and poultry. Thick sliced roasts or ham. Dry salami.
Cheese	Soft meat or cheese casseroles. Cottage cheese, soft cheeses.	Hard cheese.
Eggs	Soft scrambled eggs, soft cooked egg, poached egg, fried egg, plain egg salad.	None.
Vegetables	Soft cooked vegetables. Sliced tomato, leaf lettuce. Tomato juice.	Kernel corn. Other raw vegetables. Crunchy vegetables.
Fruits	Canned fruit. Soft fresh fruit: melon, strawberries, ripe banana, grapes, orange and grapefruit sections. Stewed prunes, raisins. Fruit juices.	All other raw fruit, fruit that contains pits, seeds, and skin. Other dried fruit.
Starches	Soft potatoes or yams, cream corn, rice, noodles. French fries.	Whole kernel corn. Crunchy noodles.
Cereals	Hot cereals. Cold flaked cereal.	All coarse cold cereals and those with nuts or dried fruits.
Breads	White, wheat or rye bread. Pancakes, waffles, French toast. Cornbread, soft rolls, sweet muffins, crumpets.	All breads that contain nuts. English muffin.
Fats and Oils	Margarine, butter, strained gravy, creamers, sour cream,	None.

	mayonnaise, salad dressings. Crisp bacon and sausage links.	
Soups	Soups made with allowed foods.	All other soups.

DENTAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
~~Fats and Oils~~	~~Margarine, butter, strained gravy, creamers, sour cream, mayonnaise, salad dressings. Crisp bacon and sausage links.~~	~~None.~~
~~Soups~~	~~Soups made with allowed foods.~~	~~All other soups.~~
Beverages	Coffee, tea, sodas, milk. Liquid nourishment supplements.	None.
Desserts	Ice cream, sherbet, smooth puddings, jello, custard. Plain pies, cakes, cookies.	All desserts which contain fibrous fruits and nuts.
Miscellaneous	Sugar, jelly, syrup, honey. Salt, spices. Hard candy.	Hard to chew snacks. Chewy candy. Pretzels

MECHANICAL SOFT DIET

I. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

This diet is designed to minimize the amount of chewing necessary to safely swallow ~~for the ingestion of~~ food by residents. ~~It includes soft textured foods while most raw foods are excluded. Regular foods are selected from all food groups and prepared by chopping, grinding mashing or pureeing, as needed. Vegetables and fruits are cooked soft or are pureed to allow a wider variety of choice for the resident.~~

II. INDICATIONS~~:~~

This diet may be ordered for residents who have difficulty chewing or swallowing solid foods because of facial paralysis, poor or broken teeth, missing or poorly fitting dentures. ~~Many food items allowed on this diet are potential choking hazards. If a resident coughs while eating foods or fluids, a swallowing evaluation is indicated.~~

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

~~This diet is nutritionally adequate in all nutrients when planned to include the recommended servings from the Food Guide Pyramid.~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	~~2300-2500~~ 1700-2600	~~100~~80-110	2~~50~~00-~~275~~300	~~95~~60-1~~0~~25
	~~grams~~	~~grams~~	~~grams~~	
~~% of Calories~~		~~18 %~~	~~44 %~~	~~36 %~~

~~V~~V. SUGGESTED MEAL PATTERN:

BREAKFAST
- ~~*~~4 oz. Fruit or Juice
- ~~6 oz~~1 Serving~~.~~ Cereal
- 1 Egg or Alternate
- 1 Slice Toast or Alternate
- 1 Pat Butter / Margarine
- 8 oz. Lowfat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

LUNCH & DINNER
- 6 oz. Soup or 6 oz Soft Salad
- 3 oz. Chopped Meat or Alternate
- 2 oz. Gravy
- 3 oz. Starch
- 3 oz. Cooked Vegetable
- 1 Slice White or Wheat Bread
- 1 Pat Butter / Margarine
- 1 Serving Dessert
- 8 oz. Lowfat Milk
- Coffee, Tea, Decaf
- Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

~~*May Be Supplied As A Neighborhood Nourishment~~

The mechanical soft diet can be reduced in texture as necessary to meet the resident's needs. One of the more common adjustments is the *mechanical soft with puree vegetables diet*. This provides the resident with soft foods without all foods having to be pureed.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. National Dysphagia Diet Mechanically Altered Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=420. Accessed July 28, 2018.

MECHANICAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	All milk: buttermilk, milkshakes, plain or fruited yogurt. Ice cream.	Yogurt with nuts. Ice cream with nuts.
Meats, Fish, Poultry, Cheese	Chopped meats, and poultry. Baked or tender grilled fish. Soft meat, fish or cheese casseroles, quiche, eggs. Cottage cheese, soft cheese. Smooth peanut butter.	All whole meats, poultry, fried fish, stringy meats. Hot dogs, hamburgers. Crunchy fried foods. Luncheon meats. Hard or strong cheeses. Crunchy peanut butter.
Eggs	Soft scrambled eggs, soft cooked, poached, fried egg. Plain egg salad.	Crunchy peanut butter.
Vegetables	Tender cooked or pureed vegetables. Tomato Juice. Asparagus tips, F.C. beans.	Cut green beans, peas, corn, leafy greens. Fibrous, tough vegetables, Brussell sprouts, broccoli, raw vegetables.
Fruits	Soft canned fruit, ripe banana. Fruit -juices.	All other raw fruit or fruit containing pits, seeds, skin.
Starches	Soft potatoes or yams, Juk. Cream corn, rice, noodles. Spaghetti, macaroni, other pastas.	Kernel corn. Snack chips. Crunchy fried foods. Snack crackers.
Cereals and Breads	Hot cooked cereals. Cold flaked or puffed cereal. White, wheat or rye bread. Pancakes, waffles, French toast, plain muffins, soft rolls.	All coarse cold cereals and breads that contain nuts, dried fruit, seeds, Crisp snacks, pretzels. Popcorn.
Fats and Oils	Margarine, butter, strained gravy, sauces, sour cream, cream, mayonnaise, mild salad dressings.	Crisp bacon, ham patty, sausage links and other breakfast meats.
Soups	Soups made with allowed foods and salt, mild herbs, spices and seasonings.	All other soups.
Beverages	Coffee, tea, sodas, milk. Liquid nourishment supplements.	None.
Desserts	Ice cream, sherbet, jello, smooth puddings, jello, plain pies, cakes, cookies. Ssugar, jelly, syrup, honey.	All desserts containing nuts and fibrous fruits. Hard to chew snacks, chewy candy. Dried fruit. Cookies

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SEMI-PUREE

I. ~~BASIC PRINCIPLES:~~PURPOSE

The Semi-Puree Diet contains food which has a smooth consistency to facilitate ease of chewing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs. ~~Food textures can vary from smooth to coarse.~~

The Semi-Puree diet is a more liberal puree diet in several ways and when tolerated is well accepted by the resident. In addition to pureed foods, the following foods are allowed~~Like the Full Puree Diet, this diet has the following basic characteristics: Foods are pureed to obtain a consistency similar to mashed potatoes. Raw foods are avoided; Soups are strained and foods are mildly seasoned; Plain desserts are served. The Semi-Puree diet is a more liberal puree diet in several ways and when tolerated is well accepted by the resident.~~

~~Additional foods are allowed on the Semi-Puree Diet as follows~~: plain breads, muffins and pancakes, baked desserts, such as cakes ~~and cookies~~, ripe banana, prepared eggs and soft sandwich mixes, cottage cheese, soft cheeses and fruit yogurt.

II. INDICATIONS~~:~~

This diet is designed for residents who are unable to chew or swallow solid foods due to: poor or broken teeth, missing or poorly fitting dentures, sore gums, or decreased mentation that interferes with eating. Food consistency is based on resident clinical condition and individual tolerance.

~~The dietitian (supported by the speech therapist) can advise the most effective food texture for the resident which can be tolerated consistently and provide feeding instructions as required. Dietary restrictions (diabetic, low sodium) can be incorporated with this diet. All diets must be ordered by the physician, including advances in texture, as resident tolerance warrants.~~

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

IV. -APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	~~F~~Fat (gm.)
Range	~~1800-1900~~1600-3000	~~75-80~~70-140	180-380~~260-265~~	60-~~65~~125
		~~grams~~	~~grams~~	~~grams~~
~~% of Calories~~		~~16%~~	~~56%~~	~~28 %~~

V. -SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH ~~and~~& DINNER
4 oz. Fruit or Juice	6 oz. Strained Soup ~~or Soft Salad~~
~~6 oz.~~1 Serving Cooked Cereal	4 oz. Pureed Meat or Alternate w/Gravy
1 Egg or Alternate	3 oz. Mashed Potato or Alternate
1 Slice ~~Toast~~Bread	3 oz. Pureed Vegetable
1 Pat Butter / Margarine	1 Serving Dessert
8 oz. Lowfat Milk	1 Slice Bread, 1 Pat Butter / Margarine
Coffee, Tea, Decaf	8 oz. Lowfat Milk

Sugar, Salt, Pepper	Coffee, Tea, Decaf
	Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served as tolerated.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. National Dysphagia Diet Pureed Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July 29, 2018.

SEMI-PUREE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream with seeds, nuts, fruit pulp or fruit skin.
Meats, Fish, Poultry	Meat, poultry and fish which are smooth pureed consistency. Soft sandwich mixes made from tuna, egg, chicken with mayonnaise.	All regular meats, fish and poultry if not pureed. Hard cheeses. Casseroles made w/ whole meats or vegetables.
Cheese	Cottage cheese, soft cheeses.	
Eggs	Eggs, soft boiled, scrambled. Plain egg salad with mayonnaise.	Lunchmeats, All other eggs.
Vegetables	Vegetables which are pureed consistency, tomato juice.	Whole or fresh vegetables unless blenderized.
Fruits	All fruit that is finely pureed. Applesauce, fruit juices, nectars thickened juices, ripe banana.	All other whole, canned or fresh fruit. Coconut.
Starches	Smooth mashed potatoes or yams, Smooth polenta, cream of rice, corn puree, pasta puree. Juk.	All other potatoes, rice or noodles. Kernel corn, French fries.
Breads, Cereals, Grains	Hot smooth cooked cereals, e.g. cream of wheat, farina, malt-o-meal. Plain Rice Porridge, Oatmeal Plain muffins, pancakes,. White, wheat bread or soft rolls. Soft cakes ~~and cookies~~	All hard breads, crackers, and those containing seeds, nuts or dried fruit. Waffles, French toast. Cold cereal, pizza, tortillas.
Fats and Oils	Margarine, sour cream, mayonnaise, strained gravies.	All fried foods. Avocado. Chunky sauces, tartar sauce.
Soups	Thickened strained cream soups, Strained broth soups.	Chunky soups containing foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements	None.
Desserts	Soft baked products, cake~~, cookies~~. Custard, smooth puddings, jello, ice cream and sherbet,.	Cookies, c~~C~~andy, jam, peanut butter. Baked products containing whole fruits, nuts, seeds. Doughnuts and pastries.

Miscellaneous	Sugar, salt, mild seasonings	Sticky /chewy food. Snack chips, pretzels, popcorn.

FULL PUREE DIET

I. ~~BASIC PRINCIPLES:~~PURPOSE

The Full Puree Diet contains food that has a smooth consistency to facilitate ease of swallowing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs. ~~Food textures are always smooth and usually the consistency of applesauce or mashed potatoes. This diet resembles the diet for Dysphagia but is more restrictive than the Semi-Puree Diet. The Full Puree Diet has the following basic characteristics: Foods are pureed to obtain a consistency similar to mashed potatoes. Coarse or raw foods and bread products are eliminated. Soups are strained and foods are mildly seasoned. Plain pureed desserts are served. Any food that is not of a pureed consistency is avoided. Thin liquids are served.~~

II. INDICATIONS~~:~~

The Full Puree diet is designed to facilitate eating for residents who are unable to chew, have difficulty swallowing or who may have other problems identified with feeding.

~~The Dietitian, working with the Speech Therapist, can assist in assessing the most effective food texture for the resident. If a swallowing disorder is identified by the Speech Therapist, the evaluation will include the safest texture that can be tolerated consistently and if required, a feeding plan with specific instructions will be posted at the bedsideavailable in resident's care plan. Necessary dietary restrictions (e.g. ADA, low sodium, etc.) can be incorporated with the Full Puree texture, as well as thickened liquids (Nectar-thick or Honey-thick).~~

~~Advanced texture, tThe Semi-Puree Diet may be ordered by the physician as resident tolerance warrants. The resident who has been evaluated by a Speech Therapist and shows significant improvement in swallowing, should receive a new evaluation.~~

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A). ~~The Full Puree diet is nutritionally adequate when planned to include the recommended servings from the Food Guide Pyramid. The Full Puree diet is low in fiber.~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1920-2200	65-85 ~~grams~~	280-300 ~~grams~~	60-70 ~~grams~~
~~% of Calories~~		~~14-16 %~~	~~55-58%~~	~~28-29 %~~

V. SUGGESTED MEAL PATTERN:

BREAKFAST

*4 oz Fruit Juice
6 oz Refined Hot Cereal
1 Serving Nx Liquid
1 Serving Custard
1 Pat Butter / Margarine
8 oz Lowfat Milk
Coffee, Tea, Decaf
Half & Half
Sugar, Salt, Pepper

LUNCH ~~and~~ & DINNER

6 oz Strained Soup/4 oz Juice
4 oz Pureed Meat/Alternate
3 oz Pureed Starch/Gravy
3 oz Pureed Vegetable
1 Pat Butter / Margarine
4 oz Pureed Fruit/Dessert
8 oz Lowfat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. National Dysphagia Diet Pureed Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July 29, 2018.

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FULL PUREE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream with seeds, nuts, fruit pulp or fruit skin.
Meats, Fish, Poultry, Cheese	Meat, poultry and fish which are smooth pureed consistency	All regular meats, fish and poultry if not pureed. Cheese.
Eggs	Custard.	**All Eggs**, boiled, scrambled. Lunchmeats.
Vegetables	Vegetables which are pureed consistency, tomato juice	Whole or fresh vegetables unless blenderized~~.~~
Fruits	All fruit that is finely pureed. Applesauce, fruit nectars, thickened juices.	All other whole, canned or fresh fruit and juices. Banana. Coconut.
Starches	Smooth mashed potatoes or yams, smooth polenta, cream of rice.	All other potatoes, rice or noodles.
Breads, Cereals, Grains	Hot smooth cooked cereals, cream of wheat, farina, malt-o-meal, cream of rice, Plain Rice Porridge, Oatmeal	**All breads,** coarse grains, oatmeal, cornmeal, rolled wheat. All crackers. Pancakes, waffles, tortillas. Cold cereal.
Fats and Oils	Margarine, sour cream, mayonnaise, s~~S~~trained gravies.	All fried foods. Avocado. Chunky sauces.
Soup	Thickened strained cream soups. Strained broth soups.	Chunky soups containing foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements.	None.
Desserts	Smooth puddings, custard, jello, plain ice cream and sherbet.	All baked products, including pies, cakes, cookies, pastry, nuts, dried fruit, jam.
Miscellaneous	Sugar, clear jelly, salt, mild spices.	Candy, peanut butter. Pizza, popcorn, chips.

Sticky or chewy food.

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SEMI-PUREE

I. BASIC PRINCIPLES:

The Semi-Puree Diet contains food which has a smooth consistency to facilitate ease of chewing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs. Food textures can vary from smooth to coarse.

Like the Full Puree Diet, this diet has the following basic characteristics: Foods are pureed to obtain a consistency similar to mashed potatoes. Raw foods are avoided; Soups are strained and foods are mildly seasoned; Plain desserts are served. The Semi-Puree diet is a more liberal puree diet in several ways and when tolerated is well accepted by the resident.

Additional foods are allowed on the Semi-Puree Diet as follows: plain breads, muffins and pancakes, baked desserts, such as cakes and cookies, ripe banana, prepared eggs and soft sandwich mixes, cottage cheese, soft cheeses and fruit yogurt.

II. INDICATIONS:

This diet is designed for residents who are unable to chew or swallow solid foods due to: poor or broken teeth, missing or poorly fitting dentures, sore gums, or decreased mentation that interferes with eating. Food consistency is based on resident clinical condition and individual tolerance.

The dietitian (supported by the speech therapist) can advise the most effective food texture for the resident which can be tolerated consistently and provide feeding instructions as required. Dietary restrictions (diabetic, low sodium) can be incorporated with this diet. All diets must be ordered by the physician, including advances in texture, as resident tolerance warrants.

III. ADEQUACY:

The Semi-Puree diet is nutritionally adequate when planned to include the recommended servings of the Food Guide Pyramid. The Semi-Puree Diet is low in fiber.

IV. APPROXIMATE COMPOSITION:

	Calories	Protein	Carbohydrate	Fat
Range	1800-1900 grams	75-80 grams	260-265 grams	60-65
% of Calories		16%	56%	28 %

V. SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH and DINNER
*4 oz. Fruit or Juice	6 oz. Strained Soup or Soft Salad
6 oz. Cooked Cereal	4 oz. Pureed Meat or Alternate w/Gravy
1 Egg or Alternate	3 oz. Mashed Potato or Alternate
1 Slice Toast	3 oz. Pureed Vegetable
1 Pat Butter / Margarine	1 Serving Dessert
8 oz. Lowfat Milk	1 Slice Bread, 1 Pat Butter / Margarine
Coffee, Tea, Decaf	8 oz. Lowfat Milk
Sugar, Salt, Pepper	Coffee, Tea, Decaf
	Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served as tolerated.

*May Be Supplied As A Neighborhood Nourishment

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SEMI-PUREE DIET

VI.. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream with seeds, nuts, fruit pulp or fruit skin.

Meats, Fish, Poultry	Meat, poultry and fish which are smooth pureed consistency. Soft sandwich mixes made from tuna, egg, chicken with mayonnaise.	All regular meats, fish and poultry if not pureed. Hard cheeses. Casseroles made with whole meats or vegetables.
Cheese	Cottage cheese, soft cheeses.	
Eggs	Eggs, soft boiled, scrambled. Plain egg salad with mayonnaise.	Lunchmeats, take-out foods. All other eggs.
Vegetables	Vegetables which are pureed consistency, tomato juice.	Whole or fresh vegetables unless blenderized.
Fruits	All fruit that is finely pureed. Applesauce, fruit juices, nectars thickened juices, ripe banana.	All other whole, canned or fresh fruit. Coconut.
Starches	Smooth mashed potatoes or yams, Smooth polenta, cream of rice, corn puree, pasta puree. Juk.	All other potatoes, rice or noodles. Kernel corn, French fries.
Breads, Cereals, Grains	Hot smooth cooked cereals, e.g. cream of wheat, farina, malt-o-meal. Plain Rice Porridge, Oatmeal Plain muffins, pancakes,. White, wheat bread or soft rolls. Soft cakes and cookies	All hard breads, crackers, and those containing seeds, nuts or dried fruit. Waffles, French toast. Cold cereal, pizza, tortillas.
Fats and Oils	Margarine, sour cream, mayonnaise, strained gravies.	All fried foods. Avocado. Chunky sauces, tartar sauce.
Soups	Thickened strained cream soups, Strained broth soups.	Chunky soups containing foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements	None.
Desserts	Soft baked products, cake, cookies. Custard, smooth puddings, jello, ice cream and sherbet,.	Candy, jam, peanut butter. Baked products containing whole fruits, nuts, seeds. Doughnuts and pastries.
Miscellaneous	Sugar, salt, mild seasonings	Sticky /chewy food. Snack chips, pretzels, popcorn.

DYSPHAGIA DIET *

Dysphagia indicates loss of oris the impaired ability to swallow.

Diagnoses that may be indicative of potential swallowing problems include any resulting in neurological impairment, head and neck cancer or surgery, patients with tracheostomy, vocal cord dysfunction, aspiration pneumonia, dementia.

A Dysphagia diet or diet texture modification may reduce the risk of aspiration. Speech Pathology evaluates for swallowing deficits and recommends the least restrictive diet texture with reduced risk of aspiration, working with the dietitian who optimizes food variety while meeting the resident's nutritional and safety needs.

due to neurological swallowing disorders and/or other mechanical swallowing difficulties. It can lead to malnutrition secondary to inadequate dietary intake or to the potential for immediate life-threatening aspiration. A Dysphagia diet can be used, when indicated, to help residents continue to enjoy eating and be independent of a feeding tube.

Diagnoses that may be indicative of potential swallowing problems in residents include: CVA, closed head trauma, cerebral palsy, poliomyelitis, diagnoses that indicate stricture or inflammation of the pharynx or esophagus, tumor or obstruction of the throat, history of aspiration/pneumonia, head or neck cancer/surgery, and degenerative diseases: Parkinson's disease, multiple sclerosis, muscular dystrophy, myasthenia gravis, Huntington's chorea, amyotrophic latexal sclerosis, myotonic dystrophy.

Signs to look for which may indicate possible Dysphagia include:

- Coughing
- Choking
- Holding food in mouth
- Significant pocketing of food
- Significantly delayed swallow
- Significant leakage of food or liquid form the mouth
- Food or liquid coming from a tracheostomy (Serious sign of aspiration!)
- Excessive drooling
- Recurrent pneumonias

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- Collection of food under tongue
- Pocketing of food in cheek
- Collecting of food on hard palate of mouth
- Spitting food out of mouth/tongue thrusting
- Poor tongue control

- Excessive tongue movement
- Slow oral transit time (more than 1 second)
- Delay or absence of elevation of Adam's apple
- Coughing or choking
- Excessive secretions
- Drooling from corner of mouth
- Gargled voice after eating or drinking
- Regurgitation of material through nose, mouth, or tracheotomy tube
- Inadequate intake of food and/or fluid
- Unexplained weight loss
- Prolonged feeding time

Note: Some persons with Dysphagia can aspirate silently without exhibiting any of the above signs.

* Refer to LHH P&P Management of Dysphagia and Aspiration Risk 20-37

Information obtained from the ANDDA Manual of Clinical Dietetics

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DYSPHAGIA DIET

Dietary Considerations for Dysphagia:

~~1. Highly seasoned, flavorful foods can be tried when maximizing the stimulus to swallow or maximizing sensation is desired.~~

~~2. When the goal is to maximize the stimulus to swallow, foods at very warm or very cold temperatures can be used. Colder temperatures can help increase sensation for residents with reduced oral sensation.~~

~~3.~~1. Avoid small pieces of food for residents with reduced sensations as they can become lost in the mouth, and increase the chance of choking.

~~4.~~2. Select foods that form a bolus within the mouth and do not break~~.~~ apart (e.g., bananas, mashed potatoes, macaroni and cheese).

~~5.~~3. Avoid sticky foods that adhere to the roof of the mouth. These can cause fatigue in residents with muscle weakness and risk of airway obstruction.

~~6.~~4. Thickening of thin liquids may be tried with select pureed foods. ~~, nonfat dry milk powder, or commercial thickeners.~~

~~7. Strictures or partial obstruction of the pharynx or esophagus necessitate only semi-solids or liquids.~~

~~8.~~5. Residents with decreased salivation need moist, well lubricated foods. Gravies, extra margarine, sauces, salad dressing may be used. Dry foods may be dunked in soup or beverage.

~~9.~~6. Avoid milk products if excess mucus formation is a problem as they increase salivation.

~~10.~~7. Individualize diets for consistency.

~~11.~~8. High calorie, high protein foods should be emphasized for ~~dysphagic~~dysphagia residents managing limited intakes at a time.

~~12.~~9. Offer small frequent meals when minimizing fatigue and optimizing food temperature and total nutrient intake is desirable.

~~13. Fluid requirement range is 20 ml/kg or 1-2 ml/kcal. Additional fluid may be indicated in some circumstances (e.g., fluid loss via fistula drainage, etc.).~~

~~14.~~10. Residents requiring thickened liquids are at increased risk for dehydration. Thickened water and thickened juice should be offered several times a day between meals.

~~15. Tube feeding should be considered if, any of the following occurs:~~

- ~~Oral intake and supplements are not adequately meeting caloric and protein needs.~~
- ~~There is failure to maintain weight.~~
- ~~Intake is inadequate for seven days.~~

~~Note: Some elderly, immobilized residents who are marginally responsive and refusing to eat may become more alert, responsive, and interested in eating after the initiation of enteral tube feeding. Prolonged tube feeding may increase difficulty in restoration of normal deglutition.~~

~~Information obtained from the ADA Manual of Clinical Dietetics~~

DYSPHAGIA DIET

I. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

The Dysphagia diet is designed to help reduce the risk of ~~choking~~ aspiration by providing foods that facilitate swallowing. ~~The diet consists of pureed, homogenous, and cohesive foods. Foods are used which have the necessary weight and bulk to stimulate the swallow mechanism and yet can be either manually removed or quickly suctioned.~~ Food texture is a smooth puree consistency~~, 'pudding-like'~~. Thin liquids are eliminated. Depending on the resident's individualized needs, liquids are served in either a nectar or a honey consistency.

II. INDICATIONS~~:~~

A swallowing evaluation is required to assess the cause of the Dysphagia and the underlying functional problem. The Speech Therapist can then provide advice on the most effective food textures and liquid consistency for the resident. ~~The therapist can also provide instructions for safe assisted feeding practices and schedule follow-up visits as necessary. Necessary dietary restrictions (diabetic, low sodium, etc.) can be incorporated with the Dysphagia diet. All diets need to be ordered by the physician, in consultation with the dietitian and speech therapist.~~

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A). ~~The Dysphagia diet is nutritionally adequate when planned to include foods as outlined in the Food Guide Pyramid.~~ Residents with Dysphagia may have difficulty consuming adequate food volume and the diet may require nutritional supplements.

IV. APPROXIMATE COMPOSITION:

	Calories	Protein	Carbohydrate	Fat
Range	2000 –2200	81-90 grams	235-289 grams	75-90 grams
Percent of Calories		15-17 %	46-54 %	31-37 %

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Thickened Juice
6 oz. Refined Cooked Cereal
4 oz. Custard or Pudding
1 Pat Butter / Margarine
8 oz. Thickened Milk
Condiments

LUNCH ~~and~~ & DINNER
6 -oz. Strained Cream Soup or
4 -oz. Thickened Juice or Gelatin
4 -oz. Meat, Fish, Poultry Puree
3 -oz. Mashed Potatoes or Starch
2 -oz. Gravy
3 -oz. Vegetable Puree
1 -Pat Butter / Margarine
4 -oz. Fruit Puree
8 -oz. Thickened Milk
Condiments

Whole grain breads, cereals and starches are served as tolerated.

~~* Refer to LHH P&P Management of Dysphagia and Aspiration Risk 20-37~~

DYSPHAGIA DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Milk and Dairy	~~Buttermilk, milkshakes, c~~Custard, smooth yogurt, ice cream ~~smooth yogurt, ice cream.~~ Milkshakes. Yogurt or ice cream with Nectar and Honey consistency milk.	Thin milk beverages.* seeds, nuts, fruit pulp or fruit skin. Buttermilk
Meats, Fish, Poultry, Cheese	Meat, poultry and fish which are pureed consistency.	All regular meats, fish, and poultry if not pureed. Cheese.
Eggs	Custard.	Eggs, boiled, scrambled. All other eggs.
Vegetables	Vegetables which are pureed consistency, tomato juice.	Whole or fresh vegetables unless blenderized.
Fruits	All fruit that is pureed. Applesauce, nectars and Thickened juices.	All other whole, canned. or fresh fruit. Thin juices. Banana. Coconut.
Starches	Smooth mashed potatoes, or smooth polenta, cream of rice.	All other potatoes, rice noodles.
Breads, Cereals, and Grains	Hot smooth cooked cereals, cream of wheat, farina, maltomeal	All breads. Tortillas. Oatmeal, rolled wheat.
Fats and Oils	Margarine, cream, mayonnaise, Strained gravies.	All fried foods. Avocado.
Soups	Thickened strained cream soups.	Thin broth or chunky soups.
Beverages	Thickened liquids: juices, milk, water. Thick milkshakes, buttermilk. Thickened liquid supplements.	Coffee, tea, sodas. Regular water and milk. All thin liquids.
Desserts	Smooth puddings, custard~~, gelatin.~~ Frozen ice cream and sherbet.	All baked products, pies cookies, cakes, pastry. Fruit ices (Sorbet).
Miscellaneous	Sugar, clear jelly, salt, mild spices.	Candy, jam, peanut butter. Snack chips, popcorn, pizza. Sticky or chewy food.

CLEAR LIQUID

I. PURPOSE
~~I.~~ This temporary, transitional diet intended to leave a minimal amount of residue in the gastrointestinal tract. It supplies fluid, ~~electolytes~~electrolytes and energy in a form that requires minimal digestion. ~~BASIC PRINCIPLES~~

This diet consists of clear fluid or foods which are fluid at body temperature.

~~Liquids with high osmolality may need to be omitted or diluted to help prevent hyperosmotic diarrhea in residents who may be susceptible.~~

~~The primary foods served for this diet are juice, jello, clear both and tea. A clear, nutritionally enhanced beverage, Resource BeverageEnsure Clear, is served to provide some nutritional value to the diet.~~

~~This diet is low in residue and requires minimal digestion.~~

II. INDICATIONS

-This diet is designed to provide fluids and calories to prevent dehydration in residents who have diarrhea and or vomiting. This diet is also used for test diets requiring a clear G.I. tract. ~~Test preparation diets may deplete the elderly resident severely and alternatives should be considered.~~

III. ADEQUACY
This diet does not meet the Recommended Daily Allowances for any nutrient. If residents are on this diet for more than three days, the rationale for the diet should be reviewed and revised, if necessary. ~~This diet should be advanced as soon as possible to a more nutritionally adequate level, for example, Enteral Tube Feeding, a Full Liquid Diet or a diet using solid foods.~~

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Clear Liquid Foods		
Soups	Clear broth or bouillon	All Others
Sweets and Desserts	Clear, flavored gelatin, Clear fruit ~~icees~~ices/popsicles, sugar, honey, hard candy, sugar substitutes. ~~sugar substitutes.~~	All Others
Beverages	Clear fruit juices, such as apple, cranberry, or grape juice. Clear coffee or tea and carbonated beverages, as allowed and tolerated.	All Others including nectars, milk, cream, juices with pulp.

Miscellaneous	High caloric clear supplement beverages, such as Resource BeverageEnsure or Enlive!®.	All Others

FULL LIQUID DIET

I. ~~BASIC PRINCIPLES~~PURPOSE

This diet consists of a variety of foods that are liquid or very soft in texture. In addition, supplements such as liquid nutritional formula products are served. The primary foods allowed on this diet are: strained soup, custard, jello, juice, milk, pudding and ice cream.

II. INDICATIONS

This diet is designed for residents who are unable to chew due to recent dental surgery or are unable to tolerate solid foods due to cancer of the mouth, throat, stomach, or G.I. tract. This diet may be used as the interim diet in weaning residents from enteral diets, when swallowing semi-soft solid foods is a problem. This diet should be progressed to normal food intake as tolerated. However, long term use of this diet may be~~is~~ warranted for quality of life and pleasure.

III. ADEQUACY

The Full Liquid Diet is not nutritionally adequate and therefore should not be used for extended periods of time without consultation with the dietitian.

IV. ~~Approximate Composition~~APPROXIMATE COMPOSITION: (includes the use of supplements)

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1500-2000	65-90 ~~grams~~	240-355 ~~grams~~	30-75 ~~grams~~
~~% of Calories~~		~~15-17%~~	~~58-64 %~~	~~18-28 %~~

V. ~~Suggested Meal Pattern~~SUGGESTED MEAL PATTERNS:

~~Breakfast~~BREAKFAST	~~Mid-Morning~~MID-MORNING ~~Nourishment~~NOURISHMENT	~~Lunch~~LUNCH ~~and~~ & ~~Dinner~~DINNER
8 oz. Juice	8 oz. Nx Liquid	8 oz. Juice
Strained Cream Soup	8 oz. Juice	5 oz. Fortified Pudding
Refined Cereal		8 oz. Nx Liquid
Low fat Milk		Low fat Milk
Coffee/Tea/Decaf		

~~Afternoon~~ AFTERNOON NOURISHMENT~~Nourishment~~
Coffee, Tea, Decaf
8 oz. Nx Liquid
5 oz. Fortified Pudding

~~Evening Nourishment~~EVENING NOURISHMENT
8 oz. Juice
8 oz. Nx Liquid
or 8 oz. Milk
5 oz. Nx Pudding

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MODIFIED BLAND - LOW FIBER DIET

I. ~~I.~~PURPOSE ~~BASIC PRINCIPLES:~~

The modified bland-low fiber diet is used to reduce the frequency and volume of stools which lessens irritation to the gastrointestinal tract. It incorporates soft, non-irritating foods. ~~and foods which some individuals may find difficult to tolerate.~~ This diet limits fiber, pepper, citrus fruits, raw fruits (except banana) and raw vegetables. It limits fatty foods, sources of caffeine and foods known to be gas-forming. Dairy products are used. ~~Alcohol is generally not given on this diet. The diet does not limit dairy products.~~ Adjustments are made for individual preferences and tolerances.

II. INDICATIONS

The intended use of this diet is for people with stated sensitivity to gas-forming foods, "sensitive stomach", a history of peptic ulcer disease, ~~hiatial~~hiatal hernia or reflux, recent GI surgery, radiation therapy to the pelvis and lower bowel. It is not intended for those individuals with a history of diverticulosis unless specifically requested by the resident.

III. ADEOUACY

This diet may be inadequate in fiber~~, vitamin C and folate~~.

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1950-2350	95-100 ~~grams~~	185-235 ~~grams~~	95-115 ~~grams~~
~~% of Calories~~		~~17-19 %~~	~~38-40 %~~	~~43 %~~

V. SUGGESTED MEAL PATTERN

BREAKFAST
- *4 oz. Fruit or Juice
- 1 Serving~~6 oz.~~ Hot Cereal
- 1 Egg or Alternate
- 1 Sl. White Toast
- 1Pat Butter / Margarine
- 8 oz. Lowfat Milk
- Decaf, Sugar, Salt

LUNCH & DINNER
- 6 oz. Soup (Lunch or Dinner)
- 3 oz. Meat or Alternate
- 2 oz. Cream Gravy
- 3 oz. Potato or Alternate
- 3 oz. Cooked Bland Vegetable
- 1 Serving Dessert
- 1 Sl. Bread, 1 Pat Butter / Margarine
- 8 oz. Lowfat Milk
- Decaf, Sugar, Salt

~~*May Be Served As A Neigborhood Nourishment~~

~~Laguna Honda Hospital and Rehabilitation Center~~
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MODIFIED BLAND – LOW FIBER DIET

VI. FOODS ALLOWED AND FOODS TO AVOID:

FOOD GROUP	FOODS ALLOWED	FOODS ALLOWED AS TOLERATED	FOODS TO AVOID
Milk	All		None
Meats, Fish, Poultry, Cheese	All eggs, meats poultry, fish, cheese, except as noted.	Fried foods.	Highly spiced or cured meats.
Vegetables	All cooked vegetables, except those to avoid.	Gas producing or irritating vegetables onions, peppers, corn, broccoli, Brusse~~l~~l sprouts, celery, cabbage, lima beans. cauliflower. Tomato products.	Raw vegetables. Legumes.
Fruits and Juices	All as tolerated.	Raw fruits and citrus.	None.
Breads, Cereals, starches	All refined breads, cereals, Pancake, waffle, French toast, potatoes, rice. .	All whole grain breads. All coarse cereals. Potato chips French fried potatoes.	None.
Fats and Oils	All fats in moderation.	All as tolerated.	Highly spiced salad dressings, sauces, gravies.
Soups	Cream soups made with allowed vegetables.		Soups made with foods to avoid.
Beverages	All fruit juices.	Caffeinated and decaffeinated coffee and soft drinks.	Alcoholic beverages.
Desserts	All as tolerated.		
Miscellaneous	Salt in moderation. Coconut, catsup, mustard, vinegar.	Popcorn, nuts. Strong spices and seasoning. Chocolate.	Black pepper. Red Pepper Chili powder. Pickles.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Heart-Healthy Fiber Tips.
https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=101. Accessed July 29, 2018

~~GASTROINTESTINAL DIETS~~

~~The Bland diet series consists of four separate but similar diets.~~

~~Each diet is designed to address a specific gastrointestinal problem. The dietitian from the regular diet order can modify the first three diets. It is recognized that there are many older people who have a combination of complex GI problems and often benefit from a diet that combines the therapeutic benefits of one or more of the following diets. The physician may choose to order the Modified Bland - Low Fiber Diet that combines the restrictions of the former diets for individual acute or transitional needs.~~

~~Chronic Peptic Ulcer Disease~~

~~The Chronic Peptic Ulcer Disease diet (PUD) is designed to restrict foods or beverages that may cause gastric irritation and excessive gastric acid secretion. Dietary restrictions are based on an individual's tolerance and should be considered supplemental to effective drug therapy.~~

~~Research indicates that the traditional bland diet as a mode of nutrition therapy for chronic ulcer disease does not decrease gastric acid secretion or increase the rate of healing. For this reason, the recommended diet is a well-balanced regular diet, in the form of three meals per day. Some individuals may require smaller, more frequent feedings. There is little rationale for completely eliminating any foods from the diet unless a particular food causes an individual repeated discomfort. Current recommendations are:~~

1. ~~Provide three well-balanced meals per day. Avoid overeating.~~
2. ~~Avoid bedtime snacks that stimulate acid production at night.~~
3. ~~Eliminate alcohol, caffeine-containing and decaffeinated beverages.~~
4. ~~Eliminate red and black pepper, chili powder and chocolate.~~

~~Hiatal Hernia and/or Reflux Esophagitis~~

~~Individuals with Hiatal Hernia and/or Reflux Esophagitis should avoid the following foods since they have been documented to cause decreased lower esophageal sphincter pressure and/or have an irritating effect on the esophageal mucosa:~~

1. ~~Tomatoes, tomato juice, and citrus juices.~~
2. ~~Chocolate, peppermint, red and black pepper and chili powder.~~
3. ~~Excessively fatty foods.~~
4. ~~Caffeinated and Decaffeinated coffee and cola beverages. Alcohol.~~

~~Inflammatory Bowel Disease~~

~~Individuals with Inflammatory Bowel Disease (ulcerative colitis and Crohn's disease, or diverticulitis) may benefit from a diet low in fiber and residue during and after acute phases to limit the frequency and pain of stools. Every effort should be made to tailor the diet to the resident's preferences and tolerances, avoiding undue restrictions when possible.~~

~~Long-term use of a fiber and residue restricted diet is generally not recommended.~~

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GASTROINTESTINAL DIETS

Inflammatory Bowel Disease

During the acute phase, the following guidelines are suggested:

1. Limit milk and milk products to 2 cups daily.

2. Limit fruits to the following: juices without pulp, (excluding prune), canned fruit and ripe bananas. Most raw fruits and dried fruits should be avoided, such as: dates, figs, prunes, apples, berries, peaches, grapes, pears, pineapple, grapefruit and orange sections.

3. Limit vegetables to the following: vegetable juices without pulp, lettuce and cooked vegetables such as: asparagus, beets, green beans, spinach, eggplant and acorn squash without seeds. Avoid peanuts, coconut, nuts, seeds, popcorn, dried beans and peas.

4. Use white or refined bread and cereal products.

5. Avoid tough fibrous meats with gristle; use ground or well-cooked tender beef, lamb, ham, veal, pork, poultry, fish, organ meats, eggs, and cheese.

*NOTE: The diet for inflammatory bowel disease may be low in vitamin A,, vitamin C and Folate.

Lactose Intolerance Diet

The Lactose restricted diet is designed to prevent or reduce symptoms associated with ingesting lactose-containing products. Lactose, the primary carbohydrate in milk, is a disaccharide compound of glucose and galactose. Lactose intolerance results when the enzyme lactase is not secreted in quantities sufficient to hydrolyze and digest the lactose consumed. Possible symptoms include bloating, flatulence, cramping and diarrhea.

This diet follows the regular diet pattern with restrictions or elimination of lactose containing foods and beverages. Since tolerance of lactose is variable, the levels are determined by the individual's tolerance. The elderly may be less tolerant of milk and milk products. Many people find they can tolerate milk in smaller amounts or milk products that have been fermented (e.g. buttermilk, yogurt, and cheese), or cooked (i.e. pudding, custard, cream soups, and sauces).

If a severe restriction is necessary, labels need to be read, avoiding foods containing milk, lactose, milk solids, whey, curd, nonfat milk powder, and nonfat milk solids. Lactose is sometimes used as a filler in medication. (Lactate, lactalbumin, lactyate, and calcium compounds are salts of lactic acid and do not contain lactose).

Based on the individual's food choices the diet can provide adequate amounts of all essential nutrients. Calcium, Vitamin D, and riboflavin may be deficient if all dairy products are avoided. Use of non-milk substitutes, soy milk products or calcium enriched foods could satisfy the nutrient needs; otherwise, supplementation may be necessary.

LOW RESIDUE DIET

I. ~~1. BASIC PRINCIPLES~~ PURPOSE

This diet limits dietary fiber and laxative foods that produce bulky intestinal residue. It eliminates spices that are known gastric irritants. Stool residue is reduced by limiting intake of fruits,

vegetables, ~~milk~~ dairy products and by eliminating whole grain products. ~~Low residue liquid nutritional supplements may be added to the diet to improve nutritional adequacy.~~

II. INDICATIONS

This diet may be used after surgery of the large bowel, after hemorrhoidectomy, or for rectal bleeding, cancer of the large bowel or acute stages of diverticulitis.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

~~The Low Residue Diet is nutritionally adequate when planned to include the recommended servings from the Food Guide Pyramid. This diet is low in cellulose.~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1700-1900	85-109 ~~grams~~	190-238 ~~grams~~	57-75 ~~grams~~
~~% of Calories~~		~~20-23 %~~	~~45-50 %~~	~~30-35 %~~

V. SUGGESTED MEAL PATTERN

BREAKFAST

4 oz. Clear Juice
1 Serving ~~6 oz.~~ Refined Cereal
1 Egg or Alternate
1 Slice White Toast
1 Pat Butter / Margarine
8 oz. Lowfat Milk
Coffee, Tea, Decaf
Sugar, Salt

LUNCH ~~and~~ & DINNER

6 oz. Clear Broth (Lunch or Dinner)
4 oz. Clear Juice (Lunch or Dinner)
3 oz. Meat or Alternate
3 oz. Rice, Noodle or Plain Potato
3 oz. Vegetable
3 oz. Dessert
1 Slice White Bread
1 Pat Butter / Margarine
8 oz. Lowfat Milk (Lunch **or** Dinner)
Coffee, Tea, Decaf
Sugar, Salt

~~*May Be Supplied As A Ward Nourishment~~

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LOW RESIDUE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk (Limit to 2 cups/day)	Milk of all kinds. Yogurt, smooth or made with unseeded fruits.	Yogurt containing seeded fruits or coconut. More than 2 cups milk per day.
Meat, Fish, Poultry,	Tender, lean beef, chicken, fish, lamb, liver, pork, turkey, shellfish, veal, and other lean meats.	Highly seasoned or tough meats with gristle. Fried, pickled, smoked or meats. Foods containing
Eggs, Cheese	Cottage cheese, cream cheese, and mild American cheese. Eggs	nuts, seeds, whole grains. Sharp or strongly flavored cheese. Fried eggs.
Vegetables (Limit to 2 servings)	Any vegetable juice, pureed vegetables. All of the following if cooked tender: asparagus tips, beets, French cut green beans, carrots, mushrooms, pimiento, Whipped yam, pumpkin, squash.	All other vegetables. Vegetable juices with pulp.
Fruits (Limit to 2 servings)	Any fruit juice except prune juice. Pureed fruit and the following cooked soft: escalloped apple (cored & peeled), applesauce, peeled apricots, pitted cherries, fruit cocktail, peeled peaches, peeled pears, peeled plums.	All other fruits including: fresh fruits, seeded fruits, all dried fruits, fruits with skins still on the fruit. Juices with pulp.
Breads, Cereals, and Starches	Breads: white, refined wheat, seedless rye, rolls or quick breads made from refined flour, biscuits, cornbread, dumplings. Cooked refined cereals. Cold, flaked or puffed cereal. Pancake, waffle, French toast.	Any containing whole grains, bran, dried fruits, nuts or seeds. Doughnuts, pastries.
	Plain sweetrolls. Graham crackers. Saltines, matzo, rusk.	Dried beans and peas. Snack Crackers.
	Macaroni, noodles, spaghetti, refined rice, white or sweet potatoes (without peel).	Wild rice, unpolished rice. Potato with peel. Corn.
Fats and Oils	Avocado, butter, margarine, oils and shortenings, cream.	Salad dressings containing strong spices.
Soups	Broths, consommé, soups made mild flavored vegetables.	All other soups.

LOW RESIDUE DIET

VI. FOODS ALLOWED AND AVOIDED ON LOW RESIDUE DIET

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Beverages	Carbonated beverages, coffee, coffee substitutes, tea.	None.
Desserts	Cakes, cookies, ice cream, sherbet, plain gelatin, plain puddings, made from food allowance. (All desserts made with milk are to be included in daily allowance)	All pastries, pies and desserts containing coconut, nuts, seeds, or dried fruits.
Miscellaneous	Clear jelly, honey, sugar, plain sugar candy, molasses, syrups, marshmallows.	Jam, marmalade, candy with coconut, nuts, seeds or fruits in this column.
	Salt, spices and herbs except those on the "to avoid" list. Cocoa powder. Gravies and sauces made from foods in the "allowed" list. Vinegar.	Chili powder, whole garlic black pepper, pickles, relishes, seed spices, and any foods containing these. Popcorn. Pretzels.

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ENTERAL NUTRITION

I. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

Enteral products provide total or supplemental nutrition orally or by tube. These formulas help residents achieve improved caloric and nutritional intake by providing calories, protein, carbohydrates, fats and essential vitamins and minerals. Most residents are able to consume these formulas with minimal gastrointestinal intolerance. Appendix 2. provides Laguna Honda's ~~oral~~ nutrition support formulary.

II. INDICATIONS~~:~~

These formulas are designed for residents who are nutritionally at risk, resulting from:

a) inadequate oral intake due to poor appetite, difficulties in chewing and swallowing, stroke, depression, decreased mentation, or other conditions which reduce nutritional intake.

b) hypermetabolic states such as: fever, trauma, cancer, pressure ulcer, sepsis, and wound healing.

Formulas should be used with caution for residents with malabsorption, maldigestion, advanced renal, cardiac or hepatic insufficiency. Specially designed formulas may be needed for these conditions.

Physicians must order a tube feeding according to the product desired, volume required to meet caloric and nutritional needs, the amount of water to assure adequate hydration and the frequency and mode of feeding. The dietitian will provide specific information and calculations for the formula order. However the MD may order less than the dietitians' estimated nutrition support needs due to medical indications or for quality of life. ~~.~~

III. ADEQ~~O~~UACY~~:~~

Volume of enteral formulas needed to meet caloric and protein requirements must be individualized by the dietitian according to nutritional assessment guidelines. The volumes to meet 100% ~~RDA/~~RDIs are listed below.

Glucerna 1Cal	1420cc	Nepro	944cc	TwoCal HN	948cc
Glucerna 1.2 Cal	1250cc	Osmolite1 Cal	1321cc		
Glucerna 1.5 Cal	1000cc	Osmolite 1.2 Cal	1000cc		
Jevity 1.0 Cal	1321cc	Osmolite 1.5 Cal	1000cc	~~Osmolite1 Cal~~	~~1321cc~~ ~~Jevity 1.5 Cal 1000cc~~
Jevity 1.2 Cal	1000cc	Perative	1155cc		
Jevity 1.5 Cal	1000cc	Promote	1000cc	~~Glucerna 1Cal~~	~~1420cc~~
~~Jevity 1 Cal~~	~~1321cc~~	~~Perative~~	~~1155cc~~	~~Nepro*~~	~~944cc~~
~~Jevity 1.2 Cal~~	~~1000cc~~	~~Promote~~	~~1000cc~~	~~Suplena*~~	~~944cc~~

~~The goal for nutrition therapy is to meet 100% of the recommended USRDA/USRDI for vitamins and minerals. If lower volumes are required due to disease management, vitamin and mineral supplements may be required. *Specialized formulas may have altered nutrient profiles to remove or reduce protein or minerals.~~

~~ENTERAL NUTRITION~~

~~V. SPECIAL INSTRUCTIONS FOR TUBE FEEDINGS~~

~~A. Elevate the head of the bed to a 450 angle during feeding and for at least one hour following the feeding to decrease risk of aspiration.~~

~~B. The rate of administration of each 250-300cc feeding should be adjusted according to resident tolerance. It is recommended that the feeding be administered in not less than 30 minutes. Flush the tube with 30-100 cc water after each feeding to maintain adequate hydration and urinary output.~~

~~C. Adjustments of water may be needed depending on the product used and the resident's condition.~~

~~D. Prepared tube feeding should be administered at room temperature. Once cans are opened, they must be covered and refrigerated immediately. Discard after 48 hours.~~

~~E. If nausea, abdominal cramps, and GI distention develop, consider measuring gastric residual before the next feeding. If more than 120cc, feeding is to be delayed 30 minutes or until emptying occurs.~~

~~F. Medications should be dissolved and diluted before administering through tube. Rinse with 30-50 cc water.~~

~~G. Tube-fed residents should be monitored for: formula tolerance, dehydration, fluid overload, electrolyte imbalance, hyperglycemia, and azotemia.~~

~~VI. POSSIBLE GI COMPLICATIONS AND THEIR CAUSES:~~

~~A. Diarrhea~~

~~1. Using contaminated formula or feeding containers.~~

~~2. Not establishing tolerance to feeding rate concentration and/or volume.~~
~~3. Formula administered at too cold a temperature.~~
~~4. Medication and medication/formula interaction.~~

~~B. Aspiration . . not elevating resident's head.~~

~~C. Constipation~~

~~1. Not providing enough bulk~~
~~2. Insufficient fluid intake~~

3. Side Effects of medication

D. Bloating
1. Increased gut motility (peristalsis)
2. Excessive air

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DIABETIC DIETS

I. BASIC PRINCIPLESPURPOSE:

The goals of nutritional therapy and diabetes management for all people are:

- to improve blood glucose and lipid levels
- to promote consistent day-to-day intake for people with insulin-dependent diabetes
- weight management for people with non-insulin-dependent diabetes
- to encourage healthy eating habits for residents during their stay at LHH, for residents with diabetes and for those with coexisting medical conditions.

