List of Hospital-wide/Department Policies & Procedures
Submitted to JCC for Approval on March 12, 2019

** Policies and procedures that are denoted with two asterisks include revisions related to Epic implementation, and shall be effective August 3, 2019.

### 1. a. New Hospital-wide Policies and Procedures

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHHPP 22-12</td>
<td>Clinical Search Protocol</td>
<td>Created to outline the process of contraband clinical search protocol at LHH.</td>
</tr>
<tr>
<td>LHHPP 29-04</td>
<td>Cremation Assistance</td>
<td>Created to establish guidelines for the request and expenditure of funding from the Gift Fund for assistance to families of LHH residents for cremation.</td>
</tr>
<tr>
<td>LHHPP 29-08</td>
<td>Unrepresented Residents and Epple Procedure</td>
<td>Created to outline the process for implementing Epple procedures and protect the rights and interests of unrepresented residents in accordance with legal standards.</td>
</tr>
<tr>
<td>LHHPP 73-12</td>
<td>Safe Resident Handling Program</td>
<td>Created to implement procedures for safe resident handling consistent with Title 8 of California Occupational Health and Safety Administration (Cal-OSHA) and LHHPP 73-01 Injury and Illness Prevention Program.</td>
</tr>
</tbody>
</table>

### b. New Department Policies and Procedures

**Department: Pharmacy**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>02.02.03</td>
<td>Erythropoeitin Stimulating Agents</td>
<td>Created to outline the process for evaluating new ESA orders, appropriate dispensing, and storage of ESAs.</td>
</tr>
</tbody>
</table>

### 2. a. Revised Hospital-wide Policies and Procedures

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHHPP 01-01</td>
<td>Approval and Format of Hospital-Wide and Departmental Policies and Procedures</td>
<td>Policy # 2 has been revised allowing LHH to implement new policies and procedures prior to the regularly scheduled JCC approval process should there be a DPH Director of Health mandate and/or situation that may impact resident safety; and procedural change designating webpage maintenance for LHHPPs to Administrative designee(s) that was previously assigned to LHH Information Systems.</td>
</tr>
<tr>
<td>LHHPP 01-06</td>
<td>Administrator on Duty</td>
<td>Revised to include CEO in notifications by the AOD during emergency situations; and added new references.</td>
</tr>
<tr>
<td>LHHPP 20-01</td>
<td>Admission to LHH Acute and SNF and Relocation Between SNF Units</td>
<td>Revised to move definition for “bed hold” to the definitions section; replaced smoke free pre-admission agreement with LHH House Rules and Responsibilities.</td>
</tr>
<tr>
<td>Document Number</td>
<td>Title</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LHHPP 20-04</td>
<td>Discharge Planning</td>
<td>Revised to include definitions for facility-initiated transfer or discharge, resident-initiated transfer or discharge, transfer and discharge, ADL and IADLs, Assessment Domains, Informal and Formal Support.</td>
</tr>
<tr>
<td>LHHPP 20-05</td>
<td>Discharge Appeal Process</td>
<td>Revised to add definition for “transfer and discharge”.</td>
</tr>
<tr>
<td>LHHPP 20-09</td>
<td>Short Stay Discharge Planning and Tracking Process</td>
<td>Revised to remove LIS service code from grid; updated initial assessment to be completed within 48 hours of admission and discharge assessment within 7 days of admission; and added an annual report to Quality Council by the Community Reintegration Performance Improvement Team.</td>
</tr>
<tr>
<td>LHHPP 20-10</td>
<td>Transfer and Discharge Notification</td>
<td>Updated with minor revisions.</td>
</tr>
<tr>
<td>LHHPP 20-11</td>
<td>Laguna Honda Hospital's Response to ZSFG Surge Condition (re-titled)</td>
<td>Retitled and revised to change condition yellow and red alerts to surge condition; and added procedure for Social Services to provide a list of residents who may be discharged immediately.</td>
</tr>
<tr>
<td>LHHPP 21-04</td>
<td>HIPAA Compliance</td>
<td>Revised to be consistent with SFDPH HIPAA Compliance policy.</td>
</tr>
<tr>
<td>LHHPP 21-17</td>
<td>Document Shredding</td>
<td>Revised to clarify that staff members shall not deposit personal documents in the document shredding bins; and erroneously deposited personal documents shall not be retrieved.</td>
</tr>
<tr>
<td>LHHPP 21-18</td>
<td>Breach Policy</td>
<td>Revised to indicate that protected health information (PHI) is maintained in either electronic health record (EHR) or physical form.</td>
</tr>
<tr>
<td>LHHPP 22-03</td>
<td>Resident Rights</td>
<td>Updated with minor revisions.</td>
</tr>
<tr>
<td>LHHPP 22-07 **</td>
<td>Physical Restraints (re-titled)</td>
<td>Re-titled to remove “including siderails”; updated side rails to bed rails; added new definitions for freedom of movement, convenience, discipline, manual method, and position change alarms; added new guideline for physicians to conduct a face-to-face assessment within 24 hours for verbal restraint orders; and revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>LHHPP 22-13 **</td>
<td>Bed Rail Use</td>
<td>Revised to reflect Epic documentation procedures (removed Form MR 172, which will be obsolete with Epic); and added new definition for freedom of movement.</td>
</tr>
<tr>
<td>LHHPP 23-01</td>
<td>Resident Care Plan, Resident Care Team and Resident Care</td>
<td>Revised to be consistent with Centers for Medicare &amp; Medicaid Services (CMS) regulations in developing a baseline plan of care within 48 hours of the resident’s admission</td>
</tr>
<tr>
<td>LHHPP 24-05</td>
<td>Advance Care Planning</td>
<td>Revised to remove outdated language regarding documentation.</td>
</tr>
<tr>
<td>Document Number</td>
<td>Topic</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LHHPP 24-06</td>
<td>Resident Complaints/Grievances</td>
<td>Added a new policy statement to be consistent with CMS regulation, stating that LHH shall make prompt efforts to resolve resident grievances by actively working toward a resolution.</td>
</tr>
<tr>
<td>LHHPP 24-08 **</td>
<td>Off Campus Appointments or Activities</td>
<td>Revised to reflect documentation to EHR; and clarify that the Physician Certification Statement form shall be completed by a Licensed Nurse or Unit Clerk and reviewed and signed by the physician.</td>
</tr>
<tr>
<td>LHHPP 24-09</td>
<td>Ambulance Calls – Utilization and Access</td>
<td>Revised to clarify that the Physician Certification Statement form shall be completed by a Licensed Nurse or Unit Clerk and reviewed and signed by the physician.</td>
</tr>
<tr>
<td>LHHPP 24-11</td>
<td>Notification of Family, Surrogate Decision Makers, and/or Conservators of Change of Condition and/or Death</td>
<td>Revised to remove outdated language regarding documentation.</td>
</tr>
<tr>
<td>LHHPP 24-15 **</td>
<td>Prevention and Management of Pressure Ulcers</td>
<td>Revised to reflect documentation to EHR; added definitions for: avoidable, unavoidable, colonized, infected, and eschar; and added procedure to evaluate and monitor resident’s pain to not interfere with movement and/or affect mood that may contribute to immobility.</td>
</tr>
<tr>
<td>LHHPP 24-16</td>
<td>Code Blue</td>
<td>Revised to clarify Code Blue procedures that occur in the Administration building or outside the LHH building; added new Appendix 9 for medical emergency outside of the LHH building.</td>
</tr>
<tr>
<td>LHHPP 24-25</td>
<td>Harm Reduction</td>
<td>Revised definition of unsafe practices to align with new fire safety standard.</td>
</tr>
<tr>
<td>LHHPP 25-01 **</td>
<td>High Risk – High Alert Medications</td>
<td>Revised Attachment B to reflect Epic processes including bar code administration; and indicate that order sets will not be pre-printed.</td>
</tr>
<tr>
<td>LHHPP 25-02 **</td>
<td>Safe Medication Orders</td>
<td>Revised to reflect documentation to EHR; and remove outdated language or processes.</td>
</tr>
<tr>
<td>LHHPP 25-03 **</td>
<td>Verbal/Telephone Orders</td>
<td>Revised to reflect new processes with Epic implementation.</td>
</tr>
<tr>
<td>LHHPP 25-04 **</td>
<td>Adverse Drug Reaction Reporting Program</td>
<td>Revised to update verbiage reflecting documentation to EHR.</td>
</tr>
<tr>
<td>LHHPP 25-06 **</td>
<td>Pain Assessment and Management</td>
<td>Revised to remove MR form numbers; and update verbiage to reflect documentation to EHR.</td>
</tr>
<tr>
<td>LHHPP 25-09 **</td>
<td>Palliative Sedation</td>
<td>Revised to reflect documentation to EHR; and updated DNR to DNAR (Do Not Attempt Resuscitate).</td>
</tr>
<tr>
<td>LHHPP 26-02</td>
<td>Management of Dysphagia and Aspiration Risk</td>
<td>Revised to replace “specialized feeding programs” with “individualized aspiration precautions”.</td>
</tr>
<tr>
<td>LHIPP</td>
<td>26-03 **</td>
<td>Enteral Tube Nutrition</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>LHIPP</td>
<td>26-04</td>
<td>Resident Dining Service</td>
</tr>
<tr>
<td>LHIPP</td>
<td>31-05</td>
<td>Preventive Maintenance Plan</td>
</tr>
<tr>
<td>LHIPP</td>
<td>35-01</td>
<td>Sales Distribution of Free Items and Solicitation on the Campus</td>
</tr>
<tr>
<td>LHIPP</td>
<td>35-04</td>
<td>Inventory and Disposal of Hospital Property (re-titled)</td>
</tr>
<tr>
<td>LHIPP</td>
<td>50-02 **</td>
<td>Resident Trust Account</td>
</tr>
<tr>
<td>LHIPP</td>
<td>70-01 A2</td>
<td>Emergency Preparedness</td>
</tr>
<tr>
<td>LHIPP</td>
<td>70-01 B2 **</td>
<td>Continuity of Operations Plan</td>
</tr>
<tr>
<td>LHIPP</td>
<td>70-01 B3</td>
<td>Resident Evacuation Plan</td>
</tr>
<tr>
<td>LHIPP</td>
<td>70-01 C1</td>
<td>Fire Response Plan</td>
</tr>
<tr>
<td>LHIPP</td>
<td>72-01 A8</td>
<td>Outbreak/Epidemic Investigation Protocol</td>
</tr>
<tr>
<td>LHIPP</td>
<td>72-01 B14</td>
<td>Visitors Guidelines for Infection Prevention</td>
</tr>
<tr>
<td>LHIPP</td>
<td>72-01 C17</td>
<td>Pediculosis (Lice) Management</td>
</tr>
<tr>
<td>LHIPP</td>
<td>72-01 C23</td>
<td>Pneumococcal Immunization</td>
</tr>
</tbody>
</table>
administration procedures; and add two new appendices for pneumococcal vaccine timing for adults.

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHHPP 72-01 C24</td>
<td>Employee Influenza Vaccination(s) Policy and Use of Surgical Masks When Vaccination(s) is Declined</td>
<td>Revised to clarify procedures for employee use of cafeteria and break rooms during mandatory masking period.</td>
</tr>
<tr>
<td>LHHPP 72-01 C25</td>
<td>CRE Management and Prevention Strategies</td>
<td>Updated to reflect current practices at the ZSFG Microbiology lab in accordance with recommendations for CRE testing by CDPH.</td>
</tr>
<tr>
<td>LHHPP 72-01 D4</td>
<td>Evaluation of Communicable Illness in Health Care Workers</td>
<td>Revised to update procedures for health care workers with symptoms or exposure to a communicable disease.</td>
</tr>
<tr>
<td>LHHPP 73-05</td>
<td>Workplace Violence Prevention Program</td>
<td>Revised to remove the Staff Incident Response Team (SIRT) as it is no longer relevant; and instead to refer employees to the Employee Assistance Program (EAP) as appropriate.</td>
</tr>
<tr>
<td>LHHPP 75-05</td>
<td>Illicit or Prohibited Drugs or Paraphernalia</td>
<td>Revised policy purpose to comply with State and City laws and regulations; replaced Appendix A with new policy LHHPP 22-12 Clinical Search Protocol.</td>
</tr>
<tr>
<td>LHHPP 76-02</td>
<td>Smoke and Tobacco Free Environment</td>
<td>Revised policy to be consistent with the new LHH fire safety standard and designated smoking area.</td>
</tr>
<tr>
<td>LHHPP 90-08</td>
<td>Campus Use for Non-Laguna Honda Groups</td>
<td>Revised procedure for costs related to use of the LHH campus for meetings and events by non-LHH groups; added attachment for Campus Use Process Map.</td>
</tr>
</tbody>
</table>

d. Revised Department Policies and Procedures

**Department: Activity Therapy**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1 **</td>
<td>Medical Record Documentation</td>
<td>Revised to change SF-GetCare to EHR.</td>
</tr>
<tr>
<td>D4 **</td>
<td>Quarterly Progress Note Format</td>
<td>Revised to change SF-GetCare to EHR.</td>
</tr>
</tbody>
</table>

**Department: Medical Staff**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-01</td>
<td>Primary Care Physician Services</td>
<td>Revised to reflect current processes.</td>
</tr>
<tr>
<td>01-02</td>
<td>Night and Weekend Physician Services</td>
<td>Revised to reflect current processes.</td>
</tr>
<tr>
<td>D01-05</td>
<td>Psychotropic Medication Management</td>
<td>Revised to clarify procedures for informed consent.</td>
</tr>
<tr>
<td>D08-05 **</td>
<td>LHH Psychiatry Documentation and Billing Guideline</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
</tbody>
</table>
## Department: Nursing

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NPP</strong></td>
<td>Nursing Policies and Procedures</td>
<td>The following terminology contained throughout all Nursing policies will be revised and updated as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. DNCR/DNCR Notes will be changed to electronic health record (EHR).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. “Interdisciplinary Progress Notes” will be changed to EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. “Integrated Progress Notes” will be changed to “Progress Notes”.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. “Treatment Administration Record (TAR)” will be changed to EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. “Medication Administration Record (MAR)” will be changed to EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. “Wound Assessment Record” will be changed to EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. “Resident Care Plan” will be changed to “Care Plan”.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. “Front card” will be changed to “care plan”.</td>
</tr>
<tr>
<td><strong>B 5.0</strong></td>
<td>Resident Identification and Color Codes</td>
<td>• Updated color coding based on current practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Included instructions on how to print wristbands.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added placing color coded stickers onto bands to indicate associated precautions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added appendix to indicate how to print ID bands.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Generalized documentation to EHR.</td>
</tr>
<tr>
<td>**B 7.0 **</td>
<td>Nursing Care of the Resident with Seizures</td>
<td>Generalized notation of seizure risk to EHR (deleted precautions section of the “Front Card of the Resident Care Plan”)</td>
</tr>
<tr>
<td>**B 9.0 **</td>
<td>Documenting/Reporting Resident Allergies/Adverse Drug Reactions</td>
<td>• Revised “Medical Record Chart Section” to indicate EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed placement of allergy stickers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed all sections pertaining to writing allergies.</td>
</tr>
<tr>
<td>**C 1.2 **</td>
<td>Nursing Guidelines for Relocation Between Laguna Honda SNF Neighborhoods</td>
<td>• Removed “arrange the medical records in the medical chart, DNCR binder, and medication and treatment record binders.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed “Chronological Sheet”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed Body diagram and generalized statement to “sending and receiving units will review resident’s skin condition together and update on EHR if needed.”</td>
</tr>
</tbody>
</table>
| **C 3.0 ** | **Documentation of Resident Care/Status by the Licensed Nurse** (Appendix 1: Obtaining Nursing Forms, Medical Records) | • Generalized documentation to EHR  
• Changed documentation from “DNCR” to EHR  
• Appendix 1: Change title from “Obtaining Nursing Forms, Medical Records” to “Obtaining Medical Records”  
• Removed Section 7 (Nursing forms chart order) |
| --- | --- | --- |
| **C 3.2 ** | **Documentation of Resident Care by Nursing Assistant** | Revised policies:  
1. Nursing Assistant (CNA and PCA documents activities of daily living (ADL) in the ADL section of the EHR.  
2. Daily Cares are completed near the end of each shift by nursing assistant.  
3. Nursing Assistant documents intake and output in the I/O Flowsheet of the EHR  
4. Nursing Assistant documents change in condition in the Notes section of the EHR and notifies the charge nurse or the licensed nurse  
• Removed coding codes for ADL (will not be using codes in EPIC, staff will select type of level of support  
• Identified Daily Cares as the section for documenting additional data (e.g., supplemental notes, interventions, restorative care) |
| **C 9.0 ** | **Transcription and Processing Orders** | • Generalized transcription of orders to licensed nurses (previously stated it can be delegated to the unit clerk)  
• Deleted section on processing of orders (entire section covered writing orders and transcription)  
• Removed sections covering “faxing or delivering” new or d/c orders to pharmacy |
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1 2.0 **</td>
<td>Resident Activities of Daily Living</td>
<td>Removed all sections pertaining to written documentation</td>
</tr>
<tr>
<td>D2 2.0 **</td>
<td>Bathing Alternatives/Bed Bath</td>
<td>Generalized documentation to EHR.</td>
</tr>
<tr>
<td>D2 3.0 **</td>
<td>Tub Baths and Showers</td>
<td>Generalized documentation to EHR, removed DNCR, generalized licensed nurse documentation of updates to resident care plan (no specifications of restorative templates or care plan templates)</td>
</tr>
<tr>
<td>D3 2.0</td>
<td>Removal of Facial Hair</td>
<td>Revised to clarify disposal of disposable razors into sharps container.</td>
</tr>
</tbody>
</table>
| D4 1.0 | Care of a Prosthetic Eye (Artificial Eye) (re-titled) | **Policy:**
- Clarified policy that resident’s will have consultation with Ocularist upon admission for prosthetic eye, then referred at least yearly and as needed for proper care, maintenance, and function
- Medical Clinic nurse is responsible for scheduling and notifying the neighborhood of the Eye Clinic appointments
- RN responsible for assessment of resident’s routine in the care of the prosthetic eye and ongoing condition of the eye socket
**Background:**
- Changed “artificial eye” to “prosthetic eye”
- Added encouragement of residents to wear the prosthesis
**Procedure:**
Included sections on General Prosthetic Eye Care, Equipment, Removal/Cleaning and Irrigation, Insertion, Resident Teaching, Recording and Documentation under the Procedure section. |
| D5 1.0 | Foot Care | Revised policies 2 & 4:
- The Licensed Nurse is responsible for documenting and observing the unusual findings and informing the physician. Consider requesting wound care consult and/or podiatry referral.
- Residents with diabetes, peripheral vascular disease, peripheral arterial disease, immobility or other foot disorders (but not limited to such as |
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5 2.0 **</td>
<td>Limb Care following Amputation</td>
<td>Section D (1) Remove &quot;DNCR, the CNA or PCA&quot; and replace with &quot;In the EHR, the Licensed Nurse will...&quot; (2) Remove &quot;interdisciplinary progress note/acute nursing flow sheet&quot; and replace with &quot;EHR&quot;.</td>
</tr>
<tr>
<td>D5 5.0 **</td>
<td>Application and Management of Braces</td>
<td>Generalized documentation to EHR.</td>
</tr>
<tr>
<td>D5 6.0 **</td>
<td>Elastic or Anti-Embolic Stockings</td>
<td>Generalized documentation to “care plan”.</td>
</tr>
<tr>
<td>D6 1.1 **</td>
<td>Battery Operated Lift Transfer</td>
<td>Generalized documentation of assessment for appropriate sling onto EHR. • Delete Appendix and document sling type onto EHR.</td>
</tr>
<tr>
<td>D6 1.4 **</td>
<td>Battery-Operated Ceiling Lift (C-625)</td>
<td>Documentation generalized to care plan for indication of use of ceiling lift and type of sling onto EHR.</td>
</tr>
<tr>
<td>D6 2.0 **</td>
<td>Transfer Techniques</td>
<td>Generalized documentation to EHR and care plan.</td>
</tr>
<tr>
<td>D6 5.0 **</td>
<td>Ambulation</td>
<td>Generalized documentation to EHR and care plan.</td>
</tr>
<tr>
<td>D9 2.0</td>
<td>Bed Making</td>
<td>• <strong>Policy:</strong> Clarified linen changes for residents who are total bed rest and incontinent. • <strong>Equipment:</strong> New section for Equipment • <strong>Procedure:</strong> Included detailed procedure for bed making.</td>
</tr>
<tr>
<td>D9 3.0</td>
<td>Bed Stripping and Terminal Cleaning (re-titled)</td>
<td>• Detailed procedure outlined • Clarified that Terminal Cleaning is similar to Bed Stripping except for inventory of resident’s belongings</td>
</tr>
<tr>
<td>D9 6.0</td>
<td>Water Pitchers</td>
<td>• Included information on water pitcher liners • Added changing water pitcher and water pitcher liners weekly and as needed • Added labeling pitchers with date changed</td>
</tr>
<tr>
<td>E 1.0</td>
<td>Oral Management of Nutritional Needs</td>
<td>• Changes made to reflect the removal of “specialized feeding programs” and replacing with “individualized precautions”</td>
</tr>
</tbody>
</table>
| E 6.0 ** | **Total Parenteral Nutrition** | - Policy statement (1) Change to "A Registered Nurse (RN), who is trained and competent, may administer and maintain Total Parenteral Nutrition (TPN) infusions upon physician order utilizing the EHR Parenteral Nutrition Order Set."  
- Procedures: (A) Equipment section, remove preprinted PN Physician Order Sheet (MR160T)  
- Section (C) Monitoring: (3) (4) (5) change the end of the sentences to state "in the EHR Adult Parenteral Nutrition Order Set"  
- Section E: Documentation (2) Remove MAR and replace with Bar Code Administration Record. (3) Remove TAR and add EHR. (4) Remove LCR.  
- Remove IV Flow Sheet and move (a) to 3(a) under Intake and Output.  
- Delete attachment for physicians written order |
| --- | --- | --- |
| F 1.0 ** | **Assistance with Elimination** | - Change Section B (1) to "The CNA or PCA documents elimination in the EHR." (2) Remove "interdisciplinary" so it reads "EHR Progress Note" (3) Remove "DNCR" and replace with "in the EHR." (4) Replace "nursing summary" with "Resident Care Plan."  
- Generalized documentation by PCA/CNA onto the ADL section of health record |
| F 3.0 ** | **Assessment and Management of Bowel Functions** | Section Documentation (3) Change to "The LN completes the bowel and bladder assessment in the EHR." (4) Change to "The CNA or PCA records bowel function in the EHR each shift." |
| F 4.0 ** | **Application and Management of Condom Catheters** | Section (E) Documentation (1) Remove "DNCR" and replace with "EHR." (2) Remove "front card of RCP" and replace with "RCP." (3) Change to "EHR Progress Notes" |
| F 6.0 ** | **Ostomy Management** | - Generalized documentation of intake and output into the I/O section of the EHR.  
- Document indications for use of ostomy into the care plan. |
| G 2.0 ** | Neurological Status Assessment | Policy statement (1) Change to "Assessments are performed by the Registered Nurse and recorded in the EHR." Section E Documentation (1) Change to "Document neurological assessment and vital signs in the EHR." (2) Change from "integrated progress notes" to "EHR." |
| G 3.0 ** | Intake and Output | • Removed totaling of 24 hour intake and output by PM shift  
• Updated table of fluid measurements based on feedback from dietary department  
• Clarified documentation of I and O onto I/O section of EHR |
| G 4.0 ** | Measuring the Resident's Height (re-titled) | • Policy:  
  o Clarified who can measure residents height  
  o Added that resident’s height is measured on admission, annually and as indicated  
• Procedure:  
  o Removed all information pertaining to measuring weight  
  o Clarified documentation on EHR |
| G 6.0 | Behavioral Risk Assessment and Care Planning | • Removed sections regarding use of the Behavioral Risk Form.  
• Generalized policy to refer to EHR. |
| G 7.0 ** | Obtaining, Recording and Evaluating Residents Weights | • Procedure:  
  o Added Procedure 2: “To obtain accurate weight, weigh in the day shift at a consistent time and have resident wear consistent clothing and/or devices.”  
  o Added:  
    • Use the scale’s manufacturer’s instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the Central Supply Room (CSR)  
    • If the manufacturer’s instructions are not readily available, contact Facility Services.  
    • Improperly functioning scales are reported to Facility Services through a work order.  
• Documentation:  
  o Added: “The type of scale (e.g. wheelchair or floor scale, EZ-Lift scale, or electronic bed...
<table>
<thead>
<tr>
<th></th>
<th>Section</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 1.0</td>
<td><strong>Collection of Urine Specimen</strong>&lt;br&gt;(Attachments 1 and 2)</td>
<td>Revised to reflect current processes and update references.</td>
<td>Generalized documentation to EHR.</td>
</tr>
<tr>
<td>H 2.0 **</td>
<td><strong>Collection of Stool Specimens</strong></td>
<td>Generalized documentation to EHR.</td>
<td></td>
</tr>
<tr>
<td>H 3.0 **</td>
<td><strong>Sputum Specimens</strong></td>
<td>Generalized documentation to EHR.</td>
<td></td>
</tr>
<tr>
<td>H 4.0 **</td>
<td><strong>Gastric Specimens</strong></td>
<td>Generalized documentation of specimen collection to EHR.</td>
<td></td>
</tr>
<tr>
<td>H 6.0</td>
<td><strong>After Hours STAT Blood Draw</strong></td>
<td>Licensed Nurse completes laboratory requisitions. Verify the physician's ID number, applicable pager number, ICD codes, pertinent medical diagnosis and medications. Indicate if STAT was ordered. Label specimens labeled with resident’s name, room number, date and time collected.</td>
<td></td>
</tr>
<tr>
<td>I 1.0 **</td>
<td><strong>Oral and Nasopharyngeal Suctioning</strong></td>
<td>Generalized documentation to EHR.</td>
<td></td>
</tr>
<tr>
<td>I 2.0 **</td>
<td><strong>Tracheobronchial Suctioning</strong></td>
<td>Generalized documentation to EHR.</td>
<td></td>
</tr>
<tr>
<td>I 3.0 **</td>
<td><strong>Tracheostomy Care</strong></td>
<td>Generalized documentation to HER, and removed Trach Order Forms.</td>
<td></td>
</tr>
<tr>
<td>I 5.0 **</td>
<td><strong>Oxygen Administration</strong></td>
<td>Clarified signage requirements per plan of correction.</td>
<td></td>
</tr>
<tr>
<td>I 12.0 **</td>
<td><strong>Chest Tube Care and Maintenance</strong></td>
<td>Section 7. Documentation (a) remove &quot;LCR&quot; and replace with &quot;EHR.&quot; (b) remove &quot;interdisciplinary progress note&quot; and replace with &quot;EHR.&quot; (c) remove &quot;TAR&quot; and replace with &quot;EHR.&quot; (d) Remove &quot;Chest Tube Resident Care Plan&quot; and replace with &quot;RCP.&quot; (e) Remove &quot;on the TAR&quot; and replace with &quot;in the EHR.&quot;</td>
<td></td>
</tr>
</tbody>
</table>
| J 1.0 | **Medication Administration** | - Added Policy #4  
- Medications should not be left unattended.  
  o LN will remain with resident until resident has completely swallowed each medication.  
  o If concerned about ability or willingness to swallow, ask resident to open mouth and inspect for presence of medication. | |
Refer to section H.2 for prescribed medications allowed at the bedside.

<table>
<thead>
<tr>
<th>Section</th>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>J 1.3 **</td>
<td>01.02.02</td>
<td>Automatic Stop Orders</td>
<td>Revised to update procedures for automatic stop orders that is applicable to specified medications.</td>
</tr>
<tr>
<td>J 6.0 **</td>
<td>03.01.00</td>
<td>Pharmacy Quality Assessment and Improvement</td>
<td>Clarified that all controlled substances stored in pharmacy is audited monthly • Monthly reports to P&amp;T for Narcotic CII Counts and Medication Storage Refrigerator Temp • Included CNO for nursing station check reports (for Title 22 regulatory compliance) and report to PIPS quarterly</td>
</tr>
<tr>
<td>J 7.3 **</td>
<td>03.01.04</td>
<td>Omnicell Medication Transaction Audit</td>
<td>Clarified and wrote out number of residents to be audited on each nursing unit (4 from each unit: 1 from each neighborhood for a total of 2 residents from each Omnicell cabinet).</td>
</tr>
</tbody>
</table>

**Department: Pharmacy**

**Department: Rehabilitation Services**
<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-02 **</td>
<td>Rehabilitation Services for General SNF Unit Patients</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>50-04 **</td>
<td>Sources and Forms Used for Referral of Patients</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>60-01 **</td>
<td>Outpatient Rehabilitation Services</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>90-04 **</td>
<td>Establishment of Treatment Programs and Documentation: Speech-Language Pathology</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>90-05 **</td>
<td>Establishment of Treatment Programs and Documentation: Dysphagia</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>90-07 **</td>
<td>Establishment of Treatment Programs and Documentation: Audiology</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>90-08 **</td>
<td>Hearing Aid Evaluation and Dispensing</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
<tr>
<td>100-02 **</td>
<td>Discharge Planning and Durable Medical Equipment</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
</tbody>
</table>

**Department: Vocational Rehabilitation**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 **</td>
<td>Scope of Services</td>
<td>Revised to reflect current processes and update documentation to EHR.</td>
</tr>
<tr>
<td>4 **</td>
<td>Documentation of Vocational Rehab Services</td>
<td>Revised to reflect documentation to EHR.</td>
</tr>
</tbody>
</table>

3. **Hospital-wide Policies and Procedures for Deletion**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Deletion</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHHP 73-04</td>
<td>Lead Paint Control Plan</td>
<td>This policy has been consolidated with LHHP 73-02 Asbestos and Lead Management Plan.</td>
</tr>
</tbody>
</table>

**Department: Nursing**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Comment(s)/Reason(s) for Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 8.0</td>
<td>Continuous Ambulatory Peritoneal Dialysis (CAPD)</td>
<td>No longer relevant.</td>
</tr>
</tbody>
</table>
New Hospital-wide Policies and Procedures
CLINICAL SEARCH PROTOCOL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall act to ensure the safety of residents and staff, and to provide necessary care for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being.