This diet controls total caloric intake to enable residents to attain and maintain a reasonable body weight. For overweight residents, return to ideal body weight is often accompanied by improvement in hyperglycemia and glycosuria.

Diabetic diets are based on the American Diabetic Association (ADA) and the Academy of /Dietetic Nutrition and Dietetics' Association Exchange Lists for Meal Planning where foods are classified by similar nutrient composition. 1 Exchange of Carbohydrates equals to 15 grams carbohydrates.

Consistency in meal schedules and portion sizes assist in normalizing blood sugar. Protein, fat and carbohydrate are divided throughout the day; concentrated sugars are avoided.

Institutional menus are carefully planned and served to accommodate a resident's preferences. The dietitian makes adjustments in dietary patterns, using the diabetic exchange system, for individual preferences and tolerances, to maximize compliance with dietary restrictions. Therefore, daily meal intake will provide approximately the ADA guidelines for distribution of calories.

Morning, afternoon or evening nourishments, composed of both protein and carbohydrate, may be planned when necessary or by request. An evening nourishment is routinely provided for residents receiving more than 1800 calories. These feedings may consist of 140-400 calories that are deducted from the total caloric allotment for the day.

II. –INDICATIONS:

Diabetes mellitus or altered glucose tolerance. The diabetic diet is ordered according to the caloric level desired and individualized for the resident based on height, weight, age and medical condition. The clinical dietitian can assist in the determination of nutrition therapy for the resident and for caloric and nutrient needs.

The diet should be as flexible as possible to encourage compliance. For some well controlled or NIDDM diabetics, a specific calorie level may not be required and a No Concentrated Sweets Diet may be more acceptable to the resident. For such residents, the goal of nutrition therapy is to prevent hyperglycemic peaks by avoiding large amounts of easily digested and absorbed sugars. Because of the complexity of obesity and generally poor prognosis for weight loss, the No Concentrated Sweets Diet is preferred for maximal compliance.

III. ADEQUACY

Diets of at least 1500 calories are nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

IV. APPROXIMATE COMPOSITION

See individual dietary patterns by caloric value in section VII.~~as they are planned to include the recommended servings from the Basic Food Groups on the Food Guide Pyramid. Diets of 1200 calories or less are marginal in several nutrients, are less palatable and resident compliance is difficult to ensure. The lower calorie diets are not recommended for the long term care of the institutionalized elderly. If they must be prescribed, a multivitamin with minerals is recommended.~~

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DIABETIC DIETS

IV. APPROXIMATE COMPOSITION

Current standard distribution for Laguna Honda Hospital diabetic diets is 20-30% protein, 40-45% carbohydrates, and 30-35% fat. See individual dietary patterns by caloric value on the next page.

V. FOODS TO AVOID:

Condiments: Sugar, honey, jam, jelly, molasses, maple syrup, corn syrup

Breakfast Foods: Sweetened or sugar coated cereals, doughnuts, sweet rolls.

Fruits: Dried fruit, frozen or canned fruit with added sugar or syrup.

Beverages: **S**weetened sodas or other beverages containing sugar.

Desserts: Cakes, pies, cookies, ice cream, jello, pudding.

Snacks: Candy, milkshakes, snack chips and snack crackers.

VI. Generally, alcoholic beverages are eliminated from the diabetic diet. With a physician's order, the dietitian can calculate these calories into the diabetic diet on a very limited basis.

FOODS CONSIDERED ACCEPTABLE IN UNLIMITED AMOUNTS

Sugar substitutes	Fat Free broth
Coffee, tea, Decaf	Bouillon
Unsweetened Gelatin	Consommé
Vinegar	Unsweetened Cranberries
Spices and Herbs	Unsweetened Lemons and Limes
Mustard	Unsweetened Pickles
Dietetic Catsup	Raw Vegetables
Horseradish	Lettuce
Sugar Free Beverages	Cucumber
Radish	Parsley

Information obtained from the ADA Manual of Clinical Dietetics

VII. MEAL PATTERN BY EXCHANGES

Calories:	~~1000~~	~~1200~~	~~1400~~	1500	1600	1800	~~2000~~	~~2200~~	~~2400~~
% Protein	~~29~~	~~28~~	~~24~~	24	22	22	~~22~~	~~23~~	~~23~~
% Carbohydrate	~~39~~	~~41~~	~~38~~	40	41	45	~~46~~	~~45~~	~~44~~
% Fat	~~32~~	~~31~~	~~38~~	36	37	33	~~32~~	~~32~~	~~33~~

Diabetic Exchange Groups* Served at Meals for Each Calorie Level

Breakfast:	~~**1000**~~	~~**1200**~~	~~**1400**~~	**1500**	**1600**	**1800**	~~**2000**~~	~~**2200**~~	~~**2400**~~
Fruit	~~1~~	~~1~~	~~1~~	1	2	1	~~1~~	~~1~~	~~1~~
Bread	~~1~~	~~1~~	~~1~~	2	2	3	~~3~~	~~3~~	~~3~~
Egg	~~1~~	~~1~~	~~1~~	1	1	1	~~1~~	~~2~~	~~2~~
Fat	~~0~~	~~1~~	~~1~~	1	1	3	~~1~~	~~1~~	~~1~~
Lowfat Milk	~~skim~~	~~skim~~	~~1~~	~~1~~	1	~~1~~	1	1	~~1~~
Lunch:									
Meat	~~3~~	~~3~~	~~3~~	3	3	3	~~3~~	~~3~~	~~3~~
Bread	~~0~~	~~0~~	~~1~~	1	1	2	~~2~~	~~2~~	~~2~~
Vegetable	~~1~~	~~1~~	~~1~~	1	1	1	~~1~~	~~2~~	~~2~~
Fruit	~~1~~	~~1~~	~~1~~	1	1	1	~~1~~	~~1~~	~~1~~
Fat	~~0~~	~~0~~	~~0~~	0	1	1	~~1~~	~~1~~	~~1~~
Lowfat Milk	~~0~~	~~skim~~	~~1~~	1	1	1	~~1~~	~~1~~	~~1~~
					~~2400 Cal: **2 P.M.** 1 meat, 1 bread, 1 fat~~				
Dinner:									
Meat	~~3~~	~~3~~	~~3~~	3	3	3	~~3~~	~~3~~	~~3~~
Bread	~~0~~	~~1~~	~~1~~	1	1	2	~~2~~	~~2~~	~~2~~
Vegetable	~~1~~	~~1~~	~~1~~	1	1	1	~~1~~	~~1~~	~~1~~
Fruit	~~1~~	~~1~~	~~1~~	1	1	1	~~1~~	~~1~~	~~1~~
Fat	~~0~~	~~0~~	~~1~~	1	1	1	~~1~~	~~1~~	~~1~~
Lowfat Milk	~~skim~~	~~skim~~	~~1~~	1	1	1	~~1~~	~~1~~	~~1~~
H.S. SNACK	~~0~~	~~0~~	~~0~~	0	0	0	~~1 bread~~	~~2 bread~~	~~2 bread~~
~~Allowance~~							~~1 lowfat milk~~	~~1 lowfat milk~~	~~1 lowfat milk~~
Approximate Total Calories:	~~1015~~	~~1230~~	~~1440~~	1532~~20~~	1630	1810	~~2010~~	~~2190~~	~~2390~~

*1 Exchange Group = 15 grams Carbohydrate

Reference
Academy of Nutrition and Dietetics. Nutrition Care Manual. Type 2 Diabetes Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=48. Accessed July 29, 2018
http://www.diabetes.org/food-and-fitness/food/what-can-i-eat/understanding-carbohydrates/carbohydrate-counting/carbohydrate-counting.html?loc=ff-slabnav. Accessed July 29, 2018

Notes: ~~The standard diabetic ADA menu follows the 1500 calorie level. Clear soup and / or salad are served daily. These are considered negligible in caloric content. Meal patterns are calculated using medium-fat meats. Breakfast fruit is served as 4 oz juice by ward nursing staff.~~

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NO CONCENTRATED SWEETS DIET

I. PURPOSE~~BASIC PRINCIPLES:~~

This diet limits foods containing concentrated forms of sucrose or glucose that may be absorbed quickly and cause rapid increases in blood sugar. This diet is appropriate for overweight individuals who require fewer calories than provided in a Regular Diet. Because of the complexity of obesity and the generally poor prognosis for weight loss, a No Concentrated Sweets Diet is preferred for maximal compliance. If this diet does not facilitate desired weight loss, a specific, individualized caloric restriction may be required.

~~Concentrated sweets can also be a source of unwanted calories.~~

II. INDICATIONS~~:~~

This diet is designed for residents with maturity-onset diabetes mellitus who do not require or are unable to follow a more structured diabetic diet using the Exchange List System. This diet can also be used for desirable weight management.

~~This diet is appropriate for overweight individuals who require fewer calories than provided in a Regular Diet. Because of the complexity of obesity and the generally poor prognosis for weight loss, a No Concentrated Sweets Diet is preferred for maximal compliance. If this diet does not facilitate desired weight loss, a specific, individualized caloric restriction may be required.~~

- See Diabetic Diet

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

~~This diet is nutritionally adequate when planned to include the recommended servings from the Food Guide Pyramid.~~

IV. APPROXIMATE COMPOSITION:

Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)	
Range	2000-2250	95-110	200-250	90-100
		~~Grams~~	~~Grams~~	~~Grams~~
~~% Of Calories~~		~~19-20 %~~	~~40-44 %~~	~~40-41 %~~

V. SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH ~~AND~~ & DINNER~~:~~
*4 oz. Fruit Juice	6 oz. Soup or Salad with Dressing
~~6 oz. Unsweetened~~1 Serving -Cereal	3 oz. Meat or Alternate
1 Egg or Alternate	2 oz. Gravy

1 Slice Toast
1 Pat Butter / Margarine
8 oz. Lowfat Milk
Coffee, Tea, Decaf
Sugar Sub., Salt, Pepper

3 oz. Starch
3 oz. Vegetable
1 Serving Calculated Dessert
1 Slice Bread, 1 Pat Butter / Margarine
8 oz. Lowfat Milk
Coffee, Tea, Decaf
Sugar Sub., Salt, Pepper

~~*May Be Supplied As A Neighborhood Nourishment~~

~~Laguna Honda Hospital and Rehabilitation Center
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NO CONCENTRATED SWEETS DIET

VI. FOODS TO BE AVOIDED:

Condiments: Sugar, honey, jam, jelly, marmalade, molasses, maple syrup, corn syrup.

Breakfast Foods: Sweetened or sugar coated cereals, doughnuts, sweet rolls, coffeecake.

Fruits: Frozen and canned fruit or juices with added sugar and syrups (High Fructose).

Desserts: Cakes, pies, cookies, ice cream, sherbet, pudding, jello, banana bread, pastries.

Beverages: Chocolate milk, carbonated or other beverages containing sugar.

Snacks: Candy, popsicles, milkshakes, chewing gum, potato chips, snack crackers. Snacks and desserts that are high in fat.

VII. ~~Alcohol: Generally, alcoholic beverages should be avoided, however, even these calories can be calculated into the diet on a very limited basis. Contact your physician before consuming wine, beer and alcoholic beverages.~~

~~Learn to read food labels. Foods containing large amounts of dextrose, sucrose, sorbitol, and mannitol or other additives, which are utilized as sugar in the body, should be limited.~~

FOODS TO BE USED AS DESIRED:

Beverages: Artificially sweetened lemonade, powdered fruit drinks or ‘0’ calorie carbonated drinks, coffee, tea, coffee substitutes.

Foods: Unsweetened gelatin, dill or sour pickles, broth, consommé, bouillon, fresh unsweetened cranberries or rhubarb, low calorie salad dressings, unsweetened jelly, jam or syrup, sugarless gum.

Seasonings: Artificial sweetener, salt, pepper and other spices, herbs, mustard, vinegar; meat sauces; Extracts such as vanilla, butter, maple.

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~~REDUCED~~ LOW FAT DIET

I. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

To restrict the total fat in the diet to less than 50 grams per day. ~~This diet limits foods containing fat to a level of 50 grams of fat per day. Foods with high fat content, such as gravy, cream, fatty meats, fried foods, and whole milk products are excluded to relieve symptoms of pancreatic or intestinal discomfort.~~ Reduced fat diet is intended for individuals who are unable to properly digest, absorb, and/or metabolize fat.

II. INDICATIONS~~:~~

This diet may be used in conditions where fat is not tolerated, such as diarrhea, steatorrhea, malabsorption syndromes, diseases of the pancreas and the biliary tract. Intestinal alterations and deficiencies of bile acid or pancreatic enzyme or obstruction of pancreatic ducts can cause maldigestion of fat. This diet may be useful in weight loss programs, in conjunction with the No Concentrated Sweets Diet.

III. ADEQUACY~~:~~

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

~~This diet is adequate in kilocalories, and macro and micronutrients. Fat content of the diet is approximately 50-55 grams per day or 25% of the caloric intake.~~

~~To increase satiety and dietary compliance, a more liberal diet is achieved by increasing the percentage of fat to 30% -35% of the daily diet.~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1800-2000	95-98	237-287	50
	~~grams~~	~~grams~~	~~grams~~	
~~% of Calories~~		~~20-21 %~~	~~50-61 %~~	~~24 %~~

V. SUGGESTED MEAL PATTERN:

BREAKFAST

*4 oz. Fruit Juice
1 Serving~~6 oz.~~ Cereal
1 Egg or Alternate
1 Slice Toast
1 Pat -Butter / Margarine
1 pkt Jelly
8 oz. Nonfat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH ~~and~~ & DINNER

Salad w/Diet Dressing **or**
6 oz. Calculated Soup
3 oz. Calculated~~d~~ Meat or Alternate
3 oz. Calculated- Starch
3 oz -Calculated Cooked Vegetable
1 Serving Fruit
1 Slice Bread, 1 Pat Butter / Margarine
8 oz. Nonfat Milk
Coffee, Tea, Decaf

Sugar, Salt, Pepper

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Heart-Healthy Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=107. Accessed July 29, 2018

~~*May Be Supplied As A Neighborhood Nourishment.~~

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REDUCED LOW FAT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	Nonfat milk, buttermilk and drinks made with nonfat (0% fat) milk, fruit drinks, except those listed to avoid. Fat Free yogurt.	All beverages made with cream whole milk, lowfat milk, ice cream. Non-dairy creamers containing fat. Half & Half. Regular yogurt.
Meat, Fish, Poultry	Lean meat. Fish. Poultry (no skin) Use alternates to red meat at least 4 meals each week.	Fatty or heavily marbled meats and luncheon meats, frankfurters, bacon, sausages, hot links. Frozen dinners.
Cheese	Cheese made with nonfat milk. Lowfat cottage cheese.	Cheese made with whole milk or cream.
Eggs	Any prepared without added fat.	Fried eggs. Use sparingly in daily diet.
Vegetables	All prepared without added fat.	Any prepared with added fat.
Breads	Enriched breads, low fat cereals, graham crackers, low fat crackers.	Any made with butter, cream, whole milk. Commercial bakery muffins, coffee cakes.
Fruits	All fruit: fresh, canned and juices.	Fruit smoothies made with milk.
Potatoes or Starches	Plain rice, low fat noodles and pasta, white and sweet potatoes and yams.	Fried potatoes, snack chips, potato chips. Any prepared with cream, half & half, milk, butter, or other fats.
Desserts	All fruits, gelatin desserts. Fruit ice, angel food cake.	Any made with butter, chocolate, cream, whole milk, eggs, commercial desserts.
Fats (limit to no more than 5 tsp./day)	Margarine, vegetable oil. Minimize use of any fat.	Shortening, lard, any deep-fried foods. Gravy, fatty sauces. Salad dressings.
Soups	Fat free, broth-base soups; soups made with nonfat milk.	Commercial soups; soups prepared with fat, whole milk or cream.
Beverages	Coffee, tea, decaf. Sodas. Tomato juice.	See Milk and Fruits sections.
Sugar, Sweets	Sugar, honey, jam, jelly, syrup, molasses, candies.	Candy containing nuts, chocolate or any containing large amounts of fat or oil.
Miscellaneous	Salt, flavorings, mild spices in moderation, cocoa powder.	Nuts, olives, cream sauces, peanut butter, Buttered popcorn, pretzels. Snack foods.

Saltine crackers.	Commercial doughnuts, pancakes, waffles.

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LOW CHOLESTEROL DIET

I. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

This diet restricts intake of cholesterol to a level of approximately 300 milligrams per day. ~~Cholesterol is found in foods of animal origin only.~~ The percentage of fat in the diet is below 30% of the total calories, with the intake of saturated fat about 10%. ~~Saturated fat, like cholesterol, mainly comes from animal origin; and coconut, palm and hydrogenated vegetable oils. Therefore, fried foods, gravy, cream, fatty meats, whole milk products and tropical oils are excluded. Eating excess fats especially those high in saturated fats and cholesterol may cause high blood cholesterol levels and increase risk of cardiovascular disease.~~

II. INDICATIONS~~:~~

~~Available epidemiological evidence indicates that as age increases above 44 years, the importance of elevated serum cholesterol levels, as a risk factor for coronary heart disease, decreases and virtually disappears after the age of 65. The appropriateness of low-cholesterol diets for older adults in long-term care is questionable.[1]~~ This diet is indicated for the residents who have high blood cholesterol levels and are at risk for heart disease. ~~Control of weight usually is recommended for most residents. The dietitian will adjust the calorie level according to the resident's weight, height, age and sex.~~

III. ADEQUACY:

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A).

~~This diet is nutritionally adequate when planned to include the recommended servings from the Food Guide Pyramid.~~

IV. APPROXIMATE COMPOSITION~~:~~

	Calories	Protein (gm.)	Carbohydrates (gm.)-	Fat (gm.)
Range	1800-2000	95-98 ~~grams~~	237-287 ~~grams~~	50 ~~grams~~
~~% of Calories~~		~~20-21 %~~	~~50-61 %~~	~~24 %~~

V. SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH ~~and~~ & DINNER
*4 oz. Fruit or Juice	Green Salad/Diet Dressing or
~~6 oz.~~ 1 Serving Cereal	6 oz. Calculated Soup/Crackers
1 Egg or Alternate (* 3/week)	3 oz. Calculated Meat or Alternate
1 Slice Toast	3 oz. Calculated Starch
1 Pat Margarine	3 oz. Calculated Vegetable
1 Pkt Jelly	1 Serving Fruit
8 oz. Nonfat Milk	1 Slice Bread/1 Pat Margarine
Coffee, Tea, Decaf	8 oz. Nonfat Milk

Sugar, Salt, Pepper	Coffee, Tea, Decaf
	Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

Reference

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. Cholesterol-Lowering Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=410. Accessed July 29, 2018

~~*May Be Supplied As A Neighborhood Nourishment~~

LOW CHOLESTEROL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	Nonfat milk, 0% fat milk, drinks made with nonfat milk, fruit drinks except those listed to avoid.	All beverages made with cream, whole milk, 2% lowfat milk ice cream or egg yolk.
Meat, Fish, Poultry, Cheese (Use alternates to red meat at least 5 times a week)	Lean meat, fish, poultry, without skin. Lowfat cottage cheese, lowfat yogurt. cheese made with nonfat milk. Dry beans and peas.	Fatty or heavily marbled meats and luncheon meats, frankfurters, bacon, sausages. Cheese made with milk or cream.
Eggs (limit 3 per week)	Any prepared without added fat. Egg substitutes. Egg whites.	Fried eggs.
Vegetables	All prepared without added fat, 3-5 servings each day.	Any prepared with added fat, sauces or cheese.
Breads, Grains, Cereals	Enriched breads, whole grain cereals graham crackers, low fat crackers.	Any made with butter, cream, egg yolk, whole milk.
Fruits	All fruits and juices, 2-4 servings/day.	Smoothies made with milk.
Potatoes or Starches	Plain rice, low fat noodles and pasta, white and sweet potatoes and yams. Grits.	Fried potatoes, potato chips, snack chips. Any prepared with fat, milk, butter or cream.
Desserts	Fruits, gelatin desserts, Fruit ices, angelfood cake.	Any made with butter, chocolate, egg yolks, milk.
Sugar, Sweets	Sugar, honey, jam, jelly, syrup, molasses, plain sugar	Candy containing nuts, chocolate, milk or cream. Most commercial desserts.
Fats, Vegetable Oils (Limit to no more than 5 teaspoons per day)	Margarine, vegetable oil and soft tub lowfat spreads.	Gravy, fatty sauces, butter, lard, any deep-fried foods. No palm & coconut oils.
Soups	Fat-free, broth-base soups; soups made with nonfat milk.	Commercial soups; soups prepared with cream, fat or milk.
Beverages	Coffee, tea, decaf. Sodas.	See Milk and Fruits sections.
Miscellaneous	Salt, flavorings, spices. Cocoa powder.	Butter, nuts, olives, cream. Sauces, peanut butter, popcorn.

SODIUM CONTROLLED DIETS

I. ~~BASIC PRINCIPLES:~~PURPOSE

~~Sodium-Controlled diets limit the daily intake of foods that contain liberal amounts of sodium, in addition to table salt. As sodium is further restricted in the diet order, more foods must be limited or eliminated since sodium is found in almost all foods. Sodium restriction is used in the management of hypertension, cardiovascular disease, severe cardiac failure, liver disease and chronic renal failure. The goal of sodium restriction is to relieve hypertension and to promote the loss of excess fluids in edema and ascites.~~The goal of sodium restriction is to help prevent fluid retention, promote the loss of excess fluids, and aid in blood pressure control.

II. INDICATIONS:

~~Sodium is the principle cation of the extracellular body fluid; one of its primary functions is to regulate blood pressure and body fluid volume.~~ Restriction of dietary sodium may decrease body fluid volume and relieve symptoms of diseases, e.g., congestive heart failure or other cardiovascular di~~e~~seases, cirrhosis, hypertension, ascites, SIADH, other conditions that may cause fluid retention, hypernatremia or renal diseases where the kidneys cannot get rid of excess sodium and water. The physician should specify the level of sodium restriction desired using the following guide:

No Added Salt (3-5 gram sodium - 130-217 mEq)--mild sodium restriction
2 Gram Sodium (87 mEq)--moderate sodium restriction
~~1 Gram Sodium (43 mEq)--strict sodium restriction~~

For greater flexibility and resident compliance, it is preferred that the No Added Salt diet be ordered for residents not exhibiting acute disease symptoms. A salt-free herb and spice seasoning is served with meals.

III. ADEQUACY;

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A). ~~Sodium-restricted diets are nutritionally adequate when planned to include the recommended servings from the Food Guide Pyramid. Use fresh foods to replace commercially packaged goods that are often high in salt and sodium.~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
~~1 and~~ 2 Gram Sodium (87 mEq)--moderate sodium restriction				
Range	1700-25400	7~~8~~5-11~~0~~5 ~~grams~~	18~~6~~0-270 ~~grams~~	5~~7~~0-1~~00~~15 ~~grams~~
~~% of Calories~~		~~18-23 %~~	~~38-45 %~~	~~37-39 %~~
No Added Salt Diet (3-5 gram sodium - 130-217 mEq)--mild sodium restriction				
Range	1900-2400	90-100 ~~grams~~	200-240 ~~grams~~	75-90 ~~grams~~

~~% of Calories 19-21 % 44 % 39 %~~

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SODIUM RESTRICTED DIETS

V. ~~SAMPLE~~ SUGGESTED MEAL PATTERN:

~~1 Gram Sodium~~

~~BREAKFAST~~	~~LUNCH and DINNER~~
~~*4 oz. Fruit or Juice~~	~~6 oz. Low Sodium Soup or Salad w/Diet Dressing~~
~~6 oz. Low Sodium Cereal~~	~~3 oz. Low Sodium Meat or Alternate~~
~~1 Low Sodium Egg~~	~~2 oz. Low Sodium Gravy~~
~~1 Slice Low Sodium Toast~~	~~3 oz. Low Sodium Starch~~
~~1 Pat LS Butter / Margarine~~	~~3 oz. Low SodiumVegetable~~
~~8 oz. Lowfat Milk~~	~~1 Serving Fruit Dessert~~
~~Coffee, Tea, Decaf~~	~~1 Sl. Low Sodium Bread - 1 Pat LS Butter / Margarine~~
~~Sugar, Pepper~~	~~8 oz. Lowfat Milk (Lunch **or** Dinner)~~
~~Low Sodium herbs and seasonings.~~	~~Coffee, Tea, Decaf~~
	~~Sugar, Pepper, LS herbs and spices~~

2 Gram Sodium

BREAKFAST	LUNCH ~~and~~ & DINNER
~~*~~4 oz. Fruit or Juice	6 oz. Low Sodium Soup or Salad w/Diet Dressing
1 Serving ~~6 oz.~~ Low Sodium Cereal	3 oz. Low Sodium Meat or Alternate
1 Serving Low Sodium Egg	2 oz. Low Sodium Gravy
1 Slice Toast	3 oz. Low Sodium Starch
1 Pat Butter / Margarine	3 oz. Low SodiumVegetable
8 oz. Lowfat Milk	1 Serving Dessert
Coffee, Tea, Decaf	1 Sl. Bread - 1 Pat- Butter / Margarine
Sugar, Pepper	8 oz. Lowfat Milk LS herbs and spices
Coffee, Tea, Decaf	
	Sugar, Pepper, LS herbs and spices

No Added Salt

BREAKFAST	LUNCH ~~and~~ & DINNER
~~*~~4 oz. Fruit or Juice	6 oz. Low Sodium Soup or Salad w/Diet Dressing
~~6 oz.~~ 1 Serving Cereal	3 oz. Meat or Alternate
1 Serving Egg or Alternate	2 oz. Gravy
1 Slice Toast	3 oz. Starch
1 Pat Butter / Margarine	3 oz. Cooked Vegetable
8 oz. Low fat Milk	1 Serving Dessert
Coffee, Tea, Decaf	1 Sl. Bread - 1 Pat Butter / Margarine
Sugar, Pepper	8 oz. Lowfat Milk
LS herbs and spices	Coffee, Tea, Decaf
	Sugar, Pepper, LS herbs and spices

Whole grain breads, cereals and starches are served daily.
~~*May Be Supplied As A Neighborhood Nourishment~~

~~Note: The 2 gm Sodium Diet Menu corresponds to the Printed Low Sodium Resident Menu.~~

SODIUM-CONTROLLED DIETS

VI. FOODS TO BE AVOIDED:

FOOD GROUP ~~1 Gram Sodium~~ 2 Gram Sodium No Added Salt

Milk ~~More than 2 cups per day~~ More than 3 cups/ day More than 3 cups per day, Buttermilk
~~Buttermilk, milkshake.~~ Buttermilk, milkshake. ~~Buttermilk.~~

Meat, Fish, ~~All prepared with added salt.~~ Same, including commercially Highly salted meats as listed.
Poultry/~~,~~ ~~All highly salted meats: ham,~~ packaged foods and instant mixes. ~~commercially as listed.~~ Processed foods (except low

Eggs/ ~~hot dog, sausages, corned beef,~~ ~~packaged foods~~ ~~foods (except low~~
sodium products). Limit cheese and
Cheese ~~Eggs~~ ~~luncheon meats. Peanut butter.~~ ~~and instant mixes.~~
salted peanut butter. ~~sodium products)~~
~~Smoked or dried meat or fish;~~ ~~Limit cheese and~~
~~Cheese~~ ~~Frozen or canned dinners, cheese.~~ ~~salted peanut butter.~~

Vegetables ~~Canned vegetables;~~ Canned vegetables. Limit use of drained canned vegetables.
(limit to 4 serv./ ~~Frozen peas, lima beans,~~ Sauerkraut.
Tomato juice with salt added. ~~canned vegetables.~~
day with no ~~Servings a~~ ~~corn, mixed vegetables.~~ Tomato juice
added salt) ~~day with no~~ ~~Pickled vegetables.~~ ~~Tomato juice~~ ~~Tomato juice~~
~~added salt)~~ ~~Tomato juice.~~ ~~with salt added.~~

Fruits (all ok) --- ---

Breads and ~~All prepared with salt~~ Same, except: Salted crackers, Potato chips.
Cereals ~~or sodium; any made with~~ 3 slices of regular Bread with salted tops. Snack foods. ~~Potato chips.~~
~~baking powder or baking soda.~~ bread allowed per day. ~~Bread with salted~~
Instant commercially prepared mixes.
~~Pancakes, waffles, French toast.~~ ~~per day.~~ ~~tops. Snack foods.~~
~~Muffins, quick breads, biscuits.~~ ~~Instant commercially~~
~~Salted crackers, potato chips,~~ ~~prepared mixes.~~
~~snack foods, canned beans.~~

Fat ~~Margarine, butter, gravies,~~ Same except: 3 pats of ~~S~~Salt pork, bacon or bacon bits, salted
and Oils ~~sauces, salad dressings:~~ ~~3 pats of~~ regular margarine per day ~~bacon bits, salted~~ nuts and seeds

any prepared with added margarine per day nuts and seeds
salt; salt pork, salted
nuts and seeds.

Soups (limit to 1 svg. per day)	Bouillon cubes and canned/dehydrated soup or broth; all soups prepared with added salt or highly salted ingredients. Canned soups.	Same
Beverages	Bottled, powdered, frozen or canned beverages containing salt or sodium preservatives.	None
Desserts (limit to 2 svgs per day)	Commercial bakery products	None

Read product labels when purchasing commercially packaged foods. Choose low sodium foods with no added salt or sodium compounds.

SODIUM CONTROLLED DIETS

VI. FOODS TO BE AVOIDED

FOOD GROUP	~~1 Gram Sodium~~	2 Gram Sodium	No Added Salt
~~Beverages~~	~~Bottled, powdered, frozen or canned beverages containing salt or sodium preservatives.~~	~~Same~~	~~None~~
~~Desserts (limit to 2 svgs per day)~~	~~All prepared with salt or sodium including any made with baking powder or baking soda. Commercial products.~~	~~Commercial bakery products~~	~~None~~
Miscellaneous	Salt. Seasoned salts such as garlic salt, onion salt, celery salt variety salt mixtures and ~~Any Salt added in~~ packaged seasoning mixes, MSG. Olives, pickles, relish. Soy, barbecue and prepared sauces, ketchup, prepared mustard, pickles, salted popcorn. Snack dips.	~~Same~~	Limit all items on this list. Any Salt added in cooking. Limit salted peanut butter ~~this list.~~ ~~cooking.~~ ~~Limit salted peanut butter~~

Supplements: All nutrition supplements are permitted with order.

-Read product labels when purchasing commercially packaged foods. Choose low sodium foods with no added salt or sodium compounds.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Low Sodium Nutrition Therapy http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=121. Accessed July 28, 2018

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U.S. Department of Health and Human Services (USDA) and the National Institutes of Health (NIH). What is the DASH Eating Plan?. http//www.nhlbi.nih.gov/health/health-topics/topics/dash/followdash.html. Accessed July 28, 2018

U.S. Departments of Agriculture (USDA) and Health and Human Services (HHS). Dietary Guidelines for Americans, 2010. 7th Edition, Washington, D.C.: U.S. Government Printing Office, December 2010

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POTASSIUM CONTROLLED DIET
3 gram potassium

I. ~~BASIC PRINCIPLES:~~PURPOSE

~~This diet restricts high potassium foods while providing adequate calories and levels of most essential nutrients. Potassium is widely distributed in food; however, because potassium is water-soluble, a significant portion of potassium is lost during cooking or processing. Therefore, frozen or canned fruits and vegetables contain a lower amount of potassium than fresh. Potassium containing salt substitutes should be avoided as they are high in potassium.~~ The diet is designed to achieve and maintain normal potassium levels in individuals at risk for hyperkalemia. This diet also allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

II. INDICATIONS~~:~~

Elevated serum potassium and resident medical condition determine level of potassium restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are: receiving Renal Dialysis ~~disease~~~~renal failure~~, hyperkalemia, receiving potassium sparing medicat~~ii~~ons and extensive tissue damage.

III. ADEQUACY~~:~~

This diet may not meet all the Recommended Dietary Allowances ~~for calcium, ascorbic acid and vitamin B complex~~, therefore, supplements may be required. The 3 gram potassium level is recommended where moderate control is desired. ~~Restrictions below this level will reduce acceptability of the diet and have the potential for resident noncompliance.~~

IV. APPROXIMATE COMPOSITION:

	Potassium	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	3 grams	2000-2100	90-100 ~~grams~~	210-220 ~~grams~~	87-93 ~~grams~~
~~% of calories~~			~~18-19 %~~	~~42 %~~	~~39-40%~~

V. SAMPLE MEAL PATTERN: 3 Gram Potassium

BREAKFAST
~~*~~4 oz. Juice (low potassium)
1 Serving~~6 oz.~~ Cereal
1 Egg
1 Slice Toast
1 Pat Margarine
8 oz. Low-fat milk- Lunch **or** Dinner
Coffee, Tea
Sugar, Pepper

LUNCH ~~and~~ & DINNER
6 oz. Salad/Soup - Lunch or Dinner
3 oz. Meat or Alternate (~~Gravy~~limit intake of fish/bean/turkey)
3 oz. Rice or Noodles (avoid potatoes)
3 oz. ~~Bland~~ Vegetable (low potassium)
1 Serving Fruit Dessert (low potassium)
1 Slice Bread
1 Pat Margarine
8 oz. Low-fat milk - Lunch **or** Dinner
Coffee, Tea
Sugar, Pepper

Snacks included per patient preference and/or to meet nutrient needs.

Reference

Academy of Nutrition Dietetics. Nutrition Care Manual. Chronic Kidney Disease Stage 5 Nutrition Therapy. http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157 Accessed July 28, 2018
Academy of Nutrition and Dietetics. Nutrition Care Manual. High-Potassium Foods List.. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=145. Accessed July 28, 2018

~~* May Be Supplied As A Neighborhood Nourishment~~

~~Phosphorus content can be adjusted by controlling the amount of milk products served.~~

LOW POTASSIUM DIET (
-3 grams potassium)

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products	~~Whole, lowfat or nonfat milk~~All in limited quantities within 8 fl. oz. restriction per day~~(Limit to 2 cup/day)~~ ~~(1 cup milk/day for 2 gm K)~~	~~Commercial milk drinks,~~Soy milk, malted milk. Excess of 8 fl. oz per day of milk, chocolate milk, buttermilk, yogurt, puddings, cream soups~~—milkshakes. Cocoa.~~ , ~~Cheese. ice cream, sherbet.~~ Cheese, cottage cheese, custard, ice cream
Meats, Fish, Poultry ~~(6 ounces per day)~~	Meats; Fish except those not Recommended ~~(4 ounces meat/day for 2 gm K)~~	~~Limit meats, fish, poultry~~ ~~Herring, mackerel, anchovies, sardines, sweetbreads, liver, beef kidneys, brains, heart.~~Fish-halibut, tuna, cod, snapper, Turkey
Meat Alternates	1 egg daily. ~~Cheese, cottage cheese.~~	~~meat extracts, meat soups.~~Beans
Vegetables ~~(Limit to 3 servings per day)~~	Beets (canned), Broccoli, Cabbage, ~~Cooked and well drained bland vegetables, except those listed.~~ Carrots, Cauliflower, Corn, Cucumber, Eggplant, Green Beans, Kale, Lettuce (1 cup), Mushrooms, Onions, Radishes, Snow Peas, Summer Squash, Turnips	~~Spinach, winter squash, tomatoes, tomato sauce, tomato juice.~~ Artichokes, Avocado, Brussel Sprouts, ~~Dried peas and beans. Broccoli, cauliflower, Brussels sprouts.~~ Butternut Squash, Greens (Mustard /Collard), Okra, Parsnips, Potato, Pumpkin Spinach, Sweet potatoes, Swiss Chard Tomatoes, Tomato Sauce/Puree/ Juice, Wax Beans, Winter Squash, Yam
Fruits ~~(Limit to 3 servings per day)~~	~~All fresh or canned fruits and fruit juices except those listed.~~ Apples, Applesauce, Blueberries Cranberry Fruit/Juice, Fruit Cocktail Grape Juice, Grapes, Lemon, Lemon Juice, Limes, Lime Juice, Peaches (canned), Pineapples, Plums(1), Strawberries, Tangerines (1), Watermelon	~~Bananas, oranges, apricots, grapefruit, cantaloupe, figs, prunes, dried fruit. Avocado. Orange juice, prune juice.~~ Pomegranate, Prune Juice, Prunes, Raisins
Breads, Cereals ~~and Starches (Limit to 2 oz potato)~~	~~Enriched bread and cereal products. Pancakes. Enriched rice, noodles, macaroni, spaghetti,~~	~~Pumpernickel bread. Coarse whole grains. Yams and sweet potato. Baked potato.~~

and other pastas. White and Brown Rice, Tortilla, flour Or corn, Waffles, Bagels, English Muffin, Oatmeal, White Bread/Pasta — Bran Muffins, dark rye bread, gingerbread, granola, Avoid potatoes(All potatoes on 2 gm K)

Fats and Oils (Limit meat gravies) — Butter or margarine. All fats and oils. — Meat gravy. Limit intake of nuts/seeds

Soups — NoneAll except those not recommended . — Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes. Butternut.

Beverages — Carbonated sodas, coffee, tea, fruit juices, as listedCranberry juice, tea. — Fruit juices listed to avoid. Limit dairy intake, fruit/veg juices high in Potassium, soy milk

Desserts — Limit desserts made with milk to maintain 2 cups/day. All, except those excluded. Peanut butter. Marshmallows, gelatin, ice pops — Mincemeat if made with meat. Desserts made with high amounts of dairy or high-potassium veg/fruits Chocolate candy, nuts.

Miscellaneous — All except foods not recommended — Salt-Substitutes, chocolate, maple syrup, barbeque sauce, soy sauce, steak sauce, Worcestershire sauceSalt, pepper, herbs and Catsup, mustard, bbq sauce. spices, vinegar. Sugar, Relish, olives, pickles. Hard candy, jelly. Meat tenderizers. Salt substitutes Polyrich or other non-dairy that contain potassium.

milk substitutes.

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PROTEIN RESTRICTED DIETS

I. BASIC PRINCIPLES:

These diets are designed to restrict protein intake while providing adequate calories to prevent catabolism of body proteins. High quality protein foods such as meat, milk, and eggs should provide at least 50% of the protein allowance. Carbohydrates and fats, such as gravy, margarine, cream, fruits, juices, and sugars are used to maximize caloric intake.

For best protein utilization, protein should be of high biological value and distributed throughout the day. Protein restrictions are frequently accompanied by electrolyte and fluid restrictions that may limit nutritional adequacy.

Residents requiring this type of diet are frequently anorectic and nauseated; therefore, adjustments of the diet to resident preferences and tolerances are important.

II. INDICATIONS:

The restricted protein diets are used when nitrogenous waste products are increased or not excreted properly. In the management of liver disease, a moderate to severe protein restricted diet is useful to prevent and/or treat hepatic encephalopathy. As the condition improves, the intake of protein should be increased.

In the management of acute or chronic renal disease, the amount of protein allowed is based on renal function and type of dialysis.

The level of protein restriction should be specified accordingly:

40 gm protein: severe protein restriction
50 gm protein: moderate protein restriction
60 gm protein: mild protein restriction
(compared with regular diet -- 100 gm at LHH)

III ADEQUACY:

Good nutritional status cannot be maintained on moderate to severe protein restricted diets as these diets do not meet RDAs for most nutrients.

IV. AVERAGE PROTEIN CONTENT OF FOOD GROUPS:

Food Group	Serving Size	Protein/Gm.
Starch/Bread	3 oz / 1 slice	3
Meat	1 oz	7
Vegetable	3 oz	2
Fruit	1 serving	0
Milk	8 oz	8
Fat	1 serving	0

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PROTEIN RESTRICTED DIET

V . APPROXIMATE COMPOSITION

40 gm Protein:	Calories	Protein	Carbohydrate	Fat
Range	1330-1646	38-40 grams	150-201 grams	50-93 grams
% of Calories		9-12 %	45-47 %	43-46 %
50 gm Protein:				
Range	1480-1996	46-50 grams	165-216 grams	50-93 grams
% of Calories		10-13 %	43-45 %	42-47 %
60 gm Protein:				
Range	1570-2086	60-62 grams	145-196 grams	85-118 grams
% of Calories		12-15 %	37-38 %	47-51 %

VI. SUGGESTED MEAL PATTERNS:

40 gm Protein

BREAKFAST	LUNCH & DINNER
4 oz. Fruit Juice	Salad with Dressing or Broth
6 oz. Hot Cereal	1/2 Portion Meat or Alternate
1 Slice Toast	1/2 Portion Starch
1 Pat Margarine	1/2 Portion Vegetable
Sugar, Half & Half	1 oz. Gravy
4 oz. Nondairy Substitute	1 Slice Bread, 1 Pat Margarine
Coffee, Tea, Decaf	1 Serving Fruit
	Coffee, Tea, Decaf
	Sugar, Half & Half
	4 oz. Nondairy Substitute

50 gm Protein

BREAKFAST	LUNCH & DINNER
4 oz. Fruit Juice	Salad with Dressing or Broth
6 oz. Cereal	1/2 Portion Meat or Alternate
1 Slice Toast	1/2 Portion Starch
1 Pat Margarine	1/2 Portion Vegetable
Coffee, Tea, Decaf	1 oz. Gravy
8 oz. Lowfat Milk	1 Serving Fruit
Half & Half	1 Slice Bread w/Margarine
Sugar, Salt, Pepper	Coffee, Tea, Decaf
	4 oz. Nondairy Substitute

Half & Half
Sugar, Salt, Pepper

PROTEIN RESTRICTED DIETS

VI. SUGGESTED MEAL PATTERNS: (continued)

60 gm Protein

BREAKFAST	LUNCH	DINNER
4 oz. Fruit Juice	Broth or Salad with Drsg.	Broth or Salad w/Drsg.
6 oz. Cereal	1/2 Portion Meat	1/2 Portion Meat
1 Egg	or Alternate	or Alternate
1 Slice Toast	1/2 Portion Starch	1/2 Portion Starch
1 Pat Margarine	1/2 Portion Vegetable	1/2 Portion Vegetable
Coffee, Tea, Decaf	1 oz. Gravy	1 oz. Gravy
8 oz. Lowfat Milk	1Serving Fruit	1 Serving Fruit
Half & Half	1Slice Bread w/Margarine	1 Slice Bread w/Margarine
Sugar, Salt, Pepper	Coffee, Tea, Decaf	Coffee, Tea, Decaf
	4 oz. Nondairy Substitute	8 oz. Lowfat Milk
	Half & Half	Half & Half
	Sugar, Salt, Pepper	Sugar, Salt, Pepper

VII. ADDITIONAL FOOD FOR CALORIE SUPPLEMENTATION:

Beverages

Artificially Flavored Fruit drinks
Carbonated, Cola type, Ginger Ale
Milk Substitute - Fruit Juices

Sugars & Sweets

Honey, Jam, Jelly, Sugar, Syrup, Popsicles

Candy **

Plain Hard Candies, Jelly Beans, Gum Drops, Lollipops

Low Protein Products **
Low Protein Bread, Crackers, Cookies

High Carbohydrate, High Calorie Modular Supplements *

* Food Items are delivered to the Neighborhood and provided to the resident by Nursing Service.

~~** Food items are not stocked in Nutrition Services and require 3 – 4 days for delivery.~~
~~Candy is available in the Gift Shop and the Resident Store.~~

RENAL DIET~~S~~

I. ~~BASIC PRINCIPLES:~~PURPOSE

The protein (60 gm.), sodium (2.0 gm.), potassium (2-3 gm.) and p~~otassium~~hosphorous (800-1000 mg.) controlled diet is designed to provide adequate amounts of essential nutrients and sufficient calories to maintain optimal nutritional status in those residents with impaired renal function. Modifications in the diet may be moderate or may require complex modification depending on the stage of kidney disease. Refer to individual sodium, potassium, phosphorous restricted diets for comprehensive information on food recommendations. ~~Calories should be sufficient to achieve and maintain optimal nutritional status and prevent catabolism. A diet high in complex carbohydrates and fat is used to spare protein. Residents with renal disease are susceptible to cardiovascular disease therefore, the diet should contain a high level of polyunsaturated fats.~~

II. –INDICATIONS~~:~~

This diet provides a guide for planning diets for persons with acute or chronic renal failure, and for residents on hemodialysis and peritoneal dialysis. The cause and the degree of kidney dysfunction should determine the level of protein, sodium, and potassium restriction in the diet.

Protein intake needs to be controlled to avoid excessive amounts of nitrogenous waste products in the blood and to prevent negative nitrogen balance. ~~The amount of protein allowed in the diet is based on renal function and type of dialysis.~~

Sodium content of the diet is controlled to help maintain normal hydration status, to avoid fluid retention, hypertension, and to help prevent congestive heart failure. Pyelonephritis and polycystic kidney diseases tend to be salt wasting conditions that require increased sodium.

Potassium content of the diet is controlled to prevent hyperkalemia, as well as hypokalemia in some instances. Consideration for the level of potassium in the diet includes checking serum potassium levels, urinary potassium level, and drug therapy (such as digoxin, furosemide, etc.). Stress, catabolism, and diabetic ketoacidosis can increase potassium levels.

~~The cause and the degree of kidney dysfunction should determine the level of protein, sodium, and potassium restriction in the diet.~~

III. ADEQUACY~~:~~

~~Diets containing less than 40 gm protein may be deficient in essential amino acids, niacin, riboflavin, thiamin, calcium, phosphorus, and iron for both men and women. Levels of protein 50 and 60 gm are deficient in niacin, riboflavin, thiamin, and calcium for men and, calcium and iron for women, according to the National Research Council Recommended Dietary Allowances, 1989.~~
Thi~~s~~ese diet~~s~~ potentially is~~are~~ low in calories, minerals and vitamins~~ and~~. ~~i~~A nutrition supplement ~~t is recommended to supplement them~~ with low protein, high calories may be recommended ~~products (such as Polyrich)~~ to bring the calories, minerals and vitamins up to optimal. Calcium-based phosphate binders are often used with this patient population and should be taken into consideration when analyzing overall calcium intake.