2. Active substance use, drug dealing, unsafe smoking and use of dangerous objects endangers the safety of residents and staff and does not promote a resident's well-being.

3. For the safety of residents and staff, and the well-being of residents, dangerous objects, illegal drugs, non-prescribed medications, cigarettes, lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame, alcohol and/or drug paraphernalia are prohibited at LHH.

4. When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors as described below.

PURPOSE:

To outline the process of contraband clinical search protocol at LHH.

DEFINITION:

Contraband: Illegal or prohibited items, such as dangerous objects, prohibited drugs and drug paraphernalia, alcohol, and smoking or tobacco paraphernalia.

Dangerous objects: Items which can be used to inflict harm to self or others (sharps, knives, firearms, etc.).

Illicit or illegal drug: A drug or substance that cannot be obtained legally or by prescription, or any substance prohibited by code or statute.

Prohibited drug: A medication or substance that is illegal or is not prescribed or otherwise authorized for the resident by a LHH provider.

Drug Paraphernalia: Medical apparatus or over-the-counter items that are commonly used in illicit drug activity such as syringes, needles, drug pipes, hemostats, etc.

Smoking or tobacco paraphernalia: lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame, etc.
PROCEDURE:

1. Indications for Searches
   a. Property of all newly admitted residents shall be inventoried when the resident arrives to the unit.
   b. Packages brought into the unit that clinical staff reasonably suspect contain contraband shall be searched in the presence of the resident before giving the package to the resident.
   c. Staff may search a resident, their property, and their room when clinical staff believes there is a potential risk and/or reasonable suspicion that the resident is in possession of contraband.
   d. Staff may search a resident, their property, and their room upon reasonable belief by clinical staff that the resident is suicidal, homicidal, or necessary to prevent serious harm to themselves or to others.
   e. Residents who return from pass privileges may be asked to empty their pockets and their packages may be searched if contraband is reasonably suspected.
   f. Staff may search a resident's property and their room when staff reasonably suspects that a resident has taken another person's property. If the property is found, the property may be returned to the owner.
   g. Staff may conduct unit-wide searches when there is a potential risk and/or reasonable suspicion that drug using/dealing may be occurring on a unit or multiple units.
   h. Staff may search a resident, their property, and their room when a resident exhibits a change in mental status or behavior and substance use is suspected.
   i. Staff may search a resident, their property, and their room when a resident exhibits unsafe smoking practices such as smoking while on, or near an oxygen delivery device.

2. Search Procedures
   a. Neighborhood staff may initiate searches to ensure the health and safety of residents and staff.
   b. Searches shall be conducted in a reasonable manner that respects the individual's dignity and privacy. A search should be conducted only to the extent required to assure contraband is not present. The method and purpose of the search shall be explained to the resident.
c. To the extent possible, residents shall be present while their property (including intended packages) and rooms are being searched.

d. The permission of the resident should be requested prior to any search (except in cases of danger to self or others). It is recommended that a SFSD deputy be present for searches that involve a resident who may display behavioral escalation during the search.

e. Repeated searches of resident’s rooms and property are permitted when there is a potential risk and/or reasonable suspicion that they are in possession of contraband. Examples include but are not limited to:

   i. Resident appearing to be under the influence of drugs or alcohol;

   ii. Reasonable suspicion that contraband is in a resident’s possession (Risk factors may include the resident having history of bringing and/or selling alcohol, street drugs and/or other contraband in LHH);

   iii. Resident having current suicidal or homicidal ideation or expressed feelings of inflicting serious harm to themselves or others;

   iv. Reasonable suspicion of theft (Risk factors may include resident history of theft while on the unit, credible witness report, etc.); and/or

   v. Resident deemed an unsafe smoker and/or smoking while on, or near an oxygen delivery device.

f. Staff shall take Universal Precautions such as wearing double gloves when handling resident belongings or suspected contraband. Staff shall avoid reaching into any pockets. Instead, staff shall pour out the contents of bags, boxes, packages, or other personal belongings, ask the resident to empty their pockets, and/or gentle patting.

g. A minimum of two staff shall be present during a search.

h. Whenever a search is conducted the following information shall be documented in the resident’s medical record:

   i. The facts constituting a reasonable suspicion to conduct the search.

   ii. The scope of the search:

      • Who conducted the search;

      • Manner the search was conducted; and
• Who was present during the search.

iii. The results of the search:

• Items found and seized; and

• Disposition of items found and seized.

iv. Resident’s response and any pertinent clinical information.

v. If a resident is not present during the search, staff shall advise the resident regarding the basis for the search and the outcome of the search process.

i. New Admissions:

i. All newly admitted residents shall be informed that admission procedures require a routine inventory of his/her property by LHH staff.

• The resident shall be asked to empty his/her pockets, purse, suitcase and other belongings.

• Any contraband shall be removed from the resident’s possession.

• Any weapons or dangerous objects shall be turned over to the SFSD.

• Illicit or illegal drugs shall be turned over to the SFSD.

• A notation shall be made in the progress note (refer to procedure 2.h.) and the resident shall be given a property receipt for items that are being held by staff.

j. When a resident is assessed as suicidal or homicidal, or has a history of drug use or violent behavior, or is suspected of having contraband, a search may be initiated. Staff shall notify the SFSD’s Office of the search and request stand-by for support, if needed. Types of searches which may be conducted by staff include:

i. Pocket Searches – resident shall be asked to empty his/her pockets and contents shall be inspected by staff for contraband.

ii. Pat Down or Frisk Searches – shall be conducted by clinical staff who are of the same sex as the individual being searched in the presence of a witness. If during the pat-down search a suspicious object is discovered, which reasonably could be, for example, a weapon, pills or other contraband – staff may remove the object for closer inspection.
iii. Clothing Searches – the resident shall be escorted to a private area accompanied by two staff members, at least one staff member of the same sex whenever possible and requested to change into a hospital gown. The clothing shall be checked for contraband. Once contraband objects are removed, the clothing can be returned to the resident.

iv. Room Searches – the resident's room and furniture/belongings in the room shall be inspected by LHH staff.

3. Unit Searches of the Resident Rooms and Common Areas

a. Preparation

i. Staff shall notify SFSD of the search and request stand-by support if the resident has a history of aggressive behavior or has exhibited aggressive behavior previously during a clinical search. On such instances, at least one LHH SFSD deputy shall be stationed outside the entrance/exit of the resident's room to provide support in the event:

- the resident threatens or becomes verbally or physically aggressive toward staff, or other residents;
- or staff observe that the resident has a dangerous object in their possession; and/or
- staff observe that the resident has illicit or illegal drugs in their possession.

ii. Staff shall review basic safety search procedures before proceeding, including nonviolent safety management and prevention of challenging behavior principles as needed.

iii. Search teams shall be identified (2 staff per household) by the nurse manager.

iv. One staff shall be assigned to monitor the unit entrance/exit.

v. Staff may request canine search assistance as needed from the SFSD’s Office (refer to procedure 4).

vi. A mandatory community meeting shall be called to announce the safety search and instruct the residents to wait in the Great Room until called to their bedside for the search.

b. During the Search
i. Two staff shall provide support for each neighborhood being searched. The duties shall include escorting residents from the Great Room to the residents’ rooms, working with agitated residents, collecting confiscated substances and paraphernalia, communicating with staff at entrance/exit, etc.

ii. At least one staff shall observe the residents in the Great Room. If available, Activity Therapy may run an activity group during the wait.

iii. Residents who have been searched may leave the unit, however shall not be able to return until the search is concluded, or may be asked to wait in a separate dining room.

iv. All confiscated substances and paraphernalia shall be bagged, labeled and secured in the medication room until the search is completed.

v. Staff shall help with de-escalation and provide support as needed.

vi. SFSD shall provide support:
   - When a resident becomes verbally or physically aggressive toward staff or other residents;
   - exhibits behavior that threatens the safety or well-being of other residents or staff;
   - staff observes that the resident has a dangerous object in their possession; and/or
   - staff observes that the resident has illicit or illegal drugs in their possession.

c. After the Search

i. All confiscated contraband shall be catalogued by the staff member that conducts the clinical search, disposed of in the manner described below, and documented in the resident’s medical record:
   - Confiscated cannabis from a resident with or without a valid cannabis card shall be disposed of by 2 staff members (including one supervising nurse) using the smart sink in the supplemental drug room.
   - Confiscated alcohol shall be poured down the sink while witnessed by another staff, and the container shall be discarded in the recycle bin.
• Cigarettes confiscated from unsafe smokers shall be held or disposed of based upon the resident’s care plan for smoking.

• E-cigarettes, lighters, matches, and other devices that ignite, light, or fuel a flame shall be bagged, labeled by nursing staff and secured by Social Services for safekeeping.

• Dangerous objects (including, but not limited to, guns or objects with a blade four inches or more in length) or illicit or illegal drugs shall be confiscated by SFSD at the direction of LHH staff, catalogued by LHH staff, and transported by SFSD for proper destruction.

• Should the resident or a surrogate decision-maker indicate that the dangerous object(s) are of sentimental value, then said item(s) shall be bagged and labeled by nursing staff, and secured by SFSD for safekeeping.

  • Said items shall be stored in a secured and locked location on LHH property for safekeeping.
  
  • Dangerous object(s) shall be transported to and from the secured and locked location by SFSD only.
  
  • The dangerous object may be released to the resident by SFSD upon discharge or to a person identified by the resident or the resident’s surrogate decision-maker or personal representative.
  
  • Only the SFSD shall retrieve the dangerous object from the storage location on the LHH campus.
  
  • Dangerous objects shall not be released to the resident, person identified by the resident, resident’s surrogate decision-maker, or personal representative if the attending physician or the SFSD reasonably determines that the person would be a safety threat to themselves or to others if the dangerous object was released to them.
  
  • LHH shall keep any such confiscated dangerous objects for a maximum period of ninety (90) days after discharge.
  
• All other confiscated contraband shall be disposed of in the following manner:

  • Any confiscated substances in pill or capsule form that cannot be identified, shall be transferred to the pharmacy for identification and proper disposal.
• Any other confiscated substances that cannot be identified shall be given to SFSD.

• Any confiscated dangerous objects that contain a blade shorter than four inches in length, shall be disposed of by the DPH Security Director, or transported by SFSD for safekeeping in the manner described in Section 3(c)(i).

• Confiscated sharps shall be disposed in the sharps container by nursing staff, and witnessed by at least one other staff member.

ii. UO’s and Focused Progress Notes shall be completed by the unit staff.

iii. The Resident Care Team (RCT) shall be informed when searches were conducted. The RCT shall review the incident and assess if the resident’s care plan shall be modified.

4. Canine Searches

a. LHH has access to canine assistance for drug searches when needed.

i. A request by LHH administrative staff can be made to the SFSD for unit-wide or hospital-wide searches.

ii. The search dog shall be handled by a professional handler only.

iii. Staff shall be sensitive to those residents who may have negative reactions when they are around dogs.

iv. Staff and residents shall be instructed about proper ways to interact with the dog, such as no petting or feeding.

5. Visitors

a. All visitors shall be informed that LHH strives to be a safe, drug-free healing environment, and that all contraband, and illegal activities are prohibited. If a visitor is suspected of bringing in contraband, LHH staff may implement interventions, including but not limited to: inspection of packages the visitor brings to the unit, restricting visits, and/or calling SFSD for support.
ATTACHMENT:
None.

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-10 Management of Resident Aggression
LHHPP 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use By Residents or Visitors
LHHPP 75-10 Security Services Standard Operating Procedures
LHHPP 76-02 Smoke and Tobacco Free Environment

Original adoption: 19/03/12 (Year/Month/Day)
CREMATION ASSISTANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) provides funding assistance to the families of LHH residents who do not have the means to pay for cremation arrangements.

2. The amount expended for cremation assistance to families shall not exceed the budgeted amount within the Laguna Honda Gift Fund (Gift Fund) for a given fiscal year.

PURPOSE:

To establish guidelines for the request and expenditure of funding from the Gift Fund for assistance to families of LHH residents for cremation.

CHARACTERISTIC:

1. The Gift Fund shall be the funding source for cremation assistance. A budget for cremation assistance shall be established on an annual basis as part of the Gift Fund budget and approved by the Health Commission.

2. The Gift Fund is limited resource and all efforts are made to find alternatives, or to use the funds to supplement other sources.

PROCEDURE:

1. The Resident Care Team (RCT) shall identify candidates for burial assistance.

   a. The resident is nearing end-of-life and is expected to pass away as a resident at LHH.

   b. The resident has no or inadequate funds in his or her trust account to pay for cremation.

   c. The family of the resident has no or inadequate funds to pay for the resident’s cremation.

   d. Without financial assistance, a referral would need to be made to the Public Administrator for disposition of the body.

2. The Social Worker shall contact the Gift Fund Program Manager or designee to confirm that there are sufficient funds remaining in the burial assistance budget for the fiscal year.
3. The Social Worker shall evaluate the need for cremation assistance.
   a. The Social Worker shall contact the Accounting Department to ascertain the resident’s balances in the Trust Account.
   b. The Social Worker shall consult with the resident’s family if available to determine if they are able to pay the cost of cremation.
   c. The Social Worker shall document the information in the resident’s medical record.

4. If need is established, the Social Worker shall contact a city-approved mortuary for a written quote for cremation.

5. The Social Worker shall facilitate the completion of a Cremation Assistance Request Form and submit to the Director of Social Services.

6. Upon approval from the Director of Social Services, the Social Worker shall consult with the resident and/or the family to establish funeral plans.

7. Copies of all documents related to the Creation Assistance Request shall be forwarded to the Program Monitor overseeing the Rols 1000325 Gift Fund project code.

8. Upon the passing of the resident, the Director of Social Services or designee shall facilitate payment to the mortuary via the PeopleSoft eProcurement process using the following chartfields.
   a. Fund: 22150
   b. Department: 207690
   c. Project Code: 10000325
   d. Authority: 10001

9. The Program Monitor shall approve the requisition within PeopleSoft.

10. Copies of all documents related to the Creation Assistance Request and service procurement shall be forwarded to the Gift Fund program Coordinator to be filed.

**ATTACHMENT:**
Attachment A: Cremation Assistance Request Form
Attachment B: List of City-Approved Mortuaries
REFERENCE:
Admissions and Eligibility Department Policy 07-02 Procedure for Disposition of Expired
LHHPP 29-06 Caring for the Deceased, Use of Morgue, and Provision of Death
Certificates
LHHPP 45-01 Gift Fund Management
NPP D8.0 Post-Mortem Care
MSPP C01-01 Patient Expiration
Social Services Departmental Policy 7.19 Burial and End of Life Care Arrangements
Resident and Distribution of Funds

Original Adoption: 19/03/12 (Year/Month/Day)
San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Cremation Assistance Request Form

Name of resident ___________________ Neighborhood ______________

Trust Account Balance: Personal Funds _______ Burial _________

Attach Copy of Ledger

Does the resident have family or other?

Yes _______ No _______

Does the family have financial resources to pay the cost of cremation?

Yes _______ No _______

Describe the circumstances that would preclude the family’s paying for cremation

Cost of cremation quoted by ________________________________ $________

Attach Quote City approved mortuary

Available funds in Cremation Assistance budget: $______________

Cremation Assistance request by: ____________________________ Date: _____

Approved: ________________________________________

Janet Gillen, Director of Social Services
LIST OF CITY-APPROVED MORTUARIES

1. Valencia, Driscoll’s Street Serra Mortuary
   1465 Valencia Street San Francisco, Ca. 94110 (415) 970-8801
   www.driscollsmortuary.com

2. Green Street Mortuary
   649 Green Street, San Francisco, CA 94133 (415) 433-5692
   www.dignitymemorial.com

3. Duggan’s Serra Mortuary
   500 Westlake Avenue, Daly City California 94014 (415) 325-2341
   www.duggans-serra.com
UNREPRESENTED RESIDENTS LACKING DECISIONAL CAPACITY AND EPPLE PROCEDURE IMPLEMENTATION

POLICY:

1. Residents at Laguna Honda Hospital and Rehabilitation Center (LHH) are presumed to have medical decision-making capacity unless there is documentation by the LHH primary care physician/attending physician to the contrary.

2. When a resident/patient has been determined to lack medical decision-making capacity, the resident care team (RCT) shall make every effort to locate (1) any previously executed advanced health care directive and (2) an appropriate surrogate decision maker, i.e. health care agent named in the advance health care directive, family members or close friend, or other health care providers who are able to articulate the resident’s/patient’s wishes and values related to the resident’s care.

3. LHH protects the rights and interests of unrepresented residents in accordance with legal standards, i.e., Epple procedure and ethical principles.

PURPOSE:

To outline the process for implementing Epple procedures for unrepresented residents and to protect the rights and interests of unrepresented residents in accordance with legal standards.

DEFINITION/BACKGROUND:

Unrepresented is a term used to describe an adult who lacks medical decision-making capacity and is without a surrogate decision maker (either health care agent/proxy; family member or friend; or court appointed guardian). Only a court makes the determination that a resident is incapacitated. A physician determines if an individual exhibits medical decision-making capacity.

Epple Procedure is a term used to describe the process, under California Health and Safety Code Section 1418.8, when a skilled nursing home resident has been determined to be unrepresented and medical interventions requiring informed consent are recommended by the resident’s attending physician. An interdisciplinary team (the resident care team, or RCT) is convened to consider the recommended treatment, risks, benefits and alternatives to consent or to decline the proposed intervention. The interdisciplinary team must periodically review medical intervention decisions to ascertain whether they remain clinically appropriate. In addition to the usual RCT members (attending physician, registered nurse, social worker, activity therapy etc.), a patient representative (e.g. family/friend who is unable to take full responsibility for the health care decisions of the resident, but who has agreed to participate on the
team, or other person authorized by state or federal law, such as an ombudsperson) is invited to join the care conferences.

PROCEDURE:

1. Determination of Decisional Capacity

   a. At the time of admission, whenever there is a change in medical condition, and on ongoing basis, the LHH primary care physician or the covering/on call physician evaluates and determines a resident’s capacity to make health care decisions.

   b. The attending physician may consult with psychiatry to help determine the resident’s capacity to make health care decision, including discharge planning.

   c. If the attending physician determines the resident lacks capacity to make health care decisions and there is no surrogate decision maker available, the physician must promptly notify the resident, orally and in writing, of such determination. In instances where the resident is comatose or in a minimally conscious state, notification is not clinically appropriate, but the physician must document his/her determination and shall notify the resident promptly if the resident’s condition changes.

   d. The attending physician and RCT must comply with the notice process outlined below.

2. RCT Review, Administration and Evaluation

   a. The RCT must review and discuss the medical treatment recommendations and considers risks, benefits and alternatives. The RCT is specifically required to consider each of the following:

   i. the treating physician’s assessment of the resident’s condition;
   ii. the reason for the proposed use of the medical intervention;
   iii. a discussion of the desires of the resident, if known (obtained through an interview of the resident, review of the medical records, and consultation with family or friends, if any have been identified);
   iv. the type of proposed medical intervention, including its probable frequency and duration;
   v. the probable impact on the resident’s condition, both with and without use of the proposed intervention; and
   vi. any reasonable alternative medical interventions considered or used and

1 For purposes of this step, “surrogate decision maker” means “a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin.” Health & Safety Code § 1418.8(c).

2 These considerations are required by statute. See Health & Safety Code § 1418.8(e)(1)-(6).
the reasons for their discontinuance or inappropriateness.

b. A patient representative is invited to participate in the discussions whenever possible. The patient representative may include a family member or friend who is unable or unwilling to take full responsibility for the resident’s health care decisions, or other person authorized by state or federal law, such as an ombudsperson.

c. The RCT must periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident’s medical condition.

d. All determinations relating to the use of this process (i.e., the resident’s lack of capacity and the absence of a person with legal authority to make decisions on behalf of the resident) and the results of the review relating to the considerations from step 1 of this section shall be noted in the resident’s medical record and made available to the resident’s representative, if any.\textsuperscript{3}

e. Determinations made in emergency situations have additional considerations.\textsuperscript{4}

3. Notice Process

Before implementing a health care decision about a medical intervention that requires informed consent, if the resident lacks capacity to make health care decisions and there is no person with legal authority able and willing to make those decisions on behalf of the resident, the physician shall promptly communicate to the resident, orally and in writing, the following:

a. The resident’s attending physician has determined that the resident lacks capacity to make health care decisions;

b. LHH has been unable to locate a person with legal authority to make medical treatment decisions on behalf of the resident, a guardian, conservator, or next of kin who is able and willing to make health care decisions on behalf of the resident;

c. The medical intervention recommended or prescribed that requires informed consent and the identity of the person recommending or prescribing the

\textsuperscript{3} These considerations are required by statute. See Health & Safety Code § 1418.8(l).

\textsuperscript{4} In emergency situations, a requested treatment that otherwise requires advance informed consent may be administered at the discretion of the treating physician, if consistent with the resident’s wishes as known at the time, after the treating physician has so ordered. If the emergency results in the application of physical or chemical restraints, the RCT is required to meet within one week of the emergency for an evaluation of the medical intervention. Otherwise, an RCT may be, but is not required to be, convened to determine if the care should be continued applying the process listed above. See Health & Safety Code § 1418.8(h).
medical intervention;

d. The RCT shall review or has reviewed the physician’s determinations, and shall continue to oversee any additional recommended or prescribed interventions unless or until a person with legal authority able and willing to make health care decisions on behalf of the resident is identified, or the attending physician or a court determines that the resident has regained the capacity to make health care decisions; and

e. The right of the resident to challenge in a judicial proceeding, (i) the determination that the resident lacks capacity to make health care decisions, (ii) the determination that the resident lacks a surrogate decision-maker, and (iii) the prescribed medical intervention.

4. Appeal Process

a. When resident contests the determination that he/she lacks decisional capacity, the resident is referred to the ombudsperson to serve as patient advocate.

b. The resident is encouraged to meet with the physician and the ombudsperson (and other RCT members if the resident requests) to discuss the reasons for the determination and is informed by the physician how the RCT shall assist with decision making.

c. If the resident continues to dispute the determination, a psychiatric consultation for testing of decisional capacity shall be requested.

d. If the psychiatric consultant agrees with the physician's determination, the resident will be so advised.

e. If the resident continues to contest the determination, the resident may seek judicial review. The physician shall consult with Deputy City Attorney and Quality Management on how to proceed.

5. Documentation

As required by Section 2.d. above, the following shall be documented:

a. The attending physician shall document in the medical record the determinations of lack of medical decision-making capacity and absence of a person with legal authority to make decisions on the resident’s behalf and notification of resident of same.

b. The RCT shall document in the medical record a conference note discussing and reviewing their determinations related to treatments
requiring consent.

6. Data Collection

a. Medical social workers shall identify/report to Hospital Administration/Quality Management, residents for whom the RCT serves as surrogate decision maker.

b. Hospital administration/Quality management shall maintain a data base as part of its Risk Management program which includes the type of interventions authorized by the RCT.

c. Annually a report shall be provided to Ethics, Medical Executive Committee, and Hospital Executive Committees about the number of residents served under the Epple procedure.

ATTACHMENT:
None.

REFERENCE:
California Health & Safety Code § 1418.8
Back, Anthony, et.al. “Why Are We Doing This?” JOURNAL OF PALLIATIVE MEDICINE Volume 18, Number 1, 2015

Original adoption: 19/03/12 (Year/Month/Day)
SAFE RESIDENT HANDLING

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to a policy of safe resident handling for the prevention of musculoskeletal injuries attributable to resident mobilization among LHH healthcare workers.

PURPOSE:

1. To implement procedures for safe resident handling consistent with Title 8 of California Occupational Health and Safety Administration (Cal-OSHA), and LHHPP 73-01 Laguna Honda Injury and Illness Prevention Program.

2. To establish a process for assessing resident mobility needs and to determine safe resident handling procedures.

3. To establish procedures to minimize hazards of manual resident handling using appropriate equipment, personnel and training.

DEFINITIONS:

1. Resident Mobilization: putting into movement or assisting in the putting into movement, part or all of a resident’s body.

2. Manual resident handling: lifting, transferring, repositioning, or mobilizing part or all of a resident’s body done without the assistance of equipment.

3. Equipment: a powered or non-powered device that effectively reduces the forces exerted by or on employees while they perform resident handling activities.

4. Musculoskeletal injury: acute injury or cumulative trauma of the muscles, tendons, ligaments, bursa, peripheral nerves, joints, bone or blood vessels.

PROCEDURE:

1. Control Strategies/Prevention Techniques

   a. A registered nurse (RN) shall complete an initial and ongoing assessment regarding the resident’s ambulation needs and assistive devices required. The RN shall communicate with the resident care team and maintain documentation of ambulation needs, devices and preferences on the resident care plan in accordance with the NPP D6 5.0 Ambulation Policy.
b. Employees shall use assistive devices during resident mobilization in accordance with the resident care plan. Devices available to Laguna Honda employees are listed in Appendix A.

c. Although employees are encouraged to do their best to prevent residents from falling, employees are not expected to catch a resident who is falling due to the risk of injury to the employee.

d. The Facility Services Department shall maintain the mechanical lifts on nursing floors.

e. The Nursing Department shall submit work orders to Facility Services for equipment repairs and/or replacing damaged equipment, and shall order any new equipment deemed necessary for safe resident handling.

f. Charge Nurses shall update assignment sheets and care plans to communicate the need for buddy system for safe resident handling.

g. Employees shall use their assigned buddy for assistance if the resident care plan states the need for a two person assist or as needed.

h. Any employee who experiences a resident handling injury shall report according to procedures listed in LHHPP 73-01 Injury and Illness Prevention Program.

2. Education and Training

a. All new employees receive training during new employee orientation on:

   i. LHH Injury and Illness Prevention Program

   ii. Employees right to refuse unsafe work unless proper training is provided

   iii. Recognizing musculoskeletal pain as a workplace injury.

b. All new employees with resident care responsibilities shall attend health and safety orientation provided by the Department of Workplace Safety and Emergency Management (WSEM) that includes the following topics:

   i. LHH Ergonomics Program

   ii. Recognizing and reporting musculoskeletal injuries that result from resident handling tasks.

   iii. Hazards and risk factors associated with poor ergonomics during resident mobilization including lifts, transfers and repositioning.
iv. Other risk factors for injury such as patient size, mobility, willingness to cooperate and clinical conditions

v. Injury prevention methods including equipment, proper body mechanics and buddy system.

vi. Hands on training on operating powered and non-powered assistive devices including mechanical lifts, ceiling lifts, gait belts, transfers.

c. All employees with resident care responsibilities shall complete online annual refreshers that review topics covered in the initial training. WSEM contact information is provided for questions.

d. All Nursing Department employees with resident care responsibilities are evaluated on their ability to demonstrate the use of assistive devices initially and annually using a competency checklist. If employees fail to successfully demonstrate these skills, additional training shall be provided.

e. Records of training shall be maintained by the Education Department and WSEM.

3. Program Administration and Maintenance

WSEM is responsible for the overall administration and maintenance of the Safe Resident Handling Program, for the tracking and analysis of resident handling incidents, and for eliciting the input of employees in making improvements to the program. WSEM shall also collaborate with Education and departments providing resident care to develop and deliver educational programs for staff on strategies and procedures to minimize the risk of musculoskeletal injuries associated with resident handling.

ATTACHMENT:
Appendix A: Assistive Devices Available for Safe Resident Handling

REFERENCE:
LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 73-15 Ergonomics Program
NPP D6 1.1 Battery Operated Lift Transfer
NPP D6 1.4 Battery-Operated Ceiling Lift
NPP D6 2.0 Transfer Techniques
NPP D6 5.0 Ambulation Policy

Original adoption: 19/03/12 (Year/Month/Day)
Appendix A: Assistive Devices Available for Safe Resident Handling

1. Mechanical Lifts
2. Ceiling Lifts
3. Slide Sheets
4. Gait Belts
5. Slide Boards
New Department Policies and Procedures
POLICY AND PROCEDURE FOR ERYTHROPOIETIN STIMULATING AGENTS (ESAs)

Policy:
Erythropoietin stimulating agents (ESAs) have a FDA boxed warning for general increased risk of cardiovascular events. In addition ESAs have a FDA boxed warning for patients with chronic kidney disease in which controlled trials have shown increase risk of death, serious cardiovascular events, and stroke when ESAs are administered to target a hemoglobin level of greater than 11 g/dL. The pharmacy shall evaluate hemoglobin labs when verifying a new order for ESA to be administered at LHH and subsequently each time it is dispensed. The pharmacist will contact the prescriber based on indication when labs values would indicate dose adjustment.

Purpose:
To outline the process for evaluating new ESA orders, appropriate dispensing, and storage of ESAs.

Procedures:
1. Evaluating new orders for ESAs
   a) When evaluating new orders for ESAs the pharmacist will clarify if it will be dispensed by LHH pharmacy and administered at LHH. Dialysis patients at LHH routinely receive ESA and corresponding labs at the dialysis center. Orders for ESAs administered by an outside dialysis center will be added to the patient’s medication profile for reference and evaluated during monthly medication regimen review.
   b) For new ESA orders to be dispensed by LHH pharmacy and administered at LHH the pharmacist will evaluate the dose based on the indication in the order with guidance from the FDA approved prescribing information from the manufacturer to an appropriate tertiary reference such as Lexicomp.