I

~~RENAL DIETS~~

~~I~~V. APPROXIMATE COMPOSITION:

~~RENAL I - 40 gm Protein, 1.5 - 2 gm Sodium, 1.5 - 2 gm Potassium~~

	~~Calories~~	~~Protein~~	~~Carbohydrate~~	~~Fat~~
~~Range~~	~~1300-1800~~	~~38-40 grams~~	~~150-200 grams~~	~~55-90 grams~~
~~% of Calories~~		~~9-12 %~~	~~45-49 %~~	~~39-46 %~~

~~RENAL 2 - 50 gm Protein, 1.5 - 2 gm Sodium, 2 -2.5 gm Potassium~~

	~~Calories~~	~~Protein~~	~~Carbohydrate~~	~~Fat~~
~~Range~~	~~1400-1900~~	~~46-50 grams~~	~~170-220 grams~~	~~60-95 grams~~
~~% of Calories~~		~~10-13 %~~	~~46-48 %~~	~~39-44 %~~

RENAL ~~3 - 60~~ - 60 gm Protein, 2 gm Sodium, 2 - 3 gm Potassium, 800-1000 mg Phosphorous

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1500-2050	60-62 ~~grams~~	185-235 ~~grams~~	65-100 ~~grams~~
~~% of Calories~~		~~12-14 %~~	~~45-47 %~~	~~39-43 %~~

V. SUGGESTED MEAL PATTERN:

~~RENAL 1 - 40 Gram Protein, 1.5-2 Gram Sodium, 1.5-2 Gram Potassium~~

~~BREAKFAST~~	~~LUNCH & DINNER~~
~~4 oz. Fruit Juice~~	~~Salad w/Diet Dressing (Lunch)~~
~~6 oz. Cereal - Half & Half~~	~~1/2 Portion LS Entree~~
~~1 Slice Toast~~	~~1/2 Portion LS Starch~~
~~1 Pat Margarine~~	~~1/2 Portion LS Vegetable~~
~~4 oz. Nondairy Substitute~~	~~1 Slice Bread - 1 Pat Margarine~~
~~Coffee, Tea, Decaf~~	~~1 Serving Fruit~~
~~Sugar~~	~~4 oz. Nondairy Substitute~~
	~~Coffee, Tea, Decaf~~
	~~Sugar, Half & Half~~

RENAL DIETS

V. SUGGESTED MEAL PATTERN

RENAL 2 - 50 Gram Protein, 1.5 - 2 Gram Sodium, 1.5 - 2 Gram Potassium

BREAKFAST	LUNCH & DINNER
4 oz. Fruit Juice	Salad w/Diet Dressing (Lunch)
6 oz. Cereal - Half & Half	1/2 Portion LS Entree
1Slice Toast w/Margarine	1/2 Portion LS Starch
1Pat Margarine	1/2 Portion LS Vegetable
8 oz. Lowfat Milk	1 Slice Bread w/1 Pat Margarine
Coffee, Tea, Decaf	1 Serving Fruit
Sugar, Pepper	4 oz. Nondairy Substitute
	Coffee, Tea, Decaf
	Sugar, Pepper, Half & Half

RENAL 603 - 60 Gram Protein, 2 Gram Sodium, 2 - 3 Gram Potassium, 800-1000 mg Phosphorous

BREAKFAST	LUNCH & DINNER
4 oz. Fruit Juice (low potassium)	Salad w/Diet Dressing (Lunch)
1 Serving 6 oz. Cereal - Half & Half	1/2 Portion LS Entree (limited beans and processed meat)
1 Slice Toast	1/2 Portion LS Starch
1 Pat Margarine	1/2 Portion LS Vegetable (low potassium)
1 Egg	1 Slice Bread - 1 Pat Margarine
8 oz. Low-fat Milk –Lunch **or** Dinner	1 Serving Fruit (low potassium)
Coffee, Tea, Decaf	8 oz. Low-fat Milk (-Lunch or Dinner)
Sugar, Pepper	4 oz. Nondairy Substitute (Lunch or Dinner)
	Coffee, Tea, Decaf
	Sugar, Pepper, Half & Half

RENAL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products	All in limited quantities within 8 fl. oz. restriction per day	Soy milk, malted milk. Excess of 8 fl. oz./ day of milk, chocolate milk, buttermilk, puddings, cream soups, light cheese, soy milk
Meats, Fish, Poultry	All except those excluded, tofu ok	Canned, cured, smoked, pickled, spiced or Processed meats, such as bacon, regular Sausage, luncheon meats, frozen dinners, Canned meats, dried peas, limit beans and lentils, avoid salted nuts
Meat Alternates	1 egg daily, tofu ok	Beans
Vegetables	All those not high in potassium Vegetables included but not limited To green and wax beans, beets, Cabbage, carrots, cauliflower, celery Corn, cucumber, green peas, Summer Squash, turnips, peppers, onions, Asparagus, zucchini, greens (mustard, Collard)	All those high in potassium Canned vegetables, vegetables in brine, artichoke, potato, sweet potato, spinach, Brussel sprouts, chard, pumpkin, yams, okra tomato and tomato sauce
Fruits	All those not high in potassium Fruits included but not limited to apple, Blueberry, cranberry, fruit cocktail, grape Juice, grapes, peaches, pears, pineapple, Strawberry, watermelon	All those high in potassium Dried fruits, bananas, orange and juice, raisins, prunes and juice, avocado, apricots, Limit: cherries, cantaloupe, grapefruit, mango
Breads, Cereals	Most bread, cereals (1 cup), pasta, rice	Whole wheat breads, croissants, Sweet potatoes, potato chips, bran Avoid potatoes
Fats and Oils	Butter or margarine. All fats and oils, low salt gravy, mayo, Salad dressings	Bacon, cream sauces, sour cream
Soups	All except those not recommended	Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes. Butternut.
Beverages	Carbonated beverages other than cola, Coffee, tea, milk limited to 1 cup/day	Cola, cocoa, tomato/veg juice, canned soup, coconut water
Desserts	All except foods not recommended	Chocolate, nuts, cream/pumpkin pies,
Miscellaneous	Herbs and spices without added salt, all Except those listed in foods not Recommended	Salt, monosodium glutamate, olives, soy sauce, teriyaki sauce, barbeque sauce, ketchup, phosphorous containing ingredients (e.g. calcium phosphate, disodium phosphate, phosphoric acid, etc.)

RENAL DIET

Reference

Nutrition Care Manual. Chronic Kidney Disease Stage 1-4 Nutrition Therapy
https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=336. Accessed July 28, 2018
Nutrition Care Manual. Chronic Kidney Disease Stage 5 Nutrition Therapy
http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157 Accessed July 28, 2018

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition Department
Diet Manual

LOW PHOSPOROUS DIET
800-1000 MG PHOSPHOROUS

I. PURPOSE

This diet is to achieve and maintain normal phosphorous levels in individuals at risk for elevated phosphorous levels in the blood. It is a modifier of the regular diet that excludes/limit foods high in phosphorous and limit phosphorous intake from meals to less than 1000 mg per day. This allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

II. INDICATIONS:

Elevated serum phosphorous and resident medical condition determine level of phosphorous restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are: Renal Dialysis disease, autoimmune~~ance~~ activating mutations of the calcium-sensing receptor, parathyroid disease, Vitamin D or Vitamin A intoxication, granulomat~~or~~ous disease, immobilization, osteolytic metastases, milk-alkali syndrome and severe hypermagnesemia or hypomagnesemia~~e~~.

III. ADEQUACY:

This diet may not meet all the ~~Recommended Dietary Allowances~~RDAS, therefore, supplements may be required. The 800-1000 gram phosphorous level is recommended where moderate control is desired.

IV. APPROXIMATE COMPOSITION:

	Phosphorous (mg.)	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	800-1000	2000-2100	90-100	210-220	87-93

V. SAMPLE MEAL PATTERN: 800-100 mg Phosphorous

BREAKFAST	LUNCH & DINNER
4 oz. Juice	6 oz. Soup - Lunch or Dinner
1 Serving Cereal	3 oz. Meat or Alternate (limit meat and legume)
1 Egg	3 oz. Rice or Noodles (avoid whole grains)
1 Slice Toast	3 oz. Bland Vegetable
1 Pat Margarine	1 Serving Fruit Dessert
8 oz. Lowfat milk (limited quality,	1 Slice Bread
no more than 1 cup/day)	1 Pat Margarine
Coffee, Tea (non-dairy creamer)	8 oz. Lowfat milk (limited quality,
Sugar, Pepper	no more than 1 cup/day)
	Coffee, Tea
	Sugar, Pepper

Additional snacks may be added based on individual patient needs if total phosphorus intake within limit.

LOW PHOSPHOROUS DIET
800-1000 grams potassium

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products	Whole, lowfat or nonfat milk Cheese. Ice cream, sherbet. (8 oz. milk/day)	Commercial milk drinks, milkshakes. Cocoa, cream soups, cottage cheese, yogurt, puddings, custard, ice cream, buttermilk
Meats, Fish, Poultry	Limit meats	Organ meats (1 oz.), nuts (1/4 cup),
Meat Alternates	1 egg daily	Tofu (1/4 cup), Vegetarian meat replacements
Vegetables	All, except peas	Peas
Fruits	All fresh or canned fruits and fruit juices	None
Breads, Cereals and Starches	Refined white grains, bread, pasta bagel (1/2 small); bread, all kinds (1 slice); dinner roll (1 ea); English Muffin (1/2)	Biscuits, muffin (1 small); granola/oatmeal (1/2 cup); pancakes/waffles (1 ea); whole wheat cereal, bran cereal (1/2 cup); tortillas, corn (2 ea); whole grain bread; brown rice
Fats and Oils	All fats and oils.	Limit intake of nut and nut butters
Soups	None.	Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes.
Beverages	All, except those not recommended	Chocolate drinks, cocoa, drinks made w/milk, canned iced teas, dark colas
Desserts	All, except those excluded.	Chocolate, caramels, desserts made primarily from diary products (cheesecake)
Miscellaneous	All, except those not recommended	Phosphorus-containing ingredients (e.g. calcium phosphate, disodium phosphate, Phosphoric acid, etc)

Reference

Nutrition Care Manual. Chronic Kidney Disease Stage 5 Nutrition Therapy. http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client _ed_id=157. Accessed July 28, 2018

LACTOSE CONTROLLED DIET

I~~1~~. ~~BASIC PRINCIPLES~~ PURPOSE~~:~~

This diet follows the regular diet pattern with restriction or elimination of lactose containing foods and beverages. Since tolerance of lactose is variable, the levels are determined by the individual's tolerance. The elderly may be less tolerant of milk and milk products. Many people find they can tolerate milk in smaller amounts or milk products that have been fermented (e.g. buttermilk, yogurt, and cheese), or cooked (i.e. pudding, custard, cream soups, and sauces).

If a severe restriction is necessary, labels need to be read, avoiding foods containing milk, lactose, milk solids, whey, curd, non fat milk powder, and non fat milk solids. Lactose is sometimes used as a filler in medication. (Lactate, lactalbumin, lactylate, and calcium compounds are salts of lactic acid and do not contain lactose).

II. INDICATIONS~~:~~

This diet is designed to prevent or reduce symptoms associated with ingesting lactose-containing products. Lactose, the primary carbohydrate in milk, is a dissaccharide compound of glucose and galactose. Lactose intolerance results when the enzyme lactase is not secreted in~~In~~ quantities sufficient enough to hydrolyze and digest the lactose consumed. Possible symptoms include bloating, flatulence, cramping and diarrhea.

Based on the individual's food choices the diet can provide adequate amounts of all essential nutrients. Calcium, Vitamin D, and riboflavin may be deficient if all dairy products are avoided. Use of nondairy or soy milk products could satisfy the nutrient needs; otherwise, supplementation may be necessary. For a Low Calcium Diet, the Regular diet can be modified to avoid Milk and Milk Products, Sardines, Clams, Oysters, Kale, Turnip Greens, Mustard Greens, and Broccoli.

III. ~~V~~ ~~.~~ APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	2000-2400	90-100	250-350	90-100
		~~grams~~	~~grams~~	~~grams~~
~~% of Calories~~		~~16-18 %~~	~~45-50 %~~	~~34-37~~

IV. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz.* Fruit or Juice
1 Serving ~~6 oz.~~ Cereal
1 Egg or Alternate
1 Slice Toast
1 Pat Margarine
8oz. Nondairy or Soy Supplement
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6oz. Soup or Salad w/ Dressing
3oz. Meat or Alternate
3oz. Starch
3oz. Vegetable
1 Serving Dessert
1 Slice Bread / I Pat Margarine
8oz. Nondairy or Soy Supplement
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole Grain breads, cereals and starches are served daily.

~~*May Be Supplied As A Neighborhood Nourishment~~

~~Laguna Honda Hospital and Rehabilitation Center~~
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~~Diet Manual~~

~~TEST DIETS~~

~~Test diets are ordered preceding laboratory tests that diagnose possible abnormalities in the alimentary tract. These diets may be inadequate in one or more nutrients and are usually ordered for one to three days.~~

~~MEAT FREE TEST DIET~~

~~I. BASIC PRINCIPLES: This diet eliminates all meat, fish, and poultry products.~~

~~II. INDICATIONS:~~

~~This diet is used in conjunction with the hemoccult test of stool specimens to detect occult gastrointestinal bleeding. A positive reaction produces a blue dye if hemoglobin is present. The dietary restriction of hemoglobin containing foods 'may increase the accuracy of the test.~~

~~Eliminate beef, lamb and liver from the meals prior to the test. Poultry, Pork and Fish are ok in moderation. Avoid oranges, orange juice or other foods high in Vitamin C.~~

~~III. Suggested Meal Pattern:~~

~~Breakfast~~	~~Lunch & Dinner~~
~~4 oz. Juice~~	~~6 oz. Vegetable Broth or ½ c. salad with dressing~~
~~6 oz. Cereal~~	~~1 serving of Entree: Fish, Pork, Poultry~~
~~1 Egg~~	~~cottage cheese, hard boiled egg or~~
~~1 Slice Toast~~	~~yogurt~~
~~1 Pat Margarine~~	~~3oz. Potato or alternate~~
~~8 oz. Low-Fat Milk~~	~~3oz. Cooked Vegetables~~
~~Coffee, Tea, Decaf, Sugar~~	~~1 Serving Dessert~~
	~~1 Slice Bread~~
	~~1 Pat Margarine~~
	~~8 oz Low-fat Milk~~
	~~Coffee, Tea, Decaf, Sugar~~

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~~LOW RESIDUE TEST DIET~~

~~I. BASIC PRINCIPLES~~

~~This diet limits dietary fiber and laxative foods that produce bulky intestinal residue. Eliminating the intake of fruits reduces stool residue, vegetables, milk and whole grain products. A Low Residue Liquid Nutrition may be added to this test diet to improve nutritional adequacy.~~

~~II. INDICATIONS~~

~~This diet is used to assist in thoroughly emptying the colon prior to x-ray for detection of possible abnormalities of the lower bowel. No food or beverage is given after dinner the day before the test or at breakfast prior to the test.~~

~~III. Suggested Meal Pattern~~

~~BREAKFAST~~	~~LUNCH & DINNER~~
~~6 oz. Clear Juice~~	~~6 oz. Broth~~
~~6 oz. Refined Cereal~~	~~4 oz. Clear Juice~~
~~1 Cooked Egg~~	~~3 oz. Soft Meat on Alternate~~
~~2 S1 White Toast~~	~~1 Serving Gelatin~~
~~2 Pats Margarine~~	~~3 oz Rice or Noodle~~
~~Coffee, Decaf, Sugar~~	~~1 Sl White Bread~~
	~~1 Pat Margarine~~
	~~Coffee, Tea, Decaf, Sugar~~

~~*This diet may be used temporarily after surgery of the large bowel, hemorrhoidectomy, rectal bleeding, cancer of the large bowel or acute stages of diverticulitis. The diet may be advanced to the regular Low Residue Diet when tolerated by the resident.~~

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~~100 GRAM FAT TEST DIET~~

~~I BASIC PRINCIPLES~~

~~This test diet provides 100 grams fat per day, provided in milk products, margarine, eggs and meats. Concentrated fats such as fried foods, gravy, sauces and fatty meats are avoided.~~

~~II. INDICATIONS~~

~~This diet is given for 6 days as an aid in the diagnosis of fat malabsorption--3 days prior to and 3 days during stool collection. Normally, less than 5 gms of fat per day are excreted in the stools. Accuracy of this test depends on 100% meal consumption.~~

~~III. Suggested Meal Pattern~~

~~BREAKFAST~~	~~LUNCH & DINNER~~
~~4 oz. Fruit or Juice~~	
~~6 oz. Cereal~~	~~6 oz. Regular Soup or 1/2 C. Salad w/Dressing~~
~~2 Cooked Eggs~~	~~3 oz. Low Fat Meat or Alternate~~
~~1 Slice Toast~~	~~3 oz. Low Fat Potato or Alternate~~
~~2 Pats Margarine~~	~~3 oz. Cooked Vegetable~~
~~2 Creamers~~	~~1 Slice Bread~~
~~8 oz. Low-Fat Milk~~	~~2 Pats Margarine~~
~~1 Serving Fruit, Gelatin, Sherbet~~	
~~8 oz. Low-Fat Milk~~	
~~Coffee, Tea, Decaf, Sugar~~	

~~LOW FAT (50 gm) TEST DIET~~

~~I BASIC PRINCIPLES~~

~~This diet limits fat-containing foods, such as margarine. eggs and meats. Whole milk products, fried foods, cream, gravy, sauces and fatty meats are avoided.~~

~~II. INDICATIONS~~

~~This diet is ordered for 2 days preceding a test to aid in the diagnosis of a gallbladder malfunction. No food or beverage is given after dinner time the day before the test and no breakfast prior to the test.~~

~~III. Suggested Meal Pattern~~

~~BREAKFAST~~	~~LUNCH & DINNER~~
~~4 oz. Fruit or Juice~~	~~6 oz. Broth soup or 1/2 c. Salad with low fat Dressing~~
~~6 oz. Cereal~~	~~3 oz. Low Fat Meat or Alternate~~
~~1Cooked Egg~~	~~3 oz. Potato or Alternate~~
~~1 Slice Toast~~	~~3 oz. Cooked Vegetable~~
~~1 Pat Margarine~~	~~1 Slice Bread & 1 Pat Margarine~~
~~1 Pkg. Jelly~~	~~1 Serving Fruit. Gelatin, Sherbet~~
~~8 oz. Fat Free Milk~~	~~8 oz Fat Free Milk~~
~~Coffee, Tea, Decaf, Sugar~~	

PURINE RESTRICTED DIET

I. ~~BASIC PRINCIPLES~~PURPOSE~~:~~

This diet eliminates foods that contain 150 mg purine or more per serving. Daily protein intake should not exceed 1gm/kg ideal body weight. The diet should not exceed 3 - 4 oz. meat per meal.

Liberal carbohydrate intake (at least 100 gm/day) is used to prevent tissue catabolism and ketosis. Liberal use of fruits and vegetables and moderate fat intake should aid in the maintenance of or gradual reduction to ideal body weight.

Fluid intake should be at least 2-3 quarts per day to eliminate the uric acid via the urine and prevent the formation of renal calcium.

II. INDICATIONS~~:~~

This diet is designed to decrease elevated blood and urinary acid levels for the treatment of gout and/or uric acid stones in conjunction with drug therapy.

III. ADEQUACY

This diet may be inadequate in thiamin and iron due to the restriction of meat.

IV. APPROXIMATE COMPOSITION:

	~~CALORIES~~Calories	P~~ROTEIN~~rotein (gm.)	C~~ARBOHYDRATE~~arbohydrate (gm)	F~~AT~~at (gm.)
Range	1850-2100	85-90 ~~grams~~	250-300 ~~grams~~	55-60 ~~grams~~
~~% of Calories~~		~~18%~~	~~56%~~	~~26%~~

~~Purine Content 150 mg.~~

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit Juice *
~~6 oz.~~1 Serving Cereal
1 Egg
2 Slices White Toast
1 Pat Margarine
1 Pkt. Jelly
8 oz. Lowfat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

~~L~~LUNCH ~~AND~~ & DINNER
6oz. Soup or Salad w/Dressing
2oz. Meat or Alternate
3oz. Starch
3oz. Vegetable
2 Slices Bread
1 Pat Margarine
1 Serving Fruit
8 oz. Lowfat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

*May Be Supplied As A Neighborhood Nourishment

Laguna Honda Hospital and Rehabilitation Center
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PURINE RESTRICTED DIET

VI.- FOODS TO BE ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products (2 cups per day)	Nonfat or lowfat milk	Whole milk
Meats, Fish, Poultry	Limit servings on this list to 2 times weekly: Salmon, shad, tunafish, white fish, blue fish, crab, oysters, lobster Limit servings from this list to one time per week: Bacon, beef, chicken soup meat soups, liver, sausages, pork, turkey, veal	Anchovies, sardines herring, mackerel, shrimp, scallops, mussels. Sweetbreads, liver, beef kidneys, brains, heart. meat extracts, meat gravies
Meat Alternates	Eggs, peanut butter, nuts, cheese	
Vegetables (2 or more servings per day)	All vegetables ok. Limit the following to two times per week or ½ cup/day: Mushrooms, peas, spinach, asparagus, cauliflower	Dried legumes, lentils
Fruits (2 or more servings per day)	All fruits and juices	None
Breads, Cereals and Starches (4 or more servings per day)	All refined enriched bread and cereal products Limit the following to 2 servings per week: Whole grain breads and cereals, wheat germ, bran, oatmeal Limit use of higher fat foods such as pancakes, French toast, biscuits, potatoes, enriched rice, barley, noodles, spaghetti, macaroni and other pastas	None

PURINE RESTRICTED DIET

VII. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Fats and Oils (Limit to 3 tsp per day)	Butter or margarine. All fats and Oils	Meat gravies
Soups	Cream soups made with lowfat milk and allowed vegetables. Vegetable broth and consommé	Meat bouillon, broth and consommé. Soups made with meat stock base
Beverages	Carbonated, chocolate, cocoa, coffee, fruit juices, tea, decaf, lowfat milk	None
Desserts	All, except those excluded. Limit desserts high in fat such as pie, cake, cookies, doughnuts, sweet rolls, ice cream	Mincemeat if made with meat
Miscellaneous	Iodized salt, herbs and spices, vinegar white sauce, olives, pickles	Bakers and brewers yeast

EElimination of alcohol: Excessive amounts of alcohol may inhibit the renal excretion of urates due to lactic acid accumulation that can lead to hyperuricemia.

Reference

Academy of Nutrition and Dietetics Nutrition Care Manual. Low Purine Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=11. Accessed July 28, 2018

VEGETARIAN DIET

I. PURPOSE

Vegetarian meal plans encompass a variety of plant-derived foods and exclude some foods derived from animals.

II. INDICATIONS

Preferred avoidance of all animal products in the diet except dairy and eggs.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix A). ~~Depending on food choices, it could mean less calories, less salt, less added sugars, and less saturated fat and trans fat than many other diets~~

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1800-2750	85-120	240-290	95-115

V. SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH & DINNER
4 oz. Fruit or Juice	6 oz. Soup or Salad w/ Dressing
1 Serving Cereal	3 oz. Meat Alternate
1 Egg or Alternate	2 oz. Gravy
1 Slice Toast or Alternate	3 oz. Starch
1 Pat Butter / Margarine	3 oz. Cooked Vegetable
8 oz. Low Fat Milk	1 Serving Dessert
Coffee, Tea, Decaf	1 Slice Bread, 1 Pat Margarine
Sugar, Salt, Pepper	8 oz. Low Fat Milk
	Coffee, Tea, Decaf
	Sugar, Salt, Pepper

Supplements: Supplements are permitted with order.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. General, Healthful Vegetarian Nutrition Therapy. Accessed July 29, 2018. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=7
American Heart Association. Vegetarian Diets-. Retrieved July 2018, from the American Heart Association http:://www.heart.org/HEARTORG/GettingHealthy/NutritonCenter/Vegetarian-Diets_UCM_306032_Article.jsp

FLUID RESTRICTION

I. PURPOSE

This is a diet modifier designed to prevent fluid retention. It can be added to any diet order and specifies the daily fluid allowance in milliliters (mL) as 1000 mL, 1200 mL, 1500mL and 2000 mL. The amount of fluids delivered on the tray will equate to half of the daily allowance or as adjusted by RD for quality life. This allows one half of fluids to be administered by nursing for medication administration and floor stock fluids requests.

II. INDICATIONS

Residents with the following diagnosis may have a fluid restriction ordered by the MD: heart failure, renal dialysis disease, hepatic disease, hypervolemia; hyponatremia.

III. ADEQUACY

Based on diet order that this modifier is added to.

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1800-2750	85-120	240-290	95-115

V. FLUID RESTRICITON MEAL PATTERN:

BREAKFAST	LUNCH & DINNER
1 Serving Cereal	3 oz. Meat Alternate
1 Egg or Alternate	2 oz. Gravy
1 Slice Toast or Alternate	3 oz. Starch
1 Pat Butter / Margarine	3 oz. Cooked Vegetable
8 oz. Low Fat Milk	1 Serving Dessert
Sugar, Salt, Pepper	1 Slice Bread, 1 Pat Margarine
	Sugar, Salt, Pepper

4 oz. fruit, 8 oz. Skim Milk and/or 6 oz. Coffee,
Total fluid no more than 8 oz. at Breakfast, Lunch and/or Dinner
Total daily dietary fluid no more than 24 oz. (720 mL)

Restriction	Breakfast	Lunch	Dinner	Total Dietary
1800 mL	240 mL	240 mL	240 mL	720 mL
1500 mL	240 mL	240 mL	240 mL	720 mL
1200 mL	240 mL	120 mL	240 mL	600 mL
1000 mL	240 mL	120 mL	120 mL	500 mL

*Additional fluid can be added if total fluid delivered by dietary within 1000 mL

VI. FLUI~~IU~~D AND CONTENT OF SELECTED FOODS

Food Item	Fluid (mL)	Food Item	Fluid (mL)
Broth (6 oz.)	180 ~~mL~~	Ice Cream	120 ~~mL~~
Hot Cocoa (7 oz.)	210 ~~mL~~	Jell-O	120 ~~mL~~
Coffee/Tea (6 oz.)	210 ~~mL~~	Milk (8 oz.)	240 ~~mL~~
Creamer	15 ~~mL~~	Soup (6 oz.)	180 ~~mL~~
Fruit Ice (4 oz.)	120 ~~mL~~	Ensure Clear (8 oz.)	240 ~~mL~~
Fruit Juice (4 oz.-)	120 ~~mL~~	Ensure Van, Choc, Straw (8 oz.)	240 ~~mL~~
Sherbet (1/2 cup)	120 ~~mL~~	Ensure Enlive (8 oz.)	240 ~~mL~~

Supplements:
Fluids provided from supplements should be accounted for in the fluid restriction

Reference
Academy of Nutrition and Dietetics. Nutrition Care Manual. Fluid-Restricted Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=413. Accessed July 29, 2018.

THICKENED LIQUIDS

I. PURPOSE

Thickened liquids are recommended for people with swallowing difficulty. Consuming thickened liquids will decease risk of choking or coughing on liquids. Laguna Honda Hospital currently supplies thin, nectar or honey thick liquids. Honey thick is the thickest consistency << Nectar thick is an upgraded liquid consistency << thin liquids (no diet order required, automatically supplied on tray with any diet order without liquid consistency specially ordered by MD). Liquid consistency may be ordered with a swallow evaluation recommendation, MD/RD/Nursing observation or resident preference for quality of life.

II. INDICATIONS

Dysphagia, difficulty swallowing, head/throat/esophageal cancer, radiation therapy, cognitive impairment, thin liquids are observed not to be tolerated by speech therapist, RD, nursing staff, MD, resident or family member

III. ADEQUACY

This diet is modifier to any diet.

IV. APPROXIMATE COMPOSITION:

	Calories	Protein (gm.)	Carbohydrate (gm.)	Fat (gm.)
Range	1800-2750	85-120	240-290	95-115

V. SUGGESTED MEAL PATTERN:

BREAKFAST	LUNCH & DINNER
4 oz. Honey or Nectar Fruit or Juice	6 oz. Nectar Thick Soup or Salad w/ Dressing
1 Serving Cereal	3 oz. Meat or Alternate
1 Egg or Alternate	2 oz. Gravy
1 Slice Toast or Alternate	3 oz. Starch
1 Pat Butter / Margarine	3 oz. Cooked Vegetable
8 oz. Honey or Nectar Low Fat Milk	1 Serving Dessert
Sugar, Salt, Pepper	1 Slice Bread, 1 Pat Margarine
	8 oz. Honey or Nectar Low Fat Milk
	Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

VI. LIQUID FOOD GUIDE

All puree and strain soups may be ordered w/specialized feeding plan and/or MD order for quality of life, and can be thicken with~~to~~ honey or nectar thick packets using instructions.

Beverages such as milk, juices without pulp, coffee, tea, soda, carbonated beverages, alcoholic beverages, eggnog and nutritional supplements should be thickened to the right thickness as ordered by MD

Frozen beverages such as malts and milk shakes should be avoided.

THICKENED LIQUIDS

VI. LIQUID FOOD GUIDE

Sherbet, frozen yogurt, and ice cream should be avoided.

Gelatin should also be avoided.

Yogurt is acceptable for honey and nectar thick liquid consistency

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Thickened Liquid Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=424. Accessed July 29, 2018

-ALLERGENS

I. PURPOSE

To eliminate the eight food allergens, that are regulated by the Food and Drug Administration (FDA), from diets to prevent harmful food reactions.

II. INDICATIONS

Harmful food reactions to:

1. Egg
2. Fish
3. Peanut
4. Milk
5. Shellfish
6. Soy
7. Tree Nut
8. Wheat

All manufactured food products regulated by the Food and Drug Administration (FDA) that contain food allergens as an ingredient must listed with the word of the "food allergy" on the product label. Food allergens are identified using the USDA or vendor database, when available.

To accommodate food allergens/intolerances outside the FDA regulated food allergens, the Clinical Nutrition~~RD~~ and Food~~ and Nutrition~~ Service Department can modify any diet to eliminate specific foods in food preferences.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. Multiple Food Allergies Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=29. Accessed July 28, 2018

Appendix 1. A. Table 1: Dietary Reference for Older Adults

Elements and Macronutrients

RDA or AI [1]	Iron (mg)	Magnesium (mg)[m]	Manganese (mg)	Molybdenum (mg)	Nickel (mg)	Phosphorus (mg)	Selenium (ug)	Vanadium (mg)[n]	Zinc (mg)
Age 51-70 Male	**8**	**420**	2.3*	**45**	ND	**700**	**55**	ND	**11**
Female	**8**	**320**	1.8*	**45**	ND	**700**	**55**	ND	**8**
Age 70+ Male	**8**	**420**	2.3*	**45**	ND	**700**	**55**	ND	**11**
Female	**8**	**320**	1.8*	**45**	ND	**700**	**55**	ND	**8**
Tolerable Upper Intake Levels[a]									
Age 51-70 Male	45	350	11	2000	1	4000	400	1.8	40
Female	45	350	11	2000	1	4000	400	1.8	40
Age 70+ Male	45	350	11	2000	1	3000	400	1.8	40
Female	45	350	11	2000	1	3000	400	1.8	40

RDA or AI [1]	Energy [2] (Kcal)	Protein [3] (g)	Carbohydrates [4] (g)	Total Fat [5,6] (% Kcal)	n-6 PUFA (g)	n-3 PUFA (g)	Total Fiber (g)	Drinking water, Beverages, Water in food (L)
Age 51-70 Male	2204	**56**	**130**		14*	1.6*	30*	3.7*
Female	1978	**46**	**130**		11*	1.1*	21*	2.7*
Age 70+ Male	2054	**56**	**130**		14*	1.6*	30*	2.6*
Female	1873	**46**	**130**		11*	1.1*	21*	2.1*
AMDR [7]		10-35%	45-65%	20-35%	5-10%	0.6-1.2%		

[1] Recommended Dietary Allowances (RDAs) are in **bold type** and Adequate Intakes (AIs) are in ordinary type followed by an asterisk (*).

[2] Values are based on Table 5-22 Estimated Energy Requirements (EER) for Men and Women 30 Years of Age. Used height of 5'7", " low active" physical activity level (PAL) and calculated the median BMI and calorie level for men and women. Caloric values based on age were calculated by substracting 10 kcal/day for males (from 2504 kcal) and 7 kcal/day for females (from 2188 kcal) for each year of age above 30. For ages 51-70, calculated for 60 years old, for 70+, calculated for 75 years old. 80 year old male calculated to require 2004 kcal, female, 1838 kcal.

[3] The RDA for protein equilibrium in adults is a minimum of 0.8 gm/kg body weight for reference body weight.

[4] The RDA for carbohydrate is the minimum adeqaute to maintain brain function in adults.

[5] Because % of energy consumed as fat can vary greatly and still meet energy needs, an AMDR is provided in absence of AI, EAR, or RDA for adults.

[6] Values for mono- and saturated fats and cholesterol not established as "they have no role in preventing chronic disease, thus not required in the diet."

[7] Acceptable Macronutrient Distribution Ranges (AMDRs) for intakes of carbohydrates, proteins, and fats expressed as % of total calories.

The values for this table were excerpted from the Institute of Medicine, *Dietary Reference Intakes: Applications in Dietary Assessment*, 2000 and *Dietary Reference Intakes for Energy, Carbohydrates, Fiber, Fat, Protein and Amino Acids (Macronutrients)* 2002.

Compiled by the National Policy and Resource Center on Nutrition and Aging, Florida International University, Revised 3/19/04

Appendix 1. B Table 2: Dietary Reference for Older Adults.

Vitamins and Elements

	Vitamin A (ug)[b,c]	Vitamin C (mg)	Vitamin D (ug)[d,e]	Vitamin E (mg)[f,g,h]	Vitamin K (ug)	Thiamin (mg)	Riboflavin (mg)	Niacin (mg)[h,i]	Vitamin B_6 (mg)	Folate (ug)[h,j]
RDA or AI [1]										
Age 51-70 Male	**900**	**90**	10*	**15**	120*	**1.2**	**1.3**	**16**	**1.7**	**400**
Female	**700**	**75**	10*	**15**	90*	**1.1**	**1.1**	**14**	**1.5**	**400**
Age 70+ Male	**900**	**90**	15*	**15**	120*	**1.2**	**1.3**	**16**	**1.7**	**400**
Female	**700**	**75**	15*	**15**	90*	**1.1**	**1.1**	**14**	**1.5**	**400**
Tolerable Upper Intake Levels[a]										
Age 51-70 Male	3000	2000	50	1000	ND	ND	ND	35	100	1000
Female	3000	2000	50	1000	ND	ND	ND	35	100	1000
Age 70+ Male	3000	2000	50	1000	ND	ND	ND	35	100	1000
Female	3000	2000	50	1000	ND	ND	ND	35	100	1000

	Vitamin B_{12} (ug)[k]	Pantothenic Acid (mg)	Biotin (ug)	Choline (mg)[l]	Boron (mg)	Calcium (mg)	Chromium (ug)	Copper (ug)	Fluoride (mg)	Iodine (ug)
RDA or AI [1]										
Age 51-70 Male	**2.4**	5*	30*	550*	ND	1200*	30*	**900**	4*	**150**
Female	**2.4**	5*	30*	425*	ND	1200*	20*	**900**	3*	**150**
Age 70+ Male	**2.4**	5*	30*	550*	ND	1200*	30*	**900**	4*	**150**
Female	**2.4**	5*	30*	425*	ND	1200*	20*	**900**	3*	**150**
Tolerable Upper Intake Levels[a]										
Age 51-70 Male	ND	ND	ND	3500	20	2500	ND	10000	10	1100
Female	ND	ND	ND	3500	20	2500	ND	10000	10	1100
Age 70+ Male	ND	ND	ND	3500	20	2500	ND	10000	10	1100
Female	ND	ND	ND	3500	20	2500	ND	10000	10	1100

[1] Recommended Dietary Allowances (RDAs) are in **bold type** and Adequate Intakes (AIs) are in ordinary type followed by an asterisk (*).
ND - Indicates values not determined.

The values for this table were excerpted from the Institute of Medicine, *Dietary Reference Intakes: Applications in Dietary Assessment*, 2000 and *Dietary Reference Intakes for Energy, Carbohydrates, Fiber, Fat, Protein and Amino Acids (Macronutrients)* 2002.

Compiled by the National Policy and Resource Center on Nutrition and Aging, Florida International University, Revised 03/19/04

Appendix 1.C. Table 3: Dietary Reference for Older Adults

Electrolytes

	Potassium (g)	Sodium (g)	Chloride (g)
RDA or AI [1]			
Age 51-70 Male	4.7	1.3*	2.0*
Female	4.7	1.3*	2.0*
Age 70+ Male	4.7	1.2*	1.8*
Female	4.7	1.2*	1.8*
Tolerable Upper Intake Levels[a]			
Age 51-70 Male		2.3	3.6
Female		2.3	3.6
Age 70+ Male		2.3	3.6
Female		2.3	3.6

[1] Recommended Dietary Allowances (RDAs) are in **bold type** and Adequate Intakes (AIs) are in ordinary type followed by an asterisk (*).
ND - Indicates values not determined.

The values for this table were excerpted from the Institute of Medicine, *Dietary Reference Intakes: Water, Potassium, Sodium, Chloride, and Sulfate*, 2004.

Compiled by the National Policy and Resource Center on Nutrition and Aging, Florida International University, Revised 3/19/04

Appendix 2. Laguna Honda Hospital Oral Nutrition Support Formulary

Category	Product Name	Nutrient Values per	Cal/ml	ml to meet 100% RDIs	PRO (g)	Major PRO Source	FAT (g)	Major FAT Source	CHO (g)	Major CHO Source	Osmolality (mOSM/kg H20)	% H20	Na (mg)	K (mg)	Ca (mg)	P (mg)	Indications for Use
ORAL SUPPLEMENTS																	
Standard Oral	Ensure®	8 fl oz	0.93	948	9	Milk [PRO],Soy PRO Isolate	6	Soy& Canola Oil	32	Sugar, Corn Maltodextrin, Sucromalt	500	83	200	370	300	250	Can be interim sole-source feeding
Concentrated Calories	Ensure® Complete	8 fl oz	1.5	948	13	Na Caseinate,Milk [PRO], Soy PRO Isolate	11	Canola&Corn Oil	51	Corn Maltodextrin, Sugar, scFOS	780	76	240	560	350	350	Recovery from general surgery for fx, presence of or at risk for PU
Pudding	Ensure® Pudding	4 oz	170kcal/ 4oz	NA	4	Milk [PRO]	5	Soy Oil	30	Sugar, Corn Maltodextrin, Modified Corn Starch, scFOS	NA	NA	120	250	100	100	Swallowing impairments, fluid restricted or volume limited diets
Clear Liquid	Ensure® Clear	10 fl oz	180 kcal/ 10fl oz	NA	9	Whey PRO Isolate	0	NA	35	Corn Syrup Solid, Sugar	796	84	50	45	60	200	Clear-liquid, pre&post-op, bowel prep, fat malabsorptive, fat restricted, low NA or low CHOL diet
Diabetes (DM)	Glucerna® Shake	8 fl oz	0.8	NA	10	Milk [PRO], Soy PRO Isolate	7	High Oleic Safflower Oil	23	Corn Maltodextrin, Fructose, Glycerine	530	84	210	380	250	250	DM or ABN BG tolerance
Renal (Dialysis)	Nepro® w/Carb Steady®	8 fl oz	1.8	944	19.1	Caseinates (Ca, Mg, Na), Milk PRO Isolates	22.7	High Oleic Safflower Oil, Canola Oil	37.9	Corn Syryp Solid, Sugar, Corn Maltodextrin, Glycerine, scFOS	745	73	250	250	250	170	Can be sole source; renal failure requiring dialysis
Renal (Predialysis)	Suplena® w/Carb Steady®	8 fl oz	1.8	948	10.6	Milk PRO Isolate, Na caseinate	22.7	High Oleic Safflower&Canola Oil	46.4	Corn Maltodextrin, Isomaltulose, Sugar, Glycerine, scFOS	780	74	190	270	250	170	Can be sole source, reduced kidney function

Appendix 3.1 Laguna Honda Hospital Tube Feeding Nutrition Support Formulary

Category	Product Name	Nutrient Values per	Cal/ml	ml to meet 100% RDIs	PRO (g)	Major PRO Source	FAT (g)	Major FAT Source	CHO (g)	Major CHO Source	Osmolality (mOSM/kg H20)	% H20	Na (mg)	K (mg)	Ca (mg)	P (mg)	Indications for Use
TUBE-FEEDING FORMULA																	
Isotonic	Osmolite® 1.0 kcal	1L	1.06	1321	44.3	Na&Ca Caseinates, Soy PRO Isolates	34.7	Canola/Corn Oil, MCT, Soy Lecithin	143.9	Corn Maltodextrin, Corn Syrup Solids	300	84	930	157	760	760	Can be sole source, kcal require<2000 kcal/day or increased PRO needs, long-term TF
High Calorie, High PRO	Osmolite® 1.2 kcal	1L	1.2	1000	55.5	Na&Ca Caseinates	39.3	High Oleic Safflower &Canola Oil, MCT, Soy Lecithin	157.5	Corn Maltodextrin	360	82	1340	1810	1200	1200	Can be sole source, increased kcal&PRO needs or limited volume tolerance
High Calorie, High PRO	Osmolite® 1.5 kcia	1L	1.5	1000	62.7	Na&Ca Caseinate, Soy PRO Isolate	49.1	High Oleic Safflower &Canola Oil, MCT, Soy Lecithin	203.6	Corn Maltodextrin	525	76	1400	1800	1000	1000	Can be sole source, increaased kcal&PRO needs or limited volume tolerance
High Calorie, High PRO	TwoCal HN	1L	2	948	83.5	Na&Ca Caseinates	90.5	High Oleic Safflower &Canola Oil, MCT, Soy Lecithin	218.5	Corn Syrup Solids, Corn Maltodextrin, Sugar, FOS	725	70	1450	2440	1050	1050	Can be sole source, increased kcal&PRO needs or limited volume tolerance
High Calorie, High PRO	Perative®	1L	1.3	1155	66.7	Partially Hydrolyzed Na Caseinate, Whey PRO Hydrolysate, L-arginine	37.3	Canola/Corn Oil, MCT, Soy Lecithin	180.3	Corn Maltodextrin, FOS	460	79	1040	1735	870	870	Can be sole source, designed for metabolically stressed patients w/PU, multiple fx, wounds, burns or benefit from arginine

Appendix 3.2. Laguna Honda Hospital Tube Feeding Nutrition Support Formulary

Category	Product Name	Nutrient Values per	Cal/ml	ml to meet 100% RDIs	PRO (g)	Major PRO Source	FAT (g)	Major FAT Source	CHO (g)	Major CHO Source	Osmolality (mOSM/kg H20)	% H20	Na (mg)	K (mg)	Ca (mg)	P (mg)	Indications for Use
TUBE-FEEDING FORMULA																	
Isotonic w/Fiber	Jevity® 1.0 Cal	1L	1.06	1321	44.3	Na&Ca Caseinates, Soy PRO Isolates	34.7	Canola/Corn Oil, MCT, Soy Lecithin	154.7	Corn Maltodextrin, Corn Syrup Solids	300	84	930	1570	910	760	Can be sole source, isotonic, intolerance of hyperosmolar feedings, long term TF
Isotonic w/Fiber	Jevity® 1.2 Cal	1 L	1.2	1000	55.5	Na&Ca Caseinates, Soy PRO Isolates	39.3	Canola Oil, MCT, Soy Lecithin	169.4	Corn Maltodextrin, Corn Syrup Solids, FOS	450	81	1350	1850	1200	1200	Can be sole source, isotonic, intolerance of hyperosmolar feedings, long term TF
Isotonic w/Fiber	Jevity® 1.5 Cal	1L	1.5	1000	63.8	Na&Ca Caseinates, Soy PRO Isolates	49.8	Canola/Corn Oil, MCT, Soy Lecithin	215.7	Corn Maltodextrin, Corn Syrup Solids, FOS	525	76	1400	2150	1200	1200	Can be sole source, isotonic, intolerance of hyperosmolar feedings, long term TF
DM	Glucerna® 1.0 Cal	1L	1	1420	41.8	Na&Ca Caseinates	54.4	High Oleic Safflower &Canola Oil, Soy Lecithin	95.6	Corn Maltodextrin, Fructose	355	85	930	1530	705	705	Can be sole source, DM or ABN BG tolerance from metabolic stress
DM	Glucerna® 1.2 Cal	1L	1.2	1250	60	Na Caseinate, Soy PRO Isolate, Milk [PRO]	60	High Oleic Safflower/Canola Oil, Soy Lecithin	114.5	Corn Maltodextrin, Isomaltulose, Fructose, Sucromalt, scFOS	720	81	1110	2020	800	800	Can be sole source, DM or ABN BG tolerance from metabolic stress
DM	Glucerna® 1.5 Cal	1L	1.5	1000	82.5	Na&Ca Caseinates, Soy PRO Isolates	75	High Oleic Safflower/Canola Oil, Soy Lecithin	133.1	Corn Maltodextrin, Isomaltulose, Fructose, Sucromalt, scFOS	875	76	1380	2520	1000	1000	Can be sole source, DM or ABN BG tolerance from metabolic stress

Appendix 3.3. Laguna Honda Hospital Tube Feeding Nutrition Support Formulary

Category	Product Name	Nutrient Values per	Cal/ml	ml to meet 100% RDIs	PRO (g)	Major PRO Source	FAT (g)	Major FAT Source	CHO (g)	Major CHO Source	Osmolality (mOSM/kg H20)	% H20	Na (mg)	K (mg)	Ca (mg)	P (mg)	Indications for Use
TUBE-FEEDING FORMULA																	
Elemental	Vital® 1.0 Cal	1L	1.0	1422	40	Whey PRO Hydrolysate, Partially Hydrolyzed Na Caseinate	38.1	Structured lipid, canola oil, MCT	130	Maltodextrin, Sugar, scFOS	390	84	1055	1400	705	705	Can be sole source, adv blend of hyrolyzed PRO, structured lipid&prebiotic, suitable for lactuose intolerance, gluten free, low residue
Elemental	Vital® 1.5 Cal	1L	1.5	1000	67.5	Whey PRO hydrolysate, Partially hydrolyzed Na caseinate	57.1	Structured lipid, canola oil, MCT	187	Maltodextrin, sugar, scFOS	610	76	1500	2000	1000	1000	Same indication for Vital 1.0 Cal
Elemental	Vital® AF 1.2 Cal	1L	1.2	1185	75	Whey PRO hydrolysate, Partially hydrolyzed Na caseinate	53.9	Structured lipid, soy/canola oil, MCT	110.6	Corn maltodextrin	425	81	1266	1688	844	844	Same indication for Vital 1.0 Cal
Renal (Dialysis)	Nepro® with Carb Steady®	1L	1.8	944	81	Ca, Ng, Na Caseinates, Milk PRO Isolate	96	High Oleic Safflower Oil, Canola Oil	161	Corn syrup solids, Corn Maltodextrin, scFOS	745	73	1060	1060	1060	720	Can be sole source, renal failure requiring dialysis

Appendix 3.4. Laguna Honda Hospital Tube Feeding Nutrition Support Formulary

Category	Product Name	Nutrient Values per	Cal/ml	ml to meet 100% RDIs	PRO (g)	Major PRO Source	FAT (g)	Major FAT Source	CHO (g)	Major CHO Source	Osmolality (mOSM/kg H20)	% H20	Na (mg)	K (mg)	Ca (mg)	P (mg)	Indications for Use
TUBE-FEEDING FORMULA																	
Very High PRO	Promote®	1L	1.0	1000	62.5	Ca Caseinate, Soy PRO Isolate	26	Safflower/Soy Oil,MCT, Soy Lecithin	130	Corn Maltodextrin, Sugar	340	84	1000	1980	1200	1200	Can be sole source, higher proportion of kcal from PRO, low kcal needs w/risk for PRO-energy malnutrition or PU
Very High PRO w/Fiber	Promote® with Fiber	1L	1.0	1000	62.5	Na&Ca Caseinates, Soy PRO Isolates	28.2	Safflower/Soy Oil,MCT, Soy Lecithin	138.3	Corn Maltodextrin, Sugar	380	83	1300	2100	1200	1200	Can be sole source, higher proportion of kcal from PRO &/or wound healing needs & those @risk for PRO-energy malnutrition or PU

Appendix 4. Laguna Honda Protein Suppment Formulary

Category	Product Name	Nutrient Values per	Cal/ml	ml to meet 100% RDIs	PRO (g)	Major PRO Source	FAT (g)	Major FAT Source	CHO (g)	Major CHO Source	Osmolality (mOSM/kg H20)	% H20	Na (mg)	K (mg)	Ca (mg)	P (mg)	Indications for Use
PROTEIN SUPPLEMENT																	
High PRO	Beneprotein®	1 scoop (7g)	25/7g	NA	6	Whey PRO Isolate	0	Soy Lecithin	0	NA	NA	NA	15	30	20	NA	Maintain muscle tissue
High PRO	Juven®	24 g	80/24g	NA	14	L-arginine, L-glutamine	0	NA	7.9	Orange Juice Powder, Sugar	NA	NA	NA	NA	200	NA	Increase lean body mass in 3 weeks in patients with illness-related weight loss, support tissue buidling, **signifcantly** increase collagen formation in 2 weeks
Clear Liquid	Promod®	1 oz	100kcal/ 1oz	NA	10	Hydrolyzed Beef Collagen	0	NA	14	Glycerine	NA	NA	55	20		95	Concentrated source of pro for increased pro needs w/indicators of wounds, protein energy malnutrition, involuntary weight loss, pre- and pos-surgery, anorexia, stress, trauma, cancer and burns

Appendix 5. Directions on Finding The Diet Manual on the **Laguna Honda Intranet**

Please follow these directions:

1. Open Internet Explorer Browser
2. The **Laguna Honda Intranet homepage** will open up
3. Under **Policies and Procedures** (on the far right side) *click* on **Departmental P&P**
4. *Click* on **Diet Manual**

1.11 Nutritionally Adequate Menus

Established and Revised: 03/87, 02/89, 5/97, 8/04, 9/06, 7/09, 8/18
Reviewed: 8/12, 8/13, 8/14, 8/15, 8/18

Policy: All menus ~~-~~are assessed for nutritional composition.

Purpose: To assure that menus meet the nutritional requirements set forth in the Recommended Daily Dietary Allowances and the RDIs established by the National Academy of Sciences.

Procedure:

- Menus are submitted to the Clinical Dietetic Staff for review and approval.
- Approved menus are assessed for nutritional adequacy using the CBORD nutritional ~~accounting~~ analysis program.
- Any menus which do not meet current standards are revised to provide appropriate nutrients.
- Nutritional composition of menus is assessed as menus are revised.
- When a modified diet does not meet the standards, it is noted in t~~t~~he diet manual with the following language:
    - ~~.~~Due to the lack of manufacturer information, not all vitamins and minerals can be reported. Vitamins and m~~M~~inerals which do not have DRI/RDAs established, and are not readily available in the USDA or vendor database, cannot be evaluated for complete nutritional adequacy in the ~~patient~~resident menu. When a diet order does not meet the nutritional adequacy as determined by the RDAs, the C~~c~~linical N~~n~~utrition team works to individualize nutritional care of the ~~patient~~resident considering their food preferences.

1.12 Registration of Dietitians

Established and Revised: 3/84, 3/85, 10/87, 12/87, 1/89, 5/97, 8/04, 9/06, 7/09, 8/12, 8/18
Reviewed: 8/12, 8/13, 8/14, 8/15, 8/18

Policy: All Clinical Dietitians, Dietetic Technicians and the Chief Dietitian are required to maintain registration with the Academy of Nutrition and Dietetics through the Commission on Dietetic Registration.

Purpose: To ensure that all qualified Dietitians maintain their registration with the Academy of Nutrition and Dietetics through the Commission on Dietetic Registration.

Procedure:
The Chief Dietitian will verify clinical dietetic registration and maintain current copies of the Academy of Nutrition and Dietetics registration cards for each qualified Dietitian in the Clinical Nutrition Department annually. The Chief Dietitian will send updated copies of the dietetic registration to Human Resources for inclusion in each qualified Dietitians employee file.

Note:

Headquarters
Academy of Nutrition and Dietetics
120 South Riverside Plaza, Suite 2000
Chicago, Illinois 60606-6995
Phone: 800/877-1600

Washington, D.C. Office
Academy of Nutrition and Dietetics
1120 Connecticut Avenue NW, Suite 480
Washington, D.C. 20036
Phone: 800/877-0877

References:

Commission on Dietetic Registration, https://www.cdrnet.org/

CMS §483.6060(a)(2)(1) Food and NutritionDietary Services, Staffing

Title 22

~~*1.14 Charging for Enteral Feedings*~~

~~Established and Revised: 5/84, 12/87, 1/89, 4/94, 3/95, 5/97, 9/06, 7/09~~
~~Reviewed: 8/12, 8/13, 8/14, 8/15~~

~~**Policy**: The cost of enteral feedings are chargeable to various agencies (Medicare Part B, specifically). Therefore, it shall be the responsibility to process necessary information for proper reimbursements.~~

~~**Purpose**: Increase the cash collections of in order to offset the high cost of enteral feedings.~~

~~**Procedure**:~~

1. ~~The needs are assessed and product is ordered through the approved vendor.~~
2. ~~Product is received by Pharmacy Department, Materials Management Department and/or Nutrition Services Department.~~
3. ~~Products are stored in Nutrition Services Department.~~
4. ~~Amount necessary to fulfill needs of every floor (neighborhood) is determined by use of the CBORD Enteral Nutrition System.~~
5. ~~Food Service Workers deliver the product according to generated list to each floor galley.~~
6. ~~Nursing to use product as necessary to feed those residents on total enteral support or total enteral support with supplementation on resident meal tray.~~
7. ~~Nursing will complete Enteral Feeding Charge Form and placed in the treatment book at the beginning of the month.~~
8. ~~The form is completed daily.~~
9. ~~At the end of the month the form is sent to Billing Department who in turn sends it to Nutrition Services for evaluation by the Diet Technician.~~
10. ~~Once evaluated the forms are sent to billing department for billing.~~
11. ~~Nutrition Services sends new billing forms to each unit on the last day of the month. New forms are available on each unit for use during the month.~~

~~*1.20 Charting Deficiencies*~~

~~Established and Revised: 03/87, 5/97, 9/06, 7/09, 8/15~~
~~Reviewed: 8/13, 8/14, 8/15~~

~~**Policy**: Charts chosen by the Chief Dietitian are reviewed monthly for appropriate documentation.~~

~~**Purpose**: To identify deficiencies in charting.~~

~~**Procedure**:~~

1. ~~The Chief Dietitian or Staff Dietitian will randomly review at least one chart/month on each neighborhood.~~

2. ~~Charts are reviewed for timeliness and complete charting techniques in nutrition assessments and follow ups prepared by clinical dietitians. Progress notes are charted in integrated charting except for the Initial Screening/ Assessment, and annual comprehensive assessments which are filed in the Assessment section of the medical record.~~

3. ~~All chart reviews are recorded on the Clinical Nutrition CQI review form.~~

4. ~~Any deficiencies are noted on the review forms and are reported at the next Clinical Nutrition meeting.~~

5. ~~Deficiencies in charting are discussed with the responsible Dietitian. Where possible, specific corrective measures will be taken.~~

6. ~~Repeated deficiencies by the same responsible Dietitian may result in appropriate disciplinary action as outlined in the "Uniform Disciplinary Code" for the Department of Public Health.~~

1.26 Test Routines

Established and Revised: 3/81, 3/84, 2/88, 2/89, 5/97, 9/06, 7/09
Reviewed: 8/13, 8/14, 8/15

Policy: There is an approved meal which is used when each specific test is ordered for a resident.

Purpose: To ensure that when a specific test routine is ordered for a resident, the dietary department will send the appropriate foods for the particular test. For Example: Barium Enema: Clear Liquids

Procedure:

1. Nursing staff notifies dietary indicating the test diet ordered, duration of the test diet and the reason for the test.

2. The dietitian requests through the Diet Office to prepare a test diet tray ticket for the test period and indicates the diet order on the current NAC.

3. At the end of the test period, the dietitian or nursing staff discontinues the test tray and reinstates the previous diet.

FORMAT OF MANUAL

POLICY: All Facility Services (F.S.) policy statements shall be issued only with the approval of the Director of Facility Services and the ~~Facility Services Hospital Associate Administrator~~Chief Operations Officer.

PURPOSE: To assure that policy statements, which are issued by the Facility Services Department, are consistent in format, address the required elements, and have received appropriate review.

I. CHARACTERISTICS:

Authority: This manual derives from the requirement in the ~~Administrative P&P Manual (ADMINISTRATION: DEPARTMENT & UNIT POLICIES & PROCEDURES MANUAL)~~Laguna Honda Hospital-Wide Policies and Procedures (LHHP) that every hospital department prepare and keep a current manual that describes its policies and procedures, in order to assure the availability of important information concerning the operation of each department.

Not an employee contract: This manual is not intended to be an employment contract between the City and its employees and does not create property or other rights in employment. Such rights are governed by the various labor agreements and where applicable, the Rules of the Civil Service Commission.

Contents: Paraphrasing the ~~Administrative P&P~~ LHHPP-- the department manual shall contain descriptions of services; an orientation covering personnel regulations unique to F.S., including safety aspects of potentially dangerous equipment, F.S.'s response to internal and external disasters, and evidence of a Hazardous Material Communication program. ~~, and a signature sheet at the end of this manual upon which each employee shall indicate (s)he has read the manual.~~

Availability: ~~This~~ A hard copy of this manual shall be kept in the Facility Services office, and ~~copies shall be provided to employees:~~kept up to date on the LHH intranet.

II. PROCEDURE:

A. Prepare the policy and procedure.

B. Submit to the Hospital ~~Associate Administrator, Facility Services~~Executive Committee for approval.

C. Upon approval, the Director of Facility Services will ensure ~~will assign the policy a category classification and release it for distribution.~~

~~Check to assure~~ that the final policy appears in the manual and is updated online~~.~~

D. When appropriate, but at least annually, the person or position title who initiated the policy shall review the validity of that policy and, if the policy has changed, shall revise the procedures and resubmit them for approval.

~~**E.** Facility Services management will re-evaluate the validity of each policy and procedure and revise them if necessary at least once annually.~~

~~**F.**~~**E.** ~~Standard operating procedures may be maintained by the performing section; however, a summary statement of the policy and procedure must be prepared in this format for this manual~~.

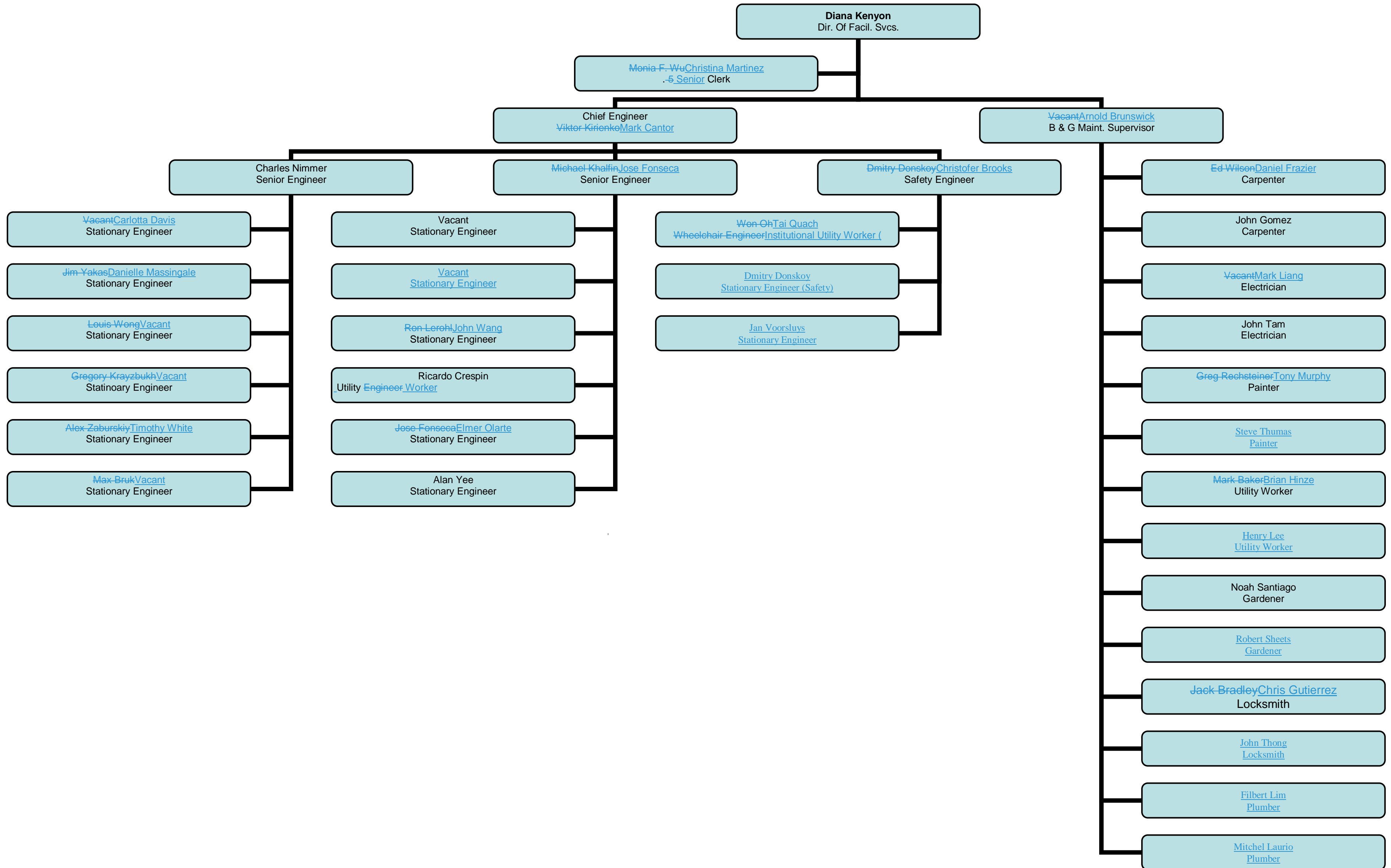
EFFECTIVE DATE: 05/18/97
REVISED: 03/29/07, 8/24/09, 8/17/18 LATEST REVIEW: 08/24/09 P&P DP-1

WRITTEN ORGANIZATIONAL CHART

POLICY: The Facility Services Department shall have a written organization chart showing the major programs of the department, the person in charge of each program, the lines of authority, responsibility, and communication and the staff assignment.

PURPOSE: To clearly define the organizational structure of the department.

PROCEDURE: Refer to the chart of the following page:



Diana Kenyon
Dir. Of Facil. Svcs.
Monia F. Wu Christina Martinez
. 5 Senior Clerk
Chief Engineer
Viktor Kirienko Mark Cantor
Vacant Arnold Brunswick
B & G Maint. Supervisor
Charles Nimmer
Senior Engineer
Michael Khalfin Jose Fonseca
Senior Engineer
Dmitry Donskoy Christofer Brooks
Safety Engineer
Vacant Carlotta Davis
Stationary Engineer
Jim Yakas Danielle Massingale
Stationary Engineer
Louis Wong Vacant
Stationary Engineer
Gregory Krayzbukh Vacant
Stationary Engineer
Alex Zaburskiy Timothy White
Stationary Engineer
Max Bruk Vacant
Stationary Engineer
Vacant
Stationary Engineer
Vacant
Stationary Engineer
Ron Lerohl John Wang
Stationary Engineer
Ricardo Crespin
Utility Engineer Worker
Jose Fonseca Elmer Olarte
Stationary Engineer
Alan Yee
Stationary Engineer
Won Oh Tai Quach
Wheelchair Engineer Institutional Utility Worker (
Dmitry Donskoy
Stationary Engineer (Safety)
Jan Voorsluys
Stationary Engineer
Ed Wilson Daniel Frazier
Carpenter
John Gomez
Carpenter
Vacant Mark Liang
Electrician
John Tam
Electrician
Greg Rechsteiner Tony Murphy
Painter
Steve Thumas
Painter
Mark Baker Brian Hinze
Utility Worker
Henry Lee
Utility Worker
Noah Santiago
Gardener
Robert Sheets
Gardener
Jack Bradley Chris Gutierrez
Locksmith
John Thong
Locksmith
Filbert Lim
Plumber
Mitchel Laurio
Plumber

WATCH ENGINEER RESPONSIBILITY AND RESPONSE TIME

POLICY: Watch engineers shall endeavor to answer calls, respond to calls, and complete repairs in a timely fashion.

PURPOSE: To assure that work is completed during the initial "hands on" in every possible instance, to fix responsibility and accountability in the shift of occurrence, and to preclude passing work from hand to hand and shift to shift.

PROCEDURE:

1. Watch engineer accepts incoming calls via the ~~radio~~ cell phone from Facility Services clerk, ~~hospital operator~~Facilities Supervisors, Nursing Operations office or via the phone/answer machine 4-2397 in G-2.
2. Watch engineer records phone/answer machine incoming job calls in the phone log, noting time, caller's name.
3. The Senior engineer will leave in the mail basket computer generated Work Orders, PM Work Orders, and any other work to be completed during that shift.
4. Watch engineer is responsible for completion of his or her work requests during the same shift (that is, not to pass uncompleted work on to the next shift).
5. Watch engineer shall leave a written memo for the Senior Engineer explaining the circumstances of any work left uncompleted at the end of each shift.
6. Watch engineer shall enter completed Work Orders in the logbook and in the computerized Work Order system ~~at~~ by the end of the each shift.
7. Watch engineer completes a Work Request for his or her own response when a Work Order has not been computer-generated.
8. Evening and night time watch engineer shall enter ~~the~~ a Work Order for the ~~crafts~~ skilled trades should ~~it be competed by the other than engineer trades. Duplicates this requests on the white board in the G-2 Facility Services break room~~the work need to be completed by an individual skilled trade.
9. Watch engineer ~~keeps updated~~shall update the Utility status board in the G-2 Engineering shop each shift.

EFFECTIVE DATE: 05/18/97
REVISED: 4/12/2007,
08/21/18.
LATEST REVIEW: 08/24/09

FACILITY SERVICES EMPLOYEES ~~RADIOS~~ CELLULAR PHONES AND PAGERS

POLICY: All Facility Services employees on duty must maintain ~~radio~~phone communications with administration, each other~~'s~~ and ~~hospital~~ the Nursing Operations office ~~switchboard~~ at all times.

PURPOSE: To assure emergency preparedness exists.

PROCEDURE:

1. All Facility Services employees must maintain ~~radio~~phone capability to communicate with Facility Services administration, clerk, and ~~operator~~ each other at all times while on duty.

2. Watch engineer is responsible for one ~~portable radio~~cell phone~~,~~ and pager.~~,~~ The Sr. Engineer shall carry the ~~radio~~ cell phone and pager at all times and must report any problems with them in the logbook and to the Senior Engineer.

3. Senior Engineers are responsible for portable radio, pager, carry the radio and pager at all times and must report any problems with them to Chief Engineer.

4. Corrective action. The following shall be grounds for corrective action:

   4.1 Misuse or damage to the ~~radio~~ cell phone or pager.
   4.2 Failure to respond to any ~~radio~~ phone call or pager.
   4.3 Failure to note required information regarding communications or communications equipment in the appropriate logbook.

   4.4 Use of inappropriate language~~. It~~ may result in disciplinary action.

EFFECTIVE DATE: 05/18/97
REVISED: 07/23/07, 8/21/18
~~REVIEWED 08/24/09~~ Reviewed 08/24/09

WORK CLOTHES

POLICY: All Facility Services employees will be provided with work clothes to be worn while on duty at LHH.

PURPOSE: To establish and maintain a high level of professionalism and to assert highly visible, readily identifiable service department.

PROCEDURE:

1. The Director of Facilities shall assure that work clothing is provided by the hospital. Each employee shall receive three sets of shirts and pants. Coveralls will be available on as needed bases upon request.work clothing as specified in their respective MOU.
2. All engineers, except the Chief Engineer and Maintenance Supervisor shall wear appropriate attire while at Laguna Honda Hospital.

   3.1 Shirt and pants shall be considered appropriate attire for work performed in any patient care area. Coveralls shall not be worn in patient care areas without prior permission of a supervisor.

   3.2 Engineers on duty in the boiler rooms, machine shop, heat exchanger rooms or any other industrial areas may wear coveralls as appropriate attire.

3.2. Work clothes must be neat and presentable.

EFFECTIVE DATE: 05/07/90
REVISED: 08/24/09, 8/17/18

P&P DP-7

STATIONARY ENGINEERS' ASSIGNED AREAS OF RESPONSIBILITY

POLICY: Responsibility for engineering preventive maintenance and repairs is assigned by specific hospital area designation.

PURPOSE: To individualize the care and upkeep of the facility, to assign specific responsibility and accountability, and to assure that all areas of the facility receive appropriate levels of maintenance and repair, as well as inspection.

PROCEDURE:

1. The following hospital structures and areas of responsibilities have been designated:

   Area A: South residential building (SRB).

   Area B: North residential building (NRB).

   Area C: Pavilion building/Kitchen and Cafeteria/Clinic and Pharmacy.

   Area D: LHH Refrigerators, Ice machines.

   Area E: Life Safety. Includes Fire alarm, Fire extinguishing systems.

   ~~**Area F: Wheelchairs.** Includes manual and power wheelchairs throughout entire LHH facility~~

   Area F~~G~~: Aquatic pool area,

   Area G~~H~~: Administration Building. Includes H, A through 0 wings.

2. Day crew Stationary Engineers will be assigned to the area of responsibility by the engineer numbers, as they were identified at the time of the shift bidding process.

3. Each day crew Stationary Engineer assigned to the specific area will be responsible for but not limited to:

   3.1 maintain and repair any mechanical equipment located in his/her assigned area;

   3.2 keep all assigned equipment and machine spaces clean at all times;

   3.3 assure that all work order records and logs of fact shall correctly indicate:
   name and location of equipment, model and serial numbers, size and number of V belts, voltage, phase, RPM, as well as any other essential basic information, and that the repair record shall correctly indicate the date and hour of lubrication oil change, inspection, cleaning

of condensers and evaporators, repacking of pumps, replacement of parts, as well as any other essential basic information.

4. Each Watch Engineer is responsible at the time of ~~an~~ their assigned shift for the operation and repair ~~entire~~ of all hospital equipment, including but not limited to: HVAC, refrigerators, pumps, wheelchairs, furniture and other hospital equipment for resident safety and comfort. He/she ~~should to~~shall inspect boilers and other equipment in all machinery rooms and on the roof.

5. The Stationary Engineer assigned to Area B will alternate hospital water supply pumps during the first week of each month. He/She will inspect the area adjacent to the pump control cabinet, tanks water level, secondary water supply pump (Pump House) once per week and log this fact in the Work order (WO) system.

6. Each Stationary Engineer ~~should to~~shall report in writing to the Senior Stationary Engineer or to the Chief Stationary Engineer any unusual conditions and exceptions.

EFFECTIVE DATE: 5/18/97
REVISED: 5/16/13,
08/21/2018

P&P DP-8

WORKSITE ORIENTATION FOR NEW EMPLOYEES

POLICY: Facility Services Department managers shall assure that adequate, appropriate and documented worksite orientation is provided for all new employees within ten working days of the first day employed at Laguna Honda Hospital, and that the orientation is documented.

PURPOSE: To assure that new employees are provided equipment-related and worksite-related information to enhance overall levels of safety, productivity, and job contentedness.

PROCEDURE: The Chief Engineer or Facility Services Maintenance Supervisor or appropriate designees, respectively shall provide an adequate and appropriate on-site job-specific and equipment-specific orientation to new employees.

A. The orientation shall occur within 10 working days of the first day worked at Laguna Honda Hospital.

B. The orientation shall be specific to the on-site equipment to be used by the employee. Most employees are hired at journey-level and should be skilled in the use of applicable trade equipment.

C. The duration of the orientation shall be no less than one hour.

D. The person providing the orientation may be a supervisor or tradesperson in the same Civil Service class as the new employee, however, the person must be knowledgeable in the orientation to the specific equipment.

E. The orientation shall be limited to not more than 3 tradespersons in each orientation for one orientation provider, a 3:1 ratio. A 1:1 ratio shall be considered optimal.

F. During the orientation, any findings provided in writing by the Safety Committee, Quality Assurance Committee, Infection Control Committee, or any other standing committee shall be included, discussed, and otherwise utilized in an appropriate manner.

G. The person providing the orientation shall utilize one approved checklist for each employee being oriented, and shall complete all items on the checklist, obtain signatures and forward one copy of the orientation to the Chief Engineer or Facility Services Maintenance Supervisor, as appropriate.

H. The Chief Engineer or Facility Services Maintenance Supervisor, respectively, shall keep documentation of this orientation (refer to P & P #14: In-service training).

EFFECTIVE DATE: 5/18/97
REVISED: 07/23/07,8/24/09, 8/17/2018
LATEST REVIEW: 08/24/09 DP-13

IN-SERVICE TRAINING

POLICY: The Facility Services Department shall provide periodic in-service training which shall utilize relevant findings of all standing committees, provided that the standing committees transmit such information in writing to the Facility Services Department or agenda discussion at the regular meeting at which a representative of Facility Services' management team is present.

PURPOSE: To assure that recommendation and findings of the major standing committees of the hospital are translated into worksite practices in keeping with the highest training standards.

PROCEDURE:

A. The Director of Facility Services or designee shall call a monthly meeting of at least one hour duration of all Facility Services employees present that day.

B. Certain elements shall be present in the meeting agenda and informally documented in a written, dated log of such meetings:

1. Any written communications from hospital standing committees shall be transmitted to employees present at this meeting.

2. Job-related safety issues shall be discussed at this meeting.

3. Any relevant findings or recommendations verbally presented during the public portion of standing committee meetings at which a member of F.SFacility Service. management was present shall be transmitted to F.S. employees by that manager at this meeting.

C. Facility Services department shall depend on the hospital's Dept of Education and Training to provide training for all employees. The Chief Engineer and Maintenance Supervisor shall be accountable to assure completion of Health Streammandatory online training by their respective employees at scheduled meetings, and to keep documentation.

D. The Safety Engineer shall call a bi-weekly safety meeting of all Facility Services employees present that day. Safety practices shall be discussed and safety movies to be shown.

E. Contractors or engineers shall give classes to F.S. engineers explaining the operation and maintenance of all new equipment installed.

6. On an annual basis, the Director of Facility Services, Chief Engineer, and Maintenance Supervisor shall review with the Hospital Associate AdministratorChief Operations Officer the effectiveness of the monthly F.S. meetings, of Title training, and of new employee general and worksite orientations.

EFFECTIVE DATE: 5/18/97
REVISED: 07/23/07,8/24/09, 8/17/18
LATEST REVIEW: 08/24/09

PATIENT'S SMOKING PRECAUTIONS

POLICY: Facility Services employees working in patient care and public areas are shall not to give patients anywhere on the premises smoking materials, lighters, or matches, nor shall they light patient's cigarettes. unless they can be sure of supervision by other hospital direct care staff. Furthermore, employees should discourage visitors from offering patients smoking materials or matches unless supervision can be assured.

PURPOSE: To provide a smoke free environment facilityt to those who wish to work or eat free from tobacco smoke and to provide for the safety of patients as appropriate.

I. CHARACTERISTIC: The above policy and procedure is specific to patient smoking in relation to safety; employee and visitor smoking is covered under another P & P.

II. PROCEDURE:

A. Facility Services managers shall cover Administrative P & P entitled PATIENTS' SMOKING PRECAUTIONSHWPP 76-02 Smoke and Tobacco Free Environment during in-service training., where the types of patient smokers and the requirement for direct care supervision are fully described.

B. Employees shall not offer smoking materials or matches to patients, nor shall they participate in assisting patients with such materials. While on the wards, F.S. employees shall refer all such requests to direct care staff. In all other areas, employees shall decline requests or refer to the nearest direct care provider.

C. F.S. employees shall be alert to recognize the chartreuse ribbon attached to the right shoulder of clothing that identifies careless smokers, and shall take appropriate action to avert unsafe situations.

D. F.S. employees shall take note of "No Smoking" signs, which must be prominently posted in any room where oxygen cylinders are in use or stored, and shall be alert to extinguish and report smoking materials or open flame in any such room.

EFFECTIVE DATE: 01/01/98
REVISED: 4/30/07, 8/24/09, 8/17/18
LATEST REVIEW: 08/24/09

REQUEST FOR HOUSEKEEPING SERVICES

POLICY: Employees shall ~~immediately~~ relay all ~~requirements~~ requests for EVS department to the appropriate action person.

PURPOSE: To assure that showers, bathrooms, and toilets in the various Facility ~~Services~~ Services shop areas receive periodic thorough cleaning by EVS department and to permit prioritization by EVS department.

PROCEDURE:

A. Routine work requests: Any Facility Services employee who notes an unclean or untidy condition ~~immediately~~ shall report the need for housekeeping services ~~as follows~~, including the location, services and supplies needed to ~~:~~the Chief Stationary Engineer or B & G Maintenance Supervisor. The notified supervisor shall enter an EVS TMS work request.

~~In F.S. work areas notify the Chief Stationary Engineer or the B & G Maintenance Supervisor.~~

~~1. In ward areas, notify the housekeeper or charge nurse.~~

~~2. In hallways and common areas, notify the Facility Services clerk. Facility Services clerk will transfer the request to EVS department.~~

B. ~~Major work~~Emergency requests: Facility Services employees shall channel requests for ~~major~~ emergency housekeeping services through the Chief Engineer or Facility Services Maintenance Supervisor, by telephone.

~~Facility Services clerk will telephone the EVS office.~~
Examples of ~~major~~ emergency work ~~projects~~requests~~:~~ wet/dry vac after a flood, clean up and sanitation after a major plumbing stoppage. ~~cleaning all showers, baths, and toilets prior to an inspection; moving heavy office furniture. Examples of equipment which might be requested: special toilets, furniture equipment, or utensils to clean mold from tile or ceilings.~~

EFFECTIVE DATE: 5/18/97
REVISED: 04/18/07, 08/17/18
REVIEWED: 08/2009

~~PERSONNEL REGULATIONS~~Employee Health/Sick Leave Policy/Call-In Sick Log

POLICY: ~~Every Laguna Honda employee shall be provided with the information necessary to understand the conditions of one's employment.~~All Facility Services Employees are required to call in sick when they are sick with an infectious disease and are under the general care of a physician. The department will record all employees that call in sick.

PURPOSE: ~~To clarify the rights and responsibilities of employees.~~

~~The following paraphrased portions of that policy are intended to provide Facility Services employees with an initial simplified basic resource for gaining knowledge of rights and responsibilities as well as where to find additional information.~~

~~Employees should refer to the Administrative P&P for a more complete summary statement, then ask a supervisor, and finally, contact the Human Resources Department~~To insure the safety of the residents, staff, and others. To document staffing levels and keep track of employee that calls in sick and their expected day of return to work. For management personnel to arrange adequate staffing of necessary duty assignments and to replace personnel when necessary. .

~~**I. CHARACTERISTIC**:~~
~~The Human Resource and Payroll Division is comprised of the Personnel Department and the Payroll Department.~~

I. PROCEDURE:

1. Individuals suffering from nausea, vomiting, diarrhea, skin lesions, heavy coughing/sneezing should not be report to work at any time. Thy are advised to seek medical attention for proper identification of their health condition.

2. How to Call in Sick:

   a. Call the Chief Engineer or Maintenance Supervisor (whoever is your supeviser, or if neither is available, the B&G Maintenance Superintendent) at least 4 hours prior to the start of your shift.

   b. After calling the above person, call the inside watch engineer on duty and report that you will be sick and tell the inside watch engineer whether or not you have already spoken with the supervisor.The watch engineer shall record the call-in information on a call-in slip for the appropriate supervisor.

   c. . If you are an engineer who is scheduled for watch duty, the supervisor will attempt to reach an engineer at home to fill your duty shift.

   d. . Watch engineers shall remain at their duty stations until relief is found, and should feel free to contact the Chief Engineer or Maintenance Superintendent at home if relief does not report to duty on time. Record this fact in the log book so that overtime can be paid for excess time worked. Watch engineers who work in excess of their shift and who make the proper reports by telephone to management and in the log book will be paid overtime for remaining at their stations.

   e. There are no exceptions to the reporting of sick leave. Calling the department secretary or the watch engineer in lieu of calling the supervisor is unacceptable. Employees who fail to provide proper notice may be subject to disciplinary action for being absent without leave (AWOL).

3. Excessive use of sick time will be considered. The use of more than one day off work per month over a period of time such as six months or year is considered excessive. Absences in relation to days off will be critically evaluated or a pattern is shown such as being off sick every other Saturday. The department will monitor employees' attendance records periodically. An employee disciplinary action may be result for excessive absenteeism. After the initial formal counsel, the attendance records will be monitored within the next three months for any improements. Further disciplinary action may follow if the employee is off sick more than three times within the three months-monitoring periods.

II.

~~A. Title 22 requirements: Employees at LHH must receive annual training in each of these certain specific topics, required under the law:~~

1. ~~Problems and needs of the aged and chronically ill, acutely ill, and disabled patients.~~
2. ~~Infection control.~~
3. ~~Interpersonal relationships and communication skills.~~
4. ~~Fire prevention and safety.~~
5. ~~Accident prevention and safety.~~
6. ~~Confidentiality of patient information.~~
7. ~~Patient rights and civil rights.~~
8. ~~Signs and symptoms of cardiopulmonary distress.~~
9. ~~Choking prevention and intervention.~~
10. ~~Pertinent Civil Service and Departmental policies and procedures.~~
11. ~~Hazardous materials management/employee right to know.~~

~~To accomplish this task, the Human Resource Department will schedule and preset to new employees the Employee Orientation Program, which meets the legal requirement for initial orientation.~~

~~B. The Facility Services Department shall conduct additional training during the year on each of the above topics, for which documented attendance is mandatory under the law for all employees of Laguna Honda Hospital. The annual training is designed to meet your need to know specific general and specific information (relative to your job class and work assignment) about each of the topics at a depth appropriate to type of work.~~

~~C. Job-specific orientation: The Facility Services Department shall provide specific WORKSITE ORIENTATION FOR NEW EMPLOYEES. Refer to Plant Services P&P, same title.~~

~~D. Employees should address personnel - or payroll - related questions first to a supervisor, and then to the Human Resources and Payroll Division.~~

~~E. Working hours:~~

~~Laguna Honda Hospital operates 24 hours per day, 7 days per week. Each day divided into three shifts, and business offices are open during the day shift, five days a week, with actual times varying by department. All hospital employees are assigned one of these shifts: 1) Midnight or Night shift; 2) Day shift; 3) "Swing" or PM shift. The Chief Engineer and Buildings and Grounds Maintenance Supervisor are directly responsible for scheduling the shift hours of each employee to meet the hospital's requirements.~~

~~1. Engineering watch shift:~~

~~#1 shift:2200 to 0800~~

~~#2 shift:0600 to 1600~~

~~#3 shift:1200 to 2200~~

~~a. The Engineering watch shift shall consist of one engineer to handle emergencies, calls, and routine maintenance.~~

~~b. All breaks and meals are required to be taken at the work station to assure that the watch station is covered at all times by a watch engineer at that station. It is acceptable for the watch engineer to obtain food from cafeteria or vending machines for the inside watch engineer. Engineers on watch shifts shall not leave the hospital grounds until relieved.~~

~~c. Watch engineers shall arrive in sufficient time to receive a briefing from the off-going watch prior to the departure of the off-going watch.~~

~~2. Engineering day maintenance shift:~~

~~#2 shift is 0700 to 1530 break 1000 to 1015 hours~~

~~meal 1200 to 1230 hours~~

~~break 1400 to 1415 hours~~

~~clean up 1500 hours~~

~~F. Leaving the Premises:~~

~~1. Routine hospital business: employee shall inform one's supervisor prior to leaving the premises on routine business;~~

~~2. Supervisors shall keep each other informed when any are off-premises;~~

~~3. Employees leaving the premises on personal emergency must obtain permission from the immediate supervisor.~~

~~4. Otherwise, employees shall observe the established working hours and -shall remain on the job except when absent on official Departmental business.~~

~~G. Overtime and Holiday Pay:~~

~~1. Employees required by management to work overtime or on a holiday because of an emergency will be paid one and one-half times their basic salary for overtime work after eight hours per day or 40 hours per week. All overtime must have prior management approval.~~

2. Employees required by management to work overtime on any holiday will be paid the usual compensation for the holiday plus additional pay at one and one-half times the normal rate of pay. All overtime must have prior management approval.

H. Compensatory Time:

1. Prior approval to work overtime must be obtained from the supervisor; the amount of overtime actually worked must be recorded on the payroll sign in sheet and actual worktime approved by the supervisor. The payroll sheet is recorded in the Payroll Office. Prior approval of use of compensatory time must be obtained in advance by the employee from the supervisor.

2. Employees covered by the Fair Labor Standards Act can accumulate a maximum amount of compensatory time of 30 days per fiscal year.

3. Separating employees may use accumulated compensatory time not to exceed 20 days.

I. Types of Leaves: There are many types of leaves of absence, including vacation, witness/jury duty, compulsory sick leave, disability leave, military, maternity, bereavement, educational, childcare, and personal leave, among others. Refer to the Administrative P & P or ask the Personnel and Payroll Division for additional information.

1. Vacation leave: Vacation leave is awarded on a first come basis, with the person having the most seniority allowed first choice in cases where two employees submit requests during the same two-week request interval; priority of seniority status will apply only to requests made within a two-week period of each other. No employee may combine sick leave with vacation or holidays. Vacation request forms are available from supervisors.

   Generally, only four weeks vacation will be granted at any one time, but requests for more than four weeks will be considered if the request is entered at least a month before the first day of vacation.

   Normally, requests for less than four weeks vacation must be submitted at least two weeks before vacation time can be used, to allow for shift coverage arrangement and necessary review.

   Additionally, management may allow approval of a maximum of two requests from employees in the same classification for vacation at any one item, dependent on circumstances and workload.

J. Absenteeism:

1. Absence without official approval, regardless of length of time, is cause for disciplinary action.

2. The Department defines excessive absenteeism as absence in excess of one day per month over a period of time, or a pattern of absences before or after days off, or on weekends. Excessive absence may be grounds for disciplinary action.

3. Tardiness: Facility Services will endeavor to treat all employees as professionals, recognizing commute, parking, and personal issues may affect arrival time. Days for which sign-in is "slightly" early should offset days for which sign-in is "slightly" late in time. Excessive variances will necessitate individual counseling.

   Tardiness in reporting to inside or outside watch engineer duty: the critical importance of the two watch engineers to the hospital's safety shall be reflected by deducting excessive time late reporting to duty shift from that engineer's pay as A.W.O.L so that overtime can

~~be authorized by management to pay the employee who had to remain on duty to cover the absence.~~

~~K. Sick Leave:~~

~~1. Number of hours: Employees earn sick pay credits based on the total number of paid hours, up to 104 hours per year, which may be accumulated up to a total of 1040 hours (=130 days).~~

~~2. Six month interim: Employees begin earning sick pay credits upon service, but will be docked for any sick leave taken prior to the completion of six months. After completing six months of continuous service, employees are granted the sick pay credits they have earned during the initial six months.~~

~~Sick leave in excess of five days must be certified by a licensed medical doctor, dentist, or other authorized medical personnel on the Request for Leave form with a statement as to the reason and expected duration of the illness. The Request for Leave form must be submitted to the Chief Engineer or Maintenance Supervisor by close of business on the fifth day.~~

~~How to Call in Sick:~~

~~**a.** Call the Chief Engineer or Maintenance Supervisor (whoever is your supeviser, or if neither is available, the B&G Maintenance Superintendent) at least 4 hours prior to the start of your shift.~~

~~**b.** After calling the above person, call the inside watch engineer on duty and report that you will be sick and tell the inside watch engineer whether or not you have already spoken with the supervisor.~~

~~3. If you are an engineer who is scheduled for watch duty, the supervisor will attempt to reach an engineer at home to fill your duty shift.~~

~~4. Watch engineers shall remain at their duty stations until relief is found, and should feel free to contact the Chief Engineer or Maintenance Superintendent at home if relief does not report to duty on time. Record this fact in the log book so that overtime can be paid for excess time worked. Watch engineers who work in excess of their shift and who make the proper reports by telephone to management and in the log book will be paid overtime for remaining at their stations.~~

~~5. There are no exceptions to the reporting of sick leave. Calling the department secretary or the watch engineer in lieu of calling the supervisor is unacceptable. Employees who fail to provide proper notice may be subject to disciplinary action for being absent without leave (AWOL).~~

~~Please refer to the Administrative P&P above or consult with Human Resources and Payroll Division about additional sick and other leave information.~~

~~L. There are 11 holidays and personal floating holidays per year. The employee must obtain prior approval from one's supervisor before scheduling the floating holidays. Temporary employees must complete six months of service prior to receiving floating holidays. Refer to annual calendars and other publications listing the holidays. Refer to your supervisor regarding holidays.~~

~~M. Wearing employee identification badges: all hospital personnel are to wear their hospital identification badges, and, failure to wear the badge shall be subject to disciplinary action if stopped by the SFSD in non-public areas. Upon separation, the employee shall return the badges to the Personnel Department.~~

~~N. Job-related injury or illness (Industrial Accident):~~

1. ~~Call 4-2999 if an injured employee needs immediate emergency care.~~
2. ~~Injured or ill employees shall:~~
   a. ~~Report injury or illness to one's supervisor.~~
   b. ~~Report to a designated workers comp treatment facility unless the injury is life threatening.~~
   c. ~~Return the yellow copy of the Patient Control Slip to one's supervisor within 24 hours when possible.~~
   d. ~~Present the completed Work Release Form to the supervisor upon return to duty. 0.~~

~~Employee's personnel file:~~

1. ~~Shall be maintained in the Personnel Office and is confidential, being open to review by only those authorized by the employee in writing, and authorized Department Management.~~
2. ~~Contains: full name, social security number, professional license or registration number, employment classification, employment history and qualifications, date of beginning employment, date of termination of employment, documented evidence of orientation to the hospital, performance evaluations, and record of successful completion and date of annual medical. The information will be maintained for at least three years after separation.~~

EFFECTIVE DATE: 5/18/97
REVISED: 07/30/07, 8/24/09, 8/21/18

KEYS, KEY SECURITY, AND SECURITY

POLICY: Employees shall exercise care and attention to the securing of keys, buildings, vehicles, equipment, tools, materials, and supplies.

PURPOSE: To assure a safe living and working environment for patients, visitors, and employees.

PROCEDURE:

A. Vehicle key security.

1. All Facility Services maintenance vehicles ~~assigned for use by the employees and~~ keys are to be kept ~~by the assigned persons. Leaving keys in unattended trucks shall be the basis for disciplinary action~~ in the locked key watcher cabinet.
2. ~~Spare keys for all LHH vehicles to be stored in the Senior Stationary engineer office.~~Facility Services staff shall remove a vehicle from the key watcher cabinet when the use of a vehicle is necessary. The key watcher cabinet will log the key used, the user of the key and the date and time the key was removed.
3. ~~Responsibility for the Watch engineer vehicle key shall pass from engineer watch to watch, regardless of whether or not either watch engineer uses the vehicles.~~Facility Services staff shall return the vehicle keys to the key watcher cabinet when done using the vehicle. Failure to return vehicle keys may result in disciplinary action.

B. Night security.

To provide safety and security for patients, staff, visitors, and for plant and equipment:

1. Access to the buildings will be restricted from 2100 hours until 0600 hours.
2. All perimeter doors will be equipped with approved hardware to allow for emergency exit at all times.
3. ~~Prior to target hours, the Sheriff Department shall secure perimeter doors, excepting the two buildings' front doors and the 5th floor east entrance. At 2100 hours, subsequent to visiting hours, the Sheriff Department shall secure the two front doors and the 5th floor east building entrance .~~
4. ~~4.~~3. ~~The Sheriff rep. shall open the front door of the West building and the entrance to Clarendon Hall from 2300 hours to 2345 hours to allow access for change shift, and shall re-secure these doors following the change of shift~~.
5. ~~5.~~4. Be aware that the Sheriff makes frequent rounds of the entrances at night.
6. ~~6. Only visitors with AOD permission (Police will know) should be present after 2100 hours.~~
7. ~~7.~~5. Facility Services employees as well as others must use the designated passages to maintain security. Sheriffs have been instructed to report the unlocked perimeter doors and unauthorized entrances or exits to the appropriate manager.
8. ~~8.~~6. ~~F.S.~~Facility Services employees who notice anyone ~~stranger lacking~~without a hospital ID or visitor badge after 9:15 p.m. or any suspicious event shall immediately ~~should request the Telecommunications operator to~~ notify the Sheriff of the place, direction headed, description, ~~time,~~ and your name.

C. Locking of Shops

1. Facility Services shops ~~is~~are intended to be used by the ~~own employees~~Facilities Staff only ~~and~~ during their ~~actual~~ duty shift, and at no other times.

2. During shift #2 and 3 the entrance doors to the Facility Services areas will be closed and locked at all times.

EFFECTIVE DATE: 5/18/96

Revised 08/21/2018

REVIEWED: 08/2009

REVISED 07/2007, 8/2009

RESPONDING TO LOCKED WARDS

POLICY: Facility Services employees who respond to perform work on ~~locked wards shall lock all doors.~~the secured neighborhood (NM) ensure that the doors are properly closed.

PURPOSE: To assure the security of the ~~locked wards~~ secured neighborhood and the safety of their residents.

PROCEDURE:

A. ~~Lock doors on lock-up wards L-6 or K-6 upon entry, and permit no patient to pass. Notify a direct caregiver if any patient tries to egress while you are working on that ward.~~All staff entering and exiting the neighborhood are required to ensure that the doors are properly closed.

1. Prior to entering the neighborhood, staff shall check to ensure there are no residents in the vestibule area that can elpe. IF a resident is present Facilities staff shall utilize the Aiphone system to alert neighborhood staff their intent to enter so the resident can be safely redirected back into the neighborhood.

2. Upon exiting the neighborhood. Facilities staff shall again ensure there are no residents in the vestibule area. If a resident is present, Facilities Staff shall notify the neighborhood staff to redirect the resident prior to opening the door to leave.

~~A.~~**B.** Facility Services employees who respond to perform work on ~~locked wards~~secured neighborhood shall be held accountable at the same level as ~~ward~~ neighborhood personnel to assure that the ~~wards~~ neighborhood remain locked at all times.

~~B.~~**C.** Failure to maintain absolute security on ~~these wards~~secured neighborhood shall become the basis for disciplinary action.

D. Facility Services employees shall use caution when using tools and equipment in ~~these wards~~secured neighborhoods. No tools or equipment should be left unattended. Remove all tools and equipment when leaving the ~~locked wards~~secured neighborhood.

Reference: HWPP 76-01 Secured Neighborhood Safety

EFFECTIVE DATE: 3/30/2007
REVISED: 03/2007, 08/2009, 08/21/2018
REVIEWED: 08/2009

BODY SUBSTANCE ISOLATION POLICY

POLICY: The Facility Services department shall abide by the procedures set forth for the LAGUNA HONDA HOSPITAL BODY SUBSTANCE ISOLATION P&P

PURPOSE: To assure that work performed by the department conforms both to the procedures described with Body Substance Isolation P & P, and that crafts persons that observe body substances on surfaces during the course of the work shall report it for removal prior to engaging in work.

I. PROCEDURE:

The hand washing admonition is repeated to emphasize the critical role which proper hand washing performed at the appropriate time has on the overall infection control program at a hospital.

A. Gardeners: Gardeners perform work in all the cultivated areas on premises while maintaining gardens adjacent to buildings and removing debris from their working areas, using a variety of cutting tools, including but limited to mowers, trimmers, saws, and knives.

a. Precautions: As a general practice for all crafts persons, regular hand washing must be done both before and after working in patient care areas as well as subsequent to contact with articles which may be soiled with body substances.

b. Gardeners should wear gloves when handling anything wet or visibly soiled by body substances. The choice of gloves should be appropriate to the type of articles being handled. Therefore, heavy gloves should be worn when handling sharp objects. Gardeners should take care in handling of needles and other sharps, which must be disposed of in puncture-proof containers.

B. Plumbers: Plumbers maintain the water supply and waste systems. Most of this work will occur in the residents' bathroom areas, while other work is required in the steam plant, underneath buildings, and to the gardeners' watering system. During the course of regular work, plumbers come into contact with patients' bathroom toilets, basins, urinals, tubs, floor drains, bed can flushers, utility sinks, shower rooms, as well as nursing station pluming fixtures such as the toilet and wash basins. Additional plumbers come into contact with laboratory sinks and drains in the clinics and surgery areas, and housekeepers' sinks throughout the hospital as well as water fountains in the corridor. Plumbers perform numerous repairs on kitchen cooking preparation equipment, the dishwasher machines, sinks and floor drains in the butcher shop, and much work involves the use of metallic tools and equipment. Plumbers may receive small cuts and bruises while working.

a. Precautions: As a general practice for all crafts persons, regular hand washing must be done both before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

b. Plumbers should wear gloves, an appropriate mask, and eye protection when working in situations where splashing of body substances is likely to occur. The plumber should wear additional protective covering over clothes and hair in cases where splashing of large quantities may occur.

c. Plumbers should wear gloves if contact with body substances are likely, but splashing is not expected.

C. Electricians: The electricians perform much work in resident areas making repairs to over bed and ceiling lighting systems and many miscellaneous fixtures.~~, which include but are not limited to the nursing call systems located at the beds, toilet areas, and bathtubs~~. Some repairs are performed at the wall receptacles near the floor, while miscellaneous repairs and servicing of equipment are performed in the laboratories, clinics, ~~surgery suite,~~ radiology, central supply, ~~kitchen~~and kitchen~~, butcher shop~~ and in the infectious waste rooms and hallways.

a. Precautions: As a general practice for all crafts persons, regular hand washing must be done both before and after working in patient care areas as well as subsequent to contact with articles which may be soiled with body substances.

D. Painters: The painters perform maintenance and repairs in all resident areas. While painters tend to perform only minor repairs in resident areas, painters move from resident area to area and therefore must observe the highest standards of care for the resident.

a. Precautions: As a general practice for all crafts persons, regular hand washing must be done both before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

E. Carpenters: The carpenters perform numerous repairs and maintenance of many different types in all resident areas. These include but are not limited to wall, accessories used for and by residents, as well as doors, windows, bathrooms, toilet rooms, and flooring materials. Additionally, carpenters move from area to area and therefore must observe the highest standards of care for the resident.

a. a. Precautions: As a general practice for all crafts persons, regular hand washing must be done before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

F: Locksmiths: The locksmith perform repairs and maintenance on doors and other locks throughout the hospital. These include but are not limited to fire doors, office doors, delayed exit devices and resident furniture. Additionally locksmith move from area to area and therefore must observe the highest standards of care for the resident.

a. Precautions: As a general practice for all crafts persons, regular hand washing must be done before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

F. Stationary Engineers: The stationary engineers perform maintenance and repairs to a variety of equipment throughout the hospital, including but not limited to electric beds, wheelchairs, patient lifts, weighting scales, clothes washers and dryers. Additionally, maintenance and repairs are performed on kitchen and refrigeration storage equipment, compressing, weighting, drying equipment, some of which maintenance occurs either both clean and soiled linen sorting areas. Additionally, stationary engineers move from resident area to area and therefore must observe the highest standards of care for the resident.

a. Precautions: As a general practice for all crafts persons, regular hand washing must be done before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

F.G. The wheelchair engineer Utility Worker: The wheelchair utility worker performs maintenance and repairs on wheelchairs both in the ward areas and in the repair shop. Although an effort is made to repair the chairs when unoccupied by patients, the mechanical and electrical repair work could bring the engineer into contact with the resident's body fluids.much work in resident care areas making repairs to over bed and bed side lighting, clocks and wheelchairs. Additionally utility workers move from area to area and therefore must observe the highest standards of care for the resident.

a. Precautions: As a general practice for all tradespersons, regular hand washing must be done both before and after working in resident care areas as well as subsequent to contact with articles which may be soiled with body substances.