2. Lab monitoring
   i) The pharmacist will evaluate the most recent hemoglobin and make recommendations for dose adjustment based on indication prior to dispensing ESA when evaluating new orders and when dispensing refills.
   (1) For patients recently started on ESA the pharmacist will contact the prescriber if there have been no hemoglobin labs within the last week
   (2) For stable patients the pharmacist will contact the prescriber if there have been no new hemoglobin labs in the last month.
   (3) For patients with CKD not on dialysis starting ESA the pharmacist will contact the prescriber if the hemoglobin is greater than or equal to 10g/dL to inform the prescriber of the FDA boxed warning and ask for documented evaluation of risks vs. benefits.
   (4) For patients with cancer the pharmacist will contact the prescriber if the hemoglobin is greater than or equal to 11g/dL to inform the prescriber of the FDA boxed warning and ask for documented evaluation of risks vs. benefits.
      (a) Per the FDA boxed warning: controlled studies reported shortened overall survival and/or increase risk of tumor progression in certain cancers and in most of these studied the patients that had a hemoglobin target of greater than or equal to 12 were at higher risk of adverse events although risk cannot be excluded for hemoglobin targets less than 12g/dL.
   ii) For new ESA orders the pharmacist will check to see if iron studies have been checked to rule out other causes of anemia. Many third party insurance including Medicare part D plans will not
reimburse for ESA if iron studies have not been performed or if iron saturation levels are low and the patient is not receiving iron repletion. The pharmacist should contact the prescriber if recent iron studies are unavailable or if iron saturation is less than 20% and the patient is not receiving iron supplementation.

3. The pharmacist will document lab evaluation and any interventions related to ESA in the electronic health record

4. The pharmacy will dispense a one week supply of ESA at a time and evaluate labs each time before dispensing as described above

5. Storage of ESA
   a) Vials should be stored in the refrigerator (2 to 8 degrees Celsius) and protected from light when not being used to prepare a dose. Do not freeze. Do not shake.

References

Amgen. Epogen- epoetin alfa solution prescribing information. Thousand Oaks, CA; Revised 7-2018

New: 10/18
Revised Hospital-wide Policies and Procedures
APPROVAL AND FORMAT OF HOSPITAL-WIDE AND DEPARTMENTAL POLICIES AND PROCEDURES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) establishes, issues, and maintains Laguna Honda Hospital-wide Policies and Procedures (LHHPP) Hospital-wide Policies and Procedures.

2. LHHPP shall be implemented only after approval of the Hospital Executive Committee (HEC) and the Joint Conference Committee (JCC); unless resident safety may be impacted and/or there is a DPH Health Director mandate.

3. Every Department Head is responsible for maintaining a current manual of their Departmental Policies and Procedures (DPP).

4. DPPs that impact disease/clinical care management require approval by the Nursing Executive Committee (NEC) and Medical Executive Committee (MEC) prior to implementation.

5. LHHPPs and DPPs shall be reviewed at least every year in accordance with Title 22 requirements.

6. A standardized formatting template shall be utilized for hospital-wide policies and procedures (refer to LHHPP 01-11).

7. The file numbers of deleted LHHPPs may be re-assigned to newly developed LHHPP the following year after the annual review of process for LHHPPs for the calendar year.

8. Hospital-LHH areas that have access to the San Francisco Health Network (SFHN) internet website are not required to maintain a hard copy of the LHHPP or Nursing DPP.

PURPOSE:

1. To provide unified and consistent statements for LHHPP and DPP of Hospital-wide and Departmental policies and procedures.

2. To describe procedures for developing and reviewing departmental policies and procedures at LHH.

CHARACTERISTIC:

1. A LHHPP describes activities or processes:
a. which must be executed by more than one department.

2. LHHPPs have broad application. They do not focus on the function and systems of individual departments and divisions. LHHPPs define administrative responsibility and staff performance relating to specified administrative and resident/patient care functions.

3. A DPP describes activities or processes:
   a. which occur within and need to be understood and executed only by the issuing department; or
   b. which may occur Hospital-wide but is executed only by a single department.

PROCEDURE:

1. Hospital-wide Policies and Procedures
   a. New LHHPP may be generated by:
      i. The chairperson of a medical staff committee,
      ii. The administrative liaison to a medical staff committee,
      iii. The chairperson of an administrative/clinical committee,
      iv. The chairperson of an ad hoc committee, or
      v. A member of the LHH executive staff.

   b. Revision of an existing policy and procedure may be initiated by the same person(s) identified above. The person initiating the revision shall request for the Word document of the LHHPP being revised from the Administrative designee. **Track changes shall be used, and use the track change document feature** to mark the proposed changes in the document.

   c. The draft of the new or substantially revised policy and procedure that impacts disease/clinical care management shall be submitted to the following individuals:
      i. Chair of Nursing Executive Committee (NEC)
      ii. Chair of Medical Executive Committee (MEC)
      iii. Chief Medical Officer (CMO)
iv. Administrative designee (as determined by the Director of Quality Management), for coordination purposes.

d. New or revised administrative policies and procedures that are not performed by Nursing or Medical staff do not require NEC or MEC approval.

e. The Administrative designee shall be responsible for issuing new LHHPP file numbers.

f. The person authoring a new LHHPP is expected to utilize the standardized formatting template shall be utilized for developing policies and procedures when creating the new LHHPP.

g. The Hospital Executive Committee (HEC) shall review and approves policies and procedures to ensure that the policies and procedures agree with the administrative philosophy and Department of Public Health guidelines.

h. MEC and NEC shall review and approve all LHHPP that impact disease/clinical care management to ensure that the procedures agree with sound medical, nursing or clinical practice.

i. Policy revisions and amendments that do not necessitate a substantial rewrite may be submitted to the HEC with corrections superimposed on a copy of the current policy.

j. All new and revised LHHPPs requiring approval by HEC, MEC and/or NEC shall be sent to the respective chairs of these committees.

k. The Administrative designee shall send the policy to appropriate individuals, committees, departments or services for review. This will help ensure that the policy agrees with current policies and practices, and does not duplicate other policies. The following factors shall be taken into consideration as appropriate in order to conduct a substantive review:

i. Relevance to other policies and procedures,

ii. Relevance to standards of care and standards of practice,

iii. Ethical and legal concerns,

iv. Current scientific knowledge, and

v. Findings from quality improvements/assurance activities

l. The policy approval process shall be sequenced in the following order: NEC, MEC,
m. When final policy approval is reached, the newly developed or revised LHHPP may be posted on the intranet.

n. The Administrative designee shall place the LHHPP on the calendar for an annual review by the HEC.

o. All existing LHHPP shall be submitted for an annual review to the Director of Health, CEO, CMO, Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager/Coordinator at the designated Annual Policy and Procedure Review meeting in August of each year.

p. Annual review and approval of existing LHHPP shall be scheduled for review and approval by the governing body as soon as practical.

q. The HEC in conjunction with Division Heads and Department Managers are responsible for disseminating information to LHH staff about new policies and revisions of existing policies and ensuring that LHHPPs are implemented at the departmental level.

r. Hospital Administration is responsible for keeping a hard copy of the manual and the Quality Management designee is responsible for updating the manual.

s. All LHHPPs are available on the LHH and SFHN Intranet. The LHHPP Website:

   i. The LHHPP is available on the LHH and SFHN website.

   ii. The webpage is maintained by the Administrative designee. The website is maintained by the LHH Information Systems (IS).

   iii. Staff are educated and trained on how to access the policy and procedures on the SFHN website.

   iv. The Administrative designee is responsible for archiving copies of the LHHPP on the designated shared network drive.

 t. Manuals: Four hard copies of the LHHPP Manual will be available in case the LHH and SFHN Intranet is disrupted. The manuals shall be placed in the Nursing Office, the HICS Command Center, the Administrative suite and in the Quality Management Office. Designated support staff shall be responsible for updating the policy and procedure manuals.

u. Communication: Hospital Executive and managerial staff are responsible for disseminating information related to policy direction and revisions to their respective departmental staff.
2. **Departmental Policies and Procedures (DPP)**

   a. DPP must be specific to the operation of each department and define the specific scope and activities of the Department in accordance with applicable state and federal regulations.

   b. Department Heads may propose to transform a DPP to a LHHPP when appropriate.

   c. Department Heads are responsible for:

      i. Obtaining the approval of the responsible Division Head;

      ii. Maintaining at least one copy in the Department Manager’s office.

      iii. Training employees to standards set forth in the manual.

      iv. All existing DPP shall be submitted for an annual review to the Director of Health, Administrator, CMO, Chief of Staff, Physician Advisor if applicable, Division Head, and Department Manager at the designated Annual Policy and Procedure Review meeting in August of each year.

   d. Each Department must have the following elements within their DPP, unless they are delineated by existing LHHPP:

      i. Department structure and organization;

      ii. Scope of service;

      iii. Applicable policies required for licensing standards and by State and Federal regulations;

      iv. Policies and procedures pertaining to administrative, resident/patient, and medical care activities unique to the Department;

      v. Protocols implementing or supplementing existing Laguna Honda personnel practices and

      vi. Education and training requirements.

   e. Department specific procedures may supplement existing LHHPP for the following areas:

      i. Infection control guidelines;

      ii. Departmental response to both internal and external disasters and emergencies (e.g., fires, mass casualty disasters, and power failures); and
iii. Performance improvement;

iv. Environment of care;

v. Contract requirements (i.e., managed care contracts); and/or

vi. Health and safety requirements.

f. Approval Process for DPP

i. The Department Manager/Director gives the initial approval for the policy.

ii. When the implementation of a DPP involves other Departments, the Department Managers of these Departments review, comment, and approve the development or revision of the Policy or Procedure.

iii. When DPPs impact disease/clinical care management, the appropriate health professional and administration shall be consulted, and the new or revised DPP shall be implemented after review and approval by NEC and MEC.

iv. DPPs shall be reviewed by the hospital governing body for approval as soon as practical, and approval by the hospital's governing body as soon as practical.

g. Implementation of DPP

i. The Department Managers are responsible for implementing DPP and for ensuring that the current DPP are readily accessible to all staff.

h. The Department Manager shall be responsible for retention of the Policy and Procedures Archives.

i. The Department Manager of each unit is delegated the responsibility for retaining original versions of all DPP for seven (7) years from date of origin, revision or deletion.

3. List of Minor Revisions Not Subject to JCC Approval

a. Refinements to formatting and layout;

b. Correction of typographical errors;

c. Correction of grammar and punctuation;

d. Changes to procedure titles;
e. Renumbering of policies and procedures;

f. Informational updates to appendices (e.g. names of personnel, contact numbers, name of vendor(s), etc.)

ATTACHMENT:
None.

REFERENCE:
LHHPP 01-10 Departmental Responsibility and Accountability
LHHPP 01-11 Standard Formatting Template for Policies and Procedures

Revised: 08/07/22, 10/08/24, 10/12/03, 13/05/28, 13/09/24, 15/07/14, 16/01/12, 16/09/13, 19/03/12 (Year/month/day)
Original adoption: 92/05/20
ADMINISTRATOR ON DUTY

POLICY:

During business hours, the Laguna Honda Hospital and Rehabilitation Center (LHH) Executive Administrator or Chief Executive Officer (CEO) or designee is the highest ranking administrator for the hospital and campus. The Executive Administrator CEO or designee is available to respond to emergency situations during business hours (M-F 8 am to 5 pm, except holidays and weekends). During non-business hours (M-F 5pm-8am, weekends and holidays 24/7), the Laguna Honda Administrator on Duty (AOD) is the highest ranking administrative authority for the hospital. The AOD on schedule is available to respond to emergency situations during non-business hours.

PURPOSE:

To provide clear lines of administrative communication and oversight during non-business hours.

PROCEDURE:

1. The Executive Administrator CEO is responsible for identifying members of the Executive staff who are designated as AOD and listed on the AOD rotation.

2. The AOD schedule shall be posted on the DPH/LHH Intranet for easy access.

3. The AOD shall act on behalf of the Executive Administrator CEO to address immediate problems and/or incidents that occur during non-business hours. S/he is responsible for application of administrative actions guided by Laguna Honda policy and practice.

4. The AOD is on call during non-business hours (M-F 5pm-8am, weekends and holidays 24/7).

5. AOD responsibilities:
   a. Notifies the administration office, nursing office and telephone switchboard operator of any temporary changes in telephone numbers.
   b. Responds within 30 minutes when notified by Operations Nurse Manager/Supervisor or Nursing Office Staff.
   c. Responds onsite, if requested by the Operations Nurse Manager/Supervisor and shall assume administrative responsibility for emergency situations.
   d. Notifies the Executive Administrator CEO of emergency situations during AOD.
d. e. Work Collaborates with the Operations Nurse Manager/Supervisor, Nursing Office Staff, Executive Colleagues and/or Department Heads to address areas of concern(s).

e. f. If the AOD does not respond within 30 minutes from receiving a call, the Operations Nurse Manager shall first call the most appropriate Executive Staff member for the issue needing to be addressed. If the appropriate Executive Staff member is not available, the Operations Nurse Manager/Nursing Office Staff shall then call the next AOD scheduled on the list.

f. g. Informs DPH Central Office/Director’s Office when HICS is activated.

5. 6. If the AOD has a scheduling conflict, the scheduled AOD may shall contact another AOD on the rotational cycle for coverage. The AOD who has the scheduling conflict is responsible for notifying the Executive Administrator CEO’s office to make the scheduling changes.

6. 7. Administration Services is responsible for:

a. Maintaining the AOD schedule and posting the schedule on the intranet.

b. Notifying the AOD two weeks before the assigned schedule, which begins at 58:00 pa.m. Thursday afternoon morning.

c. Maintaining the list of Executive Staff who are on the AOD rotational cycle and their current contact information.

d. Making changes of contact information and scheduling, and notifying the Nursing Office and the operator in writing 24 hours prior to the effective date of the change when notified by the AOD of the changes.

7. 8. When the following events occur, the AOD will be contacted by the Operations Nurse Manager and the AOD will then inform necessary Executive staff, including the LHH Executive Administrator CEO and the Health Director:

a. Adverse events, (i.e. suicide, assault or abduction, major accident or injury, unexpected or unusual death)

b. epidemic/communicable disease

c. serious security breach

d. significant security issue(s)

e. significant utility malfunction
f. significant communication issues (e.g. downtime)

g. fire, earthquake or other major disaster

h. hazardous material spill

i. media event

j. regulatory visit outside regular business hours

k. other concerns or issues as needed

8.9. If HICS is activated, the AOD/designee shall notify the DPH Central Office/Director's Office at (415) 554-2526 during business hours and via appropriate and available means (e.g. cellular phone) during non-business hours.

9.10. The Executive Staff are responsible for:

a. Serving as consultative resources to the AOD when necessary; and

b. Contacting Administration Services staff if there are changes to their contact information.

ATTACHMENT:
None.

REFERENCE:
AOD Schedule
LHHPP 60-01 Quality Assurance and Performance Improvement Program
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-04 Unusual Occurrences
LHHPP 60-08 Risk Management Program
LHHPP 60-12 Review of Sentinel and Significant Events (applicable to Acute Care Units only)

Revised: 92/05/20, 00/07/13, 07/08/13, 07/12/04, 09/10/27, 11/05/13, 13/01/29, 15/11/09, 18/11/13, 19/03/12 (Year/Month/Day)
Original adoption: 88/01/22
ADMISSION TO LAGUNA HONDA ACUTE AND SNF SERVICES AND
RELOCATION BETWEEN LAGUNA HONDA SNF UNITS

POLICY:

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

1. LHH shall accept and care for those San Francisco residents:
   a. Who meet skilled nursing facility (SNF), SNF rehabilitation, acute medical or acute rehabilitation (inpatient rehabilitation facility (IRF) care criteria;
   b. For whom it can provide safe and adequate care; and/or
   c. Who are at least 16 years of age.

2. Applicants for admission to LHH shall be screened prior to any admission.

3. LHH shall assess the physical, mental, social and emotional needs of new and current residents to determine whether each resident’s care environment is best able to meet these needs.

4. LHH shall accept pre-scheduled admissions of new and returning patients Monday through Friday.

5. LHH shall accept residents to the first available SNF bed appropriate to meet their clinical care needs when they have lost their bed hold.

6. New and returning patients from Zuckerberg San Francisco General Hospital (ZSFG) may also be admitted on Sundays if pre-arranged on Friday. Returning patients from UCSF may also be readmitted on Sundays if pre-arranged on Friday.

7. LHH shall centrally coordinate resident relocations to:
   a. Optimize utilization of resources;
   b. Optimize bed availability for new admissions; and
   c. Minimize the potential for adverse impact on the resident.

8. LHH shall notify residents and their surrogate decision-makers of plans for relocation within the facility.
9. In case of emergency and/or medical surge conditions:
   
   a. Physician may temporarily admit a patient to an in-patient acute care or skilled nursing facility bed.
   
   b. The patient's stay shall be documented according to established procedures (i.e.: Inpatient, Acute, SNF and/or Outpatient Clinic/Rehab).

PURPOSE:

1. To assure that all San Francisco residents in need of skilled nursing, acute or rehabilitation services who are admitted to LHH receive care in the most appropriate service setting.

2. To allocate services in coordination with available hospital resources.

3. To provide a standard procedure for relocation of residents within the facility.

ABBREVIATION: Definitions

1. A&E: means Admissions and Eligibility Department

2. Bed hold means a bed shall be held for a specific resident discharged to an acute unit or facility. A bed can be held up to seven (7) days, with the date of discharge being day 1. A bed hold may not be placed on a bed on LHH acute unit beds.

3. PFC: means Patient Flow Coordinator

4. RCT: means Resident Care Team

PROCEDURE:

1. Admissibility and Screening Procedures

   a. In accordance with Section 115.1 of the San Francisco Health Code, admission priority to LHH shall be given to residents of San Francisco. Exceptions may be made by the LHH Chief Executive Officer (CEO) or designee/Desigee based on special clinical or humanitarian circumstances. Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin.

   b. The LHH Chief Medical Officer (CMO) or designee shall be responsible for screening patients for admission to LHH to ensure that the facility admits only those patients for whom it can provide adequate care. The LHH CMO is the ultimate authority over admissions. The following sequential priority will be followed unless the LHH CMO or designee in his/her professional judgment, based on risk
assessment and the totality of circumstances consistent with the patient’s best interest determines otherwise.

c. People are accepted to LHH with the following priority guidelines:
   i. 1st Priority:
      Persons not in a medical facility, as well as persons who are wards of the Public Guardian or clients of Adult Protective Services, who cannot receive adequate care in the present circumstances.

   ii. 2nd Priority:
      Patients at ZSFG ready for discharge to SNF level of care.

   iii. 3rd Priority:
      Persons not in a medical facility who are receiving adequate care in their present circumstances.

   iv. 4th Priority:
      Patients at other San Francisco medical facilities.

   v. 5th Priority:
      Patients who are San Francisco residents presently in a medical facility or private circumstance outside of San Francisco.

d. LHH cannot adequately care for prospective residents with the following:
   i. Communicable diseases for which isolation rooms are unavailable

   ii. In police custody unless approved by CMO, CEO, Chief Nursing Officer (CNO) or designees.

   iii. Ventilator

   iv. Medical problem requiring Intensive Care Unit care

   v. Primary psychiatric diagnosis without coexisting dementia or other medical diagnosis requiring SNF or acute care

   vi. Highly restrictive restraints

   vii. Significant likelihood of unmanageable behavior endangering the safety or health of another resident, such as:

      • Actively suicidal

      • Violent or assaultive behavior
• Criminal behavior including but not limited to possession of weapons, drug trafficking, possession or use of illegal drugs or drug paraphernalia

• Sexual predation

• Elopement or wandering not confinable with available elopement protections

• Applicants who will not sign the Laguna Honda House Rules and Responsibilities

e. Screening of applicants:

i. The Screening Committee which includes the following: CMO or designee, CNO or designee, Admissions Coordinator, Patient Flow Coordinator and other members as designated by the Administrator CEO, is responsible for screening referrals to LHH and accepting residents for admission.

ii. Patient/Resident referrals to the specialty units (Rehabilitation, Positive Care, and Palliative Care) will be screened and accepted by the unit screening physician or screener.

iii. When an immediate decision is needed outside the regularly scheduled meeting times of the Screening Committee, the CMO or designee, and the CNO or designee will screen and approve resident referrals.

iv. The Screening Committee and/or the LHH Specialty Unit will request behavioral screening of potential admissions that have behavioral or psychiatric problems.

f. Admission of applicants:

i. LHH shall admit a patient only on a LHH Admitting Physician’s order.

ii. With the exception of admission to acute care units (Acute Rehab and Acute Medical), all admissions must meet SNF-level criteria as defined by Title 22.

iii. Decisions about admitting a resident in a setting that restricts his/her movements at LHH must be made in accordance with each resident’s individual needs and preferences and with the participation of the resident or surrogate in the placement decision and continuing care planning. ¹Resident lacking

¹ If stated purpose of a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident’s individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative (if any) participates in the placement decision, and is involved in continuing
capacity for placement decisions may not have their movements restricted on a secure unit without the participation of a surrogate or conservator.

iv. In all cases of admission from another facility, a physician to physician clinical hand off and a dictated discharge summary is required.

g. Resolution of problem screening and admissions:

i. Problems shall be brought to the LHH CMO and LHH CEO for resolution.

ii. The LHH CEO shall have the final authority over admissions to LHH.

h. The LHH CEO shall serve as the LHH Hospital’s review board in regard to any perceived discriminatory admission practices. Allegations from staff, patients, families, or others of perceived discriminatory admission practices shall be forwarded to this Committee for investigation and review.

2. Specific Admission Procedures

a. Pre-Admission Procedures

i. The Conditions of Admission agreement shall state that all residents are assessed upon admission for appropriate placement and/or relocation within the facility.

ii. Residents (or their representatives) shall receive a copy of the Conditions of Admission agreement upon admission to the LHH. The Conditions of Admission agreement shall be reviewed and signed by the resident or the resident’s surrogate decision-maker.

iii. Residents (or their representatives) shall receive a copy of the Laguna Honda House Rules and Responsibilities and Smoke-Free Campus Pre-Admission Agreement. As a condition of admission, the resident or resident’s surrogate decision-maker must agree to these conditions by signing these agreements before or upon prior to admission.

iv. The Screening Committee shall make placement decisions based on the identified physical, mental, social and emotional needs of the resident, family connection with staff, if any; and bed availability. The Screening Committee shall and communicate with the nursing unit and the Resident Care Team (RCT), including the primary physician and nurse manager admitting the new resident.

care planning to assure placement continues to meet resident’s needs and preferences.” CMS Guidance To Surveyors, LTC Facilities/State Operating Manual F223(b).
v. Referral sources may discuss the appropriateness of referrals with staff of admitting units, but no final admission decision can be made until the Admissions Coordinator has evaluated the referral packet.

vi. The specialty unit RCTs may place and take care of residents on other units, e.g., in isolation rooms or in other satellite beds.

b. Acute Medical Unit

Policies Specific to Acute Medical Unit Neighborhood

i. Only acutely ill LHH residents for whom appropriate medical care is available are admitted. Residents requiring surgical procedures, critical care, telemetry or hemodynamic monitoring cannot be accommodated on the Acute Medical Unit.

ii. All admissions to the Acute Medical Unit are subject to ongoing utilization review as outlined in the Utilization Management Plan.

iii. SNF residents who require blood transfusions, but who are not acutely ill, shall be provided care on the Acute Medical Unit as “come and go” cases.

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

Procedures Specific to the Acute Medical Unit

i. All residents admitted to the Acute Medical Unit, except those residents admitted on a “come and go” basis, shall have a separate complete medical record covering the period of their acute hospitalization.

ii. Whenever a resident is admitted to the Acute Medical Unit from either a LHH SNF care unit or from the Rehabilitation Department, she/he is discharged from the previous care unit and resident’s medical record is closed, except in those cases where residents “come and go” for transfusion.

iii. A new SNF resident record shall be started upon the resident’s re-admission to a SNF care unit.

c. Acute and SNF Rehabilitation Care Units

Admission Criteria Specific to Acute and SNF Rehabilitation Care Units
i. Presence of one or more major physical impairments which significantly interfere with the ability to function, and which require an intensive interdisciplinary approach to effectively improve functional status.

ii. Patient must be medically stable.

iii. Patient requires rehabilitation physician management.

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

Admission Criteria Specific to Acute Rehabilitation Unit

i. The LHH Pavilion Mezzanine Acute Rehabilitation Unit is designated as an Inpatient Rehabilitation Facility (IRF).

ii. Patients must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:
   - Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation.
   - 24 hour availability of nurses skilled in rehabilitation.
   - Active and ongoing intensive rehabilitation therapy program by multiple other licensed rehabilitation professionals (e.g., physical therapists, occupational therapists, speech language pathologists, and prosthetists and orthotists) in a time-intensive and medically-coordinated program. One of the therapy disciplines shall be physical or occupational therapy.

iii. The medical and/or surgical stability and comorbidities of patients admitted to the unit must be:
   - Manageable in the rehabilitation program
• Permit participation in the rehabilitation program

iv. Patients must be capable of fully participating in the patient rehabilitation program as evidenced by:

• Ability to respond to verbal, visual and/or tactile stimuli and to follow commands.

• Ability to participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day, 5 days per week).

v. Patients must demonstrate the ability to progress towards objective and measurable functional goals that:

• Will offer practical and beneficial improvements.

• Are expected to be achieved within a reasonable period of time.

vi. Patients must require and intensive and coordinated interdisciplinary team approach to care.

vii. Patients in most circumstances, has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

Admission Criteria Specific to SNF Rehabilitation Unit

i. Rehabilitation needs shall include at least one of the following: impairment in activities of daily living, impairments in mobility, bowel/bladder dysfunction, cognitive dysfunction, communication dysfunction, complicated prosthetic management, or other medical problems best addressed on the SNF-level Rehabilitation Unit.

ii. Patient requires and has the ability to engage in at least one of the following therapies: physical therapy, occupational therapy, and/or speech therapy.

iii. Patients must have a reasonable plan for functional improvement to achieve discharge into the community or relocation to a long term care unit.

Admission Procedures Specific to Acute Rehabilitation Unit

i. A physiatrist or designee shall perform pre-admission screening (PAS) to assess the patient’s ability to achieve significant improvement in a reasonable period of time with acute rehabilitation services. Pre-screening performed by a
non-physiatrist must have a physiatrist co-sign that the patient meets the requirements for acute rehab (IRF) admission.

ii. A new SNF record shall be started if the patient is discharged to a LHH SNF Care Unit.

iii. Refer to Guidelines for Inpatient Rehabilitation Facility Documentation LHHPP 27-06.

**Admission Procedures specific to SNF Rehabilitation Unit**

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

d. Positive Care Unit

**Admission Criteria Specific to the Positive Care Unit**

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

e. Palliative Care Unit

**Admission Criteria Specific to Palliative Care Unit**

i. Patients who have a terminal disease or would benefit from a palliative approach.

f. Secure Memory Care Unit

**Policies Specific to Secure Memory Care Unit**

i. The goals of the Secure Memory Care Unit are:

- To promote the well-being and protect the health and safety of cognitively-impaired residents who might harm themselves by wandering or elopement; and

- To meet the needs of cognitively-impaired residents with a stable and structured environment and specialized dementia programming while minimizing the use of individual restraints.

**Admission Criteria Specific to Secure Memory Care Unit**

i. Residents who are mobile;
ii. Residents assessed by a physician as having serious cognitive impairment which prevents the resident from making medical decisions for him/herself;

iii. Residents assessed by clinical staff as being at risk for unsafe wandering or elopement; and

iv. Resident who has a conservator or surrogate decision maker that agrees to placement of the resident in a secured setting, or who is a ZSFG patient or LHH resident with a conservatorship proceeding pending and the intended conservator does not disagree with placement of the resident in a secured setting.

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

Exclusion Criteria Specific to Secure Memory Care Unit

i. Residents whose aggressive behavior cannot be safely managed in this setting.

ii. Residents without surrogate or conservator.

Procedures Specific to Secure Memory Care Unit

i. The Admissions Coordinator and Screening Committee personnel will coordinate admission in collaboration with the Secure Memory Care Neighborhood RCT.

ii. On admission the attending physician will coordinate an interdisciplinary assessment including cognitive and/or behavioral consultation.

iii. The RCT shall reevaluate residents for unit appropriateness one month after admission, then quarterly. The RCT shall explore interventions that may reduce the wandering/elopement risk and permit relocation to another unit. For cognitively incapacitated residents whose movements throughout the facility are restricted, the RCT shall document participation of the conservator or surrogate decision-maker in placement decision-making and care planning.

iv. A resident of the LHH Secure Memory Care Unit shall be relocated as soon as practically feasible to other LHH units or transferred to another facility or the community if the resident’s status changes such that the resident is no longer mobile, the resident’s cognitive status improves such that secured placement no longer is needed; or the resident’s cognitive impairment is discovered to be caused primarily by a psychiatric rather than organic brain disorder.
v. Permissible Exception: If a resident ceases wandering but demonstrates or expresses preferential adaptation to the unit and benefits from the specialized programming, continued residence in the unit may be allowed at the discretion of the physician and RCT. To ensure availability of Secure Memory Care Unit beds when needed, attempts shall be made to adapt such a resident to another unit.

3. Sunday Admissions

a. From ZSFG

i. LHH primary physician shall refer the ZSFG team to LHH Admissions and Eligibility (A&E) once the patient is accepted.

ii. Pre-scheduled admissions shall be accepted for Palliative Care, Positive Care, General SNF, SNF and Acute Rehab (IRF) patients on Sundays.

iii. Sunday admissions from ZSFG must be approved by the LHH admissions screening committee, and accepted by the primary LHH team (including primary physician) by the Friday afternoon preceding admission.

iv. LHH A&E shall inform ZSFG (UM and MSW) via LHH tracking and text page by 3pm on Friday of admissions scheduled for Sunday. LHH A&E shall inform ZSFG MSW of LHH primary physician's pager number.

v. Approval by LHH weekend admitting physician is not required for admission.

vi. LHH A&E shall complete the admission referral sheet and deliver this along with the referral packet to the unit scheduled to receive the weekend admission by Friday afternoon.

vii. LHH primary physician shall receive clinical hand off from ZSFG physician by the Friday preceding the weekend admission, and a dictated discharge summary must be available at the time of admission.

viii. LHH nursing shall receive report from ZSFG nursing on the day of transfer.

ix. LHH A&E shall remind ZSFG MSW to arrange ambulance transport to leave ZSFG no later than 11 am.

x. Admissions are scheduled to arrive to LHH early in the day and no later than 12 noon.
b. From UCSF

i. Only prearranged–pre-scheduled readmissions are accepted, as under the conditions and processes stated above in section 3.a.ii. XXXX.