II. SUMMARY:

All tradespersons are advised that hand washing before and after working in each area can have a significant positive effect on reduction of infection throughout the hospital.

Tradespersons are among the most mobile of workers in the hospital, moving freely among the wards; therefore, the simple but highly effective hand washing procedure is particularly important, regardless of the area in which the tradesperson is working.

EFFECTIVE DATE: 5/18/97

REVISED: 05/2007, 8/21/18

REVIEWED: 08/2009

RESETTING TIME CLOCKS

SUPERSEDES: Procedure for Changing From and Returning to Pacific Standard Time

POLICY: To assure that old equipment is preserved and to assure that clocks are reset in a "timely" fashion.

PROCEDURE:

1. To Pacific Daylight Saving Time

    1.1 The first Sunday in April is the date to "spring forward".

    1.2 The engineer shall advance the generator and PG&E main switchboard clocks one hour at 0200 hours, and the boiler chart recorders at any convenient hour thereafter.

    1.3 The engineer shall set the master clock for the main building.

    1.4 The engineer shall set the time switches located in East, Middle, West, Clarendon buildings, as follows:

        1.4.1 Street lights: located at MSA Power Supply (Main Gas Meter)

        1.4.2 Woodside Avenue road lights: located K-3 machine room (East building).

        1.4.3 Hydrotherapy pool time switch: located K-3 pump room (East building).

        1.4.4 Refrigeration defrost time switches: located in service room of H wing).

        1.4.5 Nos. 3 and 9 elevator time switch: located machine room of M & 0 wing).

        1.4.6 Pathway lights: located at pedestrian gatehouse.

~~1.4.7 Clarendon night lights: located at panel EA front lobby custodian's closet; panel EB north end ward 700; panel EC linen chute room ward 900 (all in Clarendon building).~~

~~**2.** To Pacific Standard Time.~~

~~2.1 The last Sunday in October is the date to "fall back".~~

~~2.2 The shift 3 (night) watch engineer shall reset the main switchboard clocks at 0200 hours.~~

~~2.3 The building area engineers shall set their respective area time switches, as in step 1.4.~~

~~**3.** In the event of PG & E power failure:~~

~~3.1 Watch engineer shall record in the log the "OFF" and "RETURN TO SERVICE" times.~~

~~3.2 As soon as power is restored, the outside watch engineer shall:~~

~~3.2.1 Start refrigeration condenser water circulating pump and the hot water pumps in the service room.~~

~~3.2.2 Check operation of all other equipment.~~

~~3.2.3 After prolonged outage, it will be necessary to reset timer switches for refrigeration defrost and street lighting time switches (one in laundry and one in mechanical room K-3), as well as hydrotherapy pool equipment timer, etc. (refer to above).~~

~~3.2.4 Reset time recorder to correct time. 3.2.5~~

~~Reset PG & E clock to correct time.~~

~~3.2.6 Leave a W.O. for the engineer to reset the master clocks.~~

~~EFFECTIVE DATE: 05/18/97~~
~~REVISED: 03/31/07 REVIEWED:~~
~~August 2009~~

~~DP-6, Pg. 2~~

SAFETY: REPORTING VEHICLE ACCIDENTS

POLICY:

1. Employees who drive shall maintain valid driver's licenses.

2. Any employee of Laguna Honda Hospital involved in an accident either on or off- premises while driving a City vehicle on City business is insured by the City and shall exchange driver's license and auto plate identification with the other driver, and shall obtain the other driver's liability insurance information and home and office telephone numbers. Employee shall provide "City and County of San Francisco, do LHH, 375. Laguna Honda Blvd., 94116 as insurer, explaining that the City is "self-insured."

3. Employees immediately shall report any accident occurring on Hospital grounds to the Sheriff.

4. Employees immediately shall report any accident occurring off Hospital grounds to the local police jurisdiction and request the police respond to the scene of the accident and file a report.

PURPOSE: To facilitate proper documentation of accidents, timely reporting to authorities and families, and expedition of repairs.

PROCEDURE:

A. Timely report. When the accident occurs on the grounds, the employee involved immediately shall report the accident verbally to the Sheriff who shall request the employee to file a written report, a copy of which should be submitted to the Associate Administrator for Support Services. When off the grounds, the employee immediately shall request the local jurisdiction police respond and file a report. Employee shall notify the Sheriff when possible.

B. All accidents must be reported to the Chief Engineer or Maintenance Supervisor, Who will then advise the Director of Facility Services.

Data Required. The employee's report to the Sheriff department should include at least the following information:

* Indication whether a major breakdown or an accident has occurred.
* Names and address of all parties and their insurance providers.
* Description of each person's injuries.
* Description of vehicle, damage, and estimation whether it exceeds $500.

C. Transport of hazardous materials. If the employee were transporting any hazardous materials (example is auto batteries) and there be any spillage, release, or probability of same, the employee shall make a separate report to the supervisor. If the employee is off-site or in another city when this occurs, the employee shall call the hospital operator and request the hospital operator notify appropriate parties; alternately, the employee may call that area's local 911 and request that the 911 operator inform the hospital and local authorities of a potential or actual spill or release of hazardous substances.

EFFECTIVE DATE: 5/18/97
REVISED: 07/23/07
LATEST REVIEW: 08/24/09
DP-11

UNUSUAL OCCURRENCE REPORTING

POLICY: Facility Services employees shall be familiar with and comply with the Administrative P & P (1.31 UNUSUAL OCCURRENCE REPORTING) that requires that all institutional personnel when indicated shall make unusual occurrence reports.

PURPOSE: To document events or conditions that may have an adverse effect on patient health or safety or may result in harm to visitors, volunteers, students or employees, in order to institute corrective action. In addition, the system will allow evaluation of potential legal exposure and, if necessary, an appropriate legal defense by the hospital's attorney.

I. **CHARACTERISTICS**: This Facility Services P & P is merely a summary of the corresponding Administrative P & P.

A. Reportable occurrences are those involving residents, visitors, volunteers, students or employees which, if recurrent, will pose a threat to the delivery of high quality patient care or to the safety of residents, students, visitors, volunteers or employees.

B. While many unusual occurrences are inadvertent or not preventable, it is not the responsibility of the individual making the report to make this determination. Thus, all incidents as outlined here as well as or other incidents which, in the opinion of the observer, constitute a threat to the health or safety of resident, visitor, volunteer, student or employee must be reported.

C. Malicious reports or reports with punitive intent are discouraged. Interpersonal conflicts are not responsible unless there has been a clear impact on resident care.

D. Filing an unusual occurrence report in no way replaces the on-going responsibility of individuals to report problems as they occur through the normal supervisory channels.

E. Consult Administrative P & P, same title, for instructions for filing such a report.

F. Be aware that a filed report is a uniquely tracked, confidential official hospital document which is thoroughly investigated by the hospital's Quality Assurance Committee, and a copy will be sent to the hospital attorney. You will be expected to provide the names of all individuals involved, all contributing factors, and all witnesses for fact-finding. You will not be asked to assign "faulty" if you file such a report, but you must be prepared to provide accurate details to investigator from the Quality Assurance Committee.

G. Please do not hesitate privately to discuss any concerns you have about the need or procedure to file such a report with the Medical Director or any member of the Quality Assurance Committee, whose names will be furnished upon request.

II. PROCEDURE:

A. Refer to the Administrative P & P for procedural steps for completing such a report.

EFFECTIVE DATE: 5/18/97
REVISED: 07/23/07
LATEST REVIEW: 08/24/09

SMOKING POLICY

POLICY: Laguna Honda Hospital, as a provider of health care in the community, wishes to establish and maintain the most effective environment possible in which to deliver health services. To that end, this smoking policy has been adopted.

Additionally, the Fire Codes prohibit smoking in specific areas already covered by the general policy.

PURPOSE: There is indisputable evidence that smoking is detrimental to good health. We can no longer fail to respond to this significant health risk. In addition, this policy complies with Article 19C of the San Francisco Municipal Code and applicable Fire Codes.

PROCEDURE:

A. Effective November 1, 1988 smoking is prohibited throughout the facility buildings. All LHH employees and visitors are expected to comply with the NO SMOKING regulations.

B. The following areas will be designated as patient-smoking areas:

1. The breezeway between the E & K on the 3 rd floor of the Main Building.

2. Outside of the C2 Hospice (for hospice residents only).

C. Laguna Honda Hospital staff conspicuously shall post signs with the international NO SMOKING symbol consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a bar across it in NO SMOKING areas.

D. Laguna Honda Hospital Administration will implement a long-range plan to assure future compliance with this new ordinance in the design of new construction project.

E. Laguna Honda Hospital staff will make every effort to enforce this new ordinance through promptly notifying any violators that smoking is illegal in designated areas and shall request violators not to smoke in those areas.

F. In addition, Laguna Honda Hospital will respond to special requests by patients, family and staff that deal with other aspects of providing a smoke-free environment. Such requests can be submitted directly to departmental managers, the Nursing Office, or to Hospital Administration for review and action.

G. Hospital employees who fail to comply with this policy will be subject to appropriate disciplinary action.

EFFECTIVE DATE: 5/18/97
REVISED: 07/23/07, 8/24/09
LATEST REVIEW: 08/24/09

BUILDING LOCKUP PROCEDURE

POLICY: The Facility Services Department shall enhance patient safety by enforcing applicable portions of the Missing Patient Procedures paraphrased below and fully described in Administrative P & P 1.13.

PURPOSE: To assure that patient safety is maintained as the highest priority.

PROCEDURE:

A. Upon request of the Department Head, the Facility Services Maintenance Supervisor shall assure that existing locks are removed from doors, which do not require locks.

B. The Facility Services Maintenance Supervisor shall assure that keys for all doors used by Facility Services employees who remain locked are submitted to the LHH Sheriff Office, which shall be the central depository for all hospital keys.

C. Where there is a master key cabinet, the key to the master key cabinet shall be submitted in lieu of the individual keys.

D. All Facility Services keys which are not meaningfully encoded on the keys themselves shall be tagged to identify the doors they open.

E. Every Facility Services employee is responsible and accountable to search the hospital's locked areas in which (s)he has performed work prior to re-locking the areas. This search will assure that no patients are left in the area and that no hazardous substances used to perform work have been inadvertently left in the area. The worker who physically re-locks the access is the responsible and accountable employee to perform the search.

6. At the end of each workday, Facility Services Department's own areas, which will be locked for the evening, shall be searched for patients present in the area as a precautionary measure prior to locking the Department areas, including all windows for the evening. All employees are responsible for accomplishing this important check of the premises for patients; however, the worker who physically re-locks the access will be held accountable for the act of searching the area and locking all windows.

7. The Facility Services Department will receive periodic requests to participate in searching Facility Services offices and work areas for a missing patient. In this case a complete patient description will be provided to search personnel, by telephone, radio, pager, or messenger. All employees are expected to assist the Sheriff Department to provide access if requested and to assist to search Facility Services areas if requested.

EFFECTIVE DATE: 05/18/97
REVISED: 4/30/07
LATEST REVIEW: 08/24/09

RESIDENTS FOUND OFF-GROUNDS

POLICY: The Facility Services Department encourages employees to assist residents whom they find appearing to be lost or disoriented off hospital property.

PURPOSE: To provide appropriate guidelines for employees in assisting Laguna Honda Hospital residents who are out of the hospital buildings on pass or AWOL and appear either lost or disoriented.

I. CHARACTERISTIC:

Each LHH resident is required to wear an identification bracelet containing the resident's name, number and ward. There are certain exceptions (allergies or constant picking at bracelet) listed in Administrative P & P entitled Admitting: RESIDENT CONTROL NUMBER; however, the bracelet usually will provide positive identification of a Laguna Honda Hospital resident.

II PROCEDURE:

Assist the lost or disoriented resident to return to the hospital ward. If the employee acts within the scope of this policy the City and County of San Francisco will assume responsibility.

A. ON-PREMISES:

1. If on premises, provide information as requested.

2. If physical assistance seems to be needed, and the resident is co-operative, provide it only if the resident co-operates and permits you to walk her/him. Do not force the resident even if the resident appears co-operative.

3. If physical assistance seems to be needed, and the resident is un co-operative, or if the resident appears to be hopelessly disoriented, proceed to the nearest phone and call the Nursing Office to inform them of the resident sighting. Provide the location where you last saw the resident and the direction in which the patient was headed, plus the description of the resident.

B. OFF-PREMISES

1. If the resident indicates that (s) he is not in fact lost and is out of the hospital on a "pass", do not attempt to return the resident to the hospital.

2. 2. If the resident confirms that (s) he is lost, or is unable to respond to your question as to whether (s) he is lost, or whether (s) he has permission to be off hospital property, appears to be confused, or is wearing inappropriate clothing, you should endeavor to return that resident to Laguna Honda Hospital.

3. If the resident is co-operative, you may either walk or drive the resident back to Laguna Honda Hospital and deliver that resident to the proper residential ward or to the fifth floor Nursing Office.

4. If the resident is un co-operative and does not wish to enter your car or wish to be walked, do not attempt to do so. Do not force the resident.

~~5. Proceed to the nearest telephone or request assistance from someone else to call the Nursing Office (759-2705) to inform of the patient sighting. You should be able to provide the location where you last saw the resident and the direction in which the resident was headed, plus a description of the resident.~~

~~EFFECTIVE DATE: 5/18/97~~
~~REVISED: 04/18/07~~
~~LATEST REVIEW: 08/24/09~~

~~PUBLIC ACCESS~~

~~**POLICY:** Access to the Hospital is Restricted.~~

~~**PURPOSE**: To protect residents and employees, as well as the physical facility and hospital equipment, materials and supplies.~~

~~**PROCEDURE**:~~

~~A. The following persons have free access to the hospital:~~

1. ~~Admitted residents who currently are resident.~~

2. ~~Resident's visitors, between the hours of 10:00 A.M. and 9:00 P.M.; unless special visitation is authorized by the Medical Director, Director of Nurses, ward physician or head nurse, who shall so notify the ward staff.~~

3. ~~Employees during their scheduled work hours.~~

   a. ~~If greater than one hour before or after assigned work hours, employee must first report to the shift supervisor and declare the purpose, place and duration of the visit.~~

   b. ~~No specific permission is required to visit the Personnel or Payroll offices.~~

   c. ~~Persons with an appointment for official business with a supervisor.~~

   d. ~~Volunteers duly enrolled in a volunteer or pastoral care program.~~

~~B. No other person is authorized to be in the hospital beyond the main and fifth level vestibules. Facility Services employees themselves shall not interfere with anyone's presence, but immediately shall report the presence of anyone who seems not to fit into the above categories to the Sheriff. Include location, direction headed, and description.~~

~~C. Facility Services employees are instructed that no vendor is authorized to be in the hospital without a prearranged appointment with a department head. No one may sell items to residents or staff without the explicit written authorization of the Executive Administrator or designee. Facility Services employees shall report the presence of sighted vendors to the Sheriff who will determine whether the vendor is authorized.~~

~~D. The Sheriff will record the name and address of any offender and provide escort from the premises or to the S.F.P.D. This procedure applies to employee offenders as well as others; each incident will be reported to the respective department head.~~

~~EFFECTIVE DATE: 5/18/97~~
~~REVISED: 04/18/07~~
~~REVIEWED 8/24/09~~

MAJOR MEDICAL EMERGENCIES

POLICY: Employees shall identify, evaluate and respond to life-threatening medical emergencies which occur on hospital grounds.

PURPOSE: To assure timely and appropriate action when major medical emergencies occur with employees, volunteers or visitors.

PROCEDURE:

1. First person on scene remove the victim from harm if necessary; otherwise, do not move the victim.

2. Render Emergency First Aid or Cardio Pulmonary Resuscitation only if trained to do so.

3. If the accident is immediately life threatening, call or have someone else call 911 for an ambulance, and call or have someone call for physician assistance by dialing 4-2999, the operator's emergency line.

4. When the operator answers, provide the exact location of the victim, a description of the accident and the victim's condition, and inform the operator whether 911was called and whether an ambulance is already in route.

5. Do no attempt to move the victim, even if the victim appears to be dead.

6. When a physician or Registered Nurse responds, responsibility for the resident is transferred to that person. When a 911 ambulance responds, responsibility for the resident is transferred to the 911 base station upon ambulance arrival.

EFFECTIVE DATE: 5/18/97
REVISED:04/18/07, 05/2007

RESIDENT ABUSE

POLICY: Facility Services employees shall protect all residents from physical, psychological, fiduciary and verbal abuse; neglect and abandonment to the best of their abilities.

PURPOSE: To assure that residents are free from abuse and that incidents of abuse are reported and handled appropriately.

I. CHARACTERISTICS:

Abuse is any activity purposely intended to result in physical harm or mental suffering, which may include:

A. Corporal punishment or purposeful injury.

B. Assault or battery including beating and assault with a deadly weapon.

C. Sexual assault, exploitation, or molestation.

D. Verbal assault, harassment, or intimidation.

E. Deprivation of goods or services necessary to avoid physical harm or mental suffering, including unreasonable physical constraint or prolonged deprivation of food or water.

F. Neglect, by act or by omission, involving failure to assist in personal hygiene, failure to protect from health and safety hazards or malnutrition.

II. PROCEDURE:

A. In accordance with Section 15630 of the Welfare and Institutions Code, all new employees including transfers and reassignments shall, as a condition of employment, sign a statement, acknowledging obligation to report abuse of elderly or dependent adults. A copy of the signed statement shall be kept in the employee's personnel file.

B. In the event that an employee observes or receives a report of abuse of any Laguna Honda Hospital resident, that employee shall immediately notify his or her supervisor. That employee shall also complete "Reporting of Adult Abuse" and "Unusual Occurrence" forms and submit them as required.

C. The employee shall take immediate measures to assure resident safety and immediately notify the Nursing Office.

D. There are additional steps in this procedure in the Administrative P&P. Employees who complete the first three steps will have complied with the law as regards the employee's obligation.

EFFECTIVE DATE: 03/29/07
REVIEWED: 08/2009 DP-23

INTERACTION WITH THE MEDIA

POLICY: All inquiries from the media will be handled and responded to only by the Executive Administrator during the normal workday or by the AOD during other shifts.

PURPOSE: To assure that all inquiries from the media are addressed in a straightforward and professional manner that will reflect positively on the hospital.

PROCEDURE:

A. Facility Services employees shall request identification from persons whom they believe may represent the media by telephone or in person, and upon verification that such person represents the media, are to refer that individual directly to the office of the Executive Administrator and make no response whatsoever to the media.

B. Upon referral of any media representative to the Executive Administrator, Facility Services employees shall immediately telephone the Executive Administrator's secretary and report the fact.

EFFECTIVE DATE: 5/18/97
REVISED: 05/2007
REVIEWED: 08/2009

DISTRIBUTION OF LITERATURE OR OTHER PRINTED MATERIAL TO THE COMMUNITY OR PUBLIC

POLICY: The Facility Services Department shall support and enforce the Administrative P & P, which states that all material describing programs or definitions of services available at Laguna Honda Hospital intended for distribution to the community at large, community or public agencies or individuals who may refer residents to Laguna Honda Hospital shall be approved by the Executive Administrator or designee prior to distribution.

PURPOSE: To assure that all material is consistent with the intent and purpose of the Laguna Honda Hospital, that it factually represents the information to be conveyed, and is consistent with the hospital's position as a City-owned and operated facility.

PROCEDURE:

A. Facility Services employees directly submit all materials described above, but no limited to brochures and flyers, to be reviewed by the Associate Administrator for Support Services.

B. The Associate Administrator for Support Services will provide a copy of all material to the Executive Administrator for approval prior to its distribution.

C. The Executive Administrator will decide whether to accept the recommendation of the Assistant Administrator for Support Services.

D. All approved materials will be distributed as planned.

E. No unapproved materials will be distributed.

F. A copy of all material distributed will be filed in the Executive Administrator's Office.

EFFECTIVE DATE: 5/18/97
REVISED: 05/2007
REVIEWED: 08/2009

PARKING RESTRICTION

POLICY: Laguna Honda Hospital (LHH) shall reserve a limited number of parking spaces in designated areas for visitors, volunteers, physicians and specified management employees. LHH will enforce posted parking signs and restrictions. Sheriff Department will ticket vehicles that are parked in violation.

PURPOSE: To maximize parking available for volunteers, visitors and others doing business at LHH; to increase accessibility to handicapped persons; to improve in/out mobility for physicians and administrators and maintain emergency access to buildings and grounds.

PROCEDURE:

1. Signs will reserve a limited number of identified parking spaces near the Main Entrance and East Entrance for visitors.
2. A limited number of parking spaces near the K, L, M and 0 wings will be reserved by signs for LHH volunteers who display a clearly visible authorized volunteer placard on their dashboards.
3. A limited number of parking spaces near the main Entrance and near K and L Wings will be reserved by signs for physicians who display a black LHH Parking Permit tags.
4. A limited number of parking spaces near the Main Entrance will be reserved by signs for administrators who must display a red LHH Parking Permit tags.
5. A limited number of parking spaces will be reserved by signs for managers who must to display an orange LHH Parking Permit tags.
6. A limited number of parking spaces will be reserved by signs for employees with disabilities who must display a green LHH Parking Permit tags.
7. Facility Services employees are prohibited from parking in the reserved parking areas.
8. All employees' vehicles parked on the LHH premises must display valid paid Parking Permit.
9. Unauthorized vehicles in violation are subject to citation and/or towing by the Sheriff Department.
10. Parking is prohibited at red curbs or areas posted with "No Parking" signs, and in any place not specifically designated by the characteristic white lines as a parking spaces.
11. For special events, certain temporary modification of parking rules or privileges may be requested of the Associate Administrator for Operation or Sheriff Department.

Effective date: 5/18/97
Revised: 07/2007
Reviewed: 08/2009

1.1Food from Home or Outside Sources Served Directly to Residents

Established and Revised: 10/98, 9/06, 12/06, 7/09, 8/18

Reviewed: 8/13, 8/14, 8/18

Policy: Residents at Laguna Honda have the right to choose to accept food from visitors, family, friends, or other guests (Reference here: CMS regulation 483.15). Laguna Honda will make reasonable attempts to educate visitors, family, friends or other guests that f~~F~~ood intended for resident consumption from outside sources shall be held to the same ~~high~~ facility standard of safe food handling practices, including but not limited to: ~~levels of~~ food safety and sanitation, transported/stored properly~~storage~~, handling and consumption ~~and safety~~ as properly applied in the Food and ~~Food~~ Nutrition Services Department. All staff, visitors, family, friends and other guests ~~Volunteers and Staff will~~ shall be expected to adhere to all aspects of this policy.

Purpose: To ~~help~~ensure that staff, -visitors, friends, and family members understand safe food handling practices which may include holding or transporting foods containing perishable ingredients. This shall be done by assisting in their safe and sanitary storage, handling, reheat, and discard using safe food handling practices.~~Sanitary food and food service is in the best interest of the residents of Laguna Honda Hospital. Protein containing foods are potentially hazardous because bacteria can grow more easily in the food. These foods will spoil faster than foods that contain no or little protein. Food poisoning is extremely dangerous for residents who are infirm or ill. We will endeavor to protect residents from potential hazards.~~

Definitions:

1. Food from Outside sources: ~~Outside sources are those sources of food~~ Food brought to Laguna Honda from any place not produced at ~~within the portals of~~ Laguna Honda Hospital.
2. ~~.~~ The r~~R~~esident is a resident, patient, or client receiving care or services from Laguna Honda Hospital.
3. Any ~~volunteer or~~ staff member, visitor, friend or family member serving food to a resident(s) ~~s~~ must follow safe food handling procedures.~~described herein.~~

Procedure: ~~Reasonable attempt shall be made to meet the following:~~

~~1.~~ Food shall be provided from approved sources, ideally in its original packaging and procured from institutional sources such as a grocery store, retail delicatessen, or commercial restaurant and shall be handled in accordance with applicable food sanitation guidelines (Reference or attachment needed here).

~~2. Foods used shall be in its original packaging and procured from institutional sources such as a grocery store, retail delicatessen, or commercial restaurant.~~

1.
2. Food brought in by family or visitors shall be stored separately or easily distinguishable from facility food.

3. It is recommended that all food be brought in as “one serving size” microwaveable and disposable container.
4. All food brought into the unit should go immediately into the patients fridge. (Exception applies to hot foods brought for immediate consumption). Once food has entered the patient’s room, any leftover must be thrown out.
~~3.~~5. Family and visitors shall be provided with information to help them understand safe food handling practices. These may include safe cooling/reheating processes, hot/cold holding temperatures, preventing cross-contamination and hand hygiene.~~.~~(see Attachment)
~~4.~~ Preparation of any foods on the neighborhoods for resident consumption shall be only prepared in approved kitchen or galley and by trained staff~~.~~.
~~5.~~6. ~~Trained staff does all preparation.~~
~~6. All volunteers who prepare and handle food must attend mandatory food handling in-service, Volunteer Coordinators are responsible for arranging the training.~~
7. All employees, other than Clinical N~~n~~utrition and Food S~~s~~ervice ~~employees~~staff, who prepare or handle food ~~must attend~~are encouraged to attend mandatory food handling ~~in-service~~training. ~~,~~ A~~a~~ssociated department heads are responsible for arranging ~~for this in-service~~this training.
8. The Food and Nutrition Service~~ss~~ Department will notify department of the scheduled training events for ~~concerning~~ safe~~anitary~~ food handling practices.
~~9.~~1. ~~Any volunteer or staff member serving foods must follow safe food handling procedures described herein.~~
~~10. The Director of Food and Nutrition Services shall have the sole authority to authorize the use of facilities and procedures in handling of the food described above. If procedures are not followed and/or facilities are not maintained, the Director of Food and Nutrition Services shall close down a service that is not in compliance.~~

Guidelines for Keeping Food Safe:

1. All foods will be stored in the patient refrigerator with the following information: patient’s name/room number, food item, and the date prepared.
2. Always wash your hands (before and after handling food), utensils, and work surfaces with warm to hot soapy water.
3. Use extra care when cooking foods such as eggs, meat, fish, poultry, and milk products.
4. Raw meats, fish, and poultry contain bacteria and should be stored away from other foods.
5. Use pasteurized products.
6. Keep all food items refrigerated until ready to cook or serve.
7. Cook all food items thoroughly.
8. Hot food items should be kept at 135°F or above.
9. Cold foods items should be kept at 41°F or below.
10. It is recommended that perishable foods be transported in an insulated thermal container and/or cooler with ice packs.
11. Food should only be re-heated once (165°F) and then thrown away.
12. Discard food after 3 days.

References: CMS regulation 483.15, F242

Attachments: Food safety guidelines handout

1.4 Quality Assurance ~~Communication Log Book~~

Established and Revised: 6/85, 12/87, 1/89, 1/92, 5/97, 8/04, 7/09, 8/18
Reviewed: 8/13, 8/14, 8/18

Policy: The quality and safety of Food and Nutrition Services Department functions are maintained and evaluated; appropriate actions are taken based on findings. To ensure the quality of service provided to the residents and staff at Laguna Honda Hospital, a log book will be used to document all problems related to Food and Nutrition Services.

Procedure:

The Quality Assurance Log Form (Q.A log) will be completed by the Food Service Director, Chief ~~Chief~~ Dietitian/Dietitian, Food Service Manager, Chef, ~~Dietitian,~~ Supervisor or others who note below standard elements of food service.

The Quality Assurance Log Book shall contain the following:

a) Date of Occurrence
b) Summary of Problem & Evaluation
c) Problem Referral Source
d) Correction Action(s) Taken
e) Responsible Persons
f) Completion Date

~~The~~ An entry ~~note~~ in the Q.A. log will completed in the event of any of the following:

A. A variance from generally accepted standards. For example, while doing QA prior to meal service, Coffee Temperature found to be 120°F or dish machine temperature in wash tank found to be 220°F, etc.

B. Specific quality not met. For example, a call is received that a resident did not receive his prescribed puree diet, instead he received a mechanical soft diet or a call is received that inaccurate food items are found on the tray for a particular resident.

C. Unusual occurrences involving residents, guests, or staff that may result in noncompliance to state or federal regulations.

D. Specific quantity not met. For example, while serving lunch, there is a shortage of the main entrée (Roast Lamb) the substitution is Roast Beef. The substitution will be the documented for last minute substitutions.

E. Any delay in food service which results in late, 10 minutes or more, food service to residents. Neighborhood nursing units will be notified by the diet office.

F. Refrigerators & Freezers- monitored 24/7, by fully automated wireless alerting system (Temp Track) & twice daily designated Food Service staff. Temperatures are recorded by

date and location with exact temperature noted. Any temperatures outside recommended range will be evaluated. Repairs will be immediately ordered.

G. Food- is maintained prior to service. The cook is responsible for taking and recording temperatures on all batches of food. The team leader is responsible for taking and recording temperatures of hot and cold foods on tray-line.

H. Chef/Production Manager- monitors compliance to documentation of hot food temperatures, proper food storage, sanitation, and pots and pans. Takes corrective action as needed.

I. Food Storage (Covered, Labeled, and Dated) - is maintained by cooks and food service staff. Monitored by Supervisor and Chefs.

J. Pots and Pans/Trays are Air Dry Clean of Debris and Grease – are monitored by Team Leader, AM Supervisor, PM Supervisor, Chefs, and Manager.

K. Types QA Logs: Refrigerator Temps, Freezer Temps, 2-Stage Cooling, Handwashing Sinks, Dish Machine/Pot Machine Temperature Testing, Cleaning/Sanitations, Tray-line, Compost, Recycling, Thermometer Calibration, Fryer Log, department compliance training, etc.

E.L. Chef/Production Manager or Designee – monitors compliance.

The Quality Assurance Log Book is located near the department's mailboxes. When documenting a problem the Recorder needs to fill inshall contain the following:

a) Date of Occurrence d) Correction Action(s) Taken
b) Summary of Problem & Evaluation e) Responsible Persons
c) Problem Referral Source f) Completion Date

The log will be reviewed by the Food Service Management Staff on a daily basis and- at a minimum weekly by the Chief Dietitian/ or Dietitian designee. Follow up or corrective action taken will be related to the *Responsible Persons*. Ittaken. The log will also be reviewed at daily production meetings. If further action is required to correct a problem, the director Director of Food Services will investigate, analyze, develop corrective action, in-service staff, and implement, test system, and adjust to improve as needed (additional?) corrective actions.

***The results of the weekly QA log form will be presented quarterly at the hospital wide performance improvement patient safety committee.

References: *§483.75(d),(e),and (g)(1)-(2), F867, F868, Quality Assessment and Assurance,*

? Food Safety requirements: ***§483.60(i)(1)-(2)***

1.85 Congregated Meals for Residents — Social Dining Program

Established and Revised: 7/09, 11/10, 6/11, 7/12
Reviewed: 8/13, 8/14

Policy: For those residents who are physically capable, they will have access to a dining room in the neighborhoods for them to enjoy their meals in.

Purpose: To enhance the socialization program for the residents.

Procedure:

1) The Nutrition Service Department will deliver meals to each of the neighborhood according to an estimated schedule.
2) The Resident Care Team will determine if a resident may have their meals in a dining room setting.
3) Nursing plans and coordinates the seating arrangement in the three dining rooms. Along with Activity Therapy, they will ensure that the dining rooms are set up appropriately for the residents to have an enjoyable dining experience.
4) Nursing assist residents in proper dress for social dining.
5) Nursing assist residents to the dining room.
6) Nursing assist residents for social dining with bib, chair or wheel chair height, etc.
7) Nursing serves the tray to each resident.
8) Nursing will serve extra beverages such as coffee, tea, milk or juice, as required.
9) Nursing assists the residents with their meal as needed.. (Feeding; opening straws, opening packaged food, etc). Nursing will attend to the resident's needs during the meal period. Activity Therapists, Volunteers, Dietitians, Family Member and other designated hospital staff can assist in resident meal service.
10) Nursing will offer substitutions to resident within 15 minutes of service as needed.
11) The goal is 100% resident participation in the Social Dining Program. For those residents who can not participate in the Social Dining Program, it must be ordered by a physician for the resident to eat in their room.
12) For those who can not participate in the Social Dining Program, Nursing will deliver the meals to the resident's room. They will assist residents with their meal similar to the dining room service. Nursing will return soiled trays to the delivery cart ready for pick up by Nutrition Services to return to the main production kitchen for proper warewashing procedure.
13) Nursing will wipes down tables and chairs in the three dining rooms.
14) Environmental Services will sweep and mop the dining room floors at the end of each meal service. They will clean up any spills on the floor immediately.
15)1) Environmental Services will removal and dispose all garbage and recycled or compostable materials from the dining rooms after each meal service.

1.120 Isolation Trays

Established and Revised: 03/84, 02/89, 5/97, 4/00, 9/06, 7/09
Reviewed: 8/13, 8/14

Policy: All residents indicated as on "Isolation" will receive disposable tray and ware.

Purpose: To prevent the spread of infection to other residents and personnel.

Procedure:

1. Nursing staff will notify the Diet Office when a resident is put on Isolation.
2. The tray ticket for the resident will be stamped with a red "Isolation" stamp. It will be entered in the Diet Office and so noted in the Messages section.
3. In the Galley Service, the resident's disposable tray will be set up with all disposable dishes and plastic utensils.
4. The tray will be delivered to the resident by the Nursing staff.
5. All items used for the meal service will be placed in a disposable bag, in the resident's room. by the Nursing personnel, and then disposed of properly.
6. 1. Isolation service will continue until it has been discontinued.

1.125 Communication with Nutrition Services Department

Established and Revised: 3/81, 3/84, 2/89, 5/97, 9/06, 7/09
Reviewed: 8/13, 8/14

Policy: Communication between resident and Nutrition Services is through the Nursing Staff.

Purpose: To provide the highest standard of resident care. To ensure that the resident care team is informed of the entire resident's dietary needs.

Procedure:

- When a resident wishes to see a dietitian, the Nursing Unit will call the dietitian and request that the resident be seen.

- If the Nursing Staff observes problems in a resident's eating pattern, intolerance to foods, weight loss or other nutritional concerns, the Diet Office is notified so that the appropriate dietitian can be contacted.

- Nursing Staff will contact the Diet Office for diet changes, including tube feedings, and new admissions in a timely manner.

BATHING ALTERNATIVES/BED BATH

POLICY:

1. Laguna Honda Hospital shall recognize and integrate resident's past experiences in all aspects of resident's care.

1.2. Residents who do not receive tub baths or showers are provided with bathing alternatives.

2.3. Registered nurses in collaboration with the care team are responsible for assessing and planning for the bathing needs and preferences of residents.

3.4. Individualized bathing preferences (e.g., time of day and frequency) are indicated on the care plan front card, at minimum.

5. Licensed Nurses, certified nursing assistants (CNA), and patient care assistants (PCA) may assist residents with bed baths or bathing alternatives.

4.

PURPOSE:

To provide resident's hygiene through alternative bathing techniques.

DEFINITION:

Bathing aAlternatives include innovative or individualized bathing techniques and approaches for residents who have special bathing needs related to physical, cognitive, behavioral or emotional challenges. Consider alternative bathing methods for any resident who expresses discomfort during bathing or incontinent care due to possible pain, fear, cold, confusion, or aggression.

PROCEDURE:

A. Preparation for Alternative Bathing

1. Prepare and bring all of bathing supplies in advance and bring to the bedside. If indicated, provide pain medication or other pre-bathing interventions identified on the care plan before proceeding, allowing enough time for effect.

2. If new to the resident, consult with staff who are more aware of the resident's preferences before approaching. It may be necessary to assign only familiar caregivers or to relieve or assist a new caregiver.

3. Throughout the bath, examine resident's skin condition for any abnormalities, discoloration, rashes or breakdown, and if present report to the licensed nurse.

4. Verbally cue resident of each step before proceeding, to alleviate anxiety.

B. Alternative bathing techniques

For residents who require individualized hygiene plans of care, consult with ~~r~~Resident ~~c~~Care T~~t~~eam (RCT)~~ (e.g., OT and CNS)~~. (Refer to Appendix 1 for Alternative Bathing and Hair Washing Techniques~~.~~)

C. Reporting and Documentation

1. CNA / PCA

   a. Report change in resident's condition and pertinent observations regarding skin condition, mental and emotional status, and resident's progress in self-care, to the charge nurse.
   ~~a.~~b. Report to licensed nurse changes in resident preferences.
   ~~b.~~c. Record in DNCR~~ form~~.

2. Licensed Nurse

   a. Update the Resident's Care Plan Front Card and pertinent problems as needed. Restorative Nursing care planning templates are available as needed to indicate alternative bathing as a restorative dress/ grooming program.

APPENDIX:

Appendix 1: Alternative Bathing and Hair Washing Techniques

REFERENCES:

Bathing the Adult. Richards, S. and Schub, E. authors. Cinahl information Systems; 2013 – electronic access on January 17, 2014.

Bathing without a battle: Personal care of individuals with dementia. Barrick AL et al., editors. New York: Springer; 2001

CROSS REFERENCES:

NPP D1 2.0 Resident Activities of Daily Living (Basic Care)
NPP D 2 3.0 Tub Baths and Showers

Revised: 07/2006; 05/27/2014; 09/08/15

Reviewed: 09/08/15

Approved: 09/08/15

ALTERNATIVE BATHING AND HAIR WASHING TECHNIQUES – APPENDIX 1

1. Place a bath blanket (or towels) and washcloths directly into a washbasin or plastic bag with warm water or use no-rinse foam cleanser. Disposable towelette can be used.

2. Cover the resident with a warm dry bath blanket (or clean thermal blanket).

3. Reach under the bath blanket/ thermal blanket to remove the resident's gown or roll the gown up so that the resident is never exposed.

4. Starting at the feet, unroll the wet cleansing bath blanket or towels under the dry blanket until the resident is completely covered by a warm, wet blanket beneath a warm, dry blanket.

5. Massage through the washcloth or disposable towelette to cleanse the resident. Beginning at the feet with light pressure and massage is usually more acceptable to the resident than starting with the face. This approach allows the resident to gradually get comfortable with what you are doing and it allows the staff person to watch the residents' reaction, while keeping safe. Face washing can be combined with oral care and grooming and the resident may be able to assist more easily once up.

6. Coach the resident to wash parts of their body themselves whenever possible:

   a. If the resident has the physical ability to move a hand and arm, they can usually take part in at least some of the alternative bathing process.
   b. Having the resident hold a washcloth or towelette may decrease any attempts to hit or scratch and helps give demented residents the tactile cue that it is time to wash.
   c. Place the washcloth or towelette in the residents' hand and provide simple direction.

7. If the resident resists, STOP and reapproach later, keeping the resident warm and safe before leaving. Continuing to bathe after the resident has resisted, will risk injury, lose the residents trust, and continue to have problems during bathing. Assure the resident by saying, "I'm not going to do anything until you are ready." Stand so that the resident can see you with your hands relaxed and in view.

8. When cleaning the perineal area, be aware that this is the most sensitive area and is best done last. Place the cloth or towelette over the area and allow the resident to get used to it briefly before attempting to cleanse.

9. Alternative hair washing: The same principal of keeping the resident warm and covered can be applied to hair washing. Vary the technique and the frequency depending on the resident's specific needs. Rinse free foam cleanser is available for residents who are not comfortable with the typical procedure.

   a. Position the resident sitting up if possible, preferably up in a chair.
   b. Prepare all the equipment ahead including: a basin with warm water and no rinse soap, a towel soaking in the basin, and 1 or more dry towels, a shower cap as needed. Comb or other hair grooming items per the resident's preference.
   c. Cover the residents' head and hair with a towel soaked (but not dripping) with warm water with no rinse soap.
   d. Massage the hair and scalp through the warm towel, taking care not to pull the residents hair. (Most of the cleaning action is coming from soaking the hair; vigorous scrubbing is not necessary.) A shower cap can be used to keep the wet towel warm longer.

e. Cover the head and hair with a warm dry towel as you remove the wet cleansing towel so that the resident is never sitting with wet, dripping hair.
f. Wrap the head with the towel to soak up as much moisture as possible. (Avoid vigorous rubbing or letting the resident become cold as their hair drips dry).
g. Allow the resident to rest as needed before combing the hair.
h. Help the resident to comb their own hair whenever possible.
i. Adjust the amount of time you spend handling the residents' hair according to their comfort level. (Some enjoy having their hair groomed while others find it very uncomfortable. If the hair is excessively tangled, come from the bottom and gradually work your way up. Give a rest period and come back later if needed).
j. Use additional products according to the residents' hair care needs.

Revised: 09/08/15

Reviewed: 09/08/15

Approved: 09/08/15

LAGUNA HONDA HOSPITAL 01.05.00
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR SCHEDULED TIME-OFF

Policy:

No more than 2 staff pharmacists may take scheduled time-off during the same period.

No more than ~~2~~ 1 clinical pharmacist~~s~~ may take scheduled time-off during the same period.

No more than 2 pharmacy technician may take scheduled time-off during the same period.

No more than a combination of 3 operations staff (staff pharmacist, technician and pharmacy helper) may take scheduled time-off during the same period.

Purpose:

To assure appropriate pharmacy staffing levels required to provide pharmaceutical care consistent with the Department's Mission.

Procedure:

1. Pharmacy staff will be supplied a vacation priority request form each fall to request time off for the following calendar year. These vacation requests will be approved on a seniority basis. The vacation approvals will be clearly indicated on a shared electronic calendar.
    a. During peak vacation periods (i.e. Christmas, New Year's, Easter, school breaks), a rotation will be maintained by the Pharmacist in Charge / Pharmacy Director.
    b. If changes are desired amongst staff, mutual consent must be confirmed between the involved staff, and the changes must be approved by the Pharmacist in Charge/ Pharmacy Director.

~~2.~~

~~3.~~ 2. Subsequent vacation requests will be approved as staffing allows on a first come first serve basis as outlined below.
    a. The written request for time-off must indicate the inclusive date(s) of the requested time-off and the accrued time against which the time-off will be charged (e.g. vacation, compensatory time, etc.)

    b. The Pharmacist in Charge / Pharmacy Director will respond to the request in writing within 10 working days following receipt.

New: 5/98 MP/SK
Reviewed: 02/05, 04/09, 2/10, 4/11, 4/12, 8/13
Revised: 02/06dw, 01/08, 2/15, 6/18

LAGUNA HONDA HOSPITAL **02.02.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR CONTROLLED SUBSTANCES

Policy:

Record maintenance for controlled substances shall conform to requirements established by regulatory agencies.

Purpose:

To assure proper storage and handling of controlled substances.

Procedures:

I. Automated Dispensing Cabinets (ADCs): *See PHAR 09.00*
II. Floor Stock

A. All controlled substances (Schedules II, III, IV, and V) not dispensed from ADCs must be issued by the Pharmacy on a sign-out Narcotic Hypnotic sheet. Controlled substances are obtained as follows:

1. The order may be faxed directly to Pharmacy or, alternatively, the Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Psychiatric Technician (LPT) with picture identification will take the original signed physician's order to the Pharmacy.

2. To refill an established supply of controlled drugs, the Narcotic-Hypnotic Drug record sheet may be sent via FAX to Pharmacy or the RN, LVN or LPT with picture identification will take the current Narcotic-Hypnotic Drug record sheet to the Pharmacy..

3. The Pharmacy will issue to the RN, LVN or LPT a new supply of medication with a new Narcotic-Hypnotic sheet.

4. The RN, LVN or LPT with picture identification will verify the correct count and sign for all controlled substances when received from Pharmacy.

5. Emergency or "STAT" controlled substances may be dispensed immediately upon receipt of physician order, provided that the dispensing Pharmacist takes responsibility for filling out the appropriate sign-out sheet and getting the nurse's signature within one hour of dispensing the medication.

6. Each dose administered shall be signed out on the Narcotic - Hypnotic sheet with the date, time, patient name, dose, and signature of the RN, LVN or LPT administering the dose.

7. To return discontinued controlled drugs, the RN, LVN OR LPT with picture ID will deliver the remaining drug in its Container and the Narcotic-Hypnotic Drug record sheet to Pharmacy.

8. Completed sheets are returned to the Pharmacy and filed for a minimum of three years.

9. Liquid controlled substances shall be dispensed in unit of use containers.

10. Inventories of controlled substances shall be conducted each shift by nursing staff and documented on the inventory sheets.

B. Each drug dispensed by the Pharmacy shall be logged into the Unit Inventory Log Book by date.

1. Before leaving the Pharmacy, the RN, LVN or LPT must sign the Log Book for the controlled substance(s) being dispensed.

2. Completed sheets from the Log Book are filed by unit along with the completed Narcotic - Hypnotic sheets for a minimum of three years.

3. Annually, the Log Book entries shall be reconciled with the Narcotic - Hypnotic sheets to assure that all sheets have been returned.

III. Pharmacy Inventory

A. A perpetual inventory shall be maintained for all Schedule II-V drugs.

1. All schedule II-V drugs dispensed to the units, on pass, or for discharge shall be signed out on the perpetual inventory form.

2. A second count is conducted for all items that have been dispensed or added to stock at the end of the shift and documented by the technician's initials next to the line item.

3. Returned drugs and drugs received from the wholesaler shall be entered as soon as possible on the perpetual inventory.

4. Every month the perpetual inventory shall be reconciled with the actual inventory on hand. Discrepancies shall be investigated and follow-up immediately. Discrepancies shall be reported to the Hospital CQI Committee quarterly.

5. A quarterly inventory reconciliation report of all Schedule II medications will be maintained that includes a physical count, and a review of all acquisitions and dispositions records since the last inventory. The inventory reconciliation report shall be maintained in the pharmacy for at least 3 years in a readily retrievable form.

6. The perpetual inventory sheets shall be filed and retained for a minimum of three years.

B. Outdated and expired controlled substances shall be removed from stock, inventoried and handled as stated in Policy and Procedure 02.02.01.

C. A biennial inventory of all controlled substances on hand shall be conducted. Inventory records shall be kept on file for minimum of 2 years.

RESOURCES:
File: **J 11.0** , Controlled Drugs, *LHH Nursing Policies and Procedures*

New: 6/91
Revised: 3/96, 1/07, 10/09, 5/11

REVIEWED: 02/05dw, 02/06, 01/08, 04/09, 2/10, 4/12, 8/13

LAGUNA HONDA HOSPITAL 03.01.00
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY QUALITY ASSESSMENT AND IMPROVEMENT

Policy:

The Pharmacy Department shall participate in the overall Hospital quality assessment and improvement program. The Pharmacy Director shall coordinate this participation and ensure that the review and evaluation of quality for selected important aspects of care are reported to the hospital-wide ~~QA~~ Performance Improvement and Patient Safety Committee (PIPS) and/or the Pharmacy & Therapeutics Committee (P&T), and to the appropriate hospital administrators.

Purpose:

To provide high quality Pharmaceutical Services to all residents and staff, consistent with the Department's Mission.

MISSION STATEMENT:

The mission of Laguna Honda Hospital is to provide or ensure a continuum of health care services for senior and disabled residents of San Francisco.

"The mission of the Laguna Honda Hospital Pharmacy Department is to provide reliable, consistent, comprehensive and cost-effective pharmaceutical services to the residents and staff of the Hospital. These services shall be provided to promote safe and effective use of medications, and to advise, educate and offer a learning environment for students, volunteers and other health care providers. The Department is committed to assuring quality outcomes by emphasizing inter-disciplinary teamwork, continuous improvement, drug therapy expertise and sound financial management."

IMPORTANT ASPECTS OF CARE AND SERVICES PROVIDED:

1. Accurate dispensing of medications
2. Timely dispensing of medications
3. Providing counseling for residents discharged with medications
4. Providing drug information to residents and staff
5. Promoting safe and effective drug therapy

I. SPECIFIC PHARMACY QUALITY ASSESSMENT & IMPROVEMENT ACTIVITIES:

A. PHARMACY STOCK -- Pharmacy stock is checked monthly for outdated or expiring medications. Pharmacy Staff are responsible to check their assigned pharmacy stock section monthly for outdated or expiring medications.

1. Threshold: N/A
2. Reported to: Currently not reported

B. SUPPLEMENTAL DRUG ROOM -- Medications used from supplemental drug room are reconciled daily. Expiration dates are checked monthly by assigned pharmacy staff.

1. Threshold: N/A
2. Reported to: Currently not reported

C. NARCOTIC CII COUNTS PHARMACY NARCOTIC SUPPLY – CII-V reconciliation is done daily for all items that have been dispensed or added to stock at the end of the shift and documented by the technician's initials next to the line item.. An audit ~~and reconciliation of CII~~ of all controlled substances stored in the pharmacy ~~stock~~ is done monthly.

1. Threshold: 100%
2. Reported to: ~~QIC (quarterly), Pharmacy staff~~P&T (monthly)

D. MEDICATION STORAGE REFRIGERATOR TEMP – Medication Refrigerators are checked twice daily by nursing staff. The medication refrigerators in the pharmacy are checked a minimum of twice daily during pharmacy operating hours. All medication storage refrigerators and freezers are monitored continuously via wireless monitoring system. The first check each morning will include a review of the "Daily Sensor Report/ 12Hr" report for the previous 24 hours or longer if the department is not open 7 days/week. At the beginning of each month, the designated department will print a "TempTrak Equipment QA / Performance Report" for the preceding month and file with the temperature log.

1. Threshold: 100%
2. Reported to: Results of nursing station refrigerators are reported monthly via DRR to head nurse and Director of Nursing. Results of Pharmacy refrigerator temperatures are reported ~~quarterly to QIC (copy of report to Pharmacy staff)~~P&T (monthly).

E. EMERGENCY BOXES AND CRASH CARTS -- The emergency boxes and crash carts are checked monthly for completeness and freshness of stock. (or when box/cart has been opened)

1. Threshold: N/A
2. Reported to: P&T (monthly)

F. PHARMACY OMNICELL MEDICATION TRANSACTION AUDIT – Each month the omnicell transactions for 8 residents over a 5 day period is compared to the Medication Administration Record for accuracy in documentation.

~~1.~~ Reported to: Results of activities are reported to nurse manager, nursing director, Medication Error Reduction Subcommittee, ~~P&T (monthly), and QIC (quarterly, copy of report to pharmacy staff)~~

~~2.~~1.

G. NURSING STATION CHECKS -- Nursing stations are checked on a monthly basis for Title 22 regulatory compliance with proper storage of meds, expiration dates, absence of discontinued medications, cleanliness, presence of appropriate drug information sources and applicable written hospital policies.

1. Threshold: N/A
2. Reported to: Nurse Manager, ~~Director of Nursing~~Chief Nursing Officer & Hospital Administration (monthly), ~~and~~ P&T(monthly and PIPS (quarterly).

H. MEDICATION REGIMEN REVIEWS -- In accordance with State and Federal guidelines, the medical charts of all patients are reviewed every 30 days by a pharmacist (refer to Policy & Procedure 06.01.00).

1. Threshold: 100%
~~2.~~ Reported to: Medication irregularities are reported in writing to the unit physician and nurse manager monthly. ~~Copies of the reports are provided to Director of Medicine, Director of Nursing, Hospital Administration. Electronic copies are maintained in the Pharmacy Department.~~ MRR is available for viewing by members of the Resident Care Team electronically in the MRR Database. Findings and recommendations are reported to the Chief Nursing Office, the attending physician, the Chief Medical Officer and if appropriate, the administrator.

I. MEDICATION PASS OBSERVATION – At least 4 units are selected per month for observation of medication administration.

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (monthly), applicable nursing unit managers and nursing administration (monthly)

J. IV PREPARATION OBSERVATION AND STERILITY TESTING - Pharmacy personnel shall be observed during sterile compounding and evaluated at least annually as part of competency assessments required to compound sterile preparations (refer to Policy & Procedure 07.01.00).. Preparations compounded during the media fill challenge and gloved fingertip samples will be incubated per the manufacturer's specifications to test for microbial growth

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (Annually)

K. PHARMACY COMPOUNDING –At least one sterile preparation and one non-sterile preparation compounded by the pharmacy will be sent to an outside analytical laboratory for potency and sterility testing annually. See pharmacy policy and procedure 7.01.00 for details regarding retesting and recall for unacceptable results.

1. Threshold: Potency 100% +/- 10% actual concentration vs. labeled concentration;
No microbial growth 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (Annually),

L. MEDICATION RECALLS -- Medications recalled by the FDA, manufacturer, or at the discretion of the supervising pharmacist for a compounded preparation will be handled immediately upon notification. Recalled drugs are removed from stock as described in the Pharmacy Policy & Procedure for Drug Recall (02.04.00) and returned to wholesaler or manufacturer.

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee and P&T, if recalled medication was in stock and nature of reason for recall poses potential risk or danger to residents

New: 10/91
Reviewed: 4/12, 8/13
Revised: 1/94SK, 3/98SK, 3/99DY, 6/99DY, 8/01DY, 10/03DW, 11/2010mf, 2011/06, 2014/11, 2015/10, 8/18

LAGUNA HONDA HOSPITAL 03.01.02
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR MED PASS OBSERVATION

Policy:

The pharmacist shall perform observations of nursing medication administration passes.

Purpose:

To ensure medications are administered as ordered, and in accordance with applicable LH Pharmaceutical Services and Nursing Department policies and procedures.

Procedure:

1. One or two pharmacist(s)/pharmacy student(s) will be assigned ~~on a rotational basis~~ by ~~a Clinical~~ the Supervising Pharmacist to perform medication pass observation.

2. The location will be selected for observation according to the Medication Pass Observation Schedule.

3. At minimum, four med passes will be observed every month. The goal is to observe med pass on each unit at least once during every calendar year.

4. Med passes for a minimum of 20 medications per unit will be observed.

5. Errors observed during med pass will be communicated to the licensed nurse involved, and/or the Nurse Manager.

6. All observation will be reported on the Medication Pass Observation Competency Assessment form (attachment)

7. The Medication Pass Observation Competency Assessment form will be forwarded to the ~~Clinical Pharmacists~~ Supervising Pharmacist for review and follow-up.

8. Results of the med pass observations will be part of the monthly Nursing Drug Regimen Review report forwarded to the Nursing ~~Supervisor~~ Director and ~~Director of Nursing~~Chief Nursing Officer.

9. Results will also be documented monthly in the Pharmacy Department Report to the Medication Error Reduction Subcommittee and Pharmacy and Therapeutics Committee

New: 9/93CO
Reviewed: 2/05dw, 04/09, 2/10, 5/12, 8/13, 7/15

Revised: 6/99, 2/06, 01/08, 10/09, 6/11, 8/18

~~Laguna Honda Hospital~~
~~Department of Pharmacy~~
~~Medication Pass Observation~~

~~Date:__________________ Ward:____________ RN/LVN name:__________________~~

~~Resident Name:______________________________~~
~~Med:______________________________~~
~~Med:______________________________~~
~~Med:______________________________~~
~~Med:______________________________~~
~~Med:______________________________~~
~~Med:______________________________~~

~~Resident Name:______________________________~~
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~~Resident Name:______________________________~~
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Medication Pass Observation Competency Assessment

RN/LVN Specific Competency Assessment

Indicator	Yes	No, Describe	N/A
• Consistently administers medication with 5 rights (patient, drug, time, dose & route)			
• Demonstrates good infection control by: 1. Consistently washes hands with alcohol gel or soap and water between residents if any skin contact; 2. Keeps top of med cart clean, and 3. Does not take glove boxes or other clean materials to resident bedside that are not for resident's use only			
• Locks medication cart when unattended and does not leave medications unattended			
• Closes MAR when unattended to protect privacy of residents			
• Uses disposable spoon, not tongue depressor, to administer pudding/applesauce with meds if resident unable to take fluids to swallow meds			

Medication Specific Competency Assessment

Indicator	Yes	No, Describe	N/A
• **Sustained release and Enteric coated Medications:** Administer intact tab/cap (do not crush)			
• **Liquid Medications:** Shake bottle before pouring; accurately calculate dose of liquid medications; pour at eye level through direct observation			
• **Medication via enteral tube:** 1. Position resident's upper body to ≥ 45° 2. Verify tube placement by both auscultation and aspiration 3. Flush tube with 20-60mL tap water before medications are delivered by gravity (unless GT may push meds) 4. Flush tube with 20-60mL tap water after giving meds • Dilantin® suspension administration needs to be separated from the enteral feeding by at least **one hour**			
• **Inhaled Medications:** 1. Request that resident sit up straight 2. Shake the container and place inhaler into resident's mouth 3. Actuate inhaler to coincide with a slow deep breath and instruct the resident to hold breath for 5-10 seconds 4. Separate at least one minute between multiple puffs (from same metered dose inhaler (MDI)) 5. Separate at least 5 to 10 minutes between multiple MDIs • The sequence of administration is Beta2 adrenergic agonist (e.g. Albuterol) first, followed by anticholinergic agent (e.g. Atrovent®) and then lastly steroid (e.g. QVAR®) • Rinse mouth after steroid inhaler use			
• **Eye Drop administration:** 1. Wash hands with soap and water or use alcohol gel before and after instillation 2. Wait 5 minutes between instilling multiple eye drops			
• **Antineoplastic/Cytotoxic Medications:** 1. Avoid direct contact to the skin or mucous membranes with the powder contained in capsules or tablets 2. Do not open or crush capsules or tablets. Contact pharmacy for alternative preparations.			
• Other: (e.g. water but not juice with meds to diabetic patient; check apical pulse with digoxin, etc.)			

LAGUNA HONDA HOSPITAL 03.03.00
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR INFECTION CONTROL

Policy:

The pharmacy is responsible for the prevention of contamination of medications or other pharmacy products, whether caused by faulty manufacturing, handling, storage or compounding.

Purpose:

To prevent the dissemination of contaminated medications or other pharmacy products to patients.

Procedure:

1. Storage
   a. Medications, chemicals and other pharmaceutical products are stored in accordance with US Pharmacopeia, National Formulary and manufacturer's recommendations.

2. Dispensing Oral Medications
   a. The touching of medications by hands is prohibited.
   b. A counting tray and spatula will be used when dispensing tablets and capsules.
   c. Counting trays and spatulas will be cleaned daily with 70% Ethyl Alcohol.
   d. Tablets, capsules, or liquids will be dispensed in fresh clean containers with clean labels.

3. Medication Prepacking
   a. When prepacking tablets and capsules into unit doses, disposable ~~latex~~ gloves shall be worn.

4. Compounding Ointments and Creams
   a. The compounding surface and utensils shall be cleaned with 70% Ethyl Alcohol prior to and after use.
   b. Compounding will be done in accordance with the standards of pharmaceutical practices. Refer to Pharm 02.01.08.

5. ~~Manufacturing~~Compounding Topical Solutions
   a. Solutions will be compounded in accordance with the standards of pharmaceutical practices.
   b. Sterile water for irrigation U.S.P. is the water to be used in the compounding of topical solutions.
   c. ~~Unless otherwise specified or indicated, compounded topical solutions will have an expiration of 30 days from the date of compounding and a 72 hour discard after opening.~~Refer to Pharm 02.01.08 for expiration date for non-sterile compounding.

6. Expiration Dates
   a. No medications or pharmacy products will be dispensed beyond the manufacturer's recommended expiration date.
   b. Medications or pharmacy products that will expire within 30 days of the expiration date will be recalled from the wards and will be removed from pharmacy stock.

7. Sterile Product Preparation, Handling and Disposal
    a. Sterile products will be prepared, handled and disposed in accordance with the standards of pharmaceutical practices to ensure the appropriate surveillance, prevention, and infection control procedures. *Also see Pharmacy Policy & Procedure 07.01.00.*

New: 10/91
Revised: 12/96, 05/97, 07/03, 08/18
Reviewed: 02/06, 01/08, 04/09, 2/10, 6/11, 5/12, 8/13, 8/14, 7/15

RESPONSIBILITY AND ACCOUNTABILITY OF THE REHABILITATION SERVICES

POLICY:

The responsibility and accountability of the Rehabilitation Services to the medical staff and administration is outlined below.

PROCEDURE:

1. Under the direction of the Medical Director of the Hospital, the overall responsibility for Physical Medicine Services at the Rehabilitation Services lies with the Chief of Rehabilitation Services.

    a. The Chief of Rehabilitation Services ~~or appropriate designee is responsible for pre-admission screening of each patient. The Chief of Rehabilitation Services is the designated patient service coordinator, integrating the rehabilitation services of the Services with all other services, as needed, for~~provides medical oversight of Rehabilitation Services and supervision of physiarists or physicians practicing in the field of rehabilitation medicine. The Chief of Rehabilitation Services facilitates integration of the service with other services within the hospital.~~ each patient, and directing *Rehabilitation Interdisciplinary Case Conferences*.~~

    b. The DPH/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services, in consultation with the Chief of Rehabilitation Services and under the direction of the SFHN Chief Operating Officer, provides administrative management of the Rehabilitation Services, including monitoring the budget; chairing monthly department meetings; oversight of the continuing education program; assuring adherence to federal, state and local regulations; and identification and planning for future program needs.

2. The delivery of medical rehabilitation services is provided by qualified physicians on the Medical Staff who have training and experience in the field of rehabilitation medicine (e.g. physiatrists).

    a. On the Rehabilitation Unit(s), the physiatrist, in consultation with other members of the Rehabilitation Unit's Patient Care Team (PCT), determines rehabilitation goals and prescribes a comprehensive interdisciplinary rehabilitation treatment plan for each patient, which includes a detailed diagnosis and a projected length of treatment time.

    b. On general skilled nursing facility units, the Unit Physician is responsible for the general medical care of the patient and ancillary services, as needed. When

consulted, Rehabilitation Services and phyistrists interacts closely with theThe Unit Physician, along with the Unit's PCT,, interacts closely with th e patient and patient and, if needed, the patient's's family towards achieving realistic rehabilitation goals.

c. The Chief of Rehabilitation Services assumes only those clinical responsibilities for which they have been determined to be competent.

3. Under the direction of the DPH/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services, the Senior Physical Therapist, Supervising Speech/Language Pathologist, and Senior Occupational Therapist arrange scheduling of patients, supervise all staff activities, bear responsibility for carrying out prescribed treatment programs, and assure proper documentation in patient's charts.

ATTACHMENT:
None

REFERENCE:

1. Medical Staff P&P: A05-01 Rehabilitation Services
2. Barclays California Code of Regulations, Title 22 § 70597 (a)

Most Recent Review: 18/08/24, 16/08/05
Revised: 18/08/24, 06/09/22, 14/08/21, 17/07/31
Original Adoption: 99/08/23

SCOPE OF SERVICES TO BE PROVIDED

POLICY:

The Rehabilitation Center provides a wide range of services to enhance and facilitate the rehabilitation process.

BACKGROUND:

The Rehabilitation Unit at Laguna Honda Hospital and Rehabilitation Center consists of 49 SNF beds and 5 Acute Rehabilitation beds. Rehabilitation Center offers rehabilitation services for all 780 licensed beds at LH.

PROCEDURE:

The following services are provided at the Rehabilitation Center by qualified individuals:

1. ~~1.~~ Physiatry care, provided by a specialist in the field of Physical Medicine and Rehabilitation
2. ~~2.~~ Medical care, provided by an internist or family practitioner
3. ~~3.~~ Rehabilitation Nursing care

~~4. Evaluation for Restorative Care Program~~

4. ~~5.~~ Physical Therapy
5. ~~6.~~ Speech/Language Therapy
6. ~~7.~~ Occupational Therapy~~/Psychosocial Occupational Therapy~~
7. ~~8.~~ Audiology
8. ~~9.~~ Social Services ~~and Discharge Planning~~
9. ~~10.~~ Nutrition Services
10. ~~11.~~ Activity ~~Therapy/Therapeutic Recreation~~Therapy
11. ~~12~~ Phar~~macy Services~~macy Services
12. ~~13. Infection Control~~Psychiatric care
13. Psychologic support
14. Neuropsychology testing
~~12.~~15. Substance treatment and recovery services
~~13. 14. Substance Treatment and Recovery Services (STARS)~~
16. ~~15. Outpatient Rehabilitation Services~~Outpatient Rehabilitation services

14.17. Basic and advanced cardiopulmonary support

1. 16. Basic cardiopulmonary resuscitation is available at all times when patients are in the Rehabilitation Services and/or when rehabilitation services are provided on a unit.

2. 17. Advanced cardiopulmonary support is provided for the care of those patients who require it.

CONSULTATIONS

Consultations in the following medical and surgical subspecialties are available, as needed:

1. Cardiology
2. Neurology
3. Urology
4. Rheumatology
5. Dermatology
6. Neuropsychology
7. Gastrointestinal Medicine
8. Electrodiagnostic Study
9. Psychiatry
10. Hematology/Oncology
11. Endocrinology
12. Ophthalmology
13. Orthopedic Surgery
14. Vascular Surgery
15. Plastic Surgery/Hand Surgery
16. General Surgery
17. Ear, Nose, and Throat
18. Podiatry
19. Dentistry
22. Gynecology
23. Optometry
24. Nephrology
25. Pain

SUPPORT SERVICES

1. Orthotics and Prosthetic Services by contract.
2. Vocational Rehabilitation Services by referral.
3. Clinical Nurse Specialist

SPECIALTY CLINICS:

1. Custom wheelchair ordering and maintenance
2. Orthotics/Shoe/Prosthetics -Clinic

ATTACHMENT:

None

REFERENCES:

1. HWP&P: 23-01 Interdisciplinary Care Planning

2. Barclays California Code of Regulations, Title 22 § 70597(a)(4), § 72403 Physical Therapy Service Unit–Services, § 72413 Occupational Therapy Service Unit–Services, § 72423 Speech Pathology and/or Audiology–Services

Most Recent Review: 18/08/24, 17/08/14, 16/08/14
Revised: 18/08/24, 06/09/22, 10/12/07, 13/08/22, 14/08/21
Original Adoption:

PHYSICAL MEDICINE AND REHABILITATION SERVICES

POLICY:

Physical medicine and rehabilitation (PM&R) services are performed by a Physiatrist (or other physician qualified by training, experience, and knowledge). Physiatrists provide identification of the nature and extent of functional disability, and utilize diagnostic examinations to detect or confirm pathologic states that underly~~ie~~, complicate, or exist concurrently with physical impairment and disabling condition(s). Diagnostic services will be provided by specialty medical services appropriate to a patient's~~n individual's~~ presenting conditions. A synthesis of the medical diagnoses and rehabilitation evaluations/assessments pertinent to an individual is applied in the design of interventions~~ electively~~ used to prevent complications, enhance recovery, and/or promote adaptation to optimal levels of function, performance, and quality-of-life goals.

PROCEDURE:

PM&R services include, but need not be limited to, the following:

1. Assessing a patient's general medical condition, psychosocial status, and vocational history.
2. Examining the neuromusculoskeletal system and evaluation of mental status.
3. Analyzing body movement, postural control, gait, and lower- and upper-extremity skills.
4. Prescribing rehabilitation intervention(s) commensurate with a patient's medical status and care requirements.
5. Coordinating services with Patient Care Team (PCT) members, patient's families, and community agency representatives.
6. Monitoring of the quality and effectiveness of a patient's progress toward achievement of rehabilitation goals and health maintenance, as well as the degree of success in preventing complications known to occur over time in the natural history of the disorder.
7. Working in concert with the patient's primary care physician when physiatry consultation is requested.
8. Developing a rehabilitation treatment plan, which includes the general medical, physical medicine, and rehabilitation services to be provided.

9. Acts as the patient service coordinator by coordinating the services of the rehabilitation team. [Title 22 § 70597(h)(2)]

ATTACHMENT:
None

REFERENCES:

1. Medical Staff P&P: A05-01 Rehabilitation Services
2. Medical Staff By-Laws, Article IX

Most Recent Review: 18/08/24, 14/08/22
Revised: 18/08/24, 06/09/22, 17/07/31
Original Adoption: 99/08/23

NEUROPSYCHOLOGY SERVICES

POLICY:

A neuropsychologist shall be available for consultation for patients undergoing a comprehensive rehabilitation program.

PROCEDURE:

N~~A n~~europsychology services are available by referral for patients on the ~~ist is assigned to the~~ rehabilitation unit. These services may include, ~~to provide services that include,~~ but need not be limited to, the following:

1. Neuropsychologic assessment of ~~all~~ patients with cognitive dysfunction after central nervous system injury, and other patients, as indicated.

2. Design of behavior management programs appropriate to ~~all~~ patients in need of cognitive, psychosocial, or behavior therapy.

3. Coordination of the implementation of such behavior management programs with ~~all Medical, Nursing, Rehabilitation Services, psychiatry and psychology, and other therapy staff responsible for the care of the patient.~~the Patient Care Team.

4. Ongoing ~~re~~assessment of the patient's status and function, and revision of the behavior management plan, as indicated.

5. Participation in *Rehabilitation Patient Care Case Conferences* and discharge planning as needed.~~.~~

~~6. Assistance to the Chief of Rehabilitation Services in long-term program planning for the optimal therapeutic milieu for identified patients with psychological needs.~~

ATTACHMENT:
None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70599(d)(4)(g)

Most Recent Review: 18/08/24~~14/08/21~~, 17/08/14
Revised: 18/08/24, 06/09/22
Original Adoption: 99/08/23

ACTIVITY THERAPY SERVICES

POLICY:

In the rehabilitation setting, recreational and other leisure time activity therapy services provide for development, maintenance, and expression of an appropriate leisure/social lifestyle for individuals with physical or cognitive impairments.

PROCEDURE:

1. Activity therapy services provide, but need not be limited to, the following:
   a. Assessment of the patient's preferred leisure, social, and recreational abilities, as well as identifies deficiencies, interests, barriers, life experiences, needs, and potential.
   b. Activities are designed and offered to improve social, emotional, and cognitive well-being to prepare for future, leisure/social involvement.
   c. Leisure education designed to help the patient acquire the knowledge, skills, and attitudes needed for independent leisure/social involvement, adjustment in the community, decision-making ability, and appropriate use of free time.

1. Activity Therapy staff monitor the patient's participation in their chosen activities, and the extent to which goals are achieved explored relative to the use of leisure time and the acquisition of socialization skills.

ATTACHMENT:
None

REFERENCES:
Activity Therapy Services P&P

Most Recent Review: 17/08/11
Revised: 06/09/22, 14/08/21, 16/08/11, 18/08/23
Original Adoption: 99/08/23

REHABILITATION SERVICES FOR REHABILITATION UNIT (ACUTE REHABILITATION AND SNF REHABILITATION) PATIENTS

POLICY:

The following minimum requirements are included in the process of providing rehabilitation services to patients.

PROCEDURE:

1. Consistent with applicable law and Laguna Honda Hospital and Rehabilitation Services (LH) policies, rehabilitation services are initiated by a referral from a physiatrist, physician, or other qualified individual.

2. Such referrals must be dated, signed, and include a detailed diagnosis or problem for which treatment is anticipated

3. A rehabilitation treatment plan for patients admitted to the Rehabilitation Unit is developed by the physician, in conjunction with the patient care team based on the functional assessment and evaluation of the patient.

4. Patient and family participate, as appropriate, in the development and implementation of the rehabilitation treatment plan.

6. The rehabilitation treatment plan includes measurable goals and objectives (described in functional or behavioral terms) tailored to the patient, and include time frames for achievement.

7. The patient's progress and results of treatment are assessed on a timely basis, which is weekly for acute-level rehabilitation inpatients and periodically as defined by CMS guidelines for SNF-level rehabilitation inpatients. Rehabilitation treatment goals are revised, as appropriate.

8. The patient's progress and response to rehabilitation treatment are documented in the medical record.

9. Continued rehabilitation care is justified either by evidence of observed or expected improvement in functional ability.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 18/08/24,16/08/14, 17/07/28
Revised: 18/08/24, 06/09/22, 07/08/24, 14/08/21, 17/07/28
Original Adoption: 99/08/23

REHABILITATION SERVICES FOR GENERAL SNF

POLICY:

In addition to rehabilitation services provided to patients on the Rehabilitation Unit, rehabilitation services are provided to meet the rehabilitation needs of patients~~/residents~~ on the general SNF units throughout the Hospital. Rehabilitation services include Physical Therapy, Occupational Therapy, Speech Pathology, Audiology, and Physiatry.

PROCEDURE:

1. Rehabilitation services are provided only by written orders (or referrals, in the case of Physiatry consultations) of an attending physician.

2. Qualified rehabilitation professionals are responsible for the following:

   a. Evaluating each patient referred for care.

   b. Recommending a rehabilitative treatment regimen for patients who have an anticipated positive outcome as a result of therapeutic intervention~~.~~.

   c. Participating in patient care in conjunction with the ~~attending physician~~Patient Care Team.

   d. Reevaluating the patient's continuing need for rehabilitation care.

   e. Supervising the provision of care to assure an acceptable level of performance from rehabilitation assistants and~~, aides, and~~ other qualified support personnel.

   f. Providing in-service training for staff, as needed.

   g. Monitoring and evaluating, on a regular basis, the quality and appropriateness of care provided.

ATTACHMENT:
None

REFERENCE:
Medical Staff P&P: A05 Rehabilitation Services

Most Recent Review: 18/08/24, 16/08/05, 17/07/31
Revised: 18/08/24, 06/09/22, 07/08/24
Original Adoption: 99/08/23

REHABILITATION SERVICES AND MEDICAL RECORD

POLICY:

The medical record of a patient receiving rehabilitation services includes, at a minimum, the following information.

PROCEDURE:

1. The reason for referral to Rehabilitation Services, or admission to the ~~comprehensive rehabilitation program or u~~Rehabilitation Unit.
2. A summary of the patient's clinical condition, functional strengths and limitations, indications ~~and contraindications for specific~~ rehabilitation services, and prognosis.
3. The goals of treatment and treatment plan, including any problem that may affect the outcome of rehabilitation services~~, and criteria for discontinuation of services~~.
4. Treatment or~~and~~ progress records, with appropriate ongoing assessments as required by the patient's condition~~, including a description of the perception of the patient and the family towards, and their involvement in, rehabilitation services~~.
5. Assessment of rehabilitation progress and estimates of further rehabilitation potential ~~entered on a timely basis~~.
6. Discharge summary that includes recommendations for further Rehabilitation Services, if indicated.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: ~~,~~ 18/08/24, 6/08/05, 17/07/28
Revised: 18/08/24, 06/09/22
Original Adoption: 99/08/23

REHABILITATION ASSESSMENT AND INTERDISCIPLINARY CARE PLANNING

POLICY:

1. Rehabilitation staff ~~participates as ancillaryor consultative~~ members of the Patient Care Team (PCT) to assist with developing patient care plans.

2. Patient care is managed in a coordinated, systematic, comprehensive manner through assessments, evaluations, and interventions to promote and maintain the individual patient's highest practicable level of functioning.

PROCEDURE:

1. Attendance at PCT meetings

a. Rehabilitation Unit Patient Care Team (PCT) members are responsible for attending Patient Care meetings for patients who have current and active orders for rehabilitation. In instances where the primary therapist is unavailable to attend the scheduled PCT meeting, a suitable representative or written information is provided. Therapists may attend PCT meetings for patients who do not have current and active orders on an as-needed basis, but must be notified ahead of time by the PCT. Therapists may also be available on an ongoing basis for attendance at specific Unit PCT meetings, at the discretion of the individual department heads.

b. Attendance at PCT meetings assumes that the therapist will:

I. Check for scheduling of meeting times.

II. Arrange patient care schedules to accommodate PCT meetings.

III. If unavailable, notify a representative or the head of the PCT team of the current plan of care.

IV. ~~Complete additions to the~~Contribute to interdisciplinary care planning by: ~~including:~~

- Developing ~~G~~rehabilitation goals based on the patient assessment that are realistic, measurable, time limited, and consistent with the therapy prescribed by the patient's physician.

  - Whenever possible, goals are determined in collaboration with the patient.~~goals are set with the patient..~~
- Updating~~e~~ interventions as needed.

2. Documentation of Care Plans

a. The evaluating therapist has the responsibility for initiating a rehabilitation care plan within 48 hours following the evaluation.

b. The treating therapist should monitor the accuracy of the care plan and modify it as needed.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 18/08/24, 16/08/05, 17/08/01
Revised: 18/08/24, 06/09/22
Original Adoption: 99/08/23

ADMISSION AND ELIGIBILITY CRITERIA FOR SNF-LEVEL REHABILITATION SERVICES

POLICY:

Any patient over the age of 16 who requires SNF-level rehabilitation requiring~~involving~~ an interdisciplinary team approach to achieve maximal functional independence may be eligible for SNF-level rehabilitation services.

PROCEDURE:

The patient must meet the following criteria for admission:

1. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.

   These impairments may be a result of injury, recent onset of progressive and chronic disease, such as, but not limited to: stroke, traumatic brain injury, severe musculoskeletal injury resulting from trauma, neuromuscular disease, disorders of the central nervous system, severe arthritis, and lower-extremity amputation.

2. Rehabilitation needs will include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or medical problems best addressed on the SNF-level Rehabilitation Unit.

3. Patient must be medically stable.

4. Patient requires rehabilitation physician management.

5. Patient requires the availability or supervision of rehabilitation nursing 24 hours daily in one or more of the following:

   a. Training in self care
   b. Training in bowel and bladder management
   c. Training or instruction in safety precautions
   d. Cognitive function training
   e. Behavioral modification and management
   f. Training in communication

6. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

7. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a general SNF unit requiring a lower level of care.transfer to a lighter care long-term Unit.

8. Pre-admission screening must be performed by the Chief of Rehabilitation Services or his/her designee, with assessment reflecting the patient's ability to achieve significant improvement in a reasonable period of time with SNF rehabilitation services.

ATTACHMENT:
None

REFERENCE:

1. Medical Staff P&P: B01 Admission Screening
2. Barclays California Code of Regulations, Title 22 § 70597(a7)(d)

Most Recent Review: 18/08/24, 16/08/14
Revised: 18/08/24, 06/09/22, 17/07/31
Original Adoption: 99/08/23

VERBAL ORDERS

POLICY:

Physical therapists (PT), occupational therapists (OT), and speech/language pathologists (SLP) may accept verbal orders from physicians within their scope of practice.

PROCEDURE:

1. The physician must give the verbal order directly to the desired service.

2. The therapist may accept the verbal order if it falls within the scope of his practice and does not involve other disciplines in its implementation.

   Acceptable verbal orders include, but are not limited to:

   a. Initiation of therapy (PT, OT, ST)
   b. Discontinuation of therapy (PT, OT, ST)
   c. Splint fabrication (PT, OT)
   d. Swallow evaluation (ST)
   e. Ultrasound treatment (PT)
   f. Functional electrical stimulation (PT)
   g. Wheelchair evaluation (OT)
   h. Community evaluation (PT, OT)
   i. Augmentative Communication Evaluation (ST)
   j. Restorative Care

   Unacceptable verbal orders include, but are not limited to:

   a. Use of a splint or other equipment on the Unit
   b. Beginning a Unit-based ambulation program
   c. Positioning of a patient
   d. Changing the texture of a patient's diet
   e. Changing a patient's weight-bearing status

3. For verbal orders to initiate treatment, the therapist must fill out form *MR 505 (Rehabilitation Services Physician Order Form/Consultation Request*) per guidelines in Appendix A. For other orders, the therapist must write, date, time, and sign the order on the Physician's Order sheet at the front of the patient's chart.

4. The verbal order is valid at the time that it is written; it does not need an accompanying physician's signature to be implemented; however, it must be signed within by the physician within 24 hours, per Laguna Honda Hospital and Rehabilitation Services policy.

5. The verbal order does not need to be noted or initiated by Nursing staff or the Unit clerk.

6. ~~The verbal order will be cosigned by the physician within 24 hours, per Laguna Honda Hospital and Rehabilitation Services policy.~~

ATTACHMENT:
None

REFERENCE:

Medical Staff P&P: 01-01 Daytime Physicians' General Information (Orders — ¶ 1)

Most Recent Review: 18/08/24, 16/08/14, 17/07/31
Revised: 18/08/24, 06/09/22
Original Adoption: 99/08/23

SOURCES AND FORMS USED FOR REFERRAL OF PATIENTS

POLICY:

The sources and forms used to refer patients to the Rehabilitation Services will be designated. [Title 22 § 70597(a)(7)]

PROCEDURE:

1. **Sources:** Laguna Honda Hospital and Rehabilitation Center (LHH), a facility of the Department of Public Health of the City and County of San Francisco (DPH), accepts referrals for any San Francisco resident. The sources of referrals are broad and include, but are not limited to, patients at home or in other hospitals, and other healthcare referring agencies. [Title 22 § 70597(a)(6)]

2. **Referrals may be made to physiatrists, therapists and/or to one of the inpatient rehabilitation programs (e.g. Acute Rehabilitation [AKA Inpatient Rehabilitation Facility] or SNF Rehabilitation).**

3. **To make a referral for:**

   a. Therapy for LHH inpatients: Physicians must complete the *Rehabilitation Services Physician Order Form/ Consultation Request* (MR 505) and forward to the Rehabilitation Department.

   b. Physiatrists for LHH inpatients: Physicians must complete an electronic referral~~-Referral~~ for LHH Physiatry.

   c. Acute Rehabilitation (IRF) or SNF Rehabilitation: DPH or outside providers must complete the referral form located at the following link: http://lagunahonda.org/sites/default/files/docs/LHHReferralForm.pdf. This form should be forward to Admissions and Eligibility.

ATTACHMENT:

None

REFERENCE:

1. Medical Staff P&P: A05 In-House Requests for Rehabilitation Consultations and Services
2. Barclays California Code of Regulations, Title 22 § 70597(a)(6) and (a)(7)

Most Recent Review: 18/08/24, 13/08/22, 17/08/14
Revised: 18/08/24, 06/09/22, 13/08/22
Original Adoption: 99/08/23

OCCUPATIONAL THERAPY STAFF

POLICY:

1. Under the direction of the Director of Rehabilitation Services, the Senior Occupational Therapist ensures that the occupational therapy service complies with all regulatory hospital, state, and federal regulations.

2. The Occupational Therapy Department Senior is responsible for the coordination of a therapeutic program in the Rehabilitation Program (Pavilion Building, Mezzanine Floor), and consultative/SNF services on the long-term,short-term care units, and out-patient services.

3. There is sufficient staff to meet the needs of the patients and scope of the services offered. The staff consists of occupational therapists, and additionally may consist of occupational therapy aides, healthworkers, ~~and restorative therapy aides~~, and other supportive personnel.

4. An occupational therapist must supervise occupational therapy treatments rendered by occupational therapy aides and therapy aides. When occupational therapy aides are providing treatment, an occupational therapist must provide direct line of sight supervision of treatment rendered.

PROCEDURE:

1. The Occupational Therapy Department is under the direct supervision of the Occupational Therapy Department Senior (or designee), who is under the immediate supervision of the Rehabilitation Manager (or designee).

2. The Occupational Therapy Department Head is responsible for the coordination of therapies on all Units, which includes the Rehabilitation Services (Pavilion Building, Mezzanine Floor), and consultative services and treatment on all long-term, short-term care units, and out-patient services.

3. Sufficient occupational therapy staff are employed to meet the needs of the patients and provide all occupational therapy services. Staff members work under the direct supervision of the Occupational Therapy Department Senior.

4. Occupational therapy students work under the direct supervision of assigned supervising Occupational Therapists. There is an assigned Fieldwork Educator.

5. Occupational therapy aides work directly under occupational therapist supervision.

6. Restorative therapy aides work directly under the Nursing department, but may receive practice area guidance from treating therapists.

7. An occupational therapist will provide supervision to a health worker II, as described below:

"Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait, ADL care, or transfer training, housekeeping duties, clerical duties, and similar functions.

6.

7.8. Occupational Therapy Department staff work the hours necessary to accomplish those tasks listed above.

8.9. The occupational therapists employed at LH have evidence of possessing the proper qualifications (i.e., must be registered by the National Board for Certification in Occupational Therapy, Inc., or be qualified to take the next licensing exam), and have current licensure from the California Board of Occupational Therapy.

9.10. The Occupational Therapists should provide evidence of possessing an active Basic Life Safety CPT certification.

ATTACHMENT:
None

REFERENCE:¶

Barclays California Code of Regulations, Title 22 § 72417

Most recent review: 16/08/05, 17/07/28
Revised: 00/06/12, 09/11/12, 10/10/21, 16/08/05, 18/08/14
Original Adoption: 99/08/23

CUSTOM WHEELCHAIRS

POLICY:

Custom wheelchairs may be ordered for patients with specialized positioning and seating needs who cannot be safely and adequately positioned in a standard facility wheelchair, provided a funding source is identified. The funding source has to be able to pay for ongoing maintenance and repairs.

CRITERIA:

Patients who may be considered for custom wheelchairs will be based on medical necessity and upon the recommendation of the Occupational/Physical Therapist. The patient must also meet one of the following criteria:~~:~~

1. An attending MD has written a physician's order for a custom wheelchair, and a subsequent Occupational Therapy evaluation or assessment confirms that proper seating cannot be achieved with available equipment. For power wheelchairs, the patient must demonstrate the ability to drive and operate the power wheelchair independently.

~~2. A patient has a history of positioning problems, as evidenced by two or more requests from an attending MD for wheelchair evaluation or wheelchair positioning, and by repeated unsuccessful attempts by Occupational Therapists to position the patient adequately or safely in available wheelchairs.~~

~~3.~~2. A patient cannot be easily transported to activities in standard facility wheelchairs due to positioning needs (e.g., patient uses only a geri-chair or lounge chair when out of bed).

~~4.~~3. A custom wheelchair is needed for discharge to the community to enable mobility, completion of activities of daily living, or vocational activities.

~~5.~~4. When specific components are needed to position patients to reduce current contractures or to prevent the onset of further contractures.

~~6.~~5. A patient has a history of positioning problems. The Occupational Therapist is unable to safely and adequately position patient in available wheelchairs. ~~Other~~ C~~c~~riteria may include, but is~~are~~ not limited to;

   a. Supporting midline orientation.

   b. Providing normal visual access to the environment.

c. Enabling adequate respiration.
d. Enhancing ability to swallow, or improving ability to perform self-feeding.
e. Protecting a patient from injury (e.g., due to movement disorders).
f. Preventing falls to floor due to lateral, posterior, or anterior flexion.
g. Preventing slides from chair due to posterior tilt or trunk extension.

PROCEDURE:

1. If a patient meets any of the criteria for a custom wheelchair, the Unit attending physician may request a custom wheelchair evaluation using the Rehabilitation Services Physician Order Form/Consultation Request (MR 505).

2. On receipt of the physician's order, the Occupational Therapy Department will conduct an evaluation or assessment of the patient's wheelchair needs.

3. Adjustments or modifications may be made to a personal wheelchair, or a designated wheelchair, to meet the patient's needs.

4. If a wheelchair cannot be modified, a trial with an appropriate custom wheelchair (if available from a vendor or from the Occupational Therapy Department) will be conducted to see if it will benefit the patient's condition.

5. If standard facility wheelchairs and positioning devices have failed to assist the patient in meeting their highest functional independence and/or failed to meet their positioning needs, and a trial of a custom wheelchair has demonstrated medical benefit, the treating Occupational Therapist will:

   a. Discuss the assessment or evaluation with the Unit Patient Care Team and document in the patient's medical record the outcome of any trial of custom equipment.
   b. Consult with vendor(s) for evaluation of an appropriate custom wheelchair for the patient.
   c. The Occupational Therapist will assist the prescribing physician in completing the required forms regulated by specific insurance requirements (i.e. Medi-Cal or Medicare). This may also include preparing a MR Form 503 or 503i, Rx for Rehabilitation Equipment.
   d. Submit the required documentation to the vendor, identifying an appropriate funding source.
   e. Consider the following when completing the medical record documentation for skilled seating evaluations:
      i. Intervention(s) that were tried by Nursing staff;
      ii. Functional deficits due to poor seating or positioning;

iii. Most recent prior functional level;

iv. Postural deficits the patient is unable to self-correct;

v. Recent event(s) that prompted a seating evaluation;

vi. Specific wheelchair, specialty items, dimensions and/or specific cushions that were evaluated or provided;

vii. A clear explanation of how the proposed custom wheelchair or seating device will make a significant improvement in functional abilities versus current wheelchair or seating device;

viii. Transition to caregiver follow-up.

6. Custom wheelchairs requiring repair are referred to the vendor who supplied the wheelchair.

~~6.~~7. If the patient's insurance denies a custom wheelchair while the patient is still a resident at LHH, the Occupational Therapist will make no further attempts to obtain a custom wheelchair unless the patient has a firm discharge plan and a housing source is identified.

ATTACHMENT:
None

REFERENCE:

1. Barclays California Code of Regulations, Title 22 § 51303(a – i).
2. Barclays California Code of Regulations, Title 22 § 51321
3. Physical Therapy, Occupational Therapy and Speech-Language Pathology Outpatient Services Educational Update, United Government Services (fiscal intermediary), 2nd Revision, November 2003.

Most recent review: 17/07/31
Revised: 04/03/29, 04/08/18, 10/10/21,16/08/05, 18/08/14
Original Adoption: 99/08/23

CONNECTIVITY CLINIC

POLICY:

The Psychosocial Occupational Therapy groups~~Connectivity Clinic~~ are~~is a~~ treatment programs facilitated by a psychosocial occupational therapist or a trained occupational therapsits~~s~~. The program provides patients with ~~HIV neurocognitive disorder (HAND)~~, Alzheimer's Disease, and other dementias, with a unique opportunity to engage in stimulating tasks. The structured treatment groups meet weekly in a campus community space.

GOALS:

1. Patients will increase their functional capacity: i.e. increase endurance for time out of bed, and increase their participation in functional activities.

2. Patients will increase their tolerance for group participation; i.e. increased attention span, ability to follow directions, mental flexibility, and engage with peers.

3. Patients will have opportunities for increased group diversity, peer support, and developing ongoing relationships with patients from other units in mixed gender groups.

4. Patients will optimally, demonstrate improved mood, decreased use of psychotropic medications for the treatment of agitation, and decreased use of sleep medications with improved sleep.

PROCEDURE:

1. Referral to Psychosocial Occupational Therapy groups offered may be made at the request of a member of the patient's RCT or at the request of the patient to the RCT. The MD: ~~through the Connectivity Clinic may be by~~:

   a. Submits a Rehabilitation Services Physician Order Form/Consultation Request indicating Occupational Therapy Eval and Treat and Psychosocial Group Treatment.~~Request of a member of the patient's RCT~~

   ~~b. Submitting a psychosocial OT referral for assessment for Cognitive/Sensory Groups Rehabilitation Referral Form.~~

   ~~c.~~b. ~~Request of the patient to the RCT.~~

2. Psychosocial OT~~s~~ will complete an assessment and determine if patient is appropriate for group ~~-~~and recommend group assignment.

3. Patient~~s~~ and the patient's unit are notified of group schedule and the unit staff are informed that they will escort patient~~s~~ to and from the ~~clinic~~Psychosocial OT group according to group schedule.

4. Psychosocial OT completes evaluation documentation for each patient assessed ~~and for each patient who attends the Connectivity Clinic Groups in the LCR~~. The Psychosocial OT evaluation~~assessment~~ is recorded in the medical record used by the LHH Rehabilitation Department. ~~filed in the Rehabilitation Section of the Medical Record and is entered as a contact note as well as documented in the LCR.~~

ATTACHMENT:
None

R EFERENCE:
None

Most recent review: 15/08/26, 16/08/05, 17/07/31
Revised: 07/08/24, 09/11/12, 10/10/21, 14/08/22, 18/08/23
Original Adoption: 11/08/30

PHYSICAL THERAPY STAFF

POLICY:

1. Under the direction of the Director of Rehabilitation Services, the Senior Physical Therapist ensures that the physical therapy service complies with all regulatory hospital, state, and federal regulations.

2. There are sufficient staff to meet the needs of the patients and scope of the services offered. The staff consists of physical therapists, and may additionally consist of physical therapy assistants, physical therapy aides, physical therapy aideshealth worker II, and other supportive personnel.

3. A physical therapist supervises treatment rendered by aides and assistants and aides.

PROCEDURE:

1. Sufficient physical therapy staff will be employed to meet the needs of the patients and the scope of the services offered.

2. The Physical Therapy Department is under the direct supervision of the Physical Therapy Department Senior (or designee), who is under the immediate supervision of the Rehabilitation Manager (or designee).

3. The physical therapists and physical therapy assistants employed at LHH must be licensed by the State of California, or be qualified to take the next licensing exam.

4. The Physical Therapists and physical therapy assistants should provide evidence of possessing an active Basic Life Safety CPT certification.

5. A physical therapist will provide supervision to health worker II, as described below:

   "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions.

4.6. A physical therapist will provide direct supervision, as described below, when physical therapy aides are providing treatment:

   a. A physical therapist may utilize the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical

therapy. “Patient-related task” means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. “Non-patient-related task” means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide will at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section will authorize an aide to independently perform physical therapy or any physical therapy procedure. The physical therapist shall assign only those patient related tasks that can be safely and effectively performed by the aide. The physical therapist will provide continuous and immediate supervision of the aide. The physical therapist will be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and will be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist will, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and will correspondingly document the patient’s record.

b. The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment will not be prohibited by this section.

5.7. A physical therapist provides supervision for physical therapy assistants, as described below:

a. A licensed physical therapist is at all times responsible for all physical therapy services provided by the physical therapist assistant. The supervising physical therapist has continuing responsibility to follow the progress of each patient, provide direct care to the patient, and to assure that the physical therapist assistant does not function autonomously. The supervising physical therapist will be readily available in person or by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients. The supervising physical therapist provides periodic on-site supervision and observation of the assigned patient care rendered by the physical therapist assistant.

i. Evaluations

- Following an initial evaluation, the supervising physical therapist will indicate when the patient is to be re-evaluated and determine which elements of the treatment plan may be assigned to the physical therapy assistant. This information will be communicated, either verbally or in writing, to the physical therapy assistant.

- The supervising physical therapist will reevaluate the patient as previously determined, or more often if necessary, and modify the treatment, goals, and plan as needed. The reevaluation will include

treatment to the patient by the supervising physical therapist. The reevaluation will be documented and signed by the supervising physical therapist in the patient's record and will reflect the patient's progress toward the treatment goals and when the next reevaluation will be performed.

ii. Documentation

- The physical therapist assistant will document each treatment in the patient record, along with his or her signature. The physical therapist assistant will document in the patient record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a reevaluation by a supervising physical therapist before further treatment by the physical therapist assistant.

- The physical therapist assistant will document weekly notes. The supervising physical therapist will discuss the weekly notes in a care conference with the physical therapist assistant and co-sign the weekly note.

ATTACHMENT:
None

REFERENCE:

1. California Code of Regulations, Title 16, Division 13.2, Physical Therapy Regulations
2. Barclays California Code of Regulations, Title 22 § 70559(a-c);§ 70597(c); 70599(d); § 72407 (a-d);
3. § 70597(g)

Most recent review: 16/08/16, 17/07/27, 18/08/14
Revised: 00/06/14, 07/08/24, 10/10/21, 11/08/30, 16/08/16
Original Adoption: 99/08/23

ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION: AUDIOLOGY

POLICY:

Patients are seen by an audiologist for an audiological evaluation upon referral by a physician.

PROCEDURE:

1. When a physician's order for a hearing evaluation is received, the audiologist schedules the patient.

2. Once the patient has been evaluated, the audiologist enters the audiogram and a signed note, which includes test results and recommendations, in the patient's medical record.

3. After each session with the audiologist, a signed note is entered into the patient's medical record.

4. If a hearing aid is indicated, ENT or primary ~~MD~~ care physician will provide the Audiologist with a medical clearance. If a pathology is suspected~~, or impacted cerumen~~ is noted, the patient will be referred to ENT prior to assessment for a hearing aid. If impacted cerumen is noted, removal prior to the assessment for a hearing aid will be recommended.

ATTACHMENT:
None

REFERENCE:
None

Most recent review: 16/08/05, 17/08/01
Revised: 04/08/18, 14/08/22
Original Adoption: 99/08/2

HEARING AID EVALUATION AND DISPENSING

POLICY:

Hearing aid evaluation, selection, orientation, and counseling are provided.

PROCEDURE:

1. Upon referral by an the primary care physician or the ENT physician, patients are seen for a hearing aid evaluation.

2. A hearing aid is ordered if indicated by results of the hearing aid evaluation.

3. Upon receipt of hearing aid, the patient is scheduled for fitting and orientation. The orientation includes familiarizing patient with parts of the hearing aid; instructing them on insertion, adjustment, and care; training to use hearing aid to improve listening; covering selective listening skills; and utilization of visual cues. This information is also reviewed with Nursing staff and/or family, as appropriate.

4. The ENTprimary care and/or ENT physician is notified that the patient's hearing aid trial has begun.

5. The patient is given hearing aid for an approximate one-month trial. At the end of the trial period, the patient is seen for a hearing aid check. Patient's objective and subjective benefits are evaluated and it is determined whether or not patient should continue using the hearing aid.

6. If a hearing aid is reportedly malfunctioning, it is checked electro-acoustically and appropriate steps are taken for repair.

7. Other listening aids/training may be provided when a hearing aid is not indicated.

ATTACHMENT:
None

REFERENCES:
Barclays California Code of Regulations, Title 22 § 70597(h)(1–2)

Most recent review: 16/08/05, 17/08/01

Revised: 04/08/18
Original Adoption: 99/08/2

ELECTRODIAGNOSTIC STUDIES

POLICY:

Laguna Honda Hospital and Rehabilitation Program provides electrodiagnostic services. These may include electromyographic, nerve conduction, electroencephalographic and somatosensory evoked potential studies, visual evoked potentials.

PURPOSE:

To assist in the diagnosis of neurologic and/or muscular disorders.

PROCEDURE:

1. Requests for electrodiagnostic evaluation may be made ~~via e-referrral~~electronically.
2. Requests will then be routed to the physiatrist or neurologist. The physiatrist or neurologist will set up the appointment date.
3. No written consent is required for electrodiagnostic procedures, but the procedure must be explained to the patient by the examining physiatrist/neurologist.
4. The ~~EMG~~ electrodiagnostic evaluation shall be performed with sterile needle technique according to accepted standards.
5. A detailed report of each electrodiagnostic study will be generated ~~and sent to the attending physician to be filed in the patient's chart~~and added to the patient's medical record.