4. Procedures Related to Coming and Going from the Hospital

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

i. Before return of a LHH resident who has been referred to another facility for come-and-go surgery or other invasive medical care, the physician responsible for the resident at the other facility must provide a summary of information on the procedure that includes:

- Procedures done
- Complications, if any, both intra- and postoperative
- New orders recommended for the first 24 hours at LHH
- Recommendations for special studies and follow-up care

ii. A checklist reminding the responsible physician of the need for this information shall be sent with the resident from LHH to the other facility. The physician responsible for the resident at that facility may complete either the checklist or another form from their facility that provides the same information.

iii. If a resident is returned from another facility after come-and-go surgery or other medically invasive procedure without recommendations for follow-up care, the Laguna Hospital attending physician shall contact the physician responsible for the resident at the other facility and shall document the information in the medical record. If the regular unit attending physician is not present when the resident returns, the charge nurse will contact the on-call physician to carry out this policy.

b. Bed holds. Bed hold definition: A bed hold is a bed held for a specific resident discharged to an acute unit or facility. A bed can be held up to seven (7) days, with the date of discharge being day 1. A bed hold cannot be placed on a bed on LHH acute units.

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

a. Relocation Guidelines

i. Nurse Manager will explain process. Upon admission to a resident care unit, the nurse manager shall be responsible for explaining to the resident or
surrogate decision maker (SDM) the process by which the RCT assesses the resident for the purpose of appropriate placement.

ii. **Decision criteria.** Criteria for determining the appropriate unit shall be based on an assessment of the resident’s needs and knowledge of services available, including knowledge of available shift staffing and skills within the respective care units. Decisions regarding resident relocation between units shall be made by the PFC in collaboration with the CMO or designee and CNO or designee and the respective referring and receiving resident care teams of the neighborhoods.

iii. **Relocation requests.** Requests for relocation to another unit by the resident, surrogate, or RCT shall be evaluated by the PFC who facilitates the decision-making process.

iv. **Relocation.** In the event that a resident is to be relocated involuntarily in order to better match the resident’s needs with unit focus and resources, the nurse manager shall give the resident or representative notice in advance of relocation. This shall be documented by completing the Transfer of Room Notification form, which includes:

- Reasons for the relocation;
- Date the relocation will occur;
- The care unit to which the resident will be relocated; and

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

v. **Problem resolution.** Prior to making a relocation referral to the PFC for a reason other than a change in level of care, the RCT shall utilize resources at its disposal to resolve the problem, address the concern, or meet the need behind the referral.

vi. **Re-evaluation of problematic relocations.** RCTs shall re-evaluate complex or problematic relocations and roommate assignments at least one month after the relocation.

vii. **Appeal route for conflict intervention.** Conflicts about relocation process shall be referred to the CNO and CMO for joint resolution.

viii. **Neighborhood moves.** When large scale, permanent or temporary care unit moves are anticipated, the details of the move, such as how and when
residents and families shall be informed, must be worked out in advance by the RCT.

b. Relocation Procedures

i. All relocation requests, including plans for relocation to and from specialty units which accept direct admission from the community, shall be routed through the designated PFC. For relocations to specialty units, the PFC shall communicate with the unit RCT and A&E.

ii. The resident and appropriate family/surrogate decision maker(s) shall be notified when the relocation is being planned and be informed of the reason and the estimated waiting period, if known. They shall be offered an opportunity to visit the new location, if possible.

iii. The sending unit nurse manager shall communicate with the receiving unit nurse manager prior to relocation and the sending physician shall communicate with the receiving unit physician, if possible, at least one day in advance of the relocation.

iv. Once an appropriate bed becomes available, the PFC shall confirm relocation plans and confirm that the sending and receiving care units are notified.

v. A physician’s order is required for the relocation.

vi. To promote continuity in care, the sending physician shall document in the medical record, a relocation note.

vii. The receiving RCT shall review the existing treatment plans initiated by the previous team, and review the plan and all changes with the resident.

viii. Each discipline shall take appropriate measures to assure continuity of care.

ix. Ancillary Service departments, who receive the Daily Census report, shall make this information available to clinical staff on a daily basis so that caregivers can track resident transfers and readmissions.

ATTACHMENT:
Appendix A: Relocation Checklist for Individual Resident
Appendix B: Behavioral Screening
Appendix C: LHH Palliative Care Program

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

Revised: 00/07/13, 04/02/06, 04/12/16, 09/08/24, 10/11/09, 11/01/25, 11/09/27, 12/01/31, 12/07/31, 13/11/21, 14/07/29, 14/11/25, 16/09/13, 17/11/14, 18/01/09, 18/11/13, 19/03/12 (Year/Month/Day)
Original adoption: This is a consolidation of 12 previous policies
Appendix A

RELOCATION CHECKLIST FOR INDIVIDUAL RESIDENT

FROM CARE UNIT: _______________________
TO CARE UNIT: _______________________

DATE: __________________

ADDRESSOGRAPH: _________________________________________

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

CHECKED BY:
Appendix B

BEHAVIORAL SCREENING

1. Overview

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

2. Responsibility of the Screener

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

3. Areas of Review

- Review the screening packet for background history plus contact information of most knowledgeable care-providers and surrogate decision-makers. Phone calls to these individuals may be helpful.
- Review LCR and any current paper chart noting especially diagnoses, medications, conservatorship status (and any Affidavit A’s and Affidavit B’s), prior APS contact, recent progress notes, use of PRN medications, daily nursing flow sheet.
• Especially note records of current and prior history of aggression, self-harm, emotional lability, active psychotic symptoms, personality disorder, elopement risk, drug and alcohol use, history of criminality, fire-setting, predatory behaviors (sexual, aggressive, fiscal or other abuse), treatment non-compliance, and any other behavioral issues.

• Review prior and current behavioral management plans/techniques and their efficacy.

• When indicated, review current legal status, including whether the patient has any pending charges. The screener will check all behavioral referrals on the California Megan’s Law website (http://www.meganslaw.ca.gov/) and the national database (http://nsopw.gov) to verify whether the patient is a registered sex offender (RSO). If the patient is a RSO, obtain from the referring agency the registration documentation and history information regarding the sexual offense status.

• Obtain copy of psychotropic medication consent when available if the patient is on psychotropic medications.

4. Screening Schedule and Communication

• Behavioral screening requests are sent to the Chief of Psychiatry/designee by a member of the Admission Committee verbally or in writing.

• The referral information packets are usually available from A&E a few days prior to screening.

• The behavioral screener shall screen within one work day in general, or as soon as possible, but no later than within three work days unless otherwise arranged.

• The Screening Report shall be documented as an Initial Risk Assessment in the designated Electronic Health Record (EHR) for LHH Psychiatry.

• The screener will forward a copy of the Screening Report to members of the LHH Admissions Screening Committee, as well as the admitting RCT if applicable.

• The behavioral screener may be available to answer questions from the admitting RCT about screening information on the resident. Such information is for screening purposes only and does not substitute the RCT members’ own clinical assessments.

• Consents and agreements obtained by the screener will be forwarded to the Admissions Screening Committee.

5. High Behavioral Risk Admissions

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

Prior to Admission

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

Day of admission

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

After Admission

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

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

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

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, LHH continually facilitates timely and safe resident discharges to the appropriate level of care.

POLICY:

1. LHH strives to assist every client/resident (hereafter “resident”) to achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the Resident eCare tTeam (RCT) shall continue to support maximal social integration.

2. The facility LHH provides inter-disciplinary discharge planning services that meet the resident’s health and safety needs with appropriate and available resources in the community, taking into account the resident’s preferences.

3. Residents who no longer meet skilled nursing facility (SNF) level of care and/or whose SNF needs can be met a lower level of care shall be prepared for discharge into the community with supportive services.

4. Intensive discharge planning support and skills training shall be provided to the resident to assist him or her to transition from an institutional setting to community living.

5. The Resident Care Team (RCT) shall recognize that residents with decision-making capacity and/or their surrogate decision-maker (SDM), have the right to decline recommended discharge options aimed at achieving their optimal health outcome, and that they have the right to appeal their discharge plan.

6. Residents with decision making capacity who repeatedly decline discharge options, or refuse to participate in discharge planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, safe and orderly post-discharge plan of care has been formulated by the RCT.

PURPOSE:

To implement a safe and orderly discharge process for residents who desire discharge to the community, no longer need SNF services, and/or are able to be cared for at a lower level of care.
DEFINITION:

“Facility-initiated transfer or discharge”: A transfer or discharge which the resident objects to, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.

“Resident-initiated transfer or discharge”: Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

“Transfer and Discharge”: Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

ADLs and IADLs: Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the mnemonics DEATH and SHAFT:

<table>
<thead>
<tr>
<th>ADLs</th>
<th>IADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>Shopping</td>
</tr>
<tr>
<td>Eating</td>
<td>Housework</td>
</tr>
<tr>
<td>Ambulating</td>
<td>Accounting/finances</td>
</tr>
<tr>
<td>Toileting</td>
<td>Food preparation</td>
</tr>
<tr>
<td>Hygiene</td>
<td>Transportation</td>
</tr>
</tbody>
</table>

Assessment domains: Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work. Safety issues often arise in many of these domains.
Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).

PROCESS DEFINITION AND GUIDELINE:

1. Discharge assessment process considers:
   a. The resident’s characteristics, needs, and resources (including informal and formal supports) in functional, medical, and psychosocial domains (see definitions appendix).
   
   b. The resident’s values and preferences.
      i. These values and preferences remain central to the assessment process even when they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.
      
      ii. The resident’s self-assessment of needs and priorities may legitimately differ from that of the RCT.¹

2. Discharge planning:
   a. Begins during the resident’s admission assessment.

¹ Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single ‘appropriate’ setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers.” (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p. 291).
b. Is an ongoing process that adapts to changes in the resident's needs, resources, and preferences.

i. A resident may need to progress through several stages of increasing independence prior to discharge.

ii. Certain residents may be expected to leave LHH and return, perhaps repeatedly.

iii. The experience of residents who have been at a lower level of care for one or more limited periods can lead to valuable refinements of the discharge plan.

c. Requires negotiation of the goals of care, the interventions needed to overcome barriers to discharge, and the overall discharge plan.

i. Informed choice is a fundamental principle of service delivery.

ii. Independence and autonomy are often in conflict with safety, protection, and beneficence. The resident (or SDM), caregivers and RCT members may have different risk tolerances and may differ in how to weigh independence versus safety.

iii. Residents, SDMs, caregivers, and RCT members may enlist the Ethics Committee, Clinical Leadership Committee, ombudsman program, and/or administrative leadership for help in resolving conflicts.

3. Utilization issues:

a. Resident independence and resource stewardship are LHH values that inform discharge planning.

i. Residents shall be discharged to the lowest possible levels of care, consistent with the notions of least restrictive setting and most integrated setting. This includes residents who meet SNF Medicare and or Medi-Cal criteria but whose care needs can be safely provided in the community, as well as residents whose medical conditions have improved and no longer require daily SNF level of care.

ii. If there are barriers to discharge, the resident and RCT shall set reasonable care plan goals to maintain living skills, self-care readiness, and a sense of hope for future possibilities.

4. Conservatorship and decisional capacity:
a. Some conserved residents retain the legal right to make decisions regarding discharge, whereas others do not.

b. Unless otherwise specified in a written advance health care directive or absent legal adjudication, the primary physician bears responsibility for determining if a resident has lacks or has recovered capacity to make health care decisions, including informed choices about interventions and discharge planning.

   i. A resident may have only partial or varying capacity to make informed decisions.

   ii. Capacity determination for residents with mild-moderate impairments is a clinical art about which good clinicians may responsibly disagree.

   iii. The conservatorship process may be helpful in resolving disputes and protecting residents.

c. A resident with capacity retains the right to make decisions that RCT members consider unwise.

   i. RCT members shall educate the resident (or conservator or other SDM), about the risks associated with their decision(s) and document their concerns, but a resident with capacity has the final say in defining his/her well-being and self-interest.

d. For a resident who is conserved or lacking capacity, the RCT shall nevertheless elicit, document, and consider the resident's current and/or past values and preferences relevant to discharge.

e. A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.

5. Collaboration:

   a. LHH is committed to developing collaborative relationships with other organizations in order to meet the residents’ needs.

   b. The RCT members should be familiar with community-based services appropriate to their disciplines.

   c. The RCT members shall seek positive collaborations with members of the resident’s informal and formal support systems, encouraging face-to-face meetings prior to and after discharge.
PROCEDURE:

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner; or when the resident's condition improves and s/he no longer require SNF services. The RCT assessment and discharge planning process is collaborative and includes the resident, their designated family member(s), or SDM.

2. The resident and/or their SDM shall be educated on admission by designated members of the RCT that when their health condition sufficiently improves, or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be finalized to transition the resident back to the community.

3. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Director of Social Services Director or designee, the Utilization Management Nurse Manager or designee, the Chief Medical Officer Medical Director or designee, and Chief Nursing Officer or designee, shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.

4. RCT Roles and Responsibilities
   The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate.

   a. RCT Responsibilities

      The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, or speech therapist with others as needed:

      i. Perform the discharge assessment process as described and negotiate the discharge plan.

      ii. Review the discharge plan at least quarterly and document progress toward measurable discharge-related goals.

      iii. Encourage the resident to sustain healthy relationships and interests in the community.

---

2 The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.
iv. Strive to find effective graduated strategies for residents who lack motivation for discharge, who are chronically non-adherent with the care plan, who are unable to formulate an informed preference regarding discharge, or who have ill-informed fears about discharge.

v. Identify education needs for discharge, provide or arrange for education to resident and caregivers, and document the education provided.

vi. Identify need for evaluation of resident's baseline function in regards to ADLs, IADL, or mobility that require rehabilitative services to assess readiness for discharge.

vii. Document the resident's (and/or surrogate's) understanding of the discharge plan.

viii. Complete the appropriate sections of the Post-Discharge Plan of Care form.

b. Physician

i. Addresses the resident’s preliminary rehabilitation and discharge potential in the admission History & Physical.

ii. Communicates with the resident (or surrogate), caregivers, and with RCT members regarding the resident’s conditions and expected course so that the goals of care can be adjusted as needed.

iii. Documents rehabilitation and discharge potential in quarterly reassessments and as needed.

iv. Attempts to simplify the resident’s medication regimen, preferably months or weeks prior to discharge.

v. Ensures that appropriate post-discharge medical follow-up is arranged.

vi. Writes discharge order.

c. Social Worker/-/Targeted Case Manager (TCM)

i. Coordinates the discharge assessment process and plan.

ii. Contacts the resident’s caregivers and community-based support services to inform them of the admission, to invite them to care conferences, and to seek their collaboration.

iii. Attempts to secure the resident’s housing if discharge is possible.
iv. Identifies Medicaid waivers available to the resident and encourages and facilitates the application process.

v. Completes the discharge assessment instrument (MR 711), describing the resident’s needs, supports, barriers to discharge, and team recommendations. (LHH social worker only).

vi. Enters into the LHH discharge database any resident who expresses desire for discharge, has a supportive person interested in discharge, or is expected to improve and transition to a lower level of care.

vii. Updates the discharge assessment as needed due to pertinent changes or upon readmission to LHH.

viii. If discharge is not currently a viable option and is not included in the formal care plan, documents the reason(s).

ix. Identifies differences of opinion among RCT members in regard to the resident’s discharge and encourages open discussions based upon professional assessments.

x. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

xi. Makes referrals for community placement (housing and other services) consistent with the discharge assessment and plan.

xii. Makes additional referrals as needed prior to discharge.

xiii. Discusses the discharge plan with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

xiv. Prepares and provides the resident with a preliminary copy of the Post-Discharge Plan of Care when the resident is issued a Notice of Proposed Transfer/Discharge.

xv. Reviews, updates the plan as necessary and provides the resident with a revised copy of the Post-Discharge Plan of Care form (MR 705) just prior to the resident’s discharge from the facility.

xvx.-xvi. Documents discharge planning efforts and resident preparation and orientation to the discharge plan to ensure a safe and orderly discharge from the facility.

d. Nurse
i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.

ii. Provides resident and family education to support self-care and independence, based on the care plan/plan of care. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.

iii. Arranges for discharge supplies as needed.

iv. Arranges pre-discharge pharmacy consultation for medication education.

v. Coordinates completion of the Post-Discharge Plan of Care (MR 705) form, including resident or surrogate signature, and provides a copy to the resident or surrogate.

e. Activity Therapist

i. Assesses and documents the resident's pre-admission interests.

ii. Promotes maintenance/enhancement of IADLs through activities.

iii. Involves the resident in campus-based and community-based programs to provide living skills learning, socialization, and self-confidence.

iv. Provides information and education to the resident and family regarding community resources to support living in the planned discharge setting.

f. Rehabilitation Specialist (occupational, physical, speech therapy) upon receipt of referral from physician: Performs evaluation of resident's overall functioning including basic activities of daily living, instrumental activities of daily living, community re-integration, recommendations and training for use of Durable Medical Equipment, recommendations for continued therapy and support services at the appropriate level of care post-discharge.

g. Other Disciplines / Services

In addition to the RCT responsibilities noted above:

i. Pharmacist provides medication education to the resident and caregiver and completes the appropriate section of the Post-Discharge Plan of Care form (MR 705).

ii. Dietitian provides nutrition education to residents on therapeutic diets prior to discharge and collaborates with the social worker on enteral feeding supplies.
iii. Utilization management staff provides focused studies of the quality of discharge planning and documentation.

iv. Vocational Rehabilitation, the PREP (People Realizing Employment Potential Coordinator) meets with interested residents about pre-vocational options, training, and community resources.

v. Peer Mentors provide emotional and practical support to residents transitioning into the community.

5. Notification of Resident Regarding Discharge from Facility

a. The social worker, nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of the discharge and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident’s medical record. A resident or surrogate is entitled to written 30-day notification except under the following conditions:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

iii. Improvement in medical condition requiring a lower level of care.

iv. The health or safety of individuals in the facility is endangered.

v. Resident has resided in the facility less than 30 days.

b. Written notice (MR 707) to the resident or surrogate shall include:

i. Reasons for discharge.

ii. Date the discharge will occur.

iii. Discharge destination.

iv. Name, address, and phone number of the State ombudsman.

v. For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

vi. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill
individuals established under the Protection and Advocacy for Mentally Ill Individuals Act

vii. Resident’s right to appeal to the California State Department of Health Services.

viii. Resident’s right to request a seven-day bed hold.

c. Residents may choose to waive their notice period if they wish to be discharged prior to the conclusion of the notice period.

d. If the resident or SDM is opposed to discharge, s/he will be encouraged to discuss it with the RCT and ombudsman.

i. The social worker or nurse manager will alert the Medical Director, Chief Nursing Officer or designee, Director of Quality Management, and Executive Administrator (or their designee) prior to issuance of the written notification of discharge.

ii. One or more of these executive leaders will meet with the resident or surrogate if so desired.

6. Involuntary Discharges

a. Involuntary discharges, whether arising from level of care or behavioral issues, require careful assessment, planning, and documentation. Legal counsel shall be consulted in circumstances when the resident and or SDM refuses to participate in discharge planning efforts (e.g. refuses to sign release of information forms or complete housing applications, etc.).

b. A Notice of Proposed Transfer/Discharge may be issued after a resident and or the SDM has been presented with two housing options that the RCT considers to be the best viable discharge option available in the community.

c. Refer to LHHPP File 20-05 Discharge Appeal Process when the resident verbalizes that s/he disagrees with the plan to be discharged to the community and refuses reasonable placement options.

7. Residents Leaving Against Medical Advice (AMA)

a. When a resident indicates that he or she intends to leave without a discharge order, the nurse will inform the physician of the need for an urgent visit to assess the resident and situation.
b. If the resident is conserved or does not understand the nature and consequences of a decision to leave LHH without permission, the physician will immediately attempt to contact the surrogate.

c. If leaving LHH would have life-threatening consequences for the resident, the physician will obtain emergency psychological or psychiatric consultation.

d. If the consultant deems the resident a danger to self or others due to mental illness, he or she will initiate a psychiatric hold and transfer the resident to acute care.

e. The nurse or physician will present the form MR 804, “Request to Leave the Hospital Against Medical Advice,” to the resident (or surrogate) in the presence of a witness.

i. If the resident or surrogate refuses to sign, the nurse or physician will write on the form, “Resident refuses to sign.” Nurse/physician and witness will sign.

f. The nurse or physician will complete an Unusual Occurrence form.

g. When RCT members have adequate advance warning regarding a resident leaving AMA, they should consider providing appropriate medication referrals, in addition to providing a list of emergency shelters and food sources.

**DEFINITION:**

1. **ADLs and IADLs: Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the mnemonics DEATH and SHAFT:**

<table>
<thead>
<tr>
<th>ADLs</th>
<th>IADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>Shopping</td>
</tr>
<tr>
<td>Eating</td>
<td>Housework</td>
</tr>
<tr>
<td>Ambulating</td>
<td>Accounting/finances</td>
</tr>
<tr>
<td>Toileting</td>
<td>Food-preparation</td>
</tr>
<tr>
<td>Hygiene</td>
<td>Transportation</td>
</tr>
</tbody>
</table>

2. **Assessment domains:** Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work. Safety issues often arise in many of these domains.
3. Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal caregiving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).

ATTACHMENT:
Attachment A: Residential Substance Use Treatment and Dual Diagnosis Treatment Placement for LHH Residents
Attachment B: LHH Referral Protocol for Opiate Replacement Treatment

REFERENCE:
LHHPP 20-05 Discharge Appeal Process
LHHPP 20-06 Pass Policy
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Development and Implementation of an Interdisciplinary Resident Care Plan
NPP C1.0 Admission, Relocation and Discharge Procedures

Revised: 08/04/29, 09/10/27, 13/05/28, 13/09/24, 13/11/21, 15/05/12, 17/09/12, 19/03/12 (Year/Month/Day)
Original adoption: 03/07/15
DISCHARGE APPEAL PROCESS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide a written discharge notice to the resident, and if known, a family member or legal representative of the resident prior to discharging the resident to the community.

   a. At a minimum, the written Notice of Proposed Transfer/Discharge (MR 707) shall include the following information:

      i. Name of resident.

      ii. Date resident notified.

      iii. Reason for discharge.

      iv. Effective date of discharge.

      v. Location to which the resident shall be discharged.

      vi. A statement that the resident has the right to appeal the discharge action to the State, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.

      vii. Name, address (mailing and email) and telephone number of the Office of the State long term care ombudsman.

      viii. Witness signature, and explanation if resident or resident’s representative did not sign the written notice.

   b. For residents with mental illness or developmental disability, the written notice shall include the mailing and email address and telephone number of the agency responsible for the protection and advocacy of the individual. Discharge assessment and planning is initiated on admission and re-assessed at intervals throughout the resident’s stay.

2. Generally, the written Notice of Proposed Transfer/Discharge shall be provided at least 30 days prior to transfer or discharge. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because:

   a. The resident’s welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility); or
b. The health or safety of others in the facility is endangered.

PURPOSE:

To preserve the discharge appeal rights of the resident and the discharge rights of the facility.

DEFINITIONS:

“Facility-initiated transfer or discharge”: A transfer or discharge which the resident objects to, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.

“Resident-initiated transfer or discharge”: Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

“Transfer and Discharge”: Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

PROCEDURE:

1. When the Resident Care Team (RCT) identifies that a resident’s health has improved sufficiently to allow discharge to the community, and the resident verbalizes that s/he disagrees with the plan to be discharged to the community and refuses reasonable placement options, the Social Worker shall request for a level of care review by Utilization Management (UM).

2. The UM Nurse shall conduct a review of the resident’s medical record and determine if the facility has met the conditions for discharging the resident to the community. A Discharge Plan Review form is available for use to assure that a comprehensive review is carried out.

3. The UM Nurse shall notify the RCT with a recommendation to proceed with the Notice of Proposed Transfer/Discharge or continue to address identified discharge planning issues prior to issuing the Discharge Notice within 3 – 5 working days.
4. The resident shall be presented with the Notice of Proposed Transfer/Discharge at least 30 days before the resident is scheduled for discharge. The 30 day period may be waived only in cases of resident-initiated transfer or discharge.

5. When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending.

6. The Social Worker shall notify the Quality Management (QM) Department as soon as s/he is aware that the resident has filed a complaint to contest the discharge.

7. The QM designee shall gather pertinent resident information and be prepared to respond to resident issues that may be investigated by the assigned Licensing and Certification Health Facilities Evaluator Nurse.

8. When the facility is notified of a scheduled discharge hearing date, the QM designee or the Director of Social Services (or designee) shall coordinate with the RCT, UM Nurse and if necessary, the Deputy City Attorney to prepare oral and written testimony for the discharge hearing to demonstrate compliance with resident discharge planning requirements.

9. The RCT shall present oral testimony, clarify concerns and submit written documentation to the assigned Hearing Officer at the scheduled discharge hearing.

10. The resident may not be involuntarily discharged from the facility prior to the discharge hearing or issuance of the Decision and Order, but may choose to be voluntarily discharged and s/he can request for assistance with discharge planning arrangements from the RCT.

11. The RCT shall clearly document that such discharge planning arrangements were made based on the resident’s request.

12. If the resident is voluntarily discharged from the facility, the QM designee is responsible for notifying the California Department of Public Health Office of Regulations and Hearings and the local Licensing and Certification Office.

13. Following the discharge hearing, the State of California will issue a Decision and Order and the facility shall proceed with the issued directions contained in the document.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-04 Discharge Planning
LHHPP 20-10 Transfer and Discharge Notification
Discharge Plan Review Form (posted on the Laguna Honda Intranet)
State Operations Manual F622 §483.15(c)
State Operations Manual F623 §483.15(c)(4)

Revised: 09/08/31, 16/07/12, 17/09/12, 18/11/13, 19/03/12, 18/03/12, 19/04/18 (Year/Month/Day)
Original Adoption: 08/04/28
SHORT STAY DISCHARGE PLANNING AND TRACKING PROCESS

BACKGROUND:

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

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

POLICY:

1. Residents whose skilled nursing needs can be addressed in less than 100 days from admission are designated with a short stay hospital service code. The short stay service code triggers a set of discharge planning activities aimed at facilitating discharge and mitigating delays that would keep the resident at LHH longer than the anticipated skilled nursing facility stay of 100 days.

2. Effective March 13, 2018, the LSS service code shall be expanded to include residents who have resided at LHH and received SNF level of care services for more than 100 days under a different SNF service code. These include residents who have been identified by the Resident Care Team (RCT) as having a discharge potential to return to the community and is expected to do so within the next 100 days.

3. Allowance shall be made, due to extenuating circumstances within the discharge planning process that are unrelated to the resident’s condition (e.g. housing delays, benefits delays), to maintain a resident’s service code as LSS well beyond 100 days of stay for tracking purposes.

4. Residents assigned a short stay service code shall be reviewed for progress with discharge planning by the RCT, at a minimum every two weeks during Discharge Huddle.

PURPOSE:

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

1. Service Code Assignment on Admission and Readmission

   a. The Admission and Screening Committee shall consider the resident’s condition for admission using the short stay codes (LSS, LSA, LRH, and LRE), based on the anticipated course of treatment and the expected improvement in condition that the resident will be ready and appropriate for discharge within 100 days.

      i. The LSS short stay code is used primarily for residents who are at a SNF level of care on admission and have an estimated length of stay of 100 days.

      ii. The three other short stay codes shall be used for residents receiving Positive Care, Rehabilitation, and Respite services.

      ii-iii. When the resident has been admitted and identified as short stay, the Admission and Eligibility (A&E) Unit shall input the service code for the resident into the electronic Admission, Discharge, and Transfer (ADT) system.

   b. For readmissions, the Patient Flow Coordinator (PFC) shall communicate the service code to the A&E Unit, receiving neighborhood and the Utilization Management (UM) nurses.

2. Discharge Planning Assessment

   a. As with all residents who are admitted at LHH, discharge planning for residents designated with short stay codes begins immediately on admission. Specifically, for residents who are designated as short stay, the following steps must occur between the resident’s first day of admission and the seventh day post admission:

      i. Social Services – All short stay residents shall have an initial assessment completed within 48 hours of admission which shall be completed within 5 days, and a discharge assessment within seven days of admission conducted by the Medical Social Worker (MSW).

      • The Medical Social Worker (MSW) shall conduct an initial assessment for Short Stay residents within 48 hours of admission and a discharge assessment within seven days of admission. The MSW shall initiate discussion of discharge destination with residents who have decision-making capacity and/or with the responsible party, if consent is provided by the resident.

      ii. RCT – An initial Resident Care Conference (RCC) shall be held within 7 days of admission to discuss the resident’s goals of care and discharge plan including with family members and/or other caregivers, if appropriate. The RCT shall establish an estimated discharge date and discuss the meaning of
the short stay plan with the resident and/or responsible party during the first RCC meeting.

3. **Discharge Huddles**

   a. The RCT shall utilize the Discharge Huddle Guide and the Discharge Huddle Worksheet during Discharge Huddles to track residents who are assigned the short stay service code and/or residents who shall be change to a short stay service code.

   b. Discharge huddles shall be conducted at a minimum biweekly and is expected to take up approximately 2 to 5 minutes per resident.

   c. The RCT discharge huddle shall review the following information:

      i. Residents who are newly admitted or relocated to the neighborhood, their discharge destination and confirmation of their short stay service code;

      ii. Residents who were discharged during the past week;

      iii. Progress at 30, 60 and 90 days with discharge planning for short stay residents with active discharge plans, including discharge barrier(s) or issues(s) that require some assistance in resolving from the Clinical Leadership Team;

      iv. If the resident has not discharged after 90 days of admission or LSS service code designation, the Social Worker MSW, with input from the RCT shall notify the Patient Flow Coordinator and Social Services Director of Social Services and provide status updates and progress toward discharge;

      v. Residents who were newly issued a discharge notice by the MSW and any concerns related to their upcoming discharge;

      v. Updates on housing applications and acceptance from the MSW;

      vi. Residents who were identified by the Discharge Huddle Worksheet as potentially able to discharge within a 100 days;

      vii. Resident who were assessed with significant improvement in function or condition who may be appropriate for discharge to the community based on the quarterly or annual RCT review from the prior week;

      viii. Updates from the UM Nurse on modified or deferred Treatment Authorization Requests for residents deemed to be short stays.
d. The MSW and Charge Nurse or designee shall document update(s) in their respective sections of the Progress Notes and update the resident’s discharge plan as necessary.

e. If the RCT determines that a resident with a short stay service code is likely to reside at LHH for longer than 100 days, the RCT shall submit a request to have their service codes changed according to Procedures 6, 7 and 8.

4. Discharge Planning Support and Guidance to RCTs

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

5. Monthly Short Stay Reviews

a. The intent of the Monthly Hospital-wide Short Stay Reviews is to track the progress of discharge planning for short stay residents at 30, 60, 90 days and longer.

b. This review is facilitated by the Director of Social Services Social Services Director and the PFC Assistant Administrator for Clinical Services or designee during and attended by members of the Community Reintegration Performance Improvement Team.

c. The intent of this discussion is to track residents’ with all short stay codes and ensure that they are on track with their discharge plan. Any short stay resident that is not meeting the planned discharge timeline will be escalated by the Director of Social Services Social Services Director and the PFC Assistant Hospital Administrator for Clinical Services or designee to the UM Committee and/or Clinical Leadership for review and recommendations.

6. Changing Service Codes

a. Data entry changes of service codes shall be performed by the neighborhood Unit Clerk or A&E Department or the neighborhood Unit Clerk based on requests by designated individuals.

b. The Short Stay dashboard will automatically be refreshed every twelve hours.
e.b. Requests may be submitted to change a specialty service code (LSA or LRH to LSS) based on assessment by the RCT and according to the guidelines described under Procedure 7 by the Nurse Manager or designee:

i. Nurse Manager,

ii. Nursing Director,

iii. PFC,

iv. Director of Social Services,

v. UM Nurses, and/or

vi. UM Nurse Manager.

d.c. Approval for short stay service code changes described in Procedure 8 shall be made by the RCT.

e.d. The South 3 Nurse Manager, Charge Nurse or designee is responsible for submitting requests for non-short stay service code changes from LHP to LHG as outlined in procedure 8, as appropriate, for residents who have received 1 year of palliative and end of life care following completion of the annual Minimum Data Set.

f. The Nurse Manager, Charge Nurse, or designee is responsible for submitting requests for non-short stay service code changes from LHG to LIS as appropriate for bed control management.

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

a. short stay residents who have completed short stay hospital services LSA and LRH, but are not ready for discharge to the community due to housing needs shall have their service code changed to LSS for continued tracking.

b. Residents' length of stay begins anew only if the readmission occurs greater than 30 days after discharge.

i. Residents readmitted as short stay will have 100 days to discharge from the date of readmission.

c. Extenuating circumstances within the discharge planning process that are unrelated to the resident’s condition (e.g. housing delays, benefits delays) will not be criteria for changing a short stay code to LHG.
d. These factors shall be recorded and monitored via the Discharge Huddle Worksheet.

e. Residents who are not discharged within 100 days and have not had a significant change in health condition warranting a change in hospital service code shall be changed to LSS until discharge.

8. Guidelines for Changing Short Stay Service Code to LHG

a. A short stay code may be changed to a general SNF (LHG) hospital service code under the following situation:

i. In cases where the resident’s medical condition has changed such that a discharge within 100 days of admission is no longer viable. The RCT shall notify the Social Services Director of Social Services by email to request a change of service codes.

ii. The Social Services Director of Social Services shall evaluate each short stay code change to LHG request and meet with the RCT to discuss the impact to the resident’s discharge plans. The RCT Leadership Team members may also provide assistance and guidance to their respective discipline and RCT members to resolve discharge barrier(s) or issues(s).

iii. If the Social Services Director of Social Services, with input from the PFC, approves the code change, s/he informs the A&E Department, who will be responsible for updating the code from LSS short stay service code to LHG.

iv. The Social Services Director of Social Services shall notify the RCT that the resident’s discharge plan must change, and the RCT shall update the discharge plan with interventions to mitigate identified barriers to discharge.

v. If the request to change the LSS short stay service code to LHG is denied, the RCT may make a referral to the UM Committee to render a final decision on the matter.

9. Reports and Metrics

a. Metrics described below track the effectiveness of discharge planning efforts for residents having the short stay code.

b. SFGetCare Electronic health record reports shall include a short stay list showing Medical Record Number, Resident Account Number, Resident Name, Neighborhood, Bed Number, Date of Admission on Short Stay Codes, Last Date on Short Stay Codes, and Number of Accrued Days from Admission.
c. The Community Reintegration Performance Improvement Team shall perform a quarterly analysis of short stay residents for identification of learning and improvement opportunities and will report to the Quality Council at least annually. For trend analysis, the following metrics shall be reviewed quarterly:

i. Number and percent of residents designated as short stays.

ii. Number and percent of short stay residents discharged within the 100-day timeframe.

iii. Average length of stay for short stay residents.

iv. Summary characteristics of short stay residents (e.g. diagnosis, age, unit, discharge disposition) for trend analysis.

v. Number and percent of General SNF residents NOT designated short stay that are discharged within 100 days.

e.d. The SNF Performance Improvement and Patient Safety (PIPS) Committee shall review the CMS CASPER report on quality measure related to the percentage of short-stay residents who were successfully discharged to the community (claims-based) during scheduled meetings.

d.e. Quarterly analysis shall be performed to support performance improvement projects targeted toward specific sub-populations. Outcomes shall be reported to both the Community Reintegration Performance Improvement Team, Admission and Screening Committee, UM Committee and ultimately to the PIPS and/or Quality Council committee.

ATTACHMENT:
Appendix A: Changing Service Code Flowchart

REFERENCE:
None.

Revised: 16/07/12, 16/11/08, 18/03/13, 19/03/12 (Year/Month/Day)
Original adoption: 16/01/12
TRANSFER AND DISCHARGE NOTIFICATION

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall implement resident room transfer and community discharge notification process that is consistent with the State and Federal requirements.

2. Written notice for transfer and discharge shall be provided to the resident, and if known, to the family member or legal representative. The written notice must include the reason(s) for the move, and be in a language and manner that the resident and family member or legal representative understand.

3. Notification and issuance of the notice shall be documented in the medical record.

4. Except in an emergency or the safety of resident(s), facility representatives may not transfer a resident to another room against his or her wishes, unless given prior reasonable written notice as specified in the House Rules and Responsibilities.

PURPOSE:

1. To establish consistent process and meet regulatory requirements.

PROCEDURE:

1. Room Transfer Notification
   a. The Charge Nurse or designee is responsible for notifying the resident, and if known, the family member or legal representative of room transfers.
   b. The Charge Nurse shall issue the transfer notice to the resident prior to transferring the resident to another room, regardless if the room transfer occurs on the same neighborhood or another neighborhood.
   c. The notice is part of the medical record and shall serve as documentation.
   d. If the resident expresses concerns regarding the room transfer, efforts shall be made to address the resident’s concerns to the extent possible and shall be documented.

2. Timing of Room Transfer Notification
   a. A resident transferring to another room on the same neighborhood shall be provided with one day advance notice.
b. A Resident transferring to a room on another neighborhood shall be provided with a 2-day advance notice.

c. The Resident may agree to room transfers sooner than specified in Procedure 2a or 2b and waive the advance notice requirement.

d. The Charge Nurse or designee is responsible for documenting the Resident’s agreement to room transfers in the above situations.

3. Community Discharge Notification

a. The Medical Social Worker is responsible for issuing the written notice for community discharges (MR 707 Notice of Proposed Transfer/Discharge).

b. Issuance of the written notice shall be documented in the medical records.

c. Refer to LHHPP 20-04 Discharge Planning Procedures #5 and #6 for Resident and family notification for community discharges.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-04 Discharge Planning
Code of Federal Regulations (CFR), Title 42, part 483.10 et seq.
Title 42, part 488.424 et seq.
Health and Safety Code sections 1417 et seq.: 1599.1 an 1599.60 et seq.
Welfare and Institutions Code section 14124.7
California Code of Regulations, Title 22 sections 72520, 72527, 73504, and 73523
California Standard Admissions Agreement
LHHPP 20-04 Discharge Planning

Revised: 19/034/1298 (Year/Month/Day)
Original adoption: 16/07/12 (Year/Month/Day)
LAGUNA HONDA HOSPITAL’S RESPONSE TO ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER (ZSFG) 
SURGE CONDITION CONDITION YELLOW AND RED ALERTS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing quality and timely care and services that are consistent with community and professional standards, and to admit residents that can be safely cared for at the hospital.

PURPOSE:

To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG’s condition yellow and red alerts.

To identify essential communication and coordination to ensure resident safety.

ZSFG’s DEFINITION:

“Condition Yellow” – activated by ZSFG when ten (10) or more patients are waiting for beds.

“Condition Red” – activated by ZSFG when only one bed is available in Critical Care with no pending transfers, Post Anesthesia Care Unit (PACU) is at capacity, and more than ten (10) or more patients are waiting for beds at ZSFG.

PROCEDURE:

1. Notification:

   a. ZSFG’s Chief Executive Officer (CEO) or designee shall notify LHH’s CEO or designee when conditions exist that require expeditious transfer of patients from ZSFG to LHH. “Condition Yellow” or “Condition Red” is not resolved within 24 hours of activation.

   b. LHH CEO or designee shall confer with Executive leaders and activate LHH Hospital Incident Command System (HICS) if appropriate.

2. LHH Internal Communication and Planning

   a. Communication – the designated Incident Commander or designee will contact the following:

      i. LHH Chief Nursing Officer (CNO) or designee – to ascertain/provide current bed vacancies and bed hold situation
ii. LHH Patient Flow Coordinator – to provide the current list of ZSFG accepted patients/referrals, and to appropriately identify priority of patients to be admitted as well as anticipate/plan for their care needs.

iii. LHH Chief Medical Officer or designee – to confer with the Patient Flow Coordinator the appropriate neighborhood assignment and coordinate with Chief of Medicine or designee to plan for the admitting physician assignment.

iv. LHH Patient Flow Coordinator – Once patients are identified and assigned to neighborhoods, Patient Flow Coordinator is responsible for sending a notification to each Resident Care Team (RCT) to inform them of planned admission, including patient’s profile. The Coordinator shall obtain from ZFGH the most current medical information, and send referral packet(s) to the neighborhood Nurse Manager or designee.

b. Planning

i. Bed Allocation

- Current Bed Holds may be moved to North Mezzanine vacant beds, if available, to accommodate incoming admissions.

- Three (3) General SNF Isolation Rooms shall be kept available for the clinical needs of in-house residents during the flu season.

- Three (3) acute care beds (one medical acute, one acute isolation, and one acute rehab) shall be kept available for the clinical needs of in-house residents and a community acute rehab patient.

- If acute care bed(s) will be used for SNF level of care admission, the Quality Management Director or designee shall notify the San Francisco California Department of Health Licensing (CDPH) office and obtain approval prior to occupancy.

- A minimum of 3 follow-up calls to CDPH may be necessary to obtain approval for placing SNF level of care residents on the acute care unit.

- Subsequent approval from CDPH is required every 72 hours when a SNF level of care resident remains on the acute care unit past 3 days. The Quality Management Director or designee shall contact CDPH to obtain subsequent approvals every 72 hours as necessary.

- Priority shall be given to transferring SNF level of care residents who are placed on the acute care unit to relocate to the SNF unit.
ii. LHH CEO or designee – shall activate the HICS if appropriate see LHH HW 70-03 Emergency Response Plan.

iii. Nurse Managers and Directors – shall coordinate with the CNO and Patient Flow Coordinator in carrying out any bed relocation(s) needed, preparing for staffing to implement admissions, and prepare any needed special supplies/equipment, and/or staff education.

iv. LHH Chief Operating Officer – shall coordinate with EVS Supervisor terminal cleaning of any resident rooms; Facilities and or Materials Management for any special supplies/equipment needed.

v. Director of Quality Management – shall coordinate completion of Utilization Management reviews of residents to be admitted.

vi. Director of Admissions and Eligibility – shall plan to register identified resident(s) for admissions for timely processes of face sheets and blue cards.

vii. Director of Social Service – shall provide a list of residents that who could can be discharged immediately in addition to planned community discharges for the day and following day to better account LHH bed availability.

viii. Chief Finance Officer – shall assist in resource allocation or funding, to safely implement admissions.

ix. Director of Pharmacy Services – shall be informed of any pharmaceutical products that require pre-planning arrangements to ensure timely availability such as TPN.

3. External Communication and Coordination

a. Communication

i. LHH CEO or designee shall communicate with ZSFG CEO or designee to confirm number of residents LHH will admit.

b. Coordination

i. LHH Patient Flow Coordinator will coordinate with:

   • ZSFG Utilization Management Nurse Manager (UM NM) or designee – to provide names of patients for admission including assigned neighborhood, admitting physician pager number and admitting neighborhood charge nurse phone number.

   • ZSFG Case Manager – confirm time of ambulance pick up
ii. ZSFG Attending Physician – shall contact LHH Admitting MD for hand off

iii. ZSFG RN – shall contact LHH Charge Nurse for hand off report

iv. LHH Admission and Eligibility Department – shall coordinate with ZSFG UM Nurses for any documentation or insurance plan information for the identified patients to be admitted.

4. Documentation

a. The Health Information Services Department shall be notified of SNF level of care patients that are admitted to the acute care unit (admit type, full name, and bed/room assignment) by the Patient Flow Coordinator.

b. When SNF level of care patients are admitted to the acute care unit, an exception shall be made to HIS policy number 7.05 permitting the use of SNF documentation protocols for the SNF patient(s) that are physically placed on the acute care unit. SNF documentation may be continued and follow the patient to the SNF unit when the patient/resident is transferred from the acute care unit to the SNF unit and a new medical record does not have to initiated.

5. Utilization Management (UM) and Billing

a. UM Nurses shall conduct utilization reviews and processes based on the level of care determination and payer requirements.

b. When SNF level of care admissions are placed in an acute care bed, the following processes shall be followed:

i. If the resident’s primary coverage is a Medi-Cal Managed Care, or other private insurance, notify the managed care organization that the resident is admitted to an acute care bed and that the facility shall submit a claim based on the authorization for a SNF stay that was pre-approved by the health plan.

ii. If the resident’s primary coverage is Medicare, the resident shall be issued a Medicare acute care denial and informed that the resident will not be able to access his/her Medicare SNF benefits while s/he is on the acute care unit. The Billing Department shall not submit Medicare SNF claim(s) for payment of a resident who meets SNF level of care on admission while occupying an acute care bed.

iii. If the resident’s primary coverage is Medi-Cal, Hudman calls shall be initiated by staff from the UM Department. The Billing Department shall submit a claim to Medi-Cal for administrative days.
iv. A SNF level of care resident who is admitted to an acute care bed is not eligible for bed hold when s/he discharges to a community acute care hospital.

6. Change of Condition from SNF Level of Care to Acute Care

a. In the event that the SNF level of care resident becomes acutely ill and meets acute care criteria; this shall be considered a change of condition and an event that triggers a new admission, and a new medical record shall be initiated per acute care regulations.

b. The attending physician of record or designee shall make the determination of need for acute care services and notify the Patient Flow Coordinator/Operations Nurse Manager or designee.

c. The following departments shall be notified by the Patient Flow Coordinator/Operations Nurse Manager or designee as soon as practicable after the physician determines that the resident/patient meets acute level of care:

   i. Nursing staff on the acute care unit
   ii. Admissions and Eligibility
   iii. Health Information Services
   iv. Utilization Management
   v. Pharmacy Services
   vi. Billing Department

7. Post Response Debrief

a. Incident Commander (if HICS was activated) shall arrange for post HICS debrief with LHH staff involved in the incident response.

b. LHH Patient Flow Coordinator shall arrange for a debrief with ZSFG UM NM or designee.

8. Performance Improvement

a. Incident Commander (when HICS is activated) shall identify identified gaps and opportunities, including action plan(s), and report to LHH’s Quality Council.

b. LHH Patient Flow Coordinator shall identify gaps and opportunities, including action plan(s), and report to LHH’s Quality Council.
ATTACHMENT:
None.

REFERENCE:
None.

Revised: 17/11/14, 19/03/12 (Year/Month/Day)
Original adoption: 16/07/12
HIPAA COMPLIANCE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) implements procedures that comply with the San Francisco Department of Public Health’s (DPH) “HIPAA Compliance: Privacy Policy”, which adopts the Privacy Rules set forth in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and related federal and state confidentiality laws.

LHH staff are responsible for complying with both LHH and DPH Privacy and Data Security policies (Appendix A).

PURPOSE:

The purpose of this policy is to provide guidance to LHH employees by clarifying how the basic requirements for protecting the confidentiality of medical information apply to LHH work processes as required by the HIPAA Privacy Rule.

The basic tenet of the Privacy Rule is that providers may use and disclose PHI without the individual’s authorization only for treatment, payment, and health care operations, as well as certain public interest related purposes such as public health reporting. Other uses and disclosures of PHI generally require the written authorization of the individual.

The Privacy Rule also introduces the concept of "minimum necessary". This requirement mandates that when using or disclosing PHI, or when requesting PHI from external providers or entities, providers shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose. The Privacy Rule does recognize that providers may need to use all of an individual’s health information in the provision of patient care. However, access to PHI by the workforce must be limited based on job scope and the need for the information.

The Privacy Rule also includes a set of rights for consumers of health care services. These include the right to obtain a written notice explaining how DPH shall use and disclose their information, to access their health information (including requesting copies, requesting amendments, and receiving an accounting of specified disclosures), to request that certain information be restricted from use or disclosure for purposes of treatment, payment and health care operations (this request need not be granted if it is unreasonable or overly burdensome), to request that information be communicated in particular ways to ensure confidentiality, and to refuse to authorize the release of information for most purposes not related to treatment, payment or health care operations.

This policy provides an overview of the requirements of the Privacy Rule.

DEFINITION:
Protected Health Information—also known as PHI—covers information relating to an individual’s health, the care received, and/or payment for services, including demographic data. It includes all information in any media-form related to the individual’s health care that can be individually identified as belonging to a particular person.

Patient Identifiable Information (PII)—Any is individually identifiable information regarding patient/resident name, address, Social Security number, account number, security code, driver’s license number, financial or credit account numbers, phone numbers, and Internet domain addresses, and other personal identifiers.

PROCEDURE:

1. Resident notification of HIPAA Privacy Practices at Time of Admission
   a. LHH is required to provide residents with the “DPH Notice of HIPAA Privacy Practices” upon admission.
   b. Staff shall request the resident/decision maker to sign the acknowledgment of receipt, however the resident has the right to refuse to sign under privacy laws.
   c. The signed acknowledgement shall be kept in the resident’s medical record.
   d. The date the notice was provided shall be entered in the electronic health record.
   e. A copy of the notice shall be offered to the resident/decision maker.
   f. Exception: The notice does not need to be provided or signed again if the electronic health record indicates a date and user identification verifying that the HIPAA notice was previously provided (i.e. for most residents who were admitted from Zuckerberg San Francisco General Hospital).

2. Posting of the DPH Notice of Privacy Practices Notices
   a. Providers, such as hospitals and clinics, shall be required to post the DPH Notice of Privacy Practices in a clear and prominent location where it is reasonable to expect residents to be able to read the notice.
   b. LHH posts notice summaries in the main lobby of the Pavilion building outside Admissions and Eligibility, Outpatient Clinic entry area, and the entry area of each neighborhood and includes the full notice in the survey binders available to residents.
   c. Notices are available in English, Chinese, Russian, Spanish, Tagalog and Vietnamese.
d. Most ALL neighborhoods shall have a notice posted in English, except for N4 and N5 which shall have posted notices in Spanish and Chinese, respectively, as these are the most commonly used languages by the residents.

3. LHH providers, staff, affiliated students, contractors, and volunteers may use and disclose PHI for treatment, payment, and healthcare operations. Use of information applies to internal sharing or utilization of PHI. Disclosure applies to the release of PHI.

a. Treatment, payment and health care operations are defined as follows:

i. Treatment means providing, coordinating or managing a patient’s care, including patient education and training, and consultations between providers and referrals.

ii. Payment means activities related to being paid for services rendered. These activities include eligibility determinations, billing, claims management, utilization review, and debt collection.

iii. Health care operations means a broad range of activities such as quality assessment, student training, contracting for health care services, medical review, legal services, auditing functions, business planning and development, licensing and accreditation, business management, and general administrative activities.

b. Minimum Necessary Uses and Disclosures

i. Whenever using or disclosing PHI, LHH staff shall limit the PHI requested, used, or disclosed to the minimum necessary to accomplish the resident’s care or business purpose.

c. Disclosures to Family, Other Relatives, Close Personal Friends, and Personal Representatives

i. PHI shall only be disclosed to a resident’s family members, other relatives, close personal friends, or any other individual when:

   - The resident has verbally agreed;
   - The resident was provided with the opportunity to object to the disclosure and did not object; and
   - The verbal authorization was documented in the resident’s medical record.

ii. Any such disclosure shall be limited to information directly relevant to that person’s involvement with the resident’s care of payment for care.
iii. PHI shall be disclosed to a resident’s personal representative (i.e., those granted legal authority to make health care decisions on behalf of another) in the same manner as they would for the resident.

-iv. Disclosures related to mental health, substance abuse, or sexually transmitted disease, or HIV/AIDS services shall be disclosed as provided for in this policy.

5.4. Social Media

Social media includes items such as blogs, podcasts, websites, discussion forums, and social networks (e.g., Facebook, Instagram, Snapchat, YouTube, Twitter, LinkedIn or hyperlinks from email).

a. Images of residents information must not be disclosed through social media of any kind without permission of the resident, guardian or conservator as described in LHHPP 29-02 Resident As Photography Or Interview Subject (form MR802 available from the Materials Management electronic ordering system on the LHH intranet).

b.—Unauthorized disclosure of protected information is a violation of the Health Insurance Portability and Accountability Act (HIPAA Privacy Rule), DPH policy, and LHH policy. No resident PHI or PII shall be disclosed through any form of social media, which includes:

i. Protected Health Information (PHI) — Any identifiable medical information (verbal, written or electronic) about the patient’s physical or mental health, the receipt of health care, or payment for that care.

ii. Patient Identifiable Information (PII) — Any individually identifiable information regarding patient/resident name, address, Social Security number, account number, security code, driver’s license number, financial or credit account numbers, phone numbers, and Internet domain addresses, and other personal identifiers.

-iii. Posting or hyperlinking photos, images, video, recordings, text, or other information that could reasonably lead to the identification of a patient/resident.

c. DPH issued email addresses may not be used for personal access to social networking sites. Nor may you use a DPH issued email addresses shall not be used for personal use on social networking sites.

d. Staff members should consult with their supervisor or the Privacy Officer if they are unsure whether any DPH or LHH-related information or patient information is confidential.
e. Transparency: If staff members identify their affiliation with DPH or LHH in any online social medium or network or if their affiliation with DPH or LHH could be presumed, they must make it clear that they are not speaking for DPH or LHH by using this statement: “The views expressed here are my own and not those of my employer.”

f. Any social media conversation, whether public or private, may be subject to public disclosure.

6-5. Training of Staff, Volunteers and Affiliating Students Regarding PHI

a. All LHH staff, students, and volunteers who are assigned to transport medical records shall receive initial HIPAA training utilizing the DPH curriculum prior to commencing work. In addition, annual re-training is provided to all staff through the Department of Education and Training. Managers are responsible for assuring compliance. LHH staff shall not be permitted to access the electronic health record if they have not completed the initial HIPAA training, and their access to the electronic health record will shall be terminated if they do not complete the annual HIPAA training by the required deadline.

i. All volunteers receive orientation to HIPAA Privacy Practices with essential points from the DPH curriculum.

b. All LHH staff, volunteers, and affiliating affiliated students must comply with the DPH confidentiality agreement and sign the DPH User Confidentiality, Security and Electronic Signature Agreement Form (available on the LHH Intranet under “LHH Forms”, section “I”).

c. Signed confidentiality agreement forms are filed in the employee's personnel record in Human Resources, in the Volunteer Coordinators office, or in the affiliating departments' student placement coordinators office. Staff electronic signatures on this document are also acceptable and records are available through the Department of Education and Training.

d. Volunteers do not shall not access resident medical records nor and shall not chart in the medical record.

e. Similar requirements for business associates (BA’s) are described in each BA contracts agreement.

7-6. Handling of PHI

a. Copies of PHI are to be discarded directly into the confidential shredding bins when no longer needed.
b. **Copies of PHI** (electronic or hard copy) **are shall** not to be left in open view.

c. PHI discussed at resident care conferences and other team meetings is for the sole purpose of providing care and **is to shall** be kept confidential.

d. PHI shared as part of internal quality improvement efforts, such as 

d. **Performance Improvement Committees**, is used for informational purposes to continuously improve practice and outcomes.

e. Reports with containing PHI are **shall only be** shared with staff on a “need to know” basis, secured from privacy breaches and discarded in the confidential **shredding bins** for shredding, when no longer needed.

7. **Special Requirements for Mental Health and Developmental Disability Information, Substance Abuse Information, Sexually Transmitted Disease Information, and Health Information of Minors**

a. **Mental Health Information**

i. **California state law provides for special protections for mental health information.** Mental health information may be shared among DPH providers and contractors for the purposes of treatment. All other uses and disclosures require the specific authorization of the patient to disclose mental health information.

ii. Mental health information includes psychotherapy notes, medication prescription and monitoring, counseling session start and stop times, modalities/frequencies of treatment, results of clinical tests, or summaries of diagnosis, functional status, treatment plans, symptoms, prognosis, or progress recorded by mental health professionals.

iii. Disclosures of mental health information require the specific authorization from the resident for release as required by California Welfare and Institutions Code, section 5328 et seq. (also known as the Lanterman-Petris-Short Act).

b. **Substance Abuse Information**

i. **California state law provides for statutory restrictions for the release of information developed or acquired in the course of providing substance abuse treatment in a federally-funded substance abuse program.** Substance abuse treatment provided in the course of general medical treatment is not subject to these provisions.

ii. **Federal and state statutes require written authorization for disclosure of substance abuse information in certain circumstances and other special**
protections for substance abuse information. In these situations, the state law must be followed. Questions regarding the use or disclosure of substance abuse information should be referred to the Privacy Officer.

c. Sexually Transmitted Diseases and HIV/AIDS Information

   i. Except for the purpose of diagnosis, care, or treatment by DPH providers, no HIV test results shall be disclosed unless the resident has given specific written authorization.

8. Reporting Privacy Breaches

   a. An Unusual Occurrence report shall be completed for any suspected privacy breach.

   b. Suspected privacy breaches are reported to the LHH Privacy Officer for follow up.

ATTACHMENT:
Appendix A: Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms

REFERENCE:
LHHPP 21-01 Medical Records Information: Confidentiality And Release
LHHPP 21-02 Transmission of Confidential Medical Information Via Facsimile
LHHPP 21-05 Medical Record Documentation
LHHPP 21-06 Transporting the Resident's Filed Medical Records
LHHPP 24-08 Off Campus Appointments Or Activities
LHHPP 29-02 Resident as Photography or Interview Subject
LHHPP 29-07 Human Subject Research
LHHPP 60-01 Performance Improvement Program
User Agreement for Confidentiality, Data Security and Electronic Signature (Available at www.sfdph.org/DPH/privacy and the LHH intranet/ LHH forms)

Revised: 13/01/29, 13/09/24, 15/09/08, 19/03/12 (Year/Month/Day)
Original adoption: 11/09/27
Appendix A - Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms

DPH Privacy Policies
(Available at: www.sfdph.org/DPH/privacy)

1. DPH Privacy Policy
2. Authorization for Use and Disclosure of PHI
3. Privacy and the Conduct of Research
4. Patient / Client / Resident Rights Regarding PHI
5. Administrative Requirements
6. User confidentiality and Security Agreement
7. Use of PHI in Disciplinary Investigations and Proceedings
8. Secured Delivery of PHI Interoffice, Mail, Fax
9. Reporting of Unlawful or Unauthorized Access of PHI
10. Reporting Individuals with Lapse of Consciousness to DMV

DPH Data Security Policies
(Available at: www.sfdph.org/DPH/privacy)

1. DPH Electronic Data Security Policies – User Brief
2. Access Control Policy
3. Confidentiality, Security, and Electronic Signature Agreement
4. Disaster, Contingency and Business Continuity Planning
5. Data Backup
6. Policy for Classification of Data
7. Data Network Security
8. Security Documentation and Accountability
9. Malicious Software Prevention and Surveillance
10. Policy for Secure Disposal or Reuse of Media Containing Critical Data
11. Network Operating System Architecture and Administration
12. SFDPH Password Policy
13. Portable Computer and PDA Security
15. Risk Analysis and Risk Management
16. Policy for Secure Storage, Disposal or Reuse of Media Containing Critical Data
17. Secure Transmission of Protected Health Information
18. Security Activity Logging, Tracking and Reporting
19. Security Policy Violation Discipline and Sanctions
20. Security in the System and Software Development Process
21. Security Awareness, Orientation and Training
22. Wireless Network and Information Transmission Security
23. Workstation, Data Display and Printout Security Policy
DPH Privacy Forms
(Available at: https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/default.asp

DPH Privacy Policy Matrix
1. DPH Authorization to Disclose PHI
2. CBHS Authorization for Use or Disclosure of PHI
3. DPH Research Proposal Approval Form
4. Health Information Data Use Agreement and Form
5. Summary DPH Notice of HIPAA Privacy Practices
6. Detail DPH Notice of HIPAA Privacy Practices
7. User Confidentiality and Security Agreement Form
8. PHI Cover Sheet Required for Fax, Interoffice, Mail
9. Summary of Unauthorized Access of PHI
10. HIPAA Business Associate Addendum
DOCUMENT SHREDDING

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) maintains document shredding bins that serve as secure, temporary storage for documents that contain confidential information and/or protected health information (PHI) until the document shredding vendor collects the contents of the document shredding bins for final destruction processing. It is the intent of this policy to provide guidance to LHH staff as to the proper use of the document shredding bins and the proper retrieval of documents that have been deposited into the document shredding bins in error.

PURPOSE:

1. The Document Shredding Policy is to provide guidance to LHH staff regarding the proper disposal of documents that contain confidential information and/or PHI.

2. The Document Shredding Policy shall also provide the procedure for retrieval of documents that contain confidential information and/or PHI after an erroneous disposal of a document into a document shredding bin.

DEFINITIONS:

1. “Protected health information” or “PHI” is individually identifiable health information, including demographic data that relates to an individual’s past, present, or future physical or mental health or condition, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

2. “Confidential information” is any document or record containing sensitive information of a resident/patient, employee, supplier, and other sensitive facility information.

PROCEDURE:

1. Documents that contain confidential information and/or PHI shall be deposited immediately into a document shredding bin upon the final use of such document.

2. Documents that contain confidential information and/or PHI shall only be deposited into a document shredding bin and shall never be deposited into a garbage, compost, or recycling bin.

3. Health Information Services (HIS) shall hold all keys to all document shredding bins.

4. Documents deposited into a document shredding bin shall be considered shredded.

5. Documents deposited into a document shredding bin in error shall not be retrieved except in the following circumstance:
a. The document cannot be reproduced and its absence will cause resident/patient harm or is necessary to evidence the proper billing of services.

6. If a document is retrievable pursuant to section 5(a) of this policy, the following procedure shall be followed:

a. The staff member who erroneously deposited the document into the document shredding bin shall immediately notify his or her supervisor and LHH’s Privacy Officer of the type of document erroneously deposited, when it was deposited, into which document shredding bin it was deposited, whether or not the document will cause resident/patient harm or is necessary to evidence the proper billing of services, and whether or not the document is able to be reproduced.

b. The Privacy Officer shall determine if the document may be retrieved from the document shredding bin pursuant to this policy. To aid in that determination, the Privacy Officer shall confer with HIS to determine whether it is possible to reproduce the document.

c. If the Privacy Officer determines that the document may be retrieved, he or she shall contact HIS to obtain the key to the appropriate document shredding bin.

d. Both the Privacy Officer and the staff member’s supervisor shall retrieve the document from the document shredding bin using the following protocol:

i. No other person except the Privacy Officer and staff member’s supervisor shall be present in the area around the document shredding bin. If the bin is in an enclosed room, all other persons shall be cleared from the room and the door shall be closed.

ii. The Privacy Officer shall open the document shredding bin.

iii. The Privacy Officer shall remove only as many documents from the document shredding bin as necessary to reach the erroneously deposited document. All documents shall be accounted for as they are removed.

iv. The Privacy Officer shall remove the erroneously deposited document from the document shredding bin. All other removed documents shall be placed back into the document shredding bin immediately after retrieving the erroneously deposited document.

v. The Privacy Officer shall lock the document shredding bin. Only after the document shredding bin is locked shall other persons be allowed back into the room or area.

vi. The Privacy Officer shall return the erroneously deposited document to the staff member’s supervisor.
vii. The Privacy Officer shall immediately return the document shredding bin key to HIS.

7. Staff members shall not deposit any documents into a document shredding bin if doing so will cause the documents to be visible through the bin’s opening, or if doing so will cause the bin to be full or to overflow.

8. When documents are visible in a document shredding bin through the bin’s opening, or the document shredding bin is full or overflowing, the following procedure shall be followed:

   a. Whenever a staff member sees that documents are visible through the opening of a document shredding bin or that the bin is full or overflowing, the staff member shall immediately notify his or her supervisor. The supervisor shall make every effort to ensure that the overflowing documents are secured inside the document shredding bin. The supervisor shall place a sign over the document shredding bin’s opening informing users that the bin is full and to place documents in another document shredding bin.

   b. Staff members shall not deposit documents into a full or overflowing document shredding bin.

9. The destruction of a large volumes of documents containing confidential information and/or PHI shall be handled according to the following procedure:

   a. The document shredding bins shall not be used for the disposal of large volumes of documents.

   b. HIS shall be notified prior to the commencement of a project to dispose of a large volume of documents. HIS shall arrange an additional collection based on the volume of documents to be destroyed.

   c. A department or staff member shall box and store the documents in a secure area until the date of the scheduled additional collection.

9.10. Staff members shall not deposit personal documents into the document shredding bins. Under no circumstance shall a staff member’s erroneously deposited personal document be retrieved from a document shredding bin.

ATTACHMENT:
None

REFERENCES:
Health Information Services Policy 13.6, Patient Access to Health Records
Laguna Honda Hospital-wide Policy LHHPP 21-01, Medical Records Information: Confidentiality and Release
Laguna Honda Hospital Health Information Services Policy 13.6, Patient Access to Health Records

Revised: 19/03/12 (Year/Month/Day)
Original adoption: 17/03/14 (Year/Month/Day)
BREACH POLICY

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect its resident’s/patient’s personal and medical information. It is the responsibility of all staff to immediately report a privacy breach that they become aware of, or suspect.

2. This policy pertains to all individuals at the LHH campus who have access to, use, or disclose Protected Health Information (PHI) maintained in the electronic health record or in physical form regardless of their Department of Public Health (DPH)/LHH division, program, service or department.

3. The DPH Office of Compliance and Privacy Affairs (OCPA) LHH site Privacy Officer (under the direction of the DPH Chief Integrity Officer & Director, Office of Compliance and Privacy Affairs) is responsible for monitoring the adherence to this policy.

PURPOSE:

The purpose of this policy is to define the responsibility for LHH’s response to a potential or actual privacy breach of PHI. This document establishes guidance for the reporting and investigation of the breach of PHI per the 1996 Health Insurance Portability and Accountability Act (HIPAA), the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, and the 2013 HIPAA Final Omnibus Rule. In addition, federal regulation 42 CFR Part 2 governs the privacy of resident/patient in substance use disorder programs. The California Medical Information Act (CMIA) as well as other state regulations requiring LHH to investigate, report and notify a resident/patient of a suspected breach of resident/patient PHI. HIPAA requires that LHH notify the resident/patient whose unsecured PHI has been compromised by such a breach. Depending on the circumstances and size of the breach, LHH must also report certain breaches to state and federal agencies and to the media.

DEFINITION:

1. “Breach” is the mislaying/loss, theft, or the unauthorized access, use or disclosure of a resident’s/patient’s personal information and/or PHI. The personal information and protected health information includes data collected for clinical, business and/or research purposes. The privacy breach may be accidental or willful and specifically includes, without limitation, personal and/or medical information stored electronically on an unencrypted device or paper document that is lost or stolen.

2. “Health Insurance Portability and Accountability Act of 1996” or “HIPAA” is a federal privacy law that requires health care providers and organizations, as well as their business associates, develop and follow procedures that ensure the confidentiality and security of PHI when it is transferred, received, handled, or shared.
3. “Medical Information” is any individually identifiable information, in electronic or physical form, that is in the possession of, or derived from, a provider of health care, health care service plan, pharmaceutical company or contractor, regarding a resident’s/patient’s medical history, mental or physical condition, or medical treatment, or diagnosis.

4. “Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the resident’s/patient’s name, address, electronic mail address, telephone number, SSN, or other information that, alone or in combination with other publicly available information, reveals the individual’s identity.

5. “Protected Health Information” or “PHI” is health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual.

6. “Ransomware” is a type of malware (malicious software) distinct from other malware; its defining characteristic is that it attempts to deny access to a user’s data, usually by encrypting the data with a key known only to the hacker who deployed the malware, until a ransom is paid.

PROCEDURE:

1. Breach Notification/Reporting Responsibilities
   a. DPH/LHH staff at the LHH campus shall report any potential breach as soon as is reasonably possible to the LHH Privacy Officer, or to their supervisor/manager who will then make the report to the LHH Privacy Officer. LHH staff may also report the potential privacy incident or violation to the DPH Privacy Hotline (855-729-6040).
   b. DPH/LHH staff shall report any potential breach as soon as possible even if they are not sure a breach has occurred and/or do not have all of the information regarding the incident.
   c. DPH/LHH staff or the LHH Privacy Officer shall file an Unusual Occurrence (UO) report immediately upon discovering or being informed about the potential privacy breach.

2. Breach Determination — Risk Assessment
a. The LHH Privacy Officer in consultation with the DPH's Office of Compliance and Privacy Affairs (OCPA) will make the determination if a breach has occurred. The following criteria (per Federal code §164.402) will be used to determine if a breach has occurred:

i. A breach is the acquisition, access, use, or disclosure of PHI which compromises the security or privacy of the PHI. The term “breach” does NOT include:

   - Unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of LHH if the acquisition, access or use was made in good faith and within the course and scope of their authority and does not result in further use or disclosure in a manner not permitted by the HIPPA Privacy Rule.

   - Any inadvertent disclosure by a person who is authorized to access PHI at LHH to another person authorized to access PHI at LHH, and the information received is not further used or disclosed in a manner not permitted by the HIPPA Privacy Rule.

   - A disclosure of PHI where there is a good faith belief that the unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

   - Devices that are lost or stolen that contain PHI if the devices are encrypted and meet DPH standards.

ii. There may be situations where there is a low probability of a breach based on a risk assessment of the following factors:

   - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.

   - The unauthorized person who used the PHI or to whom the disclosure was made.

   - Whether the PHI was actually acquired or viewed.

   - The extent to which the risk to the PHI has been mitigated.

   - Examples of situations of a low probability of the PHI being compromised include sending PHI in the mail to the wrong address where the mail is returned unopened to the post office as undeliverable, or where a nurse mistakenly hands discharge papers to the wrong resident/patient, quickly realizes the mistake, and recovers the PHI before the resident/patient has time to read it.
iii. If it is determined that a breach did not occur, the decision-making process shall be documented and filed and by the LHH Privacy Officer shall issue a Findings and Recommendation to the appropriate LHH division.

iv. If it is determined that a breach did occur, the decision-making process shall be documented and the LHH Privacy Officer will initiate the DPH Breach Reporting Procedures (see DPH Breach Policy) in conjunction with the LHH Quality Management Department. The LHH division or staff involved in the breach shall not directly contact the resident/patient unless directed to do so by the LHH Privacy Officer.

b. Determining a Ransomware Breach: The Office of Civil Rights has issued guidance regarding determining whether a breach has occurred in a ransomware situation. The following is from that guidance: “Whether or not the presence of ransomware would be a breach under the HIPAA Rules is a fact-specific determination.” When electronic protected health information (ePHI) is encrypted as the result of a ransomware attack, a breach has occurred because the ePHI encrypted by the ransomware was acquired (i.e., unauthorized individuals have taken possession or control of the information), and thus is a “disclosure” not permitted under the HIPAA Privacy Rule. In situations “where the ePHI encrypted by the ransomware was already encrypted to comply with HIPAA,” it is also a “fact specific determination” of whether a breach has occurred. Even if the ePHI is encrypted in accordance with DPH standards, “additional analysis may still be required to ensure that the encryption solution, as implemented, has rendered the affected PHI unreadable, unusable and indecipherable to unauthorized persons.” If that is the case, then a breach has not occurred.

i. OCPA in consultation with IT and the City Attorney’s Office (CAO), will determine if a breach has occurred due to ransomware.

ii. If it is determined that a breach has occurred, the decision making process will be determined and: a) IT will contact the FBI and OCPA will initiate the breach notification process and b) the LHH Privacy Officer will initiate the DPH Breach Reporting Procedures (see DPH Breach Policy) in conjunction with the LHH Quality Risk Management Department.

3. Resident/Patient Notification Process

a. The LHH Privacy Officer shall notify resident/patient of confirmed breaches according to the following procedure:

i. Resident/patient notices will be sent via first-class mail if the resident/patient has been discharged from LHH. If the resident/patient is still admitted to LHH at the time the notice is sent, the notice shall be delivered via interoffice mail to the resident’s/patient’s room. In all cases where the resident/patient has a
designated decision-maker, the notice shall be sent to the decision-maker via first-class mail.

ii. If there is insufficient or out-of-date contact information for 10 or more individuals, a substitute individual notice will be posted on the home page of the LHH and DPH web site for at least 90 days.

iii. If there is insufficient or out-of-date contact information for fewer than 10 individuals, LHH will provide substitute notice by an alternative form such as a written notice to the emergency or other contact in the resident’s/patient’s health record or other DPH source or by telephone.

iv. If the resident/patient is a minor, notification shall be made to the parent or legal guardian. If the resident/patient is deceased, notification shall be made to the next-of-kin or personal representative indicated in the resident’s/patient’s Lifetime Clinical Recordchart (if contact information is available).

v. DPH maintains a separate toll-free phone number dedicated to all privacy breaches where individuals can learn if their information was involved in any breach.

vi. The resident/patient shall be provided notice without unreasonable delay and in no case later than 15 business days following the discovery of a breach. The notice will be written in plain language and must include, to the extent possible, the following:

- A brief description of what happened, including the date of the breach, date range of the breach and the date of the discovery of the breach, if known;

- A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number (SSN), date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

- Any steps the individual shall take to protect themselves from potential harm resulting from the breach; If the breach exposed a SSN, California Driver’s license or California ID card number, then provide the toll-free phone numbers and addresses of the major credit reporting agencies;

- A brief description of what DPH is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches; and

- Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, Web site, or postal address.
• If the breach involves a data security breach, the notice shall include the header “SUBJECT: NOTICE OF DATA BREACH” and shall present the details of the breach by using the following subject headings: “What Happened;” “What Information Was Involved;” “What Are We Doing;” “What You Can Do;” and “For More Information.” The notification shall also include information about what LHH has done to protect the individuals’ information and advice on steps that the individuals may take to protect themselves.

b. Law Enforcement Delay of Notification: If a law enforcement official states that a notification, notice, or posting required under this subpart would impede a criminal investigation or cause damage to national security, the LHH Privacy Officer or OCPA shall immediately notify the City Attorney’s Office (CAO) for guidance. Upon the direction of the CAO, requests to delay notification will be handled as follow:

i. If the statement is in writing and specifies the time for which a delay is required, OCPA will delay such notification, notice, or posting for the time period specified by the official; or

ii. If the statement is made orally, OCPA will document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement is submitted during that time.

iii. In either case, documentation related to the law enforcement delay request will be retained.

4. Reporting of Confirmed Breaches to Government Agencies

a. Reporting to the California Department of Public Health (CDPH)

i. Upon determining that there is a privacy breach, the LHH Privacy Officer shall immediately request Risk Management to notify the CDPH of the breach. Risk Management shall then immediately notify the CDPH of the breach. The CDPH must be notified of the breach no later than 15 business days from the date the LHH Privacy Officer or OCPA was notified of the potential breach.

b. Reporting to the Office of Civil Rights

i. For breaches affecting less than 500 individuals, the LHH Privacy Officer shall notify the Office of Civil Rights as soon as possible, but no later than 60 calendar days after the end of the calendar year in which the breach was discovered.

ii. For breaches affecting 500 or more individuals, the LHH Privacy Officer shall notify the Office of Civil Rights as soon as possible, but no later than later than 60 calendar days from the discovery of the breach.
c. Reporting to the San Francisco Health Plan and other Insurance Plans

i. For any breach affecting a resident/patient covered by the San Francisco Health Plan (SFHP), the LHH Privacy Officer shall notify the SFHP within 24 hours of determining a breach occurred. The LHH Privacy Officer shall provide the SFHP with as much information as possible to date regarding the breach affecting its members.

ii. Notification letters to members of the SFHP shall be submitted to the SFHP for approval prior to being sent to the affected resident/patient.

iii. Upon completion of any investigation into the breach, the LHH Privacy Officer shall provide a detailed report of the circumstance surrounding the breach to the SFHP.

iv. For all insurance plans other than SFHP, the LHH Privacy Officer will determine if a plan requires LHH report to it that its members were affected by the breach, and the LHH Privacy Officer will follow the reporting procedures specified by each plan.

5. Remediation and Corrective Action

a. The LHH Privacy Officer is responsible for providing oversight and advisory assistance to the affected LHH divisions and to ensure that appropriate remediation occurs. This includes corrective actions such as implementation and ongoing monitoring of process change, technical measures, or individual disciplinary measures designed to prevent a breach in the future. Results of corrective actions will be reported to the LHH Privacy Committee by the affected LHH division at regular intervals to be determined by the LHH Privacy Officer.

b. The OCPA Findings and Recommendations form shall be used to document the incident findings and corrective actions.

6. Documentation

a. All documentation related to a privacy breaches shall be minimally maintained from seven years from the date of the breaches or potential breaches. This documentation will include all notifications associated with the breaches and documentation if the incidents were deemed not to be breaches. Documentation will be maintained electronically on the OCPA shared drive on the DPH network.

RELATED POLICIES:

1. Complaints to DPH: Any individual who has a complaint about the Reporting of Unlawful or Unauthorized Access of Protected Health Information Policy including
administrative requirements, may call the Privacy and Compliance hotline at (855) 729-6040 or contact by email at compliance.privacy@sfdph.org. Individuals may also call the City and County of San Francisco (CCSF) Controller’s office Whistleblower hotline at (415) 701-2311 or file a complaint.

2. Sanctions: Employees committing a breach will be subject to disciplinary action per their MOUs and Human Resource policies. Disciplinary actions may include separation. Fines and penalties apply not only to DPH but to individuals and can range up to $250,000. Employees are personally responsible for fines levied against them and violations may impact their professional license. Any sanctions applied will be documented in the breach case file.

3. Refraining from Intimidating or Retaliatory Acts: DPH employees may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual reporting a potential privacy breach.

4. San Francisco Department of Public Health’s (DPH) Breach Policy.

ATTACHMENT:
None

REFERENCE:
SFDPH PP A1.0 DPH Privacy Policy
SFDPH PP A2.0 HIPAA Compliance – Admin Policies
SFDPH PP A3.0 HIPAA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI)
SFDPH PP B2.0 Major Privacy Breach Emergency Quick Reference Response Guide

Original adoption: 17/03/14, 19/03/12 (Year/Month/Day)
RESIDENT RIGHTS

POLICY:

1. Patient/Resident rights are honored without regard to cultural, economic, educational, religious background, sexual orientation, gender identity, disability or the source of payment for his/her care.

2. Laguna Honda Hospital and Rehabilitation Center (LHH) staff collaborates with the San Francisco Ombudsmen Office in their role as residents rights advocate.

3. All residents of LHH are informed of their rights and responsibilities, and are further required to acknowledge receipt of having received a copy of those rights and responsibilities, as well as an explanation if requested.

4. A list of patients'/residents' rights is posted or available in appropriate places within LHH the hospital.

PURPOSE:

To assure that each patient/resident is knowledgeable about his/her rights and the methods and circumstances by which those rights can be withheld. These rights comply with Title 22, California Code of Regulations Section 70707 and 72527, and Code of Federal Regulations, Title 42, Section 483.10.

PROCEDURE:

1. Prior to, or upon admission to LHH, the (a) Admitting Clerk or (b) a member of the Admission & Eligibility staff will give to the resident, or her/his representative or responsible relative, a copy of the resident's rights form and will have a receipt acknowledged by the signature of the receiving party.

2. The receipt (acknowledgement) is placed in the resident's medical chart.

3. Discrepancies regarding these procedures should be brought to the attention of the Director of Admissions and Eligibility Department.

ATTACHMENT:
Appendix A: List of Residents' / Patients' Rights

REFERENCE:
Resident Rights Web address:

Revised: 09/06/2002, 9/30/2008, 10/04/27, 15/11/09, 17/09/12, 19/03/12
(Year/Month/Day)
Original adoption: 01/22/198
Appendix A:

LIST OF RESIDENTS’ / PATIENTS’ RIGHTS

I. Exercising Your Rights

1. You have the right to a dignified existence, self-determination, and communication and access to people and services both inside and outside of Laguna Honda. You have the right to be free of interference, coercion, discrimination, and retaliation from Laguna Honda in exercising your rights as a resident of Laguna Honda and as a citizen or resident of the United States, and Laguna Honda shall support you exercising your rights. You have the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source.

2. You have the right to designate a representative if you are competent to do so, who may exercise your rights, in accordance with, and to the extent provided by state law.
   a. Your representative has the right to exercise your rights to the extent you have delegated those rights to your representative.
   b. You retain the right to exercise any right not delegated to your representative, including the right to revoke a delegation of rights, except as limited by state law.
   c. Laguna Honda shall treat the decisions of your representative as your decisions to the extent required by either a court or as delegated by you.
   d. Laguna Honda shall not extend to your representative the right to make decisions on behalf of you beyond the extent required by either a court or as delegated by you. Laguna Honda shall report, as required by law, if it has reason to believe that your representative is not acting in your best interest.

3. Residents adjudged incompetent by a court with jurisdiction to do so, shall have their rights devolve to and exercised by the resident representative appointed under State law to act on the resident’s behalf. The court-appointed resident representative shall exercise your rights to the extent judged necessary by the court with jurisdiction, and in accordance with state law.
   a. In cases where a representative’s decision-making authority is limited by state law or court appointment, you retain the right to make those decisions outside of the representative's authority.
   b. Your wishes and preferences must be considered in the exercise of your rights by the representative, and to the extent possible, you shall be provided with the opportunity to participate in the care planning process.
4. You have the right to exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care. The same-sex spouse or a resident shall be afforded treatment equal to that of an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

II. Planning and Implementing Your Care

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual and personal values, beliefs, and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you, and to be informed of the care to be furnished to you and the type of care giver that will furnish that care. You have the right to be informed and participate in your treatment.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in language you can understand. You have the right to be informed in advance of treatment of the risks and benefits of the proposed care, alternatives or options to the proposed treatment, and to choose the alternative or option if you prefer.

5. You have the right to effective communication and to participate in the development and implementation of your plan of care, and the right to receive the services and/or items included in the plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

6. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

7. Participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. You have the right to identify individuals or roles to be included in the
planning process, the right to request meetings, and the right to request revisions to the plan of care.

8. Choose your attending physician, provided that the physician meets the requirements of Code of Federal Regulations, Title 42.

9. See the plan of care and be informed in advance of any changes to the plan of care.

10. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

11. Self-administer medications if your care team has determined that this practice is clinically appropriate.

12. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

13. Reasonable responses to any reasonable requests made for service.

14. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve the pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

15. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

III. Respect and Dignity

You have the right to:

1. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
2. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

3. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

4. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

5. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided with this information also.

6. Know which hospital rules and policies apply to your conduct while a patient.

7. A safe, clean, and homelike environment including receiving treatment that supports your safe daily living. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Laguna Honda shall exercise reasonable care for the protection of your property from loss or theft.

8. Reside and receive services with reasonable accommodation of your needs and preferences except when to do so would endanger your health or safety or other residents.

9. Share a room with your spouse if your spouse also resides at Laguna Honda and you both consent to the arrangement.

10. Share a room with the roommate of your choice when practicable, and only when you are both residents at Laguna Honda and consent to the arrangement.

11. Receive written notice, including the reason for the change, before your room or roommate in the facility is changed.

12. Refuse to transfer to another room in the facility, if the purpose of the transfer is to relocate you from a skilled nursing unit to a non-skilled nursing unit within Laguna Honda, or if the transfer is solely for the convenience of Laguna Honda. This right shall not affect your eligibility or entitlement to Medicare or Medi-Cal benefits.

IV. Self-Determination

You have the right to:

1. Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with your interests, assessments, and
plan of care; and to make choices about aspects of your life at Laguna Honda that are significant to you.

2. Interact with members of the community and participate in community activities both inside and outside of Laguna Honda.

3. Organize and participate in resident groups within Laguna Honda. You have the right to participate in social, religious, and community activities provided that doing so does not interfere with the rights of other residents.

4. Receive visitors of your choosing at the time of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
   
   a. Laguna Honda reasonably determines that the presence of a particular visitor would endanger the health or safety of you, other residents, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.

   b. You have told Laguna Honda staff that you no longer want a particular person to visit.

   c. However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

5. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.

6. Participate in family groups and have family members or other representatives’ meet with the families or representatives of other residents of Laguna Honda.

7. Choose to or refuse to perform services for Laguna Honda. You may perform services for Laguna Honda when:

   a. Laguna Honda has documented your need or desire for work in the plan of care;

   b. The plan of care specifies the nature of the services performed and whether the services are voluntary or paid;

   c. Compensation for paid services is at or above prevailing rates; and

   d. You agree to the work arrangement described in the plan of care.

   e. At no time shall you be required to perform services for Laguna Honda.
8. Manage your own financial affairs, including the right to know in advance, what charges Laguna Honda may impose against your personal funds.

9. Examine and receive an explanation of the hospital’s bill regardless of the source of payment.

V. Information, Communication, Privacy, and Confidentiality

You have the right to:

1. Be informed of your rights and the rules and regulations governing resident conduct and responsibilities during your stay at Laguna Honda.

2. Access your personal and medical records; and to secure and confidential treatment of all communications, personal records, and medical records pertaining to your care and stay in the hospital. You have the right to refuse the release of personal and medical records unless federal or state law requires the release of those records. You will receive a separate “Notice of Privacy Practices” that explains your privacy rights in detail and how we may use and disclose your protected health information.

3. Receive notices both orally and in writing in a format and language that you understand.

4. Have reasonable access to the use of a telephone in a place where you cannot be overheard, including the right to retain and use a cellular phone at your expense. You have the right to communicate with individuals and entities within and outside of Laguna Honda with reasonable access to the internet, to the extent available within Laguna Honda.

5. Send and receive mail, including letters, packages, and other materials delivered to Laguna Honda; and to have those communications be received and sent promptly and in private. You have the right to access stationery, postage, and writing implements at your expense.

6. Have access to, and privacy in, your use of electronic communications such as email and video communications, and internet research to the extent that it is available at Laguna Honda.

7. Privacy in your medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.

8. Examine the results of the most recent survey of Laguna Honda conducted by Federal or State surveyors and any plan of correction in effect, and to receive information from agencies acting as client advocates including the right to contact such agencies.
9. Voice grievances to Laguna Honda or other agencies that hear grievances without retaliation or discrimination, and without the fear of retaliation or discrimination, including grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and any other concern regarding your stay at Laguna Honda.

If you want to file a grievance with this hospital, you may do so by writing or calling:

Mivic Hirose, RN, MS, CNS
Executive Administrator
Administration Department
Laguna Honda Hospital
375 Laguna Honda Boulevard
San Francisco, CA 94116
(415) 759-2363

You have the right to prompt resolution of grievances. The grievance committee will review each grievance and provide you with a written response within 5 days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

10. File a complaint with the state Department of Public Health regardless of whether you use the hospital’s grievance process. The state Department of Public Health’s phone number and address is:

Department of Public Health Licensing & Certification
San Francisco District Office
150 North Hill Drive Suite 22
Brisbane, CA 94005
Phone: (415) 330 6353
Fax: (415) 330 6350
PHYSICAL RESTRAINTS INCLUDING SIDERAIRS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) affirms the right of each resident to be free from any physical restraint imposed for purposes of discipline or staff convenience, and when not required to treat the resident’s medical symptoms.

2. LHH supports preventing, reducing and eliminating the use of restraints and restraint-associated risk through the use of preventive strategies, alternatives, and process improvements.

3. The least restrictive interventions shall be discontinued as soon as it is safe for the resident and staff regardless of the scheduled expiration of the restraint order.

4. Restraint order shall not be written as a standing or PRN order.

5. Restraint consent form shall be updated annually.

PURPOSE:

To assure resident freedom from physical restraints whenever possible, and to utilize the least restrictive restraints only when other less restrictive means to provide safety have been ineffective.

DEFINITIONS:

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

   a. Freedom of movement: any change in place or position for the body or any part of the body that the person is physically able to control or access.

2. Bed Side rail(s) are considered restraints when:

   a. The purpose is to keep a resident from getting out of bed when he/she wants to get out of bed.

   b. The use of the bed siderail restricts freedom of movement.

Alarms are considered restraints when the resident is afraid to move to avoid setting off the alarm.

3. Convenience: as the result of any action that has the effect of altering a resident’s behavior such that the resident requires a lesser amount of effort or care, and is not in the resident’s best interest.
4. **Discipline**: any action taken by the facility for the purpose of punishing or penalizing residents.

5. **Manual Method**: to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint.

6. **Medical symptom**: is defined as an indication or characteristic of a physical or psychological condition.

7. **Position Change Alarms**: alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in criteria ways.
   
   a. Alarms are considered restraints when the resident is afraid to move to avoid setting off the alarm.

**EXCLUSIONS:**

**Mechanical/postural Support:**

Mechanical/postural support is not considered a restraint. It is used to achieve proper body position, balance, or alignment to allow greater freedom of mobility that would not be possible without the use of the mechanical support (refer to NPP D6 4.0 Positioning and Alignment in Bed and Chair).

**STANDARDS / GUIDELINES FOR RESTRAINT USE:**

1. A physical restraint can only be used to provide safety if less-restrictive interventions have been ineffective. The ineffective physician order must be completed via EHR.

2. Complete the restraint order form in its entirety (MR 154).

3. If the covering physician writes a restraint order, this shall be communicated to the attending physician during endorsement.

4. The physician must conduct a face-to-face assessment within one calendar day of initiation when initial restraint order is verbal.

4. Only restraints approved by LHH may be used (hand mittens, abdomen binder, and ultimate walker, bed rails in certain circumstances). The appropriate size and type of restraint for the resident is to be applied following manufacturer’s directions. Restraints are to be applied so as to permit easy removal in emergency situations (e.g., in the event of a fire or disaster).

**PROCEDURE:**
1. **Procedure for Using Restraints:**

   a. Before applying a new restraint:

      i. Consult with the Resident Care Team (RCT), consisting of at least the nurse and physician, to discuss and document:

         • Circumstances leading to the use of restraints and what less-restrictive interventions were tried first;

      ii. The degree of effectiveness of the less-restrictive alternatives and how it was decided what type of restraint to use.

   b. When a decision is made to order a new physical restraint:

      i. **Orders are to be coCompleted via EHR.**

         - the Restraint Order Form (MR 154) if the restraint is a siderail, use the Siderail Order Form (MR 172) and refer to LHHPP 22-13, Siderail Use.

      ii. Complete Consent for Physical Restraint forms. (MR 812) — Consents must include discussion with the resident or resident representative, family, or surrogate decision-maker regarding:

         • Educate family/resident representatives/surrogate decision-maker on risk of removing, repositioning, or retying restraint.

         • Type of restraint and duration of use.

         • Possible benefits and risks of using, or not using, restraints.

         • Rights of resident or resident representative/surrogate decision-makers to accept or refuse the use of restraints at any time.

   iii. Update the resident’s Care Plan:

      • The type of restraint and whether the restraint used is the least restrictive device.

      • The reason for the restraint (medical symptom) and restraint use duration

      • Document ongoing efforts to evaluate/eliminate use of the restraint.

      • Interventions (restorative) to address potential functional decline.

      • A plan for reduction or eventual discontinuation of the restraint.
iii.iv. For a new order, RN’s will monitor the resident within one hour after initiating the restraint and release and document every 2 hours or sooner according to resident need – a continuous face-to-face monitoring may be required when the restraint leaves a resident vulnerable.

iv.v. The RCT will meet in a timely manner to discuss alternatives and plan for least-restrictive restraint(s).

c. For continued restraint use:

i. Ongoing use of restraints shall be discussed with the RCT quarterly, or during “Special Review” which can be conducted at any time.

ii. Discussion shall include:

- Resident’s response to restraint being used.
- Possible alternatives/least-restrictive restraint to be used.
- Referrals to ancillary departments, as appropriate.
- If the restraint is to be continued, the order must be renewed on the Restraint Order Form (MR 154) via EHR.

2. Procedures for Using Restraints: Treatment

Treatment restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.

3. Procedures for Using Restraints: Acute Patients (Medical or Rehabilitation)

Physician orders for the use of physical restraints in an acute care setting follow the same procedures as outlined above with the exception of every 24 hour renewal time.

4. DOCUMENTATION

a. The condition of the resident utilizing a restraint shall be monitored every 2 hours.
i. Assessments are to be documented by RNs via EHR on the Treatment Administration Record and shall include, but are not limited to:

- Circulation (including vascular checks such as capillary refill, temperature, edema and color of skin)
- Skin integrity of the restrained extremity(ies)
- Signs of injury associated with a restraint

ii. Clinical justification and resident response that warrants the use of the restraint are to be reflected in the weekly/monthly nursing summary by the Licensed Nurse.

b. Certified nursing assistants or patient care assistants are to document via EHR on the Daily Nursing Care Record (DNCR) the following:

i. Proper placement of restraint as ordered

ii. Release of restraint every 2 hours for:

- ROM to the restrained extremity(ies) while awake
- Turning and repositioning
- Hygiene/elimination

(Note: a temporary release that occurs for the purpose of caring for a resident’s needs, i.e., toileting, feeding, repositioning and ROM, is not considered a discontinuation of the intervention.)

5. Staff Training

a. Nursing Staff who have direct patient contact shall receive new employee orientation training and subsequent annual education and training in the proper and safe use of restraints, including, but not limited to the following:

   i. Methods to reduce and eliminate restraint use;

   ii. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger physical restraint use;

   iii. Use of non-physical intervention skills;

   iv. Choosing the least-restrictive intervention based on individualized assessment;
iv.v. Safe application of physical restraints;

v.vi. Clinical identification of behavioral changes that indicate that restraint is no longer necessary; and

vi.vii. Monitoring physical and emotional well-being of patients (e.g., respiratory and circulatory status, skin integrity, vital signs, etc.).

ATTACHMENT:

Appendix A: Alternatives to Restraint Suggestions
Appendix B: Seatbelt table

REFERENCE:
Barclays Official California Code of Regulations: §72319, Nursing Service - Restraints and Postural Supports
State Operations Manual Appendix PP - Survey Protocol, Regulations and Interpretive Guidelines for Long Term Care (Rev. 168, 03-08-2017)
Title 22

CROSS-REFERENCE:
LHHPP 22-13 Siderail Use
LHHPP 24-13 Falls
NPP D6 4.0 Positioning and Alignment in Bed and Chair

Revised: 97/04/15, 00/01/27, 02/09/06, 08/08/08, 09/01/13, 09/08/21, 10/09/24, 10/11/10, 16/01/12, 17/09/12, 19/03/12 (Year/Month/Day)

Original adoption: 96/07/15
BED RAIL USE

POLICY:

1. Prior to bed rail use, consider the use of appropriate alternatives (see Attachment A). Bed rails may only be used after careful assessment by the Resident Care Team (RCT) reviewing the risks and benefits of bed rail use.

2. SMR 172 Safety Assessments, Bed Rail Order and Informed Consent Form shall be completed for residents who use bed rail(s).

3. A new MR 172 safety assessment, order, and consent shall be completed when the resident uses a different type of bed.

4. If the bed rail is being utilized as meets the definition of a physical restraint, the hospital-wide policy and procedures outlined in LHHPP 22-07 Physical Restraints shall be followed.

5. Continued bed rail use requires at a minimum, a quarterly bed rail safety assessment by the RCT.

6. Residents who have been using non-restrictive bed rails prior to November 28, 2017, shall be assessed to have their bed rails discontinued if appropriate, tapered in use, or a determination made as to the purpose for bed rail use and or the medical justification.

7. Facility Services staff is responsible for the proper installation of bed rails and tracking completion of annual preventive maintenance on the bed used by the resident.

8. Resident or representative may choose to use bed rails per preference.

PURPOSE:

To ensure safe and appropriate use of bed rails.

DEFINITIONS:

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

2. Freedom of movement: any change in place or position for the body or any part of the body that the person is physically able to control or access.

Bed rails are considered restraints when:

2-3.
a. The purpose is to keep a resident from getting out of bed when he/she wants to get out of bed.

b. The use of a bed rail restricts freedom of movement.

PROCEDURE:

1. A safety assessment shall be completed by the RCT and documented on Form MR 172 by the Registered Nurse taking into consideration the resident’s current medical diagnosis, physical condition (size and weight), functional ability (bed mobility, transfer, ability to toilet self), cognition, communication, sleep habits, medication(s), physical and/or behavioral symptoms.

2. The safety assessment takes into consideration the following:
   
a. Risk of entrapment,
   
b. Bed’s dimensions are appropriate for the resident’s size and weight,
   
c. Fall risk,
   
d. Physical restraint assessment,
   
e. Potential negative physical outcomes such as decline in function for activities of daily living and skin integrity issues, and
   
f. Potential negative psycho-social outcomes such as an undignified self-image, low self-esteem, and feelings of isolation, anxiety or agitation.

3. Use of bed rails shall be ordered by the physician by completing the Bed Rail Order and Consent/Education sections of form MR 172.

4. The Resident or Resident Representative shall consent to bed rail use by signing on the Informed Consent section of form MR 172.

5. Nursing staff is responsible for notifying Facility Services when they find a bed that is past due for preventive maintenance.

6. The RCT is responsible for on-going monitoring and supervision of residents who use bed rails and for conducting a quarterly safety assessment and documenting the assessment in the RCT meeting notes.
7. For new admissions, the RCT shall review and consider the alternatives listed under Appendix A and determine if any of the suggested interventions are appropriate as an alternative to bed rail use.

ATTACHMENT:
Attachment A: Table for Alternatives to Bed Rail Suggestions

REFERENCE:
LHHPP 22-07 Physical Restraints
MR 172 Safety Assessment, Bed Rail Order and Informed Consent Form (revised 01/2018)

Barclays Official California Code of Regulations: §72319. Nursing Service - Restraints and Postural Supports
Centers for Medicaid and Medicare Services: 42 CFR Part 482 Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule
http://www.cms.hhs.gov/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf

Revised: 10/11/10, 16/09/13, 18/03/13, 19/03/12 (Year/Month/Day)
Original adoption: 08/21/09
RESIDENT CARE PLAN (RCP), RESIDENT CARE TEAM (RCT) & RESIDENT CARE CONFERENCE (RCC)

POLICIES:

1. An interdisciplinary Resident Care Team (RCT), in conjunction with the resident, resident’s family, or surrogate decision-maker shall develop a baseline plan of care within 48 hours of the resident’s admission. It shall include instructions needed to provide effective and person-centered care of the resident, and shall at a minimum include: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and if applicable, PASARR recommendation.

2. An interdisciplinary Resident Care Team (RCT) The RCT, in conjunction with the resident, resident’s family, or surrogate decision-maker, shall develop a comprehensive plan of care based on the care team disciplines’ assessments, that includes measurable objectives and a time table to meet the resident’s medical, nursing, and mental health needs.

3. The Resident Care Plan (RCP) will be person-centered, evaluated regularly, at a minimum of once every quarter, and revised as needed to serve as an essential resource for improved resident outcomes.

4. The resident, family, significant other(s) and/or conservator shall be part of the development and implementation of his or her person-centered plan of care.

5. Most care problems require various professional disciplines working together in planning, implementing and evaluating interventions. The RCT may care plan together in formal resident care meetings, in smaller less formal settings, in discussions over the telephone or by written communication.

6. A Resident Care Conference (RCC) will be conducted with the scheduled completion of an admission, quarterly, annually and/or with a significant change in condition MDS.

7. Special Review (SR) RCC’s shall be held when the review of specific care issues are clinically indicated.

8. Stable, ongoing resident needs and resident preferences are addressed on the Front Card (MR 318A). Unstable, alterable problems that require a more goal directed approach are addressed on the RCP (MR 318). Together they comprise the resident’s care plan.

PURPOSE:

To promote the resident’s highest possible physical, mental and psychosocial well-being.
DEFINITION:

Resident’s goal: The resident’s desired outcomes and preferences for admission, which guide decision making during care planning.

Interventions: Actions, treatments, procedures, or activities designed to meet an objective.

Measurable: The ability to be evaluated or quantified.

Objective: A statement describing the results to be achieved to meet the resident’s goals.

Person-centered care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

PROCEDURE:

1. The Resident Care Team

   a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include:

      i. Resident, family, significant other(s) and/or conservator

      ii. Nurse Managers (or designee) – Facilitator of RCC

      iii. Licensed Nurse

      iv. Nursing Assistant

      v. Attending Physician

      vi. Medical Social Worker

      vii. MDS Coordinator

      viii. Activity Therapist

      ix. Registered Dietitian
b. The resident, family, significant other(s) and/or conservator shall be part of the development and implementation of his or her person-centered plan of care, including but not limited to:

i. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

iii. The right to be informed, in advance, of changes to the plan of care.

iv. The right to receive the services and/or items included in the plan of care.

i.v. The right to see the care plan, including the right to sign after significant changes to the plan of care.

c. In the event that a special review meeting is necessary, at least two (2) appropriate team members from two different disciplines shall attend, of which one shall be a nurse. The entire RCT shall be notified of any care plan changes, including the resident, family, significant other(s) and/or conservator.

d. Consultative Members may be part of the RCT if actively involved in the care of the resident and may include as appropriate:

- Chaplaincy
- Clinical Nurse Specialist
- LHH Psychiatry providers (Psychiatrist/Psychologist/Behavioral Health Clinician/mental health or substance treatment counselor/Psychiatric Social Worker/Psychosocial
- Occupational Therapist/SATS Counselor
- Quality Management
- Pharmacy
- Rehabilitation Services
- Dietary Technicians
• Peer Mentors

• Ombudsmen

• Any other consultants as needed

e. The RCT will address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP.

f. The RCT shall incorporate the resident’s personal and cultural preferences in developing goals of care, and address the resident’s care needs through assessments such as the:

i. Minimum Data Set (See LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set)

ii. Admission assessments including but not limited to:

• Physician History and Physical

• Resident Social History Assessment (MR 703)

• Nutrition Screening and Assessment (MR 121)

• Admission Nursing Assessment (MR 321)

• Comprehensive Pain Assessment (MR 337)

• Behavioral Risk Assessment (MR 340)

• Discharge Assessment (MR 711)

• Pressure Ulcer Risk Assessment (MR 347)

• Activity Therapy Assessment (MR 602)

• RCT Pre and Post Elopement Event (MR 170) (Cross Reference LHHPP 24-22 Code Green Protocol)

• Siderail Order Form (if appropriate) (MR 172)

• Smoking Assessment and Plan of Care (MR 161)

2. Resident Care Conferences
a. The RCC will serve as the forum for interdisciplinary development and review of the care plan. Care plan review shall be done:

i. Within seven days of new admission

ii. On a quarterly schedule with the MDS

iii. Annually

iv. With a significant change in resident condition status

v. With discharge planning

vi. Within 14 – 21 days of relocation to another unit in LHH

vii. Special Review(s)

b. RCT members shall conduct their assessments and prepare for prior to the RCC. Members will prepare for the conference prior to the meeting. This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident.

c. The RCT shall facilitate the inclusion of the resident and/or resident representative. The resident and/or surrogate decision-maker shall be informed of the meeting, date and time. The resident shall be invited and encouraged to attend the RCC care conference, unless contraindicated by the resident’s condition.

i. The social worker shall contact the surrogate/conservator about the meeting date and time.

ii. The meeting will provide the resident/surrogate shall have the opportunity to express concerns and preferences during the RCC.

c. The nursing assistant and assigned licensed nurse shall be present, or provide information if unable to attend, at the RCC care conference and consultants shall be invited as appropriate.

d. The RCT Interdisciplinary Conference Note (MR 335) shall be completed for each RCC.

3. Admission Baseline Care Plan

a. Shall be initiated by nursing within 8-eight hours on the day of admission.
a-b. Shall be completed and implemented within 48 hours of a resident’s admission.

c. It addresses the baseline care plan shall address the resident’s immediate needs for safety, management of risks, and medical attention, including but not limited to the minimum healthcare information necessary to properly care for the resident as outlined in policy statement #1.

d. The baseline care plan shall reflect the resident’s stated goals and objectives, and include interventions that address his or her current needs.

i. It shall be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

ii. The baseline care plan documents the interim approaches for meeting the resident’s immediate needs, professional standards of quality care shall dictate that it shall also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.

iii. LHH staff shall implement the interventions to assist the resident to achieve care plan goals and objectives.

e. Is reviewed with the resident and/or authorized resident representative, in their preferred language, no later than seven days after admission.

f. LHH shall provide the resident and/or resident representative with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary shall include:

i. Initial goals for the resident;

ii. A list of current medication and dietary instructions; and

iii. Services and treatments that shall be administered by LHH.

b. As resident preferences become apparent they are entered on the Front Card.

e.g. Problems identified by the Resident Assessment Instrument (RAI), must be care planned within seven days of the completion of the comprehensive assessment.

4. Comprehensive Care Plan
a. LHH shall develop and implement a comprehensive person-centered care plan within seven days of completion of the comprehensive assessment.

b. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident’s medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment.

i. Describe any specialized services or specialized rehabilitative services LHH shall provide as a result of the PASARR.

c. In consultation with the resident and/or the resident’s representative, the comprehensive care plan shall describe:

i. The resident’s goals for admission and desired outcomes.

ii. The resident’s preference and potential for future discharge. LHH shall document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

iii. Discharge plans in the comprehensive care plan, as appropriate.

4.5. Identifying and Writing the Problem Statement

a. Problems, needs, strengths, and preferences are identified by members of the RCT and the resident as a result of careful, comprehensive, and ongoing assessments.

b. Problem statements are resident focused and not staff focused.

c. The statement may, but does not require the reason for the problem, (i.e. what the problem is related to “R/T”).

d. The statement may include some, but not all, of the common observable signs and be described as “As Evidenced by (AEB)”.

e. Problems with the same root cause or same interventions may, but are not required to, be grouped together.

5.6. Determining the Goal Statement

a. The goal statement indicates the outcome desired by the resident or surrogate decision-maker and aims at promoting or maintaining the resident’s highest practicable physical, mental, and psycho-social well-being.
b. Goals must be realistic, specific, reflect the problem, measurable, and have a target date.

6.7. Developing Interventions

a. Interventions answer the questions:

i. “What can the team do to minimize the risk of a problem developing?”

ii. “What can be done to address the resident’s preferences?”

iii. “How can the resident’s goal be met?”

b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions.

c. Interventions reflect standards of current professional practice.

7.8. Evaluating Effectiveness of the Care Plan

a. Evaluation of the care plan requires accurate knowledge and analysis of the resident’s present status, and is documented in the summary notes.

b. There is evidence that the goal has been met or that there is progress towards the goal.

i. If there is evidence or progress towards the outcome desired by the resident or surrogate decision-maker.

ii. If the evaluation indicates that the goal is not being met, the RCT shall determine the cause for the lack of progress and make the necessary changes.

c. Consideration by the RCT should include:

i. Identification of the problem. Is it an accurate reflection of resident’s present status?

ii. Measurable and realistic goals.

iii. Appropriate interventions for each goal.

iv. What else can be done?

v. Additional information as appropriate.
d. The evaluation of the effectiveness of the care plan is documented in:
   i. The RCT summary note
   ii. The nursing weekly/monthly summary
   iii. Discipline specific progress notes in the chart or electronic health record

8.9. Behavioral Treatment Plans are a part of the Resident’s Plan of Care and a copy is to be kept in the Care Plan Binder

a. These plans are developed by the interdisciplinary RCT members. Plan development may require specialized behavioral planning meetings. Planning discussion is documented by a summary special review meeting note.

b. These plans are drafted by team members, most often the Social Worker, in consultation with a LHH Psychiatry provider, Psychologist or Psychiatrist, and/or consultation with other key team members on different shifts.

c. The RCT is to discuss behavioral plans with the resident and/or the resident’s surrogate decision-maker when appropriate.

d. Behavioral Treatment Plans are revised as needed and discontinued when the target behavior no longer poses a problem.

e. Behaviors identified for modification will be clearly described, noted and tracked in the Behavior Monitoring Record (BMR).

9.10. Communication

a. Nursing (i.e., MDS Coordinator, Nurse Manager or Charge Nurse) will coordinate all Special Review RCC meeting dates and times.

b. The RCT will communicate with one another in a timely manner using the RCT clipboard, email, and text paging, as needed.

c. The Behavior Monitoring Record (BMR) is a tool used by nursing to document resident behaviors so that the RCT may evaluate the resident’s response to the behavioral treatment plan.

d. Changes that affect the resident’s care or daily routine will be communicated to the resident/surrogate as soon as possible in the method that is most practical for the resident/surrogate and will be repeated as needed or provided in writing.
ATTACHMENT:
None.

REFERENCE:
LHHPP 23-02 Completion of Resident Assessment Instrument
LHHPP 24-22 Code Green Protocol
MSPP D08-10 Behavioral Management Services by LHH Psychiatry
Long Term Care Survey, June 2006 Edition
42 Code of Federal Regulation (CFR) 483.21(a)(1)-(3) Comprehensive Person-Centered Care Planning, Baseline Care Plans
42 Code of Federal Regulation (CFR) 483.10(c)(2)-(3) Resident Rights – Planning and Implementing Care

Revised: 01/10/20, 09/10/27, 10/05/25, 16/11/08, 19/03/12 (Year/Month/Day)
Original adoption: 92/05/20
ADVANCE CARE PLANNING

Revision/Consolidation of
LHHPP 24-05 Patient Self Determination Act
LHHPP MSPP C02-03 Advance health care directives to Healthcare Providers

BACKGROUND INFORMATION:

1. Advance Care Planning – California Law
   a. California law provides individuals the opportunity to insure that their health care wishes are known and considered if they become unable to make these decisions themselves. By completing a form called an "Advance Health Care Directive," California law allows individuals to do either or both of two things:
      i. First, an individual may appoint another person to be a health care agent or power of attorney for health care. This person will have legal authority to make decisions about medical care if the individual patient becomes unable to make these decisions for him/her-self or delegates decision making to his/her agent or surrogate decision maker (SDM).
      ii. Second, an individual may document in writing his or her health care wishes in the Advance Health Care Directive (AHCD) form. Physicians and health care agents must follow lawful instructions set out in the Advance Health Care Directive (AHCD) form.
   b. The Advance Health Care Directive (AHCD) is now the legally recognized format for a living will in California. It replaces the former legislation, the Natural Death Act Declaration. It allows individuals to state wishes about refusing or accepting life-sustaining treatment in any situation, and clarifies the procedure for appointment of a health care proxy or power of attorney for health care.
      i. A power of attorney must either be acknowledged before a notary public or signed by at least two witnesses. However, in skilled nursing facilities, the signature must be witnessed by the ombudsmen.
      ii. An Advance Health Care Directive is valid indefinitely unless specifically revoked.

2. California law:
   a. Effective July 1, 2000, the Natural Death Act and the laws governing Durable Powers of Attorney for Health Care was replaced by the new Health Care Decisions Law (AB 891Chapter 658).
3. **Federal Law:**

   a. Patient Self-Determination Act (PSDA), 42 USCA § 1395cc(f)(3)

**PURPOSE:**

To comply with regulatory standards and ethical guidelines.

**LAGUNA HONDA POLICY STATEMENTS:**

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to providing residents information about their medical condition to facilitate their involvement in medical decisions, in an ongoing process called advance care planning.

2. Laguna Honda residents are presumed to have decision-making capacity unless a determination is documented otherwise by their Laguna Honda attending physician, or a lack of decision-making capacity is documented by another Laguna Honda physician or by a court.

3. Residents are provided information about their rights to make medical decisions at the time of admission.

4. If a resident lacks capacity, decisions made by surrogate decision-makers (SDM) are honored in the same way as a decision made by the resident is honored.

5. Provision of care at Laguna Honda is not contingent upon or denied on the basis of the presence or absence of an established Advance Health Care Directive (AHCD) that describes the resident’s wishes and/or names a surrogate decision-maker.

6. Consistent with California law (CA Probate Code Section 4600-4805), Advance Health Care Directives (AHCD) may be oral and documented in the medical record, or documented in a written advance care planning document attached to the medical record.

7. Consistent with California law (CA Probate Code Section 4600-4805), residents with decision-making capacity have the right to delegate medical decision making to a SDM in advance of incapacity.

8. All information related to a resident’s treatment preferences, including changes, is documented in the advance care planning section of the medical record.

9. A competent resident may change his/her AHDC at any time.
10. Laguna Honda physicians may decline to comply with the wishes of a resident or the resident’s surrogate decision-maker only if the requested medical care would be ineffective or contrary to generally accepted standards. *Refusal to comply with resident/SDM wishes may include referral to other clinicians/institutions to avoid abandonment and will include discussion with Bioethics Committee and/or clinical/administrative leaders.

11. Laguna Honda clinicians may decline to comply with the wishes of a resident or the resident’s surrogate decision-maker for reasons of conscience. *Refusal to comply with resident/SDM wishes may include referral to other clinicians/institutions to avoid abandonment and will include discussion with Bioethics Committee and/or clinical/administrative leaders.

PROCEDURES:

1. Admission Procedures

   a. Admission and Eligibility

      i. Provides written information to residents or their SDMs about their right to participate in medical decisions.

   b. Medical Staff

      i. Asks resident or SDM about the existence of any advance health care directive (oral or written) at the time of admission and asks for a copy of written directive to place in the medical record in the Legal Documents section.

      ii. Documents information about the resident’s treatment wishes in the Advance Care Planning section of the medical record.

      iii. Writes appropriate orders implementing the resident’s treatment wishes.

   c. Social Worker

      i. Provides written information about Advance Health Care Directives, i.e. formerly known as Durable Power of Attorney for Health Care. Information is available in Spanish, Chinese and English.

      ii. Documents in the social work assessment, if information regarding advance health care directives was provided to resident and SDM.

      iii. Contacts the Ombudsmen Office if the resident would like to execute or to modify the legal document, Advance Health Care Directive.
2. Updates or Modifications to Advance Health Care Directives

   a. If a resident or SDM wishes to modify a previous directive, the attending physician is notified and the information documented in the medical record in the Advance Care Planning section and is communicated to the RCT.

   b. The resident’s treatment wishes are reviewed whenever clinically indicated.

   c. To revoke the entire form, including the appointment of the agent, the resident must inform the treating health care provider personally or in writing. Completing a new Advance Health Care Directive will revoke all previous directives.

   d. For any AHCDs executed or modified at Laguna Honda, the ombudsman must serve as witness.

ATTACHMENT:
None.

REFERENCES:
Web Access to Low Literacy Advance Directive Forms in English, Spanish and Chinese: http://in-sfghweb01.in.sfdph.net/chnpolicies/sfghadmin/ZZSFGHWebForms/TOC.htm

Revised: 08/3/05, 08/3/25, 19/03/12 (Year/Month/Day)
Original adoption: 92/05/20
RESIDENT COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) strives to create an environment that is responsive to residents’ complaints/grievances and addresses residents’ concerns.

2. LHH encourages residents to raise concerns for resolution with their care team (RCT), at Community meetings, or at Residents Council without discrimination or fear of reprisal.

3. LHH shall make prompt efforts to resolve grievances the resident may have by actively working toward a resolution.

4. Individual resident concerns that are addressed by the RCT shall be documented in the medical record. Concerns raised during Residents Council and Community meetings shall be reflected in meeting minutes and or notes of those meetings respectively.

5. When methods for resolving concerns have not been successful and the resident chooses not to use any of the above methods, LHH has a Resident Complaint/Grievance form that can be submitted to the Quality Management (QM) Department to address unresolved complaints/grievances in a culturally sensitive manner.

6. The neighborhood bulletin board shall display necessary information, consistent with federal requirements, on the resident’s right to file complaints/grievances orally and in writing, including anonymously, and the process for submitting complaints/grievances.

PURPOSE:

1. To ensure that significant complaints are addressed and appropriate follow-up actions are taken to resolve the issue to the fullest extent possible.

2. To optimize the quality of life of the residents and satisfaction with the care and services in a timely manner.

DEFINITION:

Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction surveys, or given directly to staff. Examples of complaints may include those about treatment, care, management of funds, lost clothing, or violation of rights.
PROCEDURE:

1. On admission, each resident receives the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy.
2. The Resident Complaint/Grievance policy will be reviewed in Hospital-wide orientation for new employees and will be included in Resident’s Rights annual in-services when policy changes occur.

3. Resident Complaint/Grievance forms shall be kept on each unit, in the Social Services Office, in the Nursing Office, and in the Administration Office to be available for residents or families as requested.

4. The Resident Care Team shall encourage a resident to complete the Resident Complaint/Grievance form when methods for resolving concerns are not successful despite interventions by the Team and the resident’s concerns continue to be unresolved.

5. If the resident is unable to or does not wish to complete the complaint form, staff may document the resident’s complaint/grievance on behalf of the resident. The Resident Complaint/Grievance form shall be submitted to staff in Nursing, Social Service, or Administration. Any staff that receives a complaint/grievance form is responsible for submitting the completed form to the QM department.

6. Residents who wish to file their grievances anonymously may submit their Complaint/Grievance form into drop boxes labelled “Suggestion box” located at the Pavilion lobby entrance (ground floor), Out-patient clinic lobby (first floor Pavilion) and the Administration lobby.

7. Contents from Suggestion boxes shall be picked up Monday through Friday, excluding holidays by a designee from the QM department. Resident Complaint/Grievance forms shall be routed to Risk Management Nurses and Suggestion forms shall be routed to Administration.

8. Risk Management Nurses shall triage the complaint/grievance, create an Unusual Occurrence (UO) report, and conduct follow up through the established UO process. Risk Management Nurses shall act as Grievance Officials and are responsible for managing the grievance process; receiving and tracking grievances through to their conclusions; leading/directing any necessary investigations; maintaining confidentiality of information compiled; issuing written grievance decisions on behalf of department/unit managers; and coordinating with state and federal agencies as necessary. The QM Director or designee shall provide oversight for the overall Resident Complaint/Grievance process.

9. The appropriate department/unit manager shall acknowledge the complaint/grievance and contact the resident in a timely manner (1 to 2 business days). The resident’s right to confidentiality and privacy will be respected at all times.
10. If the complaint/grievance is anonymous, follow up with the complainant is not possible. However, the appropriate department head is still responsible for acknowledging receipt of the complaint/grievance, investigate the complaint/grievance, and address the general concerns of the complainant if the matter can be confirmed.

11. Appropriate corrective action(s) shall be implemented by the facility if an alleged violation of resident’s rights is confirmed.

12. Documentation consistent with federal requirements related to resident grievances shall be maintained for a period of 3 years from the issuance of the grievance decision.

13. Data on Resident complaints/grievances shall be aggregated quarterly and presented bi-annually at the Performance Improvement and Patient Safety (PIPS) meeting. Complaints/grievances shall be evaluated and analyzed with respect to type, timely follow-up, trends, identification of problems/process gaps and the prevention of similar future problems.

ATTACHMENT:
Attachment A: Resident Grievance Information Flyer
Attachment B: Resident Grievance Form
Attachment C: Resident Grievance Acknowledgment
Attachment D: Resident Grievance Response Form

REFERENCE:
LHHP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHP 22-03 Residents’ Rights
Appendix PP/Guidance to Surveyors for Long Term Care Facilities F165 -F166/Sections 483.10(j) (1) – (4)

Revised: 09/10/01, 10/04/27, 16/01/12, 17/09/12, 19/03/12 (Year/Month/Day)
Original adoption: 92/03/01
OFF CAMPUS APPOINTMENTS OR ACTIVITIES

POLICY:

1. Escorts shall be provided with the necessary training and or information for resident safety.

2. Staff, volunteers, peer mentors, resident family members/surrogate decision-makers and their approved friends may escort a resident to an off campus appointment or activity, if deemed appropriate through an assessment by the Resident Care Team (RCT).

PURPOSE:

To provide resident safety and supervision during off campus appointments or activities.

PROCEDURE:

1. Assessment and Documentation

   a. The Resident Care Team (RCT); comprising at a minimum, a physician and the licensed nurse; shall determine
      i. if a resident needs to be accompanied by an escort, and
      ii. the escort must be deemed appropriate to accompany the resident.

   b. A physician's order shall be written for resident activities.

   c. A physician shall be responsible for completing referrals for off-campus medical appointments.

2. Transportation

   a. The Transportation Prescription shall be completed for any off-site appointments needing transportation. A physician shall review and sign the form and certify that the information is correct. The details of the appointment and patient information on the form may be completed by someone other than the physician. The physician shall complete the Transportation Prescription Form for any off-site appointments needing transportation arranged by Admission and Eligibility (A&E).

   b. The Unit Clerk or designee shall:
i. fax the Transportation Prescription Form to A&E to arrange transportation services.

ii. write the appointment on the Treatment Authorization Record (TAR) and the Neighborhood’s calendar.

iii. complete the Transportation and Appointment Ticket and attach it to the specially designated envelope for off-site appointments.

c. Nursing and non-nursing staff may escort the resident using a hospital vehicle or contracted transportation service.

d. If the contracted transportation service is unable to fulfill the transportation arrangement, the Nurse Manager or designee may arrange alternative transportation, including use of hospital vehicle or taxi service, to transport the resident to the appointment and or back from the appointment.

e. Use of Taxi Service:

   i. Taxi service is used when the contracted transportation is unable to pick up or drop off resident to appointments. When the resident ends up to be admitted to acute hospital and escort needs to return to hospital use public transportation unless considered as over time.

   ii. The Nursing Office Supervisor is the designated safe keeper of the taxi voucher, and shall provide oversight of the process, including the reconciliation of the used of vouchers to ensure accurate accounting of the funds used.

   iii. Taxi Vouchers are available in the Nursing Office. (A receipt is submitted to Nursing Office whenever a Taxi Voucher is used, including completion of the log to reflect date, amount used and staff who voucher was issued to).

   iv. Vouchers are in triplicate form: the original copy shall be given to the taxi driver; the second copy (yellow) for Finance Department; and the third copy (pink) shall be filed in the Nursing Office.

   v. Nursing Office submits the receipt and log to Accounting on a monthly basis for invoice payments to replenish the Taxi Vouchers when the remaining amount number of voucher is less than $5.00.

   vi. In the absence of an approved taxi voucher, a staff member may provide personal funds as necessary in the event of a transportation need for patients/residents. The staff member shall be entitled to be reimbursed of all
funds used by completing properly the “Employee Expense Authorization and Reimbursement Form”, which is being kept in the Nursing Office.

3. Request for Nursing Staff Escort

a. When a nursing staff escort is needed to accompany the resident to an off-site appointment or activity, the nursing staff shall carry out the following steps according to the timeline established below:

i. The Day the Transportation Prescription is written signed by the Physician:

   - Fax the completed Transportation Prescription form to Nursing Office.
   - Write a reminder on the calendar to call nursing office the day before the scheduled appointment to confirm an escort.

ii. The Weekend prior to the appointment:

   - In order to assign an escort, Nursing Office Staff will call the neighborhood the weekend prior to the appointment. Once confirmed, they shall assign an escort for the scheduled date.

iii. The Day before the appointment:

   - The Neighborhood will call the Nursing Office to confirm the escort requested.

iv. The Day of the appointment:

   - The Charge Nurse or designee will:
     - give hand off report to the escort, and
     - provides the escort with the completed Transportation and Appointment Ticket enclosed in a specifically designated envelope for off-site appointment.

   - The Escort shall:
     - obtain hand off report from the Charge Nurse or designeex.
     - upon return to Laguna Honda:
       - hand the Transportation and Appointment Ticket back and give a verbal report to the charge nurse.
➢ report back to the Nursing Office once resident has been returned to the neighborhood.

4. Medical Record Information needed for off campus appointment

a. Information shared for off campus appointments shall be the minimum necessary for treatment or billing purposes during the appointment.

b. For SFGH clinic visits, only the clinic addressograph card (currently a gold card) and the transport ticket shall accompany the resident.

c. Whenever possible, the staff at the appointment destination shall access the needed information through an electronic health record. (i.e. on the LCR or eCW for SFGH clinics.)

d. When needed information is not in an electronic health record the LCR or eCW or the clinic does not have access to the SFDPH electronic health records, the medical record information may be processed through the medical records department or faxed securely to the clinic according to the facility's facsimile transmission process (as described in LHHPP File 21-02 Transmission of Confidential Medical Information via Facsimile).

5. Non-staff Escort

a. Family or Surrogate Decision-Makers and Approved Friends as Escorts

i. The RCT designee shall contact and make arrangements for the resident's family or surrogate decision-makers or approved friend to accompany the resident to an off campus appointment or activity.

ii. Resident families or surrogate decision-makers or their approved friend shall be trained by the Charge Nurse or designee.

iii. Resident families or surrogate decision-makers and their approved friends may transport the resident using their personal vehicles or contracted transportation service.

b. Volunteer Escorts (when available)

i. When the RCT determines that a volunteer escort is appropriate to accompany the resident to an off campus activity, the RCT designee shall submit a request to the Volunteer Services Department for a volunteer to escort the resident.

ii. The Volunteer Services Department shall recruit for a volunteer to escort the resident and notify the Charge Nurse or designee.
iii. The Charge Nurse or designee shall introduce the volunteer to the resident and provide pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Volunteers shall escort the resident using contracted transportation service or public transportation.

c. Peer Mentor Escorts (when available)

i. When the RCT determines that a peer mentor is appropriate to accompany the resident to an off campus activity, Social Services shall submit a referral request to the Peer Mentor coordinator.

ii. The Peer Mentor Program Coordinator shall recruit a peer mentor to match with the resident and notify the Social Worker.

iii. The social worker shall introduce the peer mentor to the resident and the peer mentor shall check in with the Charge Nurse or designee prior to outings for any pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Peer mentors shall escort the resident using contracted transportation service or public transportation.

ATTACHMENT:
Attachment A: Transportation and Appointment Ticket

REFERENCE:
LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile
LHHPP 21-06 Transporting the Resident’s Filed Medical Records on Campus
LHHPP 24-120 Coach Use for Close Observation
MR908 Transportation Prescription
[Add reference re training escorts]

Revised: 96/07/15, 99/01/12, 12/07/31, 13/05/28, 13/09/24, 15/09/08, 19/03/12
(Year/Month/Day)
AMBULANCE CALLS – UTILIZATION AND ACCESS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall utilize routine and emergency transportation in accordance with agreed-upon Emergency Medical Services (EMS) and LHH standards.

<table>
<thead>
<tr>
<th>Name of Ambulance Provider/Contact #</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary:</strong> Pro Transport</td>
<td>• Basic Life Support (BLS) Non-Emergent</td>
</tr>
<tr>
<td>Telephone #: 1-800-650-4003</td>
<td>• BLS Emergent</td>
</tr>
<tr>
<td></td>
<td>• Advanced Life Support (ALS) Non-Emergent</td>
</tr>
<tr>
<td></td>
<td>• ALS Emergent</td>
</tr>
<tr>
<td></td>
<td>• Specialty Care Transport (SCT)</td>
</tr>
<tr>
<td></td>
<td>• Urgent and Non-Urgent Routine and Bariatric Transport</td>
</tr>
<tr>
<td></td>
<td>• Wheel Chair Van</td>
</tr>
<tr>
<td><strong>Secondary:</strong> King American</td>
<td>• ALS Non-urgent</td>
</tr>
<tr>
<td>Telephone #: 1-415-931-1400</td>
<td>• ALS Emergent</td>
</tr>
<tr>
<td>Fax #: 1-415-621-2100</td>
<td>• BLS Non Emergent</td>
</tr>
<tr>
<td><strong>Tertiary:</strong> American Medical Response</td>
<td>• ALS</td>
</tr>
<tr>
<td>Telephone #: 1-800-540-3066 or</td>
<td>• BLS</td>
</tr>
<tr>
<td>1-800-913-9197</td>
<td></td>
</tr>
</tbody>
</table>

PURPOSE:

To assure safe and timely transfer of residents to acute care or medical appointments in the community utilizing the appropriate service level of care.

DEFINITION:

1. Basic Life Support (BLS): Emergency first aid and cardiopulmonary resuscitation procedures which, at a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the resident can be safely transported or until ALS is available.
2. Advanced Life Support (ALS): Means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specific drugs and other medicinal preparations, and other specified techniques and procedures administered by certified personnel under the direct supervision of a base hospital

3. Specialty Care Transportation (SCT): Ground medical transportation services that exceed the normal scope of paramedic services and require a higher trained level of personnel and additional equipment.

Note: Special transport situations include but are not limited to the following conditions:

a. Obesity (>250 lbs.)

b. Cervical immobilization

c. BiPAP or CPAP support required

PROCEDURE:

1. Transfers of residents outside of LHH

a. Transfers outside of LHH include non-urgent (i.e., scheduled routine transport) and emergent medical transfers.

b. Non-urgent, routine transfers are generally pre-arranged, however circumstances may arise requiring request for services by telephone.

c. The Physician Certification Statement, (PCS) form transportation order shall be completed and reviewed and signed by the physician, and includes the resident’s diagnosis relating to the purpose of the transfer/medical appointment, as required by the payer. The details of the appointment and patient information on the form shall be completed by a Licensed Nurse or Unit Clerk.

d. During off-hours, weekends/holidays, and same day transportation is arranged directly with the ambulance company by the licensed nurse.

e. During regular business hours, 8:00am – 4:00pm the transportation prescription PCS form is faxed to 415-682-5689 or hand-delivered or via inter-office mail to Admissions & Eligibility (A&E) at Pavilion Ground (PG123). When transportation is arranged after hours, a copy of the completed PCS form is faxed to the A&E

f. A&E shall fax the transportation prescription PCS form to the ambulance provider.
g. A&E shall provide and confirm the transportation arrangement to the licensed nurse or unit clerk.

h. Inquiries and concerns are to be addressed with A&E (located at PG123) at extension 4-5680 or 4-5681.

i. Do not call A&E for STAT or 911 transfers, as this is the responsibility of the health care team members, charge nurse or nursing operations nurse manager/supervisor.

1. Bariatric Transports (Non-Urgent)

a. Pro Transport can accommodate bariatric transportation with a bariatric gurney.

i. Arrangement shall be made with as much advance notice as possible to ensure that the gurney is available.

ii. Pro Transport shall provide the gurney for the resident going to the appointment.

2. Urgent Bariatric Transports

a. Pro Transport also provides urgent bariatric transportation services.

i. The bariatric gurney is not stored on site, so allow time for the transportation service to pick up their gurney before coming to LHH.

3. Emergent acute medical transfers

a. Code 1 transfers: For residents who are medically stable but require BLS ambulance, staff can anticipate a response time of approximately 1 hour or less subject to the availability of resources:

i. Call the primary contracted ambulance company,

ii. The LHH physician, nursing operations nurse manager/supervisor or charge nurse shall be asked to:

   • Provide information regarding the resident’s status and needs related to transport.

   • state whether basic EMT or ALS Paramedic Ambulance is needed; and

   • provide other information as requested by the ambulance dispatcher. Based on standardized criteria, the dispatcher shall determine whether an
appropriate ambulance team is available and state an estimated time of arrival.

iii. If the primary contracted ambulance service is not able to arrive within an hour, call the secondary or tertiary ambulance company and request for transportation services to transfer the resident. If the alternate ambulance company cannot arrive in time; and it is urgent that the resident be transported, call 911.

Note: If you have called a private ambulance company and subsequently need to call 911 because of the resident’s condition is deteriorating, be sure to call the private ambulance back and tell them not to come.

b. **Code 2 transfers**: For medically unstable residents who require ALS ambulance response within 20 minutes or less:

i. Call the primary ambulance company, or 911 and request a paramedic unit.

ii. The LHH physician, nursing operations nurse manager/supervisor or charge nurse shall:

   • state this call is for a Code 2 transfer for a deteriorating or acute patient; but the condition is not immediately life-threatening (i.e., not Code 3); and

   • provide other requested by the ambulance dispatcher. The dispatcher shall use standardized criteria to triage the call and dispatch an appropriate unit. Lights and sirens shall not be used.

c. **Code 3 transfers**: Immediately life-threatening situations (lights/sirens; ambulance response time 8-10 minutes or less with ALS paramedic transfer):

i. Call 9-1-1 directly from the neighborhood.

ii. LHH physician, nursing operations nurse manager/supervisor, or charge nurse:

   • Shall state that this is a Code 3 transfer for a life-threatening medical emergency and

   • describe the resident’s condition and the immediacy of response needs.

iii. After 911 is called, alert the LHH Sheriff’s Department regarding the exact location where arriving emergency personnel is needed.

4. **Communication with hospital to which patient is referred to**

   a. When 911 is called regarding immediate life-threatening situations (Code 3):
i. the paramedics shall determine which hospital the resident shall be transported to; and in most instances the resident shall be transported to UCSF Moffett/Long Hospital, because it is geographically closest to LHH;

ii. the LHH physician shall call the designated receiving ER to provide necessary medical information.

iii. For 911 calls, a staff member is sent to wait at the Pavilion entrance to escort EMS to the neighborhood.

b. When residents are transferred for acute medical problems (other than Code 3):

i. The LHH physician shall communicate with the emergency room attending physician at the receiving hospital before sending the resident, or as the resident is being transported.

ii. In general, residents shall be sent to Zuckerberg San Francisco General Hospital (ZSFG) (after calling the E. R.) unless ZSFG is on diversion or the resident has a health plan which determines where acute care shall be provided (e.g., Kaiser). Also, if the resident or family requests transfer to another hospital, that request shall be honored, if possible.

iii. A copy of the resident’s Advance Directives shall be included in the resident transfer packet.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-16 Code Blue
NPP C1.3 Discharge to Acute

Revised: 00/03/09, 11/09/27, 12/03/27, 15/09/08, 19/03/12 (Year/Month/Day)
Original adoption: 98/11/16
NOTIFICATION OF FAMILY / SURROGATE DECISION-MAKERS (SDMs) AND / OR CONSERVATORS OF CHANGE IN CONDITION AND / OR DEATH

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to notify appropriate family members, surrogate decision makers (SDMs) and/or conservators in the event of a significant change in resident condition and/or death; and to document such notification in the medical record.

PURPOSE:

To ensure timely notification of appropriate family/surrogate decision-makers and conservators of a significant change in resident condition and/or death.

PROCEDURE:

1. Residents who are capable of making decisions regarding their health care and capable of expressing preferences regarding notifications shall be queried by the Resident Care Team (RCT) regarding notification preferences and these preferences shall be documented in the advance directives section of the medical record.
   a. The nurse manager/charge nurse shall note in the resident care plan preferences regarding family notification expressed by residents with decision-making capacity. All stated resident preferences shall be honored.
   b. The RCT shall identify the surrogate decision-maker for all residents without decision making capacity and the physician shall document this information in the advanced directive section of the medical record. The nurse manager/charge nurse shall record and update this information in the resident care plan.

2. The physician shall be responsible for notifying appropriate family members, SDMs and/or conservators regarding:
   a. significant change in condition or treatment (including but not limited to deterioration of physical, mental, or psychosocial status from life-threatening conditions or clinical complications);
   b. transfer to acute care or discharge from the facility; and/or
   c. death (see section 6).

3. The physician shall document these notifications listed under Procedure 2 in the progress notes of the medical records.
4. The nurse manager/charge nurse shall be responsible for notifying appropriate family and/or surrogate decision-maker regarding:

   a. an accident involving injury to the resident

   b. an update concerning a resident’s condition (including but not limited to a new pressure ulcer, change in functional status, change in mental status, need for restraints, poor oral intake, weight loss of 5% or greater in 30 days, elopement, and the need for observation precautions)

   c. a change in room or roommate assignment

   Notification of appropriate individuals shall be documented in the medical record.

5. The social worker shall be responsible for contacting appropriate family and/or surrogate decision-makers when nursing staff and/or physicians are unable to reach family despite repeated attempts. The social worker shall also be responsible for contacting appropriate family and/or surrogate decision makers regarding changes in psychosocial, financial or legal status. Certified letters may be sent by the social workers if necessary. Notification of appropriate individuals shall be documented in the medical record.

6. Notice of Resident's Death

   a. The physician who pronounces the death is responsible for notifying the family/SDM/conservator.

   b. In addition, the primary physician shall contact the family/SDM within 48 hours of resident death when possible to express condolences and answer questions.

   c. The attending physician shall complete the death certificate as soon as possible and forward it to HIS.

   d. The physician who pronounces the death shall be responsible for reporting cases that meet criteria to the Medical Examiner. In these cases the body shall not be released until first released by the Medical Examiner.

ATTACHMENT:
None.

REFERENCE:
MSPP C01-03 Organ/Tissue Transplant Donation Program

Revised: 00/04/06, 12/08/29, 15/01/13, 17/09/12, 19/03/12 (Year/Month/Day)
Original adoption: 98/11/16
PREVENTION AND MANAGEMENT OF PRESSURE ULCERS/PRESSURE INJURIES

POLICY:

1. Residents admitted to Laguna Honda Hospital and Rehabilitation Center (LHH) shall receive care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the resident’s clinical condition demonstrates that they were unavoidable.

2. A resident with pressure ulcers or pressure injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

3. The Resident Care Team (RCT) shall evaluate and implement a treatment or prevention plan for residents that the licensed nurse identifies as having pressure ulcers or as being at risk for pressure ulcers/pressure injuries.

4. Residents at the end of life, in terminal stages of an illness or having multiple system failures shall be provided with care to prevent or treat existing pressure ulcers or pressure injuries (including pertinent, routine, lesser aggressive approaches, such as cleaning, turning, repositioning) that is not prohibited by the resident’s Advance Directive.

PURPOSE:

1. To identify residents at risk of developing pressure ulcers/pressure injuries (PU/PI).

2. To prevent the occurrence or reoccurrence of PU/PI.

3. To facilitate healing of existing PU/PI.

DEFINITION:

1. “Avoidable”: the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

2. “Unavoidable”: the resident developed a pressure ulcer/injury even though the facility had evaluated the resident’s clinical condition and risk factors; defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.
3. “Colonized”: the presence of micro-organisms on the surface or in the tissue of a wound without the signs and symptoms of an infection.

4. “Infected”: the presence of micro-organisms in sufficient quantity to overwhelm the defenses of viable tissues and produce the signs and symptoms of infection.

4-5. “Eschar”: dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

2.6. Pressure Ulcer/Pressure Injury (PU/PI)
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or as an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft issue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of soft tissue.

7. Stage 1 Pressure Ulcer: Non-blanchable erythema of intact skin
Intact skin with a localized of non-blanchable erythema, which may appear in darkly pigmented skin. Presence of erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration, these may indicate deep tissue pressure injury.

8. Stage 2 Pressure Ulcer: Partial thickness skin loss with exposed dermis
The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough, and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD), including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSII), or traumatic wounds (skin tears, burns, abrasions).

9. Stage 3 Pressure Ulcer: Full thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location, areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the extent of tissue this is an Unstageable Pressure Injury.

10. Stage 4 Pressure Ulcer: Full thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling may occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
11. **Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss**

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e.: dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

12. **Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, or purple discoloration.** Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

13. **Medical Device Related Pressure Injury (this describes an etiology)**

Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

14. **Mucosal Membrane Pressure Injury**

Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

**PROCEDURE:**

1. **Identification of Residents at Risk of Developing PU/PI**

   a. Licensed Nurses shall complete the Braden scale to identify residents at risk of developing PU/PI. The Braden scale shall be completed on admission, every Tuesday thereafter for three consecutive weeks; then quarterly and annually following the Minimum Data Set schedule; and when there is a significant decline or change of condition. If the resident’s day of admission falls on a Monday, the next Braden scale shall be completed on Day 8.

2. **Assessment and Interdisciplinary Care Planning of PU/PI**

   a. Refer to Nursing Policies and Procedures K 1.0 Assessment, Prevention and Management of Pressure Ulcer.
b. The Nurse Manager/licensed nurse (NM/LN) shall inform the RCT of any resident identified at risk for PU/PI, and develop an initial care plan. The RCT shall review and contribute to the care plan as needed.

3. Prevention of Pressure Ulcer/Pressure Injury for Residents at Risk

a. Activity: maintain current activity, mobility and range of motion exercise level to improve or maintain strength, flexibility and coordination. Encourage ambulation, if appropriate.

b. Nutrition and fluids: encourage resident to consume all foods and fluids served, particularly high protein foods, served during meals. When apparently well-nourished residents develop inadequate dietary intake, assess contributory factors to determine whether other nutritional interventions may be needed. Consult with the dietitian for appropriate interventions.

c. Teaching and counseling the resident: residents are to be encouraged to participate in efforts to minimize pressure ulcer risk through such actions as repositioning self and good nutritional intake and hydration. When the resident refuses treatment, or refuses to be repositioned off the affected site (e.g., coccyx) the resident shall be counseled about alternative interventions and consequences of non-compliance with interventions. Psychiatry and Social Services staff are to be utilized to promote resident's cooperation.

d. Use caution when moving the resident: avoid friction by using lifting devices such as a trapeze or bed linen to move (rather than drag) residents who cannot assist during transfers and position changes.

e. Positioning devices: use positioning devices such as wedge, pillows and pads to keep bony prominences from direct contact with one another.

f. Support surfaces: nursing staff shall place a pressure relieving support surface (such as an air or gel mattress or other static support surface) to the bed or wheelchair (such as a Roho cushion) as per protocol following evaluation by the wound care CNS or designee. If re-evaluation is needed, inform the Wound Care CNS or designee. Also refer to LHHPP File-24-03 Specialized Bed and Support Surface Equipment.

Note: To check whether a support surface reduces pressure enough slide hand with palm up and fingers flat under the support surface, just under the pressure point. With good support, one inch or more of uncompressed support surface is between the hand and the resident. If there is less than 1 inch, request adjustment of the device.

g. Protective devices: use protectors for the heel, ankle and elbow to minimize friction. Use specially designed boots, devices, or pillows under the length of the
lower legs to suspend the heels. Do not put the pillow directly under the knees. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet. Foam arm rest covers (available in central supply room) for wheelchair arms can be used.

Note: Heel booties, sheepskins and protective dressings are not pressure relieving devices. They may, however, be used to relieve/prevent friction of the skin and to promote comfort.

h. Careful placement in chairs: position chair-bound resident in good postural alignment, distribution of weight, balance and pressure relief.

i. Refer to occupational therapy for evaluation of appropriate seating device.

ii. Avoid sitting directly on the pressure ulcer.

iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.

iv. Rest elbows, forearms and wrists on arm supports. Use foam arm rest supports on wheelchair.

v. Instruct or assist resident to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes, if they are able.

vi. Document the use of positioning devices and lifting schedules in the resident care plan.

4. Management of Pressure Ulcer/Pressure Injury

a. Refer to Nursing Policies and Procedures K 1.0 Assessment, Prevention and Management of Pressure Ulcer/Pressure Injury.

b. Following detection of a PU/PI, the NM/LN shall:

i. Notify the physician and a treatment plan shall be implemented within eight (8) hours;

ii. Notify the Wound Care Clinical Nurse Specialist;

iii. Notify the dietitian within 24 hours;

iv. Notify the resident and/or SDM within forty-eight (48) hours;

v. Complete a wound assessment form and progress note in the electronic health
vi. Develop a plan of care for prevention and treatment of the ulcer(s);

vii. Complete an Unusual Occurrence form.

c. Interdisciplinary Resident Care Plan: If the resident is identified as being at risk for pressure ulcers as determined by the Braden scale, or has a pressure ulcer, a comprehensive interdisciplinary care plan is developed that:

i. Identifies the problem (i.e.: risk factors and/or presence of ulcer),

ii. Develops individualized goal(s), and

iii. Develops interventions to address prevention or treatment.

d. The RCT shall conduct a meeting to review the plan of care of residents with newly identified PU/PI.

e. The RCT shall reevaluate the treatment plan if the ulcer(s) fails to show evidence of healing within two (2) weeks, or when the ulcer shows signs of deterioration.

f. The attending physician shall evaluate those ulcers that fail to heal or that worsens, and ulcers covered with eschar, and shall refer to the Plastics Clinic as needed.

f-g. The resident’s pain shall be evaluated and monitored as it may to not interfere with movement and/or affect mood that may contribute to immobility.

g-h. Provide resident education and counseling on the importance and potential consequences of non-compliance with treatment interventions.

5. Documentation of Pressure Ulcers/Pressure Injuries

a. Refer to Nursing Policies and Procedures K 1.0 Assessment, Prevention and Management of Pressure Ulcer/Pressure Injury.

b. Document notification to the physician, dietitian and family or surrogate decision maker when a pressure ulcer is detected, and when the PU/PI fails to show evidence of healing.

c. Document RCT meetings and revisions to the plan of care.

d. Resident teaching or counseling related to management of pressure ulcers shall be documented in the progress notes and/or resident care plan.
ATTACHMENT:
None.

REFERENCE:
AHCPR Guidelines for Prevention and Treatment of Pressure Ulcers, 1992, 1994
AMDA Clinical Practice Guidelines. Pressure Ulcer Therapy Companion, 1999
LHHP 24-03 Support Surfaces
Nursing Policy C 1.0 Admission-Relocation-Discharge and Readmission Procedures
Nursing Policy C 2.0 Resident Care Plan
Nursing Policy C 3.0 Documentation of Resident Care /Status by the Licensed Nurse
Nursing Policy C 4.0 Notification for Change in Resident's Status
Nursing Policy K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury
Nursing Policy C 7.0 Interdisciplinary assessment / Rounds
Nursing Policy C 8.0 Resident Assessment Instrument

Revised: 17/11/14, 19/03/12 (Year/Month/Day)
Original adoption: 00/08/15
CODE BLUE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide all residents with cardiopulmonary resuscitation (CPR) in the event of an acute cardiac or respiratory arrest if appropriate.

2. The Code Blue process shall also be utilized for choking events, unless specific directive has been expressed in the resident’s Advanced Directive, stating otherwise. Refer to the NPP L 1.0 Emergency Intervention for Choking Policy and Procedure.

3. The Code Blue process shall be utilized in the event of a resident experiencing Autonomic Dysreflexia (AD), seizure, or when staff feels that the medical emergency could be life threatening.

4. CPR and interventions for choking shall conform to the American Heart Association’s standards approved for Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS).

5. All licensed nurses shall be trained and remain current in BLS.

6. All physicians with primary care or general on-call duties shall be trained and maintain current ACLS certification.

7. All LHH staff are responsible for initiating Code Blue activities when cardiac or respiratory arrest occurs for residents/patients who do not show obvious clinical signs of irreversible death and:
   a. Who have requested CPR in their advance directives or declared CPR in their code status; or
   b. Who have not formulated an advance directive, or declared a code status; or
   c. Who do not have a valid DNR order.

8. Code Blue shall be used and the Code Blue Team shall respond to patient/resident events in the Hospital Buildings and in the Administration Building’s Gerald Simon Chapel and Moran Hall. For patient/resident events outside the Hospital Building, 911 shall be called.

9. LHH shall maintain staff preparedness by conducting periodic Code Blue drills.
   a. One Code Blue drill shall be conducted for each shift monthly.
b. The Code Blue Committee, in collaboration with Nursing Education & Training, shall develop and implement a schedule identifying the location, shift, and time of the drills and scenarios.

10.9. Each resident with a documented cardiac arrest who has been resuscitated shall be discharged for further care, unless otherwise expressed via their surrogate decision maker (SDM) or physician. If discharge to another acute hospital is planned, 9-1-1 shall be called for emergency transport. Refer to Appendix 3: 9-1-1 Code Blue Activation Information.

11.10. A Code Blue Record and Code Blue Checklist shall be completed for every Code Blue event (i.e., whether or not the event is full cardiac or respiratory arrest) and shall be reviewed by the Code Blue Committee.

11. A Code Blue “All Clear” will be called when the resident has either been transferred by EMS, or the medical condition has been stabilized and resident will remain at LHH, or resident has expired and MD has declared death, canceled after the resident has either been transferred by EMS, or the medical condition has been stabilized to a condition that no longer requires additional clinical support, as agreed upon between the Charge RN and MD after discussion.

12. Any medical emergency which occurs outside the LHH building, or in the Administration building (except Serenity Park, the Chapel, and Gerald Simon Theater), will be a 9-1-1 call (See Attachment 1)

12.13. A code blue that has been called and is a false alarm, such as resident has been determined to be DNR/DNI and resuscitation efforts will not be performed, alarm was called/pushed in error, or resident does not require emergency intervention. A code blue “cancelled” will be announced overhead

PURPOSE:

1. To provide CPR clinical care during a medical emergency.

2. To establish guidelines for LHH staff members to respond to a Code Blue event in a rapid, competent and coordinated manner.

DEFINITION:

Code Blue: Rescue efforts including activating the emergency response system (chain of survival) and CPR activities in the event of a cardiopulmonary arrest or choking.

CPR: An emergency procedure that shall be done without delay to attempt to restore or maintain circulation or respirations during cardiac and/or respiratory arrest.

PROCEDURE:
1. Equipment

a. Crash Carts

   i. Locations
      
      - South Tower: Marina Suite storage room
      - North Tower: Cypress Suite storage room
      - Pavilion Mezzanine SNF: Clean utility room
      - Pavilion Mezzanine Acute: Medication room
      - Clinics: Behind the medical nurses' station
      - Pavilion Ground Floor: Rehabilitation Department exam room
      - Central Supply: Spare crash cart

   ii. Maintenance
      
      - The crash carts on each neighborhood shall be checked daily by a licensed nurse and maintained in operational condition.
      
      - If the crash cart seal is broken, or the cart has been used, the cart shall be returned to Central Supply (Materials Management), and a new crash cart shall be provided.

b. Automated External Defibrillator (AED)

   i. Locations
      
      - Respiratory Department (Esplanade Level 1)
      - Wellness Center: behind the front desk
      - Sheriff's Desk – Main Lobby, Pavilion
      - Moran Hall
      - Gerald Simon Theater (Hallway)
      - Cafeteria (Hallway)
• **Kanaley Center**

  ii. Maintenance
  
  • The AEDs are checked, at a minimum, Monday through Friday, excluding holidays, by designated department staff.

c. AD Kit (see Appendix 1)

  i. Location
  
  • The AD Kit is located in the bottom drawer of the crash cart.

  • AD emergency medications shall be placed in the medication drawer of the crash cart in a labeled plastic bag.

  d. Magill Forceps (8” and 10”): Stored in the respiratory drawer of the crash cart.

  d.e. Intraosseous access (EZ-IO) and supplies: Stored in the intravenous section of the crash cart.

  e.f. EKG Machine: Stored in Pavilion Mezzanine Acute across from nurses’ station.

  f.g. Cervical spine immobilizer board and collar are stored in Pavilion Mezzanine SNF.

2. **Initial Code Blue Response**

a. Initiating a Code Blue

  i. Activating the Emergency Response:

  • If in the resident