ATTACHMENT:
None

REFERENCE:
None

Most Recent Review: 18/08/27, 16/08/14
Revised: 06/09/22, 10/12/07
Original Adoption: 99/08/23

GUIDELINES FOR COMPLETION OF MR 505 (*REHABILITATION SERVICES PHYSICIAN ORDER FORM/CONSULTATION REQUEST)*

N.B.: 1. Ancillary departments (including Rehabilitation Services) should not honor requests for services that lack required patient information, including the procedure(s) being requested, the nursing care Unit, and the date of request. This policy is to protect patients of LH and to comply with legal requirements. ***Waiting for corrections to improperly completed order forms can result in a delay of treatment.***

2**.** The MR 505 can no longer be used for referral for Physiatric Services. Referrals for Physiatry must be made through the electronic referral system.

PROCEDURE:

1. **Form Use**

   Use form for only one patient (i.e., do not order services for two patients on one form); if ordering multiple services for the same patient *on the same day*, it is not necessary to use more than one order form for each service type. Do not complete *both* a Form 505 and a Form 101; this creates duplicate orders in the chart. Use Form 505 for the Order, not a Form 101.

2. **Form Preparation**

   Please write legibly and clearly. Do not set other pieces of paper on top of the white copy of the order form; the pressure from writing onto a second document placed on top of the white copy of the MR 505 will be transferred onto the yellow copy of the MR 505, making the orders unreadable.

3. **Addressograph**

   Use the addressograph whenever possible; it contains vital information, including the patient's medical record number, date of birth, gender, Unit, and Invision number. This is also important for distinguishing one *John Smith* from another *John Smith*. Align the addressograph so that it imprints cleanly and completely on the form; do not position the addressograph so that the imprint is unreadable.

   If the addressograph card cannot be located, at minimum the first and last names and the MR number should be handwritten on the form.

4. **Date and Time**

   This is a requirement for all physician orders.

5. **Unit**

   Specify the originating Unit; as this may distinguish between multiple patients with the same name.

6. **Status**

   If neither the *Routine* nor the *Urgent* checkbox is checked, the order will be considered routine.

7. **Diagnosis** and **Reason for Consultation**

   This information informs the therapist as to why a patient needs to be seen.

8. **Precautions**

   This is crucial for the protection and safety of patients.

9. **Services Ordered**

   Check all checkboxes that apply; multiple/interdisciplinary services may be ordered for the same patient on the same day on one form. Do not use the MR 505 to order services not provided by Rehabilitation Services (e.g., bed trapeze), as this may result in cancellation of the order. Use care in requesting services from the correct department (e.g., requesting that OT provide chair alarms, which is provided by PT, as the order will need to be changed.)

10. **Sign the Order**

    Treatment cannot be initiated without a signature.

11. **Noted By**

    The *Noted By* section must be completed by a member of the unit staff.

12. **Distribution**

    File the *white* copy in the Physician's Orders section of the medical record, as it is a Physician Order. Send the ***yellow*** copy to Rehabilitation Services outside Room PG-132, Ground Floor in the Pavilion Building.

Most Recent Review: 18/08/24

Revised: 18/08/24

Original Adoption: 17/08/21

CHIEF OF REHABILITATION SERVICES

The Chief of Rehabilitation Services will be responsible for the overall administrative and medical management of the Rehabilitation Services. Specific duties will include:

1. Pre-admissions screening of all referrals or delegation of this duty to a designee.~~, either directly or by giving medical clearance and final approval to those evaluated by others.~~

2. Scheduling all admissions and transfers or delegation of this duty to a designee.

3. Providing Physiatric services for inpatients on the Rehabilitation Unit, other SNF Units, and outpatients.

4. Developing and implementing new programs and services.

5. Coordinating rehabilitation services between Zuckerberg San Francisco General Hospital and LH.

6. Facilitating Rehabilitation Leadership Meetings in conjunction with the DPH/San Francisco Health Network (SFHN) Director of Integrated Rehabilitation Services.

7. Coordinating physiatry staff vacations, leaves, and cross-coverage.

8. Presenting in-service education programs for physicians and other staff as needed.

9. Developing and ~~performing~~ implementing Performance Improvement monitoring activities and taking action on problems identified for the physician component of rehabilitation care.

11. Developing and reviewing policies and procedures for Rehabilitation Services.

12. Attending hospital wide committees by virtue of the position of ~~as~~ Chief of Rehabilitation Services

13. Other duties, as required.

Most Recent Review: 18/08/24

Revised: 18/08/24, 06/09/22, 10/12/07, 13/08/22, 17/07/31

Original Adoption: 99/08/23

INTERNIST, REHABILITATION SERVICES

The internist/family practitioner will co-follow all patients admitted to R~~r~~ehabilitation Unit~~s~~. Specific duties include:

1. Performing evaluations of all patients admitted to the Rehabilitation Unit.
2. Admitting patients to the rehabilitation unit as needed.
3. Providing support for the medical management of rehabilitation patients.
4. Other duties, as required.

Most Recent Review: 18/08/24, 17/07/31
Revised: 18/08/24
Original Adoption: 14/08/21

STAFF PHYSIATRIST, REHABILITATION SERVICES

The physiatrist will serve as a consultant admitting physician for patients admitted to theon the rehabilitation unitsRehabilitation Unit and the SNF Units. Specific duties will include:

1. Performing a phsyiatric evaluation functional evaluation of all referred patients with subsequent development and implementation of a rehabilitation treatment plan.

2. Participatingon in all *Rehabilitation Patient Care Conferences*.

3. Attending the *Rehabilitation Services Unit meetings Staff Meetings* and *Rehabilitation Leadership Meetings*.

4. Serving as consultant forAssisting in the admission screening process as needed.

5. Participatingion in Performance Improvement activities.

6.5. Performing electrodiagnostic studies, as needed.

7.6. Other duties, as required.

Most Recent Review: 18/08/24, 17/07/31

Revised: 18/08/24

Original Adoption: 14/08/31

MISSION STATEMENT

POLICY:

Laguna Honda Hospital will be a center of excellence in providing a continuum of care that integrates residents in the least restrictive setting, thereby supporting their highest level of independence.

MISSION

As part of the Department of Public Health safety net, the mission of Laguna Honda Hospital is to provide high-quality, culturally competent rehabilitation and skilled nursing services to the diverse population of San Francisco.

Skilled nursing service includes long-term care for residents who cannot be cared for in the community and/or short-term care for those who can be rehabilitated and discharged to a lower level of care within the community.

7.4 Social Services Department: Recording

Policy: It is Social Services Department policy to have a written social history on all residents and a social services plan for those who need such services.

Purpose:

1. To provide continuity of care.

2. To provide better communication among staff members.

3. To document a history of social assessments and services provided to each resident.

4. To assess each resident for discharge potential to a lower level of care.

Procedure:

1. A written Resident Social History Assessment is part of the resident's medical record and social services record. This assessment must be in the record within five (5) working days of admission and is the basis on which a social work treatment plan is developed. If resident is coded as a short stay resident, the assessment must be in the record within two (2) working days of admission.

2. By day 5, the Social Worker will complete and digitally sign Sections A & Q on the MDS page. If #7 Psychosocial Well-Being, #8 Mood State, #9 Behavioral Symptoms, or #20 Community Referral are triggered, a CAA must be completed. The Social Worker is responsible for completing the Summary section and indicating if we are proceeding with care planning.

3. A computerized Discharge Assessment (MR 711) is completed within 14 days of admission or re-admission and updated if resident's condition changes. If resident is coded as short stay resident, the Discharge Assessment must be completed within seven (7) days of admission. Discharge Considerations and interventions are listed for all residents. If resident desires discharge or has potential for discharge, pertinent information is entered into the Social Services Discharge database. A Preliminary Post-Discharge Plan of Care (MR 705) is printed out to review discharge plans with resident and inform them of community services available to them. A finalized version is given to resident and placed in the medical record at time of discharge. A computerized Discharge Linkage Plan (MR 714(i)) is initiated by the social worker and placed in the Care Plan Book. The Discharge Linkage Plan is reviewed and/or updated on a quarterly basis.

7.4 Social Services Department: Recording (cont.)

4. Quarterly progress notes and a semi-annual progress note which update the goals and plans outlined in the annual assessment will be in the resident's medical record within 30 days of the due date. The semi-annual progress note will verify correct address and phone number of any next-of-kin, emergency contact and conservator, if applicable, and update face sheet information with Admissions and Eligibility staff. MSW will manually update the face sheet in the medical record until the corrected copy is placed in the medical record.

5. Annual assessments are documented in the resident's medical record within 13 months of the date of the prior annual assessment. The annual assessments update any activities or changes, which have occurred since the resident's last assessment. The annual assessment will verify correct address and phone number of any next-of-kin, emergency contact and conservator, if applicable, and update face sheet information with Admissions and Eligibility staff. MSW will manually update the face sheet in the medical record until the corrected copy is placed in the medical record.

6. Progress notes are documented as appropriate in the medical record of those residents who are actively receiving assistance from Social Services.

7.7 Social Services Department: Discharge Planning and Implementation

Policy: The Social Services Department is responsible for coordinating discharge planning. Discharge Planning is a process that includes collaboration of the Resident Care Team, residents, families and residents' legal decision makers.

Purpose: To ensure continuity of care, sustain the optimal level of health gained through hospitalization, and provide care in the least restrictive setting.

Procedure:

1. All residents on admission will be assessed by Social Services for discharge potential within five working days (two working days for short stay residents) and this will be documented in the initial psychosocial assessment (MR 703).~~.~~ The Resident Care Team will further assess for discharge potential and identify residents appropriate for discharge to the community. A Discharge Assessment (MR 711) will be filled out within 14 days (7 days for short stay residents) of admission to coincide with the MDS care planning process and contain a team recommendation for discharge. Social Workers will actively coordinate discharge plans at the request of the Attending Physician.

2. After assessment process is completed, MSW will coordinate an interdisciplinary determination of a discharge care plan to assist the resident in the transition to the community and in identifying discharge considerations and interventions that impact the discharge plan.

3. A Resident Discharge Information sheet including projected discharge date and equipment needed will be placed in resident's room with resident's permission and updated as needed.

~~3.~~4. If the resident is conserved, the permission of the Conservator must be obtained prior to discharge. Conservators will be invited to team meetings to participate in the discharge planning process.

~~4.~~5. Counsel resident, family, and caregivers regarding resident's needs and options for services. This includes psychosocial support to deal with issues of loss and transition and education about the resident's diagnosis and what services will need to be implemented for a safe discharge to a lower level of care.

~~5.~~6. The Discharge Linkage Plan (MR 714) will be reevaluated quarterly at the Resident Care Team meeting and when there is a significant change of the resident's condition. The MSW will update the discharge care plan accordingly and identify new discharge considerations and interventions the team is working on.

~~7.7 Social Services Department: Discharge Planning and Implementation (cont.)~~

~~6.~~7. Coordinate with hospital staff and community care providers to enable the resident to return to the community with the necessary supportive shelter, health, medical, and other services. Referrals include housing, substance abuse treatment programs, outpatient counseling, In-Home Support Service and home care services, case management, durable medical equipment, Adult day health programs and meal and transportation programs. Coordinate home evaluation with resident/caregiver, OT and PT. Email the Rehab team and A&E via "DPH-LHH Discharge Address" list when discharge date and location is established to start DME ordering process. Hospital beds and hoyer lifts require a minimum one month notification.

~~7.~~8. When a discharge date is finalized, the MSW will initiate and provide the resident or legal representative with a 30-day notice (Notice of Proposed Transfer/Discharge).~~.~~ The signed notice is placed in the "Legal Section" of the medical record. If a resident should refuse to sign, the MSW will so note this and place one copy in the "Legal Section" and furnish the resident with one copy. A copy will be faxed to the Ombudsman program at 415-751-9789 and if any changes are made to the notice, all recipients will be updated.

9. A Discharge Checklist will be placed in left side of medical record for all team members to review and initial to ensure resident is ready to go.

~~8.~~10. A medical social services Post-Discharge Plan of Care (MR 705~~MR705~~) is given to resident at the inception of the discharge planning process and a finalized version at discharge delineating all community services arranged to facilitate their transition to community living. A copy of the written discharge instructions (MR 313A Post-Discharge Plan of Care/Home Instructions) will be given to the resident and/or resident representative and box will be checked off on the MR 705.

7.18 Social Services Department: Discharge Database Information

Policy: It is the policy of the Social Services Department to track information relevant to residents' discharges in a centralized database. A Discharge Assessment (MR 711) is generated within 14 days of admission on all residents (7 days for short stay residents) and placed in the medical record. A Medical Social Services Post-Discharge Plan of Care (MR 705) is done for residents with active discharge plans, reviewed with resident and placed in the medical record as soon as discharge planning begins. A Discharge Linkage Plan (MR 714) is generated within 30 days of admission on all residents and placed in the Care Plan Book.

Purpose: To maintain an active log of all residents who have discharge potential and to track aggregate statistics on age, ward location, accessibility needs and barriers to discharge to better advocate for resources to assist residents in relocating to lower levels of care.

Procedure:

1. Social Workers upon hire obtain a password to access the database through Microsoft Access.

2. All residents upon admission have a Discharge Assessment (MR 711) completed within 14 days (7 days for short stay residents).~~.~~ The assessment contains numerous fields that are a combination of check-off boxes and narrative entries. The form contains a team recommendation at the bottom related to discharge. A signed, dated copy is placed in the medical record. The MR 711 is updated with any change in resident condition related to discharge potential. If a resident is discharged to acute care, a new MR 711 is generated upon their return. Information from a previous admission can be transferred over to the current admission if no changes have occurred.

3. Any resident in the social workers' caseload who expresses a desire for discharge or whom the Resident Care Team feels has potential to be discharged will be entered into the Discharge Planning Module. The Module contains five components: 1) Discharge Status and Placement, 2) Agencies Referred, 3) Social Support, 4) Discharge Issues. Supervisors are responsible for training new staff on how to correctly fill out the fields.

7.18 Social Services Department: Discharge Database Information (cont.)

4. When entries are completed, a printed Discharge Plan of Care (MR 705) is reviewed with the resident and placed in the medical record. A PASRR level II box is checked for any resident with an MR/DD diagnosis or mental health issues. An Axis I box and a Substance Abuse box are also checked for residents with these issues. The MR 705 is updated as plans progress towards discharge and can be printed out at any time to be reviewed with the resident at team meetings.

5. A Discharge Linkage Plan (MR 714) is maintained in the database and reviewed and updated on a quarterly basis. Resources added in the MR 705 are linked to CAPS in the MR 714. All forms are signed via Digital Signature.

6. Ongoing discharge plans and referrals are entered into the Progress Notes section of the discharge database.

ROMAN CATHOLIC PROGRAM (RCP)

POLICY: Laguna Honda Hospital and the Roman Catholic Arch-Diocese of S.F. will maintain a working relationship to meet the spiritual care needs of the residents of LHH

PURPOSE: In an interfaith context provide for the spiritual care needs of the Roman Catholic residents of LHH.

Laguna Honda Hospital and the Roman Catholic Arch-Diocese of S.F. maintains a working relationship to meet the spiritual care needs of the residents of LHH. To this end the Arch-Diocese of S.F. provides a Catholic Nun and a Catholic Priest to serve at LHH. These positions are not funded by the hospital and no City and County employee benefits are provided however office space and office supplies are made available if needed.

Both the Nun and Priest work in an interfaith context providing spiritual care for the residents who are Roman Catholic. They work under the coordination of the Spiritual Care Coordinator.

Essential Duties and Responsibilities

- Visiting the Catholic residents, and providing counsel and care.
- Taking care of Catholic residents' needs, e.g. providing spiritual reading, bibles, rosaries, holy water.
- Meeting with the Spiritual Care Coordinator on a regular basis, and reporting on the sacramental needs of the Catholic residents.
- Coordinating the current schedule of ~~three~~ Masses each week and taking responsibility for having all needed liturgical supplies safeguarded, accounted for, and in place.
- Recruiting volunteers, especially for the Sunday Mass when volunteers bring residents to the chapel and then back to their rooms.
- Training volunteers with the aid of Laguna Honda staff. Ensure that all new volunteers attend the Laguna Honda Volunteer orientation.

Revised: 2018~~7~~/08/01
Original adoption: 2012/08/29 (Year/Month/Day)

SCD NODA VOLUNTEER PROGRAM

POLICIES: It is the policy of the Spiritual Care Department to be an integral part of LHH's mission and health care teams to provide holistic care through its qualified End of Life Volunteer Program. NODA (No-one Dies Alone) Volunteers offer personal, attentive and non-judgmental spiritual presence to LHH's residents, their loved ones, staff and volunteers. They strive to facilitate the dynamic spiritual needs of persons of all faiths or no expressed faith in their search for meaning, love, connection and hope.

The purpose of this program is to enlist, train, and place volunteers with LHH residents who are on comfort care and are actively dying. The volunteers will serve as "companions" and will provide practical, emotional and spiritual support.

PROCEDURES:

1. Recruitment

Recruitment is both proactive and passive by the SCC and Volunteer Services Department. Recruitment considers the current needs assessment and the department's vision, goals and objectives at any given time. Information concerning the NODA program will be communicated at all volunteer orientations.

Proactive recruitment occurs externally in the community with faith-based organizations, hospitals, schools, other groups and individuals. It also happens with existing relationships such as the current base of LHH volunteers, resident family members and other hospital contacts. Periodically, there are presentations, letters, phone calls and personal contacts. Particular emphasis is placed upon neighborhood resources to tap on their local outreach ministries and for the convenience of geographic closeness for volunteer activities. Passive recruitment occurs through Volunteer Services Department.

Specifically, potential NODA Volunteers can be recruited from existing LHH Volunteers, current Volunteer Chaplains, community groups who are already working at LHH (such as churches, temples, synagogues, etc…), and students from area seminaries.

LHH continually seeks to attract, place, support, educate and recognize NODA volunteers. The Spiritual Care Department embraces a diversity of beliefs, gender, age, race, culture and sexual orientation.

Qualifications of an NODA Volunteer

- Completed interview with the NODA ~~Spiritual Care~~ Coordinator.
- Has completed the LHH Volunteer Orientation.
- Will commit to a one year term as well as regular attendance at the NODA support meetings.
- Attends the Volunteer Training for NODA.

1. Training

Initial, Mandatory Training -- The Spiritual Care Department provides initial, mandatory training for NODA volunteers. This training addresses aspects of end of life care to enable an appropriate introduction, knowledge of guidelines and, ultimately, a positive experience.

LHH will conduct an in-house training for NODA volunteers. The training will take place at least once per year. Topics for training will include but are not limited to:

Grief and bereavement work.
Typical medical conditions that lead to death at LHH.
Signs and symptoms of death, what happens in the dying process, resident physical and emotional reactions.
How to support family members and staff.
Personal coping skills, learning to be comfortable at the bedside.
Cultural and religious sensitivity
Comfort measures to take and when to take them, basic bedside skills.
How to get to know someone who can't speak.
Healing and grieving broken relationships.
Dementia and end of life.

- Ongoing Education and Support – Education on select topics and team-building will be available once per month. Meetings will take place twice a month with required attendance at one meeting per month for the volunteers.

1. Placement

The program will focus on residents who are on comfort care orders and have around one week to live. As best as we can tell the residents must also wish to have volunteer visits. Referrals will be will be gathered from Medical Doctors, Nurse Managers, Charge Nurses and other appropriate staff. The NODA~~Spiritual Care~~ Coordinator will alert the unit staff that the NODA Volunteers will be sitting vigil

- Volunteers will sit for one two hour shifts (shifts can be longer if needed). The NODA~~Spiritual Care~~ Coordinator maintains full authority to reassign volunteers. Timing – The NODA~~Spiritual Care~~ Coordinator will maintain an on-call list of volunteers to be contacted once a referral is received. Volunteers will serve on the on-call for one year terms. Exceptions are made for vacations, personal obligations and other expected or unexpected reasons. Volunteers report schedule changes in advance to the NODA~~Spiritual Care~~ Coordinator. Termination and Notice – The Spiritual Care Coordinator may terminate the volunteer arrangement at any time with or without cause. Volunteers also may terminate this arrangement for which thirty days' notice is requested.

Roles, Responsibilities and Expectations of NODA Volunteers

Embracing the Mission

Mission Statement

> Spiritual Care is an integral part of Laguna Honda Hospital's mission to provide holistic care. We offer personal, attentive and non-judgmental spiritual presence to our residents, their loved ones, our staff and volunteers. We recognize the unique gifts that each person brings to community, cherishing each individual's spirit, name, feelings, beliefs, culture and life story. We nurture these gifts by striving to facilitate the dynamic needs of persons of all faiths and no expressed faith in their search for meaning love, connection and hope.

NODA Volunteers embody the spirit of the above Mission Statement.

Regular Duties

- Offering a reassuring, empathetic and receptive presence,
- Approaching states of loss, including grief, anger, guilt, fear and despair,
- Responding to personal beliefs, cultural values and spiritual practices,
- Giving comfort and spiritual presence to someone who is dying.

Supervision, Accountability and Documentation Requirements

The NODA~~Spiritual Care~~ Coordinator is responsible for the implementation of the NODA Program and is the primary supervisor for each volunteer. In this role, the Spiritual Care Coordinator assists in the recruitment, selection, orientation, training, assignment, supervision, feedback, continuing education and recognition of NODA Volunteers. ~~Each NODA volunteer meets quarterly with the Spiritual Care Coordinator or, more frequently, if the circumstances warrant it.~~ NODA volunteers will be expected to attend 75% of the Team Meetings; currently there are six to seven meetings a year.

We ask that NODA Volunteers not read any medical charts while in the hospital. However if the volunteer feels it necessary to access medical charts for further information concerning a resident please relate this need to the Spiritual Care Coordinator. All information given to the volunteers about the condition of the residents will conform with HIPPA.

Revised: 14/08/26, 17/08/01, 18/08/01
Original adoption: 2012/08/29 (Year/Month/Day)

SCD SPIRITUAL CARE REFERRALS

POLICY: The Spiritual Care Department manages effectively a system of responding to spiritual care referrals from staff, residents, their loved ones and volunteers. A written referral form is available for regular spiritual care referrals – worship services, special religious observances, visitations and spirituality groups. In addition, contact information is available for weekday evenings and weekend spiritual care emergencies.

PURPOSE: A well-communicated system of spiritual care referrals facilitates timely responses to the needs of residents and their loved ones on their spiritual journeys for meaning, love, connection, comfort and hope.

PROCEDURES:

1. A written Spiritual Care Referral Form is available on the LHH Intranet under the Spiritual Care Icon for purposes of making referrals for worship services, special religious observances, visitations and spirituality groups.
2. The Spiritual Care Coordinator (SCC) receives referral forms, reviews them for appropriate action, coordinates necessary resources to respond to requests and conducts quality assurance.
3. If further information is necessary, the SCC contacts the person making the referral and/or visits the person requesting the spiritual care service. Sometimes, it also is appropriate to consult with unit staff or resident family members.
4. Referrals can also be made over the phone by contacting the SCC. (phone: 4-3043, 415-759-3043, pager: 415-327-1675 or cell phone at 415-269-5512.
5. In the case of an urgent or emergency request during **evenings** and **weekends (or if you are unable to contact the Spiritual Care Coordinator during the week)**, please refer to the Emergency Contact Information found on the LHH Intranet page under the Spiritual Care Icon. (copy is attached)
6. The target response time by the SCC/CPC to non-urgent referrals is 24 hours, although the actual service may require more time to coordinate such as arranging for attendance at an upcoming worship service.
7. The target response time to first contact referral parties for urgent or emergency requests is one hour for weekdays and two hours for evenings and weekends.
8. The Spiritual Care Coordinator maintains a comprehensive Spiritual Care contact directory for purposes of fully meeting the diverse needs of residents, staff, loved ones and volunteers of many faiths, cultures, ethnicities and languages.

Revised: 16/08/10, 17/08/01, 18/08/16(Year/Month/Day)
Original adoption: 2010/01/17

LAGUNA HONDA HOSPITAL
SPIRITUAL CARE REFERRAL FORM

Date ______________________________

Resident ______________________________

Unit ______________ **Bed #** ______________

Type of Referral (check appropriate box):

☐ One-on-one pastoral care visit

☐ Religious service Which one? ____________________
Day and Time? ____________________
Requires Transportation? ____________________

☐ Prayer, Communion, Anointing or Blessing in Unit (Circle preference)

☐ Other Identify ______________________________

Faith Tradition, If Any ______________________________

Reason for Referral

____
____
____

Special Considerations

____
____
____

Referred By ____

Department ___________________________ **Phone** ______________

Send this form to LHH Spiritual Care and maintain a copy for your records.
If this request is urgent, call 4-3043 or pager 415-327-1675 or cell 415-269-5512..

Emergency Contact Information for Spiritual Care

Updated on ~~2-1-2017~~8-3-2018

1. In the case of an urgent or emergency request such as the death or impending death of a resident: ***Tuesday thru Saturday*** *between 8:30am and 5:00pm* the referring party calls or pages the Spiritual Care Coordinator (cell phone: 415-269-5512 pager: 415-327-1675).

   On ***Sundays and Mondays*** *from 8:30am to 5:00pm* please call Rev. Malaena Nahmias at 650-399-5660 or 415-759-3022.

2. In the evening hours or you are unable to contact any of the above please call the following parties in this order:

   If the resident is a Roman Catholic Christian call in this order:

   A. During the hours of 8:00am to 10:00pm call and text Father Celestine ~~Hoang~~ at cell phone at 415-374-9283~~213-330-5445~~. If Father Celelstine ~~Hoang~~ can't come or you get no answer please call the Saint Brendon's Church at 415-681-4225. You can also call St. Brendon's 24 hours a day. .
   B. Call St. Anne's at 415-665-1600 or the 24 hour line at .415-866-6455.
   C. Call St. Cecilla'a 24 hour line at 415-664-8483.
   D. Call Sister Olga~~Dolores Maguire~~ at 415-928-9408~~415-548-0475 or 415-759-3077~~
   E. If during the day you can call St. Agnes at 415-487-8560 or Holy Name at 415-664-8590~~.~~
   F. For **Spanish speaking priests** please call Father John Jimenez (415-240-8095). You can also call Sister Kathleen at 415-205-7329~~408-334-6110~~. ~~Call Sister Dolores at 415-548-0475~~.
   G. Call the Spiritual Care Coordinator at 415-269-5512.

   If the resident is Orthodox Christian (Russian, Syrian, etc…) please call in this order:

   A. Father Stephen at 415-516-6767.
   B. Father James at 415-571-3539.
   C. Call the Spiritual Care Coordinator at 415-269-5512.

   For Protestant Christian residents call in this order:

   A. Call the Spiritual Care Coordinator at 415-269-5512.
   B. Call Rev. Stephen Barlett-Re at 415-271-9080.
   C. For Chinese speaking Protestant Christians please call Rev. So. at 650-872-2563 or 415-221-7115.

   For Buddhist Residents (Cantonese, Mandarin or English speakers) please call in this order:

   A. Call and text Binh Trinh at 415-533-8728. You can also reach Binh at 415-585-2797.
   B. Call the Spiritual Care Coordinator at 415-269-5512.

   For Jewish Residents please call in this order:

   A. Call Rabbi Nosson Potash 415-598-8718.
   B. Call the Jewish Healing Center at 415-750-4197.
   C. Call Rabbi Jon Sommer at 415-750-4198; Rabbi Naton Fenner at 415-750-4129; Rabbi Eric Weiss at 415-750-4199.
   D. Call the Spiritual Care Coordinator at 415-269-5512.

   For Muslim Residents please call in this order:

   A. Call Imam Khaled at 415-374-3191.
   B. Call Imam Safwat at 415-261-0554.
   C. Call Spiritual Care Coordinator at 415-269-5512.

For residents of no expressed faith but wish to speak with clergy please call the Spiritual Care Coordinator at 415-269-5512.

SCOPE OF SERVICES

The Vocational Rehabilitation Program is designed to meet the needs of both residents who are approaching discharge and those ~~who plan to be~~are at Laguna Honda ~~here~~ long-term.

I. Consultations for residents pending discharge

a. RCT requests consultation by completing request form and invites staff to the next appropriate RCT meeting.~~;~~ The Vocational Rehabilitation~~vo~~ ~~c. Rehab.~~ ~~A~~a~~a~~ssessment is initiated upon notification.
b. Vocational Rehabilitation staff (VR) has formal and informal meetings with resident
c. VR offers the following options to resident, depending on their needs
- i. Resident can choose experience
  - a. Gift Shop
  - b. General Store
  - c. Guest Escort
- ii. VR can provide connections to community programs
- iii. VR provides information on government benefits and work
- ~~iiii. VR assists with career exploration~~
  - ~~a. Job match considerations~~
  - ~~b. Overviews~~
  - ~~c. Training locations~~
  - ~~d. Career-specific information~~
- v. VR provides information on the Americans with Disabilities Act
  - a. Overview
  - b. Accommodations
- ~~vi. VR assists with job search~~
  - ~~a. Community resources~~
  - ~~b. Resumes, cover letters, and applications~~
  - ~~c. Interviewing~~
  - ~~d. Preparing for first day~~
  - ~~e. Adjusting to workplace~~

d. VR communicates with RCT via SFGetcare~~LCR~~, email and personal contact

2. Long-term care vocational services

a.. RCT requests consultation
b.. VR has formal and informal meetings with resident
c.. VR offers options to resident
  i. Resident can choose experience in one of our on-site enterprises
    a. General store
    b. Gift Shop
    c. Guest Escort
  ii. ~~Volunteer opportunities in community for qualified residents~~
d. VR communicates with RCT via ~~LCR~~ SF Get Care progress note, e-mail and personal contact

3. On site Vocational Rehabilitation opportunities
The Vocational Rehabilitation Specialist oversees the operation of all of the Vocational Rehabilitation Program elements. All enterprises share two common expectations – that residents take responsibility for reliably being at their work site at their scheduled time and that residents follow directions.

a. General Store: Vocational Rehabilitation is responsible for the operation of the G~~g~~eneral S~~s~~tore. In this retail setting participants work set shifts where, depending on their abilities and interests, they take part in customer service, money-handling, counting, stocking, packaging, sorting, promotions, and/or inventory display. They have the opportunity to add tasks as they progress. Residents are involved in decision-making regarding all aspects of the operations.

The participants work alongside a combination of other residents, volunteers, and, on occasion, transitional work assignment personnel, all of whom provide additional support and training.

b~~h~~**. Gift Shop:** Vocational Rehabilitation is responsible for the operation of the G~~g~~ift S~~s~~hop. In this retail setting participants work set shifts where, depending on their abilities and interests, they take part in customer service, money-handling, counting, stocking, packaging, sorting, promotions, and/or inventory display. They have the opportunity to add tasks as they progress. Residents are involved in decision-making regarding all aspects of the operations.

The participants work alongside a combination of other residents, volunteers, and, on occasion, transitional work assignment personnel, all of whom provide additional support and training.

c. Guest Escort/Guide: Guides visitors to destinations

REFERRAL AND ASSESSMENT

POLICY:

The Vocational Rehabilitation program has a procedure in place for receiving referrals and assessing resident ~~their~~ appropriateness for the Vocational Rehabilitation program.

PURPOSE:

To maintain a system for enrolling appropriate residents into the Vocational Rehabilitation program with the goal of preparing them for community re-integration. ~~into the community.~~

PROCEDURE:

1. The Resident Care Team (RCT) identifies ~~appropriate~~ residents ~~(idea can be resident/patient or staff initiated)~~ who display a baseline ~~competency and~~ potential for participation and/or improvement in ~~these~~ the following areas:

    a. Get to and from the job on time
    b. Be ready to work as soon as the shift starts
    c. Perform ~~the~~ demonstrated tasks in a neat, safe manner
    d. Be dependable
    e. Have a good attitude and treat people with respect
    f. Work well with supervisor, staff, residents and customers
    g. Organize time well
    h. Be clean and well-groomed
    i. Be able to wait his turn for the supervisor's time
    j. Listen carefully to instructions and follow instructions
    k. Stay at the assigned work location for the entire shift
    l. Keep track of project due dates and turn in assignments on time
    m. Concentrate/stay focused for the entire shift
    n. Accept feedback from the supervisor
    o. Not interrupt
    p. Control anger and language
    q. Have goals consistent with the parameters of the program

2. A RCT member talks to ~~those~~ the resident~~s/patients~~ to affirm their interest in Vocational Rehabilitation. ~~.~~

3. On R~~r~~ehabilitation units, physicians put a Request for Consultation form in the resident's chart.

4. A RCT member contacts Vocational Rehabilitation (VR) to initiate the referral and invite Vocational Rehabilitation ~~PREP~~ staff to a RCT meeting to share pertinent information. Assessment of the resident is initiated upon notification.

5. As a part of the assessment, ~~After receiving a referral from the RCT, Vocational Rehabilitation~~VR may review relevant ~~sections of the chart~~documentation from the following areas: ~~and plans such~~ Medicine~~physician's notes~~, Nursing, ~~A~~Activity Therapy, ~~T~~Social Work,~~ report, social work page,~~ N~~n~~europsychology, ~~OT and PT information,~~Rehabilitation (OT, PT, ST) ~~chart notes,~~ and the resident's care plan.

6. ~~Staff~~ VR meets with resident to assess appropriateness for program based on attitude, interests, abilities, and perceived potential to meet basic behavioral and functional expectations as outlined under #1.

7. ~~Staff~~ VR and resident~~/patient~~ choose which services, if any, are appropriate.

8. ~~Staff~~ VR ~~charts and enters information~~completes the ~~on~~ "Vocational Rehabilitation Assessment and monthly progress notes in the resident's electronic medical record in SFGetCare.~~"~~

9. VR monitors resident progress by ~~On-going assessment involves~~ observing ~~resident's~~ their performance of criteria listed under #1 above. ~~Staff works with resident on improvement where needed.~~Areas for improvement are identified and addressed as needed.

10. RCT is ~~informed~~ updated about resident progress at quarterly Resident Care Conferences, or more frequently if the resident is short stay and/or participation requires closer monitoring. ~~periodically via conversations, meetings, email, phone calls and/or chart notes as resident progresses through the program.~~

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 18/8/23, 17/09/12 (Year/Month/Day)
Original adoption: 12/07/13

DOCUMENTATION OF VOCATIONAL REHABILITATION SERVICES

POLICY:

The Vocational Rehabilitation Program provides documentation ~~in the resident charts via the Vocational Rehabilitation Assessment Form and monthly LCR note~~for assessments and progress notes electronically in SFGetCare.

PURPOSE:

To document the services provided to residents by the department

PROCEDURE:

1. Member of RCC contacts Vocational Rehabilitation with referral information.

2. Vocational Rehabilitation staff complete an assessment of resident's skills and needs ~~and enters the information on the assessment form~~in the Vocational Rehabilitation Assessment section of the resident's electronic record..

~~3. A copy of the assessment form is placed in the Assessment section of the medical record.~~

~~4.~~3. Vocational Rehabilitation staff informs the person making the referral of the outcome of the interview with the resident.

~~5.~~4. ~~LCR~~ Progress notes in SFGetCare are ~~made~~ completed if resident's participation changes from that indicated on the assessment form. In addition, events with particularly positive or negative implications are documented ~~in the LCR Notes~~as a progress note as they occur. This may include the addition or elimination of training components, the alteration of a long-term plan, improvement, or issues.

~~6.~~5. A new assessment form, indicating "re-assessment" is added to medical records when a resident is re-admitted after discharge.

ATTACHMENT:
None.

REFERENCE:
~~None~~Vocational Rehabilitation Departmental policy VR 2.0.

Revised: 18/8/23, 17/09/12 (Year/Month/Day)
Original adoption: 12/07/13

SCOPE OF SERVICES

POLICY:

The Activity Therapy Department provides a wide range of services to enhance resident quality of life, skill development and independence.

PURPOSE:

To provide Laguna Honda Hospital residents opportunities for self improvement, leisure and connections to the community.

PROCEDURE:

Activity therapy services are an integral part of the rehabilitation and skilled nursing services at Laguna Honda Hospital. Services include but are not limited to:

1. Neighborhood based services which engages the interdisciplinary team to provide (See Activity Therapy Policy and Procedure ~~File D1:~~ File P1-0 Activity Calendars)
   a. Social opportunities
   b. Educational opportunities
   c. Creative expression
   d. Religious referrals
   e. Exercise activities
   f. Community connections
   g. Outdoor experiences

2. Evening and Weekend ~~divisional~~ activities (See Activity Therapy Policy and Procedure File D2 ~~C2~~: Tracking of Resident Participation ~~Hospital-Wide Activity Attendance Record)~~

3. Support to the residents council (See Hospital Wide Policy and Procedure File 22-06: Residents' Council)

4. Wellness Center recreational activities (See Hospital Wide Policy and Procedure File 28-03: Aquatic Services)

5. Therapeutic farm and garden activities (See Hospital Wide Policy and Procedure File 28-02: The Farm and Therapeutic Gardens and Animal Control 76-03)

6. Therapeutic outings in collaboration with nursing services (See Hospital Wide Policy and Procedure File 28-01 and Activity Therapy Policy and Procedure File ~~D2~~P7: Community Outing Program)

~~7.~~ A documentation process which includes assessment, care plans, reviews, participation and the MDS. (See Activity Therapy Policy and Procedure File D1: Medical Record Documentation, D2-0 Tracking of Resident Participation, D4 Quarterly Progress Note Format, ~~C1: Medical Record Documentation)~~

~~8.~~7.

REFERENCES:

~~Activity Therapy Policy and Procedure File P1: Activity Calendars~~
~~Activity Therapy Policy and Procedure File D2: Tracking of Resident Participation~~
Hospital Wide Policy and Procedure File 22-06: Residents' Council
~~Hospital Wide Policy and Procedure File 28-03: Aquatic Services~~
Hospital Wide Policy and Procedure File 28-01: Community Outing Program

Hospital Wide Policy and Procedure File 28-02: The Farm and Therapeutic Gardens
Hospital Wide Policy and Procedure File 28-03: Aquatic Services
Hospital Wide Policy and Procedure File 76-03 Animal Control
Activity Therapy Policy and Procedure File P2: Community Outing Program
Activity Therapy Policy and Procedure File D1: Medical Record Documentation
Activity Therapy Policy and Procedure File D2: Tracking of Resident Participation
Activity Therapy Policy and Procedure File P1: Activity Calendars
Activity Therapy Policy and Procedure File P2: Community Outing Program

ATTACHMENTS:
None

Most recent review:	8/28/2018, 6/25/20186/25/2018, 5/5/2015
Revised:	10/12/2010, 8/29/2013, 8/29/2014
Adopted:	6/1/1999

STAFFING PLAN

POLICY:

The Activity Therapy Department is staffed by qualified activity professionals as defined by the State of California and the Center for Medicare and Medicaid Services.

PURPOSE:

1. To ensure and provide professional, effective activity services to the residents at Laguna Honda Hospital.
2. To provide labor resources for the provision of activity services that meet regulatory standards, resident needs and the Department of Public Health priorities.

PROCEDURE:

1. Staffing within the Activity Therapy Department may include; 2587 Activity Therapist, 2588 Activity Therapy Supervisor, 1404 Clerk, ~~and~~ 2303 Nursing Assistant ~~ce~~ and 7524 Utility Worker.

2. Activity Therapy staff oversee activities and services on the resident neighborhood(s) and/or hospital wide programs. These staff must meet experiential and/or educational criteria outlined in Code of Federal Regulations: ~~42CFR 483.00~~, Department of Health and Human Services Centers for Medicare & Medicaid Services ~~F248 and~~ F680, and California Code of Regulations, Title 22, Division 5 Chapter 3 – Skilled Nursing Facilities Section

3. The Director of Activity Therapy and supervisors assign staff as needed to meet operational needs including direct services, operations, supervision and quality assurance.

4. Vacation bidding is done in accordance to the collective bargaining agreement.

5. Overtime is completed in accordance to the collective bargaining agreement.

6. Permanent assignments are posted and assigned in accordance to the collective bargaining agreement as they become available.

7. All residents admitted to the skilled nursing section of the hospital must be assessed ~~accessed~~ and provided with a treatment plan.
~~7.~~

8. Staff permanently assigned to neighborhoods with isolation rooms must be fit tested for appropriate personal protective equipment that would allow them to provide the necessary care for the resident. Efforts would be made to minimize the need to enter the isolation room by using the phone, other technology or resources for the resident.

9. Staff assigned to the language focused neighborhoods must be able to pass the appropriate language test within 6 months of being awarded the assignment or run the risk of being reassigned.

10. Staff assigned to the ~~Wellness Center~~Aquatic Services should be able to pass a basic swim test within 6 months of being awarded the assignment or run the risk of being reassigned.

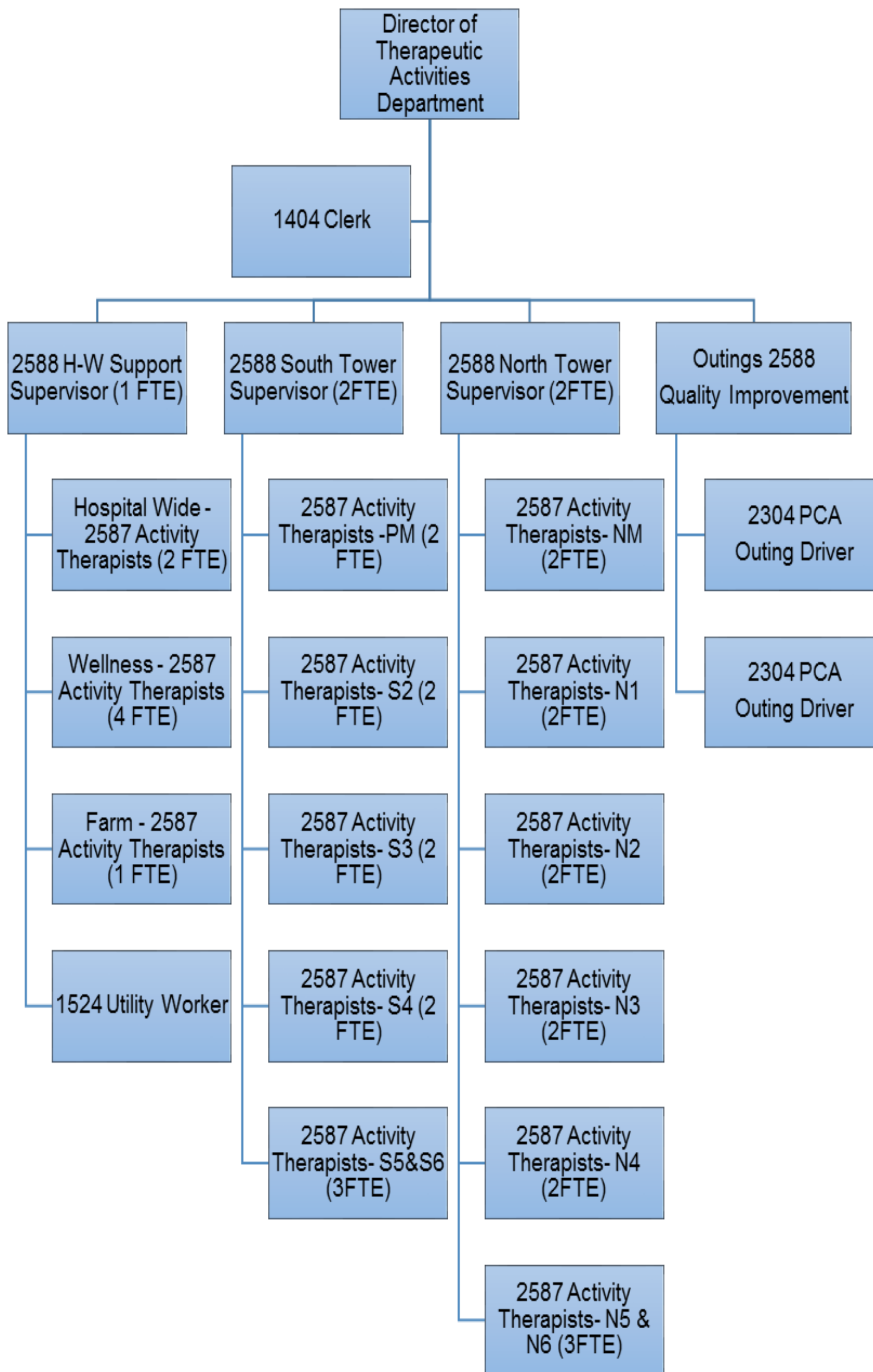
REFERENCES:

COLLECTIVE BARGAINING AGREEMENT BETWEEN AND FOR SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021 AND THE CITY AND COUNTY OF SAN FRANCISCO JULY 1, 2012 – JUNE 30, 2014
Code of Federal Regulations: 42CFR 483.00
California Code of Regulations, Title 22, Division 5 Chapter 3 – Skilled Nursing Facilities Section
Activity Therapy Policies and Procedures, File A6, Overtime Utilization and Monitoring
Department of Health and Human Services Centers for Medicare & Medicaid Services F248 and F680 79

ATTACHMENTS:

1: Activity Therapy Department Organizational Chart
2: Time off request form

Most recent review: 8/28/187/1/2018, 4/1/2016
Revised: 7/27/2009, 8/29/2013, 8/29/2014, 5/12/2015
Adopted: 6/1/1999


Director of Therapeutic Activities Department
1404 Clerk
2588 H-W Support Supervisor (1 FTE)
2588 South Tower Supervisor (2FTE)
2588 North Tower Supervisor (2FTE)
Outings 2588 Quality Improvement
Hospital Wide - 2587 Activity Therapists (2 FTE)
Wellness - 2587 Activity Therapists (4 FTE)
Farm - 2587 Activity Therapists (1 FTE)
1524 Utility Worker
2587 Activity Therapists -PM (2 FTE)
2587 Activity Therapists- S2 (2 FTE)
2587 Activity Therapists- S3 (2 FTE)
2587 Activity Therapists- S4 (2 FTE)
2587 Activity Therapists- S5&S6 (3FTE)
2587 Activity Therapists- NM (2FTE)
2587 Activity Therapists- N1 (2FTE)
2587 Activity Therapists- N2 (2FTE)
2587 Activity Therapists- N3 (2FTE)
2587 Activity Therapists- N4 (2FTE)
2587 Activity Therapists- N5 & N6 (3FTE)
2304 PCA Outing Driver
2304 PCA Outing Driver

CONTINUING EDUCATION

POLICY:

The Activity Therapy Department supports continuing education of staff by allowing paid time off for attending approved training.

PURPOSE:

To provide Activity Therapy staff with opportunities for enhancing knowledge, skill, and effectiveness through continuing education and networking opportunities.

PROCEDURE:

1. Requests to attend trainings are submitted to the supervisor using the time off request form. Brochures or other information describing the training should be included or attached for consideration.

2. The supervisor will evaluate if the training is relevant to the employee classification/assignment and if staffing levels allow for the staff member to be granted the time away.

3. Requests to attend educational opportunities may not exceed one request in a calendar year and a maximum of 24 hours (3days).

4. Staff will not be compensated if the training falls on a day that they are regularly scheduled off.

5. Request approval is subject to regular time off request requirements. Once the request is granted, it is considered benefited time off and is considered when reviewing other requests for time off on the same day(s).

6. ~~Staff attending training will be required to share information with the entire department.~~

7.6. Cost of the training by be reimbursed using the tuition reimbursement program per Hospital Wide Policy and Procedure 50-06: Employee Reimbursement Requests: Departmental Guidelines. ~~the collective bargaining agreement~~.

REFERENCES:
COLLECTIVE BARGAINING AGREEMENT BETWEEN AND FOR SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021 AND THE CITY AND COUNTY OF SAN FRANCISCO JULY 1, 2012 – JUNE 30, 2014
Activity Therapy P&P File A3: Staffing Plan
Hospital Wide Policy and Procedure 50-06: Employee Reimbursement Requests: Departmental Guidelines.

ATTACHMENTS:
None

Most recent review: 8/28/18 ~~6/26/2018~~, 5/5/2015
Revised: 4/14/2013, 8/29/2013, 8/29/2014

Adopted: 6/1/1998

OVERTIME UTILIZATION AND MONITORING

POLICY:

Per the collective bargaining agreement, overtime will be awarded based on seniority on a rotational basis.

PURPOSE:

Activity Therapy will manage overtime to meet resident care needs while honoring the collective bargaining agreement to follow seniority and rotate overtime opportunities.

PROCEDURE:

1. The need for overtime is determined by the department leadership. Shift times will be i~~n~~dentified. Location of the assignment is not guaranteed.

2. A calendar of class 2587 job duty available shifts is distributed via email as soon as reasonably possible to all staff in the Activity Therapy Department. Every effort to post the calendar as the neighborhood activity scheduling is in process is made.

3. A deadline is established in the email for Activity Therapists to submit dates/shifts in which they are interested in volunteering and the system of seniority.
~~3. and rotation of _______ days is used the set the schedule.~~

4. Class 2588 or 2591~~89~~ employees who volunteer may be considered for shifts after all volunteers in the lower class have been reviewed.

5. A calendar with coverage information is distributed via email to those who volunteered.

6. Mandatory overtime would only be implemented under extreme circumstances. If mandatory overtime is implemented, notification will be made as soon as reasonability possible using reverse seniority. All employees are considered part of the rotation. The rotation continues until the situation is resolved and operations return to normal.

7. Any limitation on the number of hours one can work in period of time is determined by human resource regulation.

~~8. Staffs who have completed the farm operations training are eligible for overtime coverage at the farm.~~

~~9. Staffs in the farm operations pool are not eligible for shifts within the hospital.~~

~~10. They must have completed their orientation prior to being considered for overtime.~~

REFERENCES:
COLLECTIVE BARGAINING AGREEMENT BETWEEN AND FOR SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021 AND THE CITY AND COUNTY OF SAN FRANCISCO JULY 1, 2012 – JUNE 30, 2014
Activity Therapy P&P File A3: Staffing Plan

ATTACHMENT:
None

Most recent review: 8/27/2018, 8/29/2014
Revised: 8/29/2013, 8/29/2014, 8/27/2018
Adopted: 9/2013

EQUIPMENT AND PROGRAM SUPPLIES

POLICY:

The Activity Therapy Department obtains and maintains equipment and program supplies to be use in the provision of services to the residents of Laguna Honda Hospital.

PURPOSE:

1. To ensure that Activity Therapy staff have equipment and supplies with which to implement programs and activities in the most effective and safe manner possible.
2. To ensure equipment ~~are~~ is purchased in a fiscally responsible manner.

PROCEDURE:

1. **BUDGETING:** ~~**FOR PURCHASING SUPPLIES:**~~

   a. Activity Therapy Director will collaborate with Accounting Department and Gift Fund Approver to confirm funding for the Fiscal Year. Funding sources include:
      i. Operation Fund
      ii. Gift Fund
      iii. "Wishlist" Program

   b. Activity Therapy Director will create annual budgets for Activity Therapy Programs. Program budgets include:

      i. Neighborhood supplies and luncheons
      ii. Hospital Wide Services
      iii. Farm and Wellness Center items
      iv. Activity Therapy Department Equipment

   c. Activity Therapy Supervisors of each program will ensure items purchased are within the designated budget.

2. **REQUISITION:**

~~1. The purchasing agent develops and maintains a schedule for ordering unit program supplies.~~

   a. ~~Neighborhood~~ Activity therapy staff will ~~be able to make~~ orders ~~of~~ program supplies using the Activity Therapy Purchasing Request form (see attached). Activity Therapy Staff is responsible for the following:
      i. Complete the form using 1 Vendor.
      ii. List clearly the item(s), item number(s) and cost(s).
      iii. If requested, an explanation of requested item.
      ~~2.~~

   b. ~~The form is completed electronically and submitted to the neighborhood~~ Activity Therapy supervisor ~~for approval~~will review form for approval. Activity Therapy Supervisor will consider:

      i. Allotted Budget
      ii. Appropriateness of item
      iii. For large items, check for Facilities approval.

iv. For electronic items such as tablets, Activity Therapy Supervisor will be mindful that procurement will need to be handle through the IT Procurement process.

c. Once approved and signed, Activity Therapy Supervisor will forwarded the form to Director for approval.

3. **PURCHASING:**

3. Activity Therapy .

When approved by the supervisor, it is forwarded to the Director for approval.Director will appoint Purchasing Agent(s) to complete purchasing transactions for Activity Therapy Department.

a. Purchasing Agent will facilitate operational purchases in the following manner:

i. No orders can be initiated without written approval from the Director (see Activity Therapy Purchasing Request Form).
ii. Verify appropriate Funding Source in F$P system by referencing Budget.
iii. Contact Central Purchasing Department for technical issues or other purchasing related issues.
iv. Inform Approvers when requisitions have been initiated.
v. For items without Blanket Purchase Order numbers, Purchasing Agent will initiate requisition through the F$P System. Once the Purchase Order has been generated (through the Approval Processes), purchasing Agent will ensure order has been completed by contacting the vendor.
vi. For items with a Blanket Purchase Order, Purchasing Agent will contact Vendor and place the order.
vii. Indicate completed orders on the “Activity Therapy Purchasing Request form”.
4.**viii.** For Electronics that need to be purchased through the IT Procurement process, purchasing agent will complete either the “RPO for Standard IT Equipment and Hardware”, or “RPO for non-standard IT Equipment”.

4. **RECEIVING:**

a. Purchasing Agent and/or Activity Therapy Supervisory staff will receive items in the following manner:

i. Materials Management will deliver item to Activity Therapy Department, receiving staff will sign appropriate log book.

ii. Review packing slips and verify the Purchase Order Number.

1. If there is no Purchase Order number or the number does not match Recorded Purchase Order number, report to Activity Therapy Director/ Supervisor to investigate possible errors.
2. If the packing slip does not reflect the items order, Purchasing agent will contact the vendor to address issue. Notify Materials management if items need to be returned.

iii. Indicate received item in the Activity Therapy Purchasing Request form.

iv. Organize the items to requesting program and place item(s) in the Shipping/ Receiving Area.

v. Inform program requested items have arrived.

5. **INVOICING:**

a. Purchasing Agent will process Invoices from Vendors. Purchasing Agent will:
i. Stamp the invoice with "Time and Date" and "Received" stamp.
ii. Make copy of the completed "Activity Therapy Purchasing Request form", attach to invoice for Funding approver's review.
iii. Confirm receipt in the F$P, record receipt number on the invoice.
iv. Deliver invoices for Approver's signature.
v. Submit to accounting signed and completed invoice(s).

6. **INVENTORY AND WORKPLACE MANAGEMENT:**

a. Activity Therapy Department will ensure effective Workplace management practices.

b. Purchasing Agent will inventory Electronic Goods (as referenced in Activity Therapy Policy A13 Portable Electronic Goods) by using tagging procedures outlined in Hospital Wide Policy and Procedures 31-05 Preventive Maintenance. Tagged Inventory will be updated annually.

5. Supplies are ordered by neighborhood by the purchasing agent and all electronic information is forwarded to the activity therapists when possible.

6. Deliveries are made from Material Management to either the Activity Therapy Department or the neighborhood.

7. The order is inventoried by Activity Therapy staff and any problems with the order are forwarded to the purchasing agent for follow up.

8. **Neighborhood supplies should be secured and maintained to minimize loss or damage by neighborhood staff.**

PROCEDURE FOR DEPARTMENTAL EQUIPMENT:

a. Electronic items that are not used actively will be returned to clerk. The clerk will red tag the item and announce the availability of this item. Red Tag items generally lasts for 30 days. If item has not been claimed by a program staff, Activity Therapy Department will discard item in accordance to Hospital Wide Policy 35-04 Disposal of Hospital Property.

b. Electronic items that are deem damaged or ineffective will be reported and returned to Activity Therapy Department for review. If item is no longer functioning, Activity Therapy Department will discard item in accordance to Hospital Wide Policy 35-04 Disposal of Hospital Property.

c. Electronic items stored in the Activity Therapy Department can be checked out through the reservation binder. Staff who signed out equipment will return the item clean and functioning. Damages will be reported promptly to clerk or Activity Therapy Supervisor.

7. **P-CARD**

1. Activity Therapy Director will designate a purchasing agent to handle purchases using the Procurement Card system (aka "P-Card". Purchasing agent will purchase items in accordance to Hospital Wide Policy and Procedure 50-11 Procurement Card.Equipment

items which are large, expensive and/or are utilized on an infrequent basis are designated as departmental equipment and are stored in the Activity Therapy office.

2. Departmental Equipment is managed by the P1111 office staff.

3. Binders with reservation sheets for equipment are maintained when necessary. A sign out system is also maintained when needed, based on utilization.

4. Equipment must be returned clean and in the same condition as it was received.

5. Damage to equipment should be reported verbally or in writing to office staff.

6.a. Other departments or residents may check out equipment form the Equipment Library with pre-arranged reservations through Activity Therapy staff following the systems above.

REFERENCE:
Hospital Wide Policy and Procedures 31-05 Preventive Maintenance.
Hospital Wide Policy 35-04 Disposal of Hospital Property
IT Procurement Forms: RPO for Standard IT Equipment and Hardware and RPO for non-standard IT Equipment.
Hospital Wide Policy and Procedure 50-11 Procurement Card
None

ATTACHMENT:
Neighborhood Supply request Form

Most recent review:	8/28/18 7/15/2018, 7/2/2015
Revised:	10/21/2010, 4/2013, 8/29/2013, 8/29/2014
Adopted:	6/1/1999

CALL-IN PROCEDURE

POLICY:

Staff will communicate unscheduled absences that will assist in the coverage process.

PURPOSE:

Enable departmental leadership to assess services needs and deploy resources as needed.

PROCEDURE:

1. Activity Therapy Staff will report an unscheduled absence by cCallingcalling 415I 682—-5600, the department's main number, to report the unscheduled absence between 8:30 and 9:00 a.m. regardless of your normal shift hours. –Clerk and/or Activity Therapy Supervisors will receive calls during those hours.

2. Staff should make an attempt to directly communicate with someone and include the following information.

   a. Activities or tasks that need to be covered.

   b. Whether you are scheduled for an outing.

   c. Whether volunteers need to be contacted.

   d. Whether you have a food ordered.

   e. Any other important information.

3. Because the Activity Therapy Department is not staffed 24/7, if one is unable to reach another staff member while calling, a voice message would be acceptable.

REFERENCE:
None

ATTACHMENT:
None

Most recent review: 8/28/18, 5/21/2015
Revised: 9/2013, 8/29/2014
Adopted: 9/2013

ASSIGNMENT BIDDING PROCESS

POLICY:

The Activity Therapy Department Collaborates with labor to initiate a process to assign staff to permanent assignments based on seniority.

PURPOSE:

1. To assign permanent staff to assignments as soon a possible supporting hospital initiatives of service delivery improvements (consistent assignment) and wellness (staff retention).

2. To provide staff with a transparent, fair and consistence process that meets the intent of the MOU.

PROCEDURE:

1. ~~The department management~~Activity Therapy Director will post a seniority list in Department Bulletin Board.

2. Activity Therapy Director will announce open assignment via email and post in Department Bulletin Board.

~~2.~~3. The assignment(s) ~~are~~ will be posted for at least 14 calendar days. ~~in which any s~~Staff members within the activity department i~~i~~in that class may express interest ~~relinquishing their current permanent assignment~~ by notifying the director with~~-~~in the designated time frame. Acceptable forms of notification include: written email or~~,~~ written letter. ~~(filling the paper in bulletin board?)~~The deadline for submission must be clear on the posting including date and time.
~~3. Assignments are posted for at least 14 calendar days with clear deadline for submission of interest.~~

~~4. Any staff member within the department in that appropriate class, may express interest in the assignment in writing to the director.~~

~~5.~~4. Staff with the highest seniority will be awarded the assignment.

~~6.~~5. Transition plans are made based on the circumstances,

~~7.~~6. Additional assignments may result from the process.

~~8.~~7. Assignments with additional skill requirements include language focus neighborhoods and the Wellness Center.

REFERENCES:
COLLECTIVE BARGAINING AGREEMENT BETWEEN AND FOR SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1021 AND THE CITY AND COUNTY OF SAN FRANCISCO JULY 1, 2014 – JUNE 30, 2019
Activity Therapy P&P File A3: Staffing Plan

Revised: 8/28/18
Reviewed: 7/15/2018, 7/2/2015
Adopted: 9/2013

EMERGENCY RESPONSE PLAN

POLICY:

Activity Department will lead in the assessment and coordination of needs for particular areas of the hospital during a Department Emergency and Disaster Response.

PURPOSE:

1. To streamline information to the Disaster Response Command Center

2. To ensure the well being of residents for residents in those designated areas.

PROCEDURE:

1. Code Yellow is announced, Department Emergency/ Disaster Response Plan will be activated.

2. During normal business hours (8:30am-5pm), non-neighborhood Activity Therapy personnel will initiate the Department Operations Status Report (DOSR), in accordance to Hospital Wide Policies and ~~Proceduress~~Procedures 70-01 and 70-03. Activity Therapy Personnel will gather ~~, collect~~ information in the 1st Floor Pavilion area between the rooms P1111 and P1162, ~~Ground floor Rooms PG 222 and 223 (Wellness and Pool~~), and Farm.

3. The information of the 1st floor pavilion areas will ~~be taken~~faxed to. ~~to Nursing Office (P1).~~ The information pertaining to ~~PG 222, 223~~ and Farm will be taken to Ground Floor Lobby.

4. Activity Therapy Staff should be prepared to manage residents in the common spaces if necessary.

5. Farm staff should be prepared to move animals, provide First Aid, and call a veterinarian if necessary.

REFERENCES:
Hospital Wide Policies and Procedure 70-01 Emergency Response Plan

ATTACHMENTS:
None

Most recent review: 8/28/18, 4/20/2015
Revised: 6/2014, 8/29/2014
Adopted: 2/2014

MEDICAL RECORD DOCUMENTATION

POLICY:

Activity Therapy Department completes documentation that includes assessment, care plans, quarterly reviews and the MDS, which are all part of the medical record, in accordance to Code of Federal Regulations: Department of Health and Human Services Centers for Medicare & Medicaid Services F679, and California Code of Regulations, Title 22..

PURPOSE:

1. Provide information regarding residents that relate to their preferred leisure interests and lifestyle, and improve continuity of care.

2. Comply with State and Federal Regulations.

PROCEDURE:

1. The assigned RAI Coordinator creates and distributes a schedule which includes due dates for documentation.

2. The following are documents and/or processes required for all skilled nursing admissions.
   a. Within the initial 48 hours of admission the Activity Department completes
      i. **Wellness & Activity Therapy Assessment (602)** which is completed in the electronically in SFGetCare
      ii. **Resident Activities Care Plan Template MR353i,** which corresponds with the assessment, shall be saved on the secure Activity Therapy drive and printed for the care plan book on the neighborhood.

   b. Minimum Data Set 3.0 (MDS) is electronically completed and signed, within 7 days of Assessment Reference Date (ARD)..
      - Section F for Preferences for Customary Routine Activities
      - If necessary, Section V for Care Area Assessment (CAA)

3. Assessments, care plans and MDS are completed annually(annual), on readmission and in the case of a significant change (, and are to be complete within 7 days of the ARD. The ARD is which is determined by the MDS coordinator.
   c.a. Significant Change assessments and Care plans are completed within 7 days of assigned date.`

4. Progress Notes are written in the SFGetCare, at a minimum, 3 times per year. At the same time, the care plan is reviewed and modified if necessary to reflect any changes to resident preferred activities.
   d.b. Transfer notes are written in the SFGetCare within 7 days of transfer from one neighborhood to another. At the same time, the care plan is reviewed and modified if necessary.

4. The assigned RAI Coordinator creates and distributes a schedule which includes due dates for the documentation.

3.5. Assigned therapists make arrangements for the completion of the MDS process if scheduled for time off or unscheduled absence.

4.6. In the event staff is unable to complete the **Wellness & Activity Therapy Assessment (602)** within 48 hours of admission, a progress note shall be written to justify the cause for delay.

5.7. In the event of SFGetCare, or electronic health record, system failure:

a. Staff shall complete assessments utilizing Activity Therapy Assessment **MR602i**. It will be electronically saved in the L: drive, printed, and signed for the paper medical chart.

b. Staff shall complete all Progress Notes and Transfer Notes in the Integrated Progress Notes MR104 in the rack chart.

REFERENCES:

Code of Federal Regulations: Department of Health and Human Services Centers for Medicare & Medicaid Services F680
California Code of Regulations, Title 22,

Code of Federal Regulations: 42CFR 483.00
California Code of Regulations, Title 22, Division 5 Chapter 3 – Skilled Nursing Facilities Section
https://sfgetcare.com/
HW 48 hour policy??????????????????

ATTACHMENTS:

1:	MR602i:	Activity Therapy Assessment
2:	MR353i:	Resident Activities Care Plan Template
3:	MR104:	Integrated Progress Note

Most recent review:	7/1/2018, 7/2/2015, 8/10/2014
Revised:	7/28/2009, 10/13/2010, 7/20/2012, 4/2013, 9/2013, 8/29/2014, 8/10/2014
Adopted:	6/1/1999

TRACKING OF RESIDENT PARTICIPATION

POLICY:

The Activity Therapy Department maintains records of resident participation in activities in accordance to Code of Federal Regulations: ~~42CFR 483.00,~~ Department of Health and Human Services Centers for Medicare & Medicaid Services ~~F248 and~~ F6~~80~~79, and California Code of Regulations, Title 22.

PURPOSE:

To comply with California state regulations and to assist with resident care planning.

PROCEDURE:

1. Neighborhood based activities

   a. Activity staff assigned to the neighborhoods utilize the "Activity Therapy Group Attendance Record" to document resident(s) daily participation in activities.

      i. Activity staff maintain the form with the neighborhood's residents' full name.

      ii. Activity staff list the group activities along the top vertical section. The group activities coincide with the neighborhood calendar for each day. Slots are left blank to allow the recording of additional groups as needed.

      iii. If a group provided differs from the neighborhood calendar, "Scheduled programs were changed due to:" shall be marked with reason for change noted.

      iv. Resident participation is recorded at the intersecting square between the residents name and the activity: "A" is used for "Active", "P" "Passive", "D" "Declined", and "N" "Not Available" is the preferred notation.

      v. The notes section is utilized for the recording of individualized activities including 1:1 interventions, non-neighborhood program attendance, and resident independent leisure activities. 1:1 interventions must be recorded here to be tracked.

   b. One form is used for each day of the week.

   c. Completed forms are maintained on the neighborhood binder for 3 months. Records older than 90 days are transferred and stored in the specific neighborhood attendance record binder in the activity therapy department.

   d. Neighborhood participation records are maintained for one year, after which they are discarded using confidential shedder bins.

Hospital-wide activities

   a. Activity staff record and maintain hospital wide activity participation electronically.

   b. Records are saved in the departmental L drive.

c. Records include:
    a. Residents full name
    b. Neighborhood in which they reside
    c. Date of the activity
    d. Title of the activity
    e. Mark residents participation

d. Completed records are maintained for 1 year.

REFERENCE:
Code of Federal Regulations: ~~42CFR 483.00~~
California Code of Regulations, Title 22, Division 5 Chapter 3 – Skilled Nursing Facilities Section
Activity Therapy Group Attendance Record Guidelines

ATTACHMENT:
1: Neighborhood Activity Therapy Group Attendance Record Form

Most recent review: 6/18/2015
Revised: 10/18/2010, 8/15/2012, 9/2013, 8/29/2014, 6/18/2015
Adopted: 8/21/2008

Quarterly Progress Note ~~FORMAT~~Format

POLICY:

Every three months, a quarterly progress note is required for each resident,~~.~~ in accordance to Code of Federal Regulations: ~~42CFR 483.0000,~~ Department of Health and Human Services Centers for Medicare & Medicaid Services ~~F248 and~~ F679, and California Code of Regulations, Title 22,

PURPOSE:

The note demonstrates a plan has created and monitoring is occurring.

PROCEDURE:

1. Resident quarterly ~~P~~progress ~~Notes~~ is~~are~~ written in the ~~Integrated~~ SF-GetCare Progress Notes section of their medical record.

2. The progress notes are written on are before the due date indicated on the RAI schedule for quarterly assessments

~~3. Activity Therapy progress notes are written in the next available space within the Integrated Progress Notes section.~~

~~4.~~3. ~~Notes are dated, timed, and entitled "Activity Therapy Progress Note."~~ Progress notes are written in a narrative format and include the following:
   a. A statement of the Activity Therapy plan of care or goals for the past three months.
   b. A description of the resident's participation in activities including types of activities ~~483.00~~and behaviors during activities. Note any changes to activity participation and precipitating factors.
   c. Changes in functional abilities.
   d. Current problems or needs that are limiting the resident's participation in activities or having a negative impact on the resident's functional abilities and life in general.
   e. An indication of the general direction of Activity Therapy interventions for the coming quarter.

~~5.~~4. Activity Therapy staff write progress notes more frequently to document something of significance related to the resident's plan of care.

~~6.~~5. The note may document something positive such as an accomplishment.

~~7.~~6. The note may document an issue or situation that is impacting or may have impact on the residents overall plan of care.

~~8.~~7. This type of Activity Therapy Progress Note should not to be confused with a Focused Progress Note which documents a significant event, usually negative, and usually requires review and/or revision to the resident care plan.

~~9.~~8. The progress note is electronically signed by the Therapist.

REFERENCE:
~~None~~ Code of Federal Regulations: ~~42CFR 483.00,~~ Department of Health and Human Services Centers for Medicare & Medicaid Services ~~F248 and~~ F680~~79~~, and California Code of Regulations, Title 22,

ATTACHMENT:
None

Most recent review: 8/28/18, 7/2/2015
Revised: 12/12/2012, 8/29/2013, 8/29/2014
Adopted: September, 2013

COMMUNITY SERVICES, SPECIAL EVENTS AND SERVICES COORDINATOR

POLICY:

The Activity Therapy Department facilitates the provision of special events, entertainment, and service projects by individuals or groups from the community.

PURPOSE:

1. To enhance the frequency, the variety, and overall quality of leisure opportunities available to the residents of Laguna Honda Hospital.

2. To provide culturally appropriate activities and to enhance connections between the hospital and the community at large.

PROCEDURE:

1. ~~An~~ Activity Therapy Director will assign Activity Therapy ~~Supervisor is assigned to~~staff the role(s) of Special Event Coordinator.

2. Special Event Coordinator will:

    a. Plan and implement Special events pertain to activities, entertainment, social events, and cultural celebrations.

    b. Coordinate hospital staff, volunteers, and/or members of the community that take place on a one-time basis to implement event. ~~implemented by hospital staff,~~

    ~~a. volunteers, and/or members of the community that take place on a one-time basis.~~

    c. Field phone calls and other inquiries from the community groups regarding the provision of special events/services. Determination of the appropriateness and the feasibility of the proposed special event and either accepts the event or politely declines.

    d. Work with Activity Therapy and other departments to schedule events provided by staff and volunteers.

    e. Evaluates the proposed special event and determines if the event be best suited for an individual neighborhood or made available hospital-wide. The availability of rooms in which to hold the event is part of the evaluation. The Special Events Coordinator communicates with Activity Therapy staff working on resident neighborhoods about the scheduling of special events on the neighborhoods.

    f. Schedule rooms to be used for hospital-wide special events and arranging the necessary support services.

    g. Serve as the contact staff person or identify another staff as the contact person for the special event. The staff contact is responsible for overseeing the implementation of the events. The staff contact will greet, assist, and supervise the individuals or groups during the event. The contact person is responsible for ensuring that the individuals or groups comply with all appropriate hospital policies including food restrictions and access to the hospital and its residents.

h. Write or email confirmation to individuals or groups from the community providing special events generally no later than 2 weeks prior to the event. The confirmation letter includes the following information:

i. Times and location of the event
ii. Suggested arrival time
iii. Staff contact
iv. Guidelines related to hospital policies to which individuals or groups must adhere while at the hospital.

i. Creates a schedule of hospital-wide special events and distributes the listings to the Activity Therapy Clerk for posting on the monthly hospital wide event calendar. These calendars are posted on the resident neighborhoods and throughout the hospital including via computer network and/or electronic media systems within the facility.

j.
b.
Phone calls and other inquiries from the community groups regarding the provision of special events are received and processed by the Special Events Coordinator.

The Special Events Coordinator will work with Activity Therapy and other departments to schedule events provided by staff and volunteers.

2. The Special Events Coordinator makes a determination of the appropriateness and the feasibility of the proposed special event and either accepts the event or politely declines.

3. The Special Events Coordinator evaluates the proposed special event and determines if the event be best suited for an individual neighborhood or made available hospital-wide. The availability of rooms in which to hold the event is part of the evaluation. The Special Events Coordinator communicates with Activity Therapy staff working on resident neighborhoods about the scheduling of special events on the neighborhoods=.

4. The Special Events Coordinator is responsible for scheduling rooms to be used for hospital-wide special events and arranging the necessary support services.

1.2. The Special Events Coordinator will serve as the contact staff person or identify another staff as the contact person for the special event. The staff contact is responsible for overseeing the implementation of the events. The staff contact will greet, assist, and supervise the individuals or groups during the event. The contact person is responsible for ensuring that the individuals or groups comply with all appropriate hospital policies including food restrictions and access to the hospital and its residents.

a. g. A written or email confirmation will be sent to individuals or groups from the community providing special events generally no later than 2 weeks prior to the event. The confirmation letter includes the following information:
b.
c. Times and location of the event
d. Suggested arrival time
e. Staff contact
f. Guidelines related to hospital policies to which individuals or groups must adhere while at the hospital.

2. The Special Events Coordinator creates a schedule of hospital-wide special events and distributes the listings to the Activity Therapy Clerk for posting on the monthly hospital wide event calendar. These calendars are posted on the resident neighborhoods and

~~throughout the hospital including via computer network and/or electronic media systems within the facility.~~

~~3.~~

~~4. Flyers advertising special events may be posted on resident neighborhood and throughout the hospital including electronic media systems within the facility.~~

~~5.~~

~~6. Groups from the community wishing to perform service projects are directed to and coordinated by the Special Events Coordinator.~~

~~7.~~

~~8. The Special Event Coordinator/staff will facilitate written acknowledgment of special events provided by community groups. Acknowledgement letters are sent out no later than one week following the event.~~

~~9.~~

REFERENCE:
None

ATTACHMENT:
None

Most recent review: 8/29/2014
Revised: 8/3/2009, 10/17/2010, 7/14/2012, 4/6/2013, 9/2013, 8/29/2014
Adopted: 6/1/1998

ANIMAL ASSISTED THERAPY

POLICY:

As part of a spectrum of programs and interventions, The Activity Therapy Department provides Animal Assisted Therapy (AAT) to the residents of Laguna Honda Hospital (LHH) in accordance to **Hospital Wide Policy 76-03 Animal Control**.
~~.~~ This service is achieved through maintaining animals on site and through collaborative efforts with individuals and organizations from the community.

PURPOSE:

To provide the residents of Laguna Honda Hospital with the benefits of animal-human contact including companionship and enhanced self esteem ~~.~~

DEFINITIONS FROM Hospital Wide Policy 76-03 Animal Control:

Service Animal: Any Dog, or in some cases a miniature horse, that is individually trained to work specifically for a person with a physical, sensory, psychiatric, or other disability.

Support Animal: Animals of any species that are not trained to perform specific tasks. Their presence provides assistance to people with psychological disabilities.

Therapy Animal: Animals that have certified by a recognized animal assisted therapy program such as the San Francisco SPCA.

PROCEDURE:

1. The Activity Therapy Department maintains Support animals living on site for the purpose of interactions with residents. The area of the hospital that is used to house the animals is referred to as The Farm and Therapeutic Gardens (the Farm). Two full-time positions are dedicated to the operations of the ATT program. Those staff members are responsible for the care of the animals, maintenance of The Farm and the facilitation to the ATT program.
2. Farm staff will:
   a. Manage veterinarian services for regular health inspection of the animals as well as emergency care. The medical record of each animal is maintained by the Animal Assisted Therapy (ATT) staff, and housed at The Farm/Activity Therapy Department.
   b. Manage and implement regular schedule of feeding and cleaning procedures is established and implemented by the ATT staff.
   c. Train and manage volunteers for the maintenance of the provision of animal assisted therapy and maintenance of the Farm.
      i.
      ii.
   ~~a.~~
   ~~b.~~

~~The services of a Veterinarian are employed for the regular health inspection of the animals as well as emergency care. The medical record of each animal is maintained by the Animal Assisted Therapy (ATT) staff, and housed at The Farm/Activity Therapy Department.~~

~~2. Regular schedule of feeding and cleaning procedures is established and implemented by the ATT staff.~~

~~3. Two full-time positions are dedicated to the operations of the ATT program. Those staff members are responsible for the care of the animals, maintenance of The Farm and the facilitation to the ATT program.~~

a. The Activity Therapy Department dedicates additional personnel resources as available members for the provision of the animal as sited therapy.

~~b. The ATT program also utilizes volunteers for the maintenance of the provision of animal assisted therapy and maintenance of the Farm.~~

~~4.~~3. The program elements of the ATT program include but are not limited to the following:

a. Neighborhood Animal Visits
   i. The activity therapists are able to check out Support~~the~~ animals from the farm for visits on individual neighborhoods.
   ii. Activity Therapists are required to reserve the Support animals in advance on the farm calendar, sign the animal out when they take them from the farm, and sign them back in when they are returned to the farm.

b. ATT Staff Sponsored Programs
   i. Animals from the Farm are brought into the facility for scheduled interactions with the residents. This program is coordinated between ATT staff and Activity Therapist assigned to the neighborhoods.
   ii. The program may take place on the individual resident unit or in a communal space in the facility or at the farm/greenhouse.

c. Use of the Farm
   i. Activity Therapists may reserve the Farm for programs though coordination with the ATT staff.

d. Visits to the Farm
   i. Hours of operation are maintained at the Farm and Therapeutic Gardens during which staff are available to supervise visits by residents, staff and members of the community.

~~5.~~4. The AAT program maintains relationships with ~~other~~ animal assisted therapy community programs such as the San Francisco SPCA. Visits by other animal assisted therapy programs are coordinated by the Activity Therapy Supervisor responsible for the animal assisted therapy program. The Activity Therapy Department defers to the participating organization ensure that its animals are appropriate and safe and health records and behavioral certificates are maintained in the organization's files.

REFERENCES:

~~None~~ Hospital Wide Policy 76-03 Animal Control.

ATTACHMENT:
None

Most recent review: 8/28/18 ~~8/29/2014~~
Revised: 4/14/2013, 9/2013, 8/29/2014
Adopted: 10/20/2010

COMMUNITY ~~OUTING~~ OUTINGS PROTOCOLS

POLICY: ~~All~~ Activity Therapy Staff will plan and implement Community outings ~~are planned and implemented using~~ following the ~~following~~ protocols outlined in Hospital Wide Policy 28-01.

PURPOSE: To identify Activity Therapy personnel to perform ~~standardize~~ planning, implementation, quality assurance and training functions. ~~processes related to community outings.~~

DEFINITONS:

Community Outings: Group Outings scheduled by Activity Therapy Department with an Assigned Driver, and follow planning and implementation protocols outlined in HW policy 28-01.

PROCEDURE:

Planning

~~1. Department clerk processes Therapeutic Outing Planning Guides (planning guide) by 2 pm during scheduled work days.~~

1. Outing Coordinator schedules all Community Outings on a quarterly basis, and posts the schedule in LH Outlook Calendar (titled "Outings"). Outing Coordinator ensures neighborhoods are assigned a consistent day that rotates once every 3 weeks. Activity Therapy Supervisors will assign an Activity Therapist to lead the outing. All ~~change requests for scheduled outing days are due for the following quarter~~schedules are finalized with the staff assignment by the 3rd Wednesday of the month prior to the next quarter starting, which is December, March, June and September. No more than 1 Community Outing will be scheduled per day.

2. Outing Coordinator will assign the driver for Community Outings, and ensure s/he is able to execute outings following protocols outlined in Hospital Wide Policy and Procedures 28-01 and the Community Outing Guidebook guidelines.

3. Activity Therapy Staff will document the planning of a Community Outing by completing the "Therapeutic Outing Planning Guide, Resident Assessment & Bag Lunch Request Form". Within the form, Activity Therapist will follow safety practices outlined in Hospital Wide Policy 28-01 and the Outing Program Safety Guidebook and the Community Outing Policy.
~~2. When completing the planning guide, refer to the Outing Program Safety Guidebook and the Community Outing Policy.~~

~~3.~~ Planning ~~for~~ forms for outings ~~should~~ will be completed at least one week prior to the outing ~~including submission of the planning guide~~.
4.

~~4.~~ Activity Therapy Supervisor will approve the Therapeutic Outing Planning Guide, Resident Assessment & Bag Lunch Request Form" and ensure standards outlined in the Hospital Wide Policy 28-01 have been operationally planned. Once approved, Activity Therapy Supervisor will submit form to Activity Therapy Clerk.
~~5. When completing the planning guide, refer to the Outing Program Safety Guidebook and the Community Outing Policy.~~
~~6.~~ 5.

6. Activity Therapy clerk processes Therapeutic Outing Planning Guides upon receipt within 1 work day, Monday through Friday. From the Planning Form information, Clerk will complete the following tasks:
   a) Enter staff, location and time of outing in the Outlook Schedule, and invite Activity Therapy Leader, Activity Therapy Supervisor, Unit Clerk, Unit Dietician and Unit Diet Technician as Outing Staff Participants.
   b) Using a copy of the Planning Form, submit "Food requests" to the Kitchen Clerk. Clerk will file the copy in the department "Food Order Book"
   c) Using a copy of the Planning Form, submit "Funding requests" to the Outing Coordinator.
   d) Write Volunteer requests on AT Volunteer Coordinator's board.
   e) Forward the Original Planning form to the assigned Driver's inbox.

~~7. A physician's order is required for resident participation in community outings. If the community outing orders do not appear in the monthly physician's orders, a separate order must be obtained from the physician specific to the date of the outing.~~

~~8. Outings should be planned to conclude and be back to Laguna Honda prior to 3:00 pm.~~

~~9. Non-restaurant outings that take place during meal times are planned to take and order bag lunches through the LHH kitchen following their policies and procedures using the planning guide.~~

~~All stops or extra trips during an outing must be noted on the outing planning guide and approved during the planning process.~~

7. Activity Therapy Staff will ensure Nursing Staff are notified of Outing details and attendees via LCR. A Copy of the Form will be provided for nursing.

Planning Considerations:

1. Outings should return to Laguna Honda prior to 2:30 pm so Outing Team staff can take breaks accordingly.

2. All stops, extra trips during an outing or alternative locations in the event for inclement weather must be noted on the outing planning guide and approved during the planning process.

3. Activity Staff will work with Resident Care Team to determine if smoking is permitted during the trip. If smoking is not allowed, residents need to be notified prior to the trip.

4. Volunteers and Family members are welcome to participate on outings. Family members are only allowed to support their family resident. Volunteers, both Outing and Neighborhood assigned, must go through Outing Safety Orientation prior to 1st trip.

Day of Outing Procedures:

1. Activity Therapy staff, driver and nursing support will follow procedures outlined in the "Community Outing Guidebook".

2. Prior to leaving for outing, Driver will photograph the form and the vitals using the Outing Tablet.

3. Upon return, driver will complete the "Evaluations Section" on the back of the Planning Form and submit to Outing Coordinator.

Cancellation Procedures:

1. Neighborhood Activity Therapy Supervisors, in collaboration with Nursing Directors and Activity Therapy Director will determine if an outing is cancelled. Every effort will be made to find an alternative should staffing become an issue.

2. Inclement Weather: Nursing Directors will consider cancelling an outing if the weather is inclement, and will discuss with Activity Therapy Supervisor.

3. Community Outings will be in cancelled in accordance to guidelines outlined in Infection Control Hospital Wide Policies.

Quality Assurance:

1. Activity Therapy Supervisors will initiate "Day of Outing QA Form" for every Community Outing, and ensure the operational criteria and safety checks have been met. Once completed, the Outing team will sign the form, and Activity Therapy Supervisor will submit completed form to the Outing Coordinator. Outing Coordinator will collect the forms and provide reports to Performance Improvement Committee or Quality Assurance Initiatives.

2. Activity Therapy Supervisors will conduct annual evaluations for all Outing Leaders. Outing Coordinator will collect the evaluations.

3. Outing Coordinator will chair the "Outing Safety Committee" Meeting, and generate reports that support Performance Improvement Initiatives.

~~Spending~~Funding

All Community Outing Funding request and spending procedures are in accordance with Hospital Wide Policies and Procedures 45-01: Gift Fund Management

Activity Therapy Community Outing Funding requests procedures:

1. Outing Coordinator will coordinate Requisition and Liquidation of Outing Funds with Accounting Personnel. Records of these transactions are filed in the Activity Therapy Department.

2. Activity Therapy Staff will request Outing funds through the "Therapeutic Outing Planning Guide, Resident Assessment and Bag Lunch Request" Form. Activity Therapy supervisor will verify requested amount and approve based on the following criteria.

   a. Snack money may be requested if refreshments are available on site of the proposed destination. $4.50 per resident is the allocation for snacks, deviation from this amount is at the discretion of the Activity Therapy Supervisor during the planning process.

   b. Approved restaurants have a designated amount per resident (see community outing location list), an amount of money per resident is designated. The Activity Therapist multiplies that amount times the number of residents participating when requesting funding for restaurant outings. $14.50 per staff member is allocated to pay for staff meals, which includes tip. Charges in excess are the responsibility of the staff, Activity Therapy Supervisor will complete the "Staff overspent Receipt" note.

   c. Funding for Staff to Resident ratio should not exceed 1 to 1, unless clinically noted.

~~1.~~
~~2.~~
3. Activity Therapy staff will obtain requested funds ~~for an outing~~ from the department clerk, Outing Coordinator, or AT Supervisor on the morning of the outing. Activity Staff will verify the

requested amount and sign the "Funding Sign Out Sheet".

4. At the end of the Outing, Activity Therapy Staff will submit receipts, participant information and SSB Compliance Form (if needed) to Activity Therapy Supervisor.

5. Once the receipts and forms are collected, Activity Therapy Supervisor will complete the "Gift Fund Reimbursement" Form with the receipts attached. Supervisor is responsible for reviewing deviations from Funding Guidelines and determine if deviation was appropriate. If the deviation is deemed appropriate, Activity Therapy Supervisor will provide written explanation to Accounting Department. If deviation is deemed inappropriate, then this will be considered mismanagement of funds and Activity Therapy supervisor will redeem remaining funds from Activity Therapy Staff. Activity Therapy Supervisor will also provide written explanation to Accounting. Activity Therapy Supervisor will submitted completed Gift Fund Reimbursement form with supportive receipts and documentation to Outing Coordinator.

Funding Guidelines:

1. Snack money may be requested if refreshments are available on site of the proposed destination. Stops either before or after the proposed destination are to be avoided. Deviation from this policy is at the discretion of the Activity Therapy Supervisor during the planning process. $4.50 per resident is the allocation for snacksDeviation from this policy is at the discretion of the Activity Therapy Supervisor during the planning process.. No snack money will be provided for staff and/or volunteers.

1. Approved restaurants have a designated amount per resident (see community outing location list), an amount of money per resident is designated. The Activity Therapist multiplies that amount times the number of residents participating when requesting funding for restaurant outings ($14.50 per staff member is allocated to pay for staff meals, which includes tip). Charges in excess are the responsibility of the staff. Volunteers are not utilized for restaurant outings. Laguna Honda does not pay for family or volunteer meals. Casinos are the exception to the paying for volunteer meal and full amount of meals for staff and volunteers are paid for by the hospital for outings to casinos.

2.

3. The appropriate funding will be provided for outings to nightclubs that have a minimum drink requirement including a tip for all in attendance.

4. No alcoholic beverages should be made available to residents during an outing unless approved by a physician and discussed with the RCC.

5. Funding cannot be useds forto purchase personneal items while shopping is not allowed. Purchases made during a shopping trip outing is provided by the individual residents.

6. Hand-written receipts are to be avoided. Receipts should have bare the name of the business establishment at which the purchases were made. If accepting a written receipt without a name of the business on it, a business card or take out menu must be added to the receipt.

7. As per San Francisco Ordinance 99-15 re: Sugar Sweetened Beverages, beverages that can be purchased for residents using hospital funds are sugar free. When the restaurant or snack receipt does not specify that the soda purchased is diet, the AT must complete a Sugar Sweetened Beverage (SSB) Ordinance Outing Disclosure sheet and turn it into their AT Supervisor.

8. Tips are to be given only for the provision of food services. Tips are calculated at 15% of the grand total, rounded up to the nearest dollar. A tip of a lower amount may be given if the Activity Therapist considers the services to be less than adequate. Tip should be hand-written on the receipt if the tip does not appear on the regular receipt as provided by the restaurant. If the tip is entered into the receipt by the restaurant that is more than the aforementioned amount, that AT is allowed to honor that tip amount.

9. Two receipts must be returned for restaurant outings, one for resident and one for staff. All ticket stubs should be returned for movie outings or any other venue that issues tickets unless a comprehensive receipt can be provided by the vendor.

Safety and Emergency:

1. Activity Therapy staff and Drivers will practice safety and emergency protocols outlined in the Hospital Wide Policies and Procedures 28-01 Community Outings and the Outing Program Safety Guidebook.

Training (Staff and Drivers):

2. All drivers will meet the education and training criteria outlined in Hospital Wide Policy 28-01. Outing Coordinator will oversee facilitate trainings as needed.

3. All Activity Therapy staff must demonstrate knowledge of the "Community Outing Guidebook" and will be evaluated by Activity Therapy Supervisor.

Bus Maintenance

Driver and Outing Coordinator will collaborate with Environment Services to ensure the following:

a. Safety Inspections are conducted on a Quarterly Basis.
b. Daily Driver logs are completed by Driver and submitted to EVS
c. Prompt reporting of mechanical failures of the vehicles.
d. If requested, submit reporting of mileage and passenger usage to accounting.
e. Routine maintenance runs when there are no Outings scheduled.

REFERENCE:
28-01 Community Outing Program
28-01 Outing Program Safety Guidebook
Outing location list
Staff Overspent Receipt Note
San Francisco Ordinance 99-15 re: Sugar Sweetened Beverages
Hospital Wide Policies and Procedures 45-01: Gift Fund Management

ATTACHMENT:
Therapeutic Outing Planning Guide, Resident Assessment & Bag Lunch Request Form
Sugar Sweetened Beverage Ordinance Outing Disclosure

Revised: 7/1/2018, 10/13/2016
Adopted: 10/13/2016

~~The only soda that can be purchased for residents using hospital funds is diet soda. When the restaurant or snack receipt does not specify that the soda purchased is diet, the AT must complete a Sugar Sweetened Beverage (SSB) Ordinance Outing Disclosure sheet~~

and turn it into their AT Supervisor.

~~Tips are to be given only for the provision of food services. Tips are calculated at 15% of the grand total, rounded up to the nearest dollar. A tip of a lower amount may be given if the Activity Therapist considers the services to be less than adequate. Tip should be hand-written on the receipt if the tip does not appear on the regular receipt as provided by the restaurant. If the tip is entered into the receipt by the restaurant that is more than the aforementioned amount, that AT is allowed to honor that tip amount.~~

4. ~~Two receipts must be returned for restaurant outings, one for resident and one for staff.All ticket stubs should be returned for movie outings or any other venue that issues tickets unless a comprehensive receipt can be provided by the vendor.~~
5.

6.
7. ~~Approved restaurants have a designated amount per resident (see community outing location list), an amount of money per resident is designated. The Activity Therapist multiplies that amount times the number of residents participating when requesting funding for restaurant outings ($14.50 per staff member is allocated to pay for staff meals, which includes tip). Charges in excess are the responsibility of the staff. Volunteers are not utilized for restaurant outings. Laguna Honda does not pay for family or volunteer meals. Casinos are the exception to the paying for volunteer meal and full amount of meals for staff and volunteers are paid for by the hospital for outings to casinos.~~

~~Managing AT staff overspends -~~

~~Overspending on resident meals: when an AT overspends on residents meals it is managed by providing the employee with corrective actions including providing the employee with an email from the Outing Coordinator that documents the overspend and a memo from their direct supervisor.~~
~~Overspending on staff meals: when an AT and other staff overspend on their own meals then the AT Supervisor collects the overspent money (>$14.50) from the AT. A Staff Overspent Receipt Note about staff spending no greater than allotted amount is to be completed and signed by AT staff and added to Outing Coordinator's accounting receipts.~~
~~Overspending on tipping (see tipping rules #13):~~
~~when the AT overspends on a the tip for residents, the sameprocess as #16a.~~
~~when the AT overspends on a the tip for staff, the AT Supervisor collects the overspent money from the AT only in the event it exceeds the allotted amount.~~

~~Receipts and unused cash are returned to the supervisor or back up supervisor immediately following the outing during the outing debrief.~~

~~Funds for personnel items while shopping is not allowed. Purchases made during a shopping trip outing is provided by the individual residents.~~

~~Hand-written receipts are to be avoided. Receipts should bare the name of the business establishment at which the purchases were made. If accepting a written receipt without a name of the business on it, a business card or take out menu must be added to the receipt.~~

~~All ticket stubs should be returned for movie outings or any other venue that issues tickets unless a comprehensive receipt can be provided by the vendor.~~

~~The only soda that can be purchased for residents using hospital funds is diet soda. When the restaurant or snack receipt does not specify that the soda purchased is diet, the AT must complete a Sugar Sweetened Beverage (SSB) Ordinance Outing Disclosure sheet and turn it into their AT Supervisor.~~

Safety

Use the Outing Program Safety Guidebook as the guide to reference all safety procedures.

Volunteers are to be trained by the bus driver or outing coordinator using the Volunteer Training for Outings Checklist prior to supporting an outing.

Resident smoking while out on a trip will comply with their care plan and/or the neighborhood's agreed upon limitations for the trip.

Staff smoking should not impact outing/residents. Leaving the group must be communicated to the trip leader.

There is no eating or drinking on the bus.

Staff ratio expectations are ≤ # of residents.

Any variations from these protocols should be approved by the Activity Therapy Supervisor prior to the trip.

REFERENCE:
Outing Program Safety Guidebook 28-01 Community Outing Program Outing location list
Staff Overspent Receipt Note
Sugar Sweetened Beverage Ordinance Outing Disclosure

ATTACHMENT:
Sugar Sweetened Beverage Ordinance Outing Disclosure
None

Revised: 10/13/2016 Adopted: 10/13/2016

NEIGHBORHOOD MONEY/SHOPPING TIME

Policy: Money is made available monthly to purchase items that would benefit the residents of each neighborhood. The money is the result of the on-going donations from Friends of Laguna Honda. The Activity Therapy Department is responsible for the appropriate utilization of this resource.

Purpose: To enable the purchase of items that will enhance the lives and living environments of the residents of Laguna Honda Hospital.

Procedure:

1. The amount of money available to each neighborhood on a monthly basis is established and modified at the discretion of Friends of Laguna Honda Hospital through the Director of Therapeutic Activities provide recommendation for neighborhood money funding.

2. At the beginning of each month, an Activity Therapy Supervisor receives a check from Accounting as reimbursement for the prior month's purchases and cashes the check at the cashier's office in order to distribute the funds to each neighborhood.

3. The Neighborhood Money is distributed to the Activity Therapists assigned to each neighborhood as close to the beginning of the month as possible using the Neighborhood Money Sign Out Form.

4. Items purchased are at the discretion of the Activity Therapists after consultation with the residents and staff of the neighborhoods. Examples of items purchased with Neighborhood Money are game prizes, decorations, games, arts and crafts supplies, etc.

5. Paid time to leave the facility and buy items to be used on resident neighborhoods is allocated to Activity Therapist with primary neighborhood assignments at a rate of four hours per neighborhood per month. However, no single staff member may take more than 2 hours of time per month.

   a. Activity Therapists are required to sign-up for shopping time at least 24 hours prior to taking shopping time with the appropriate Activity Supervisor.

   b. The Activity Therapist must notify the appropriate Supervisor either verbally or in writing if they are scheduled to take shopping time during an evening or weekend.

   c. The Activity Therapy Supervisor will contact the Activity Therapist if there is any conflict with the shopping time.

   d. Shopping time can not be taking at a time that will conflict with routine responsibilities of the Activity Therapist including programs and regularly scheduled meetings and in-services.

   e. Shopping time can only be utilized at the beginning or the end of a shift.

   f. Shopping time can not be used in conjunction with benefited time off.

6. The Activity Therapist shall fully spend the total amount allotted each month. If the full amount of money allocated is not spent, neighborhood Activity staff will retain the money not spent and apply it to the next month. The neighborhood will then receive the amount

of money that equals the sum of the receipts submitted. Any neighborhood that exceeds the monthly amount will not be compensated for the overage.

7. The Activity Therapists are responsible to submit receipts for all purchases to Activity Therapy Supervisor responsible for neighborhood receipts generally by the last Wednesday of the month using the Laguna Honda Hospital and Rehabilitation Center Activity Therapy Department Neighborhood Money Program form.

8. All receipts must

a. be dated within the month that the funds were allocated.

b. have the date of purchase noted.

c. be submitted taped on the back of the Laguna Honda Hospital and Rehabilitation Center Activity Therapy Department Neighborhood Money Program form.

d. identify the business establishment at which the purchase is made.

e. be itemized.

f. be from a register. Hand-written receipts are to be avoided. If hand-written receipts become necessary, a representative of the business must sign a receipt, list items purchased and supply a business address and phone number.

g. no receipts from outings can be used.

h. meet these requirements. If they do not they will not be accepted for processing. If receipts are not accepted, the neighborhood will receive the amount of money the next month that equals the sum of accepted receipts.

9. Receipts are collected from each neighborhood and all are submitted to accounting together for reimbursement using the Laguna Honda Hospital City and County of San Francisco Gift Fund-Revolving Fund Reimbursement form by an Activity Therapy Supervisor.

Attachments:

None

References:

Laguna Honda Hospital City and County of San Francisco Gift Fund Revolving Fund Reimbursement form

Laguna Honda Hospital and Rehabilitation Center Activity Therapy Department Neighborhood Money Program form

Neighborhood Money Sign Out Form

Most recent review: 02/01/2016
Revised: 04/14/13, 03/10/15, 06/29/15, 02/01/2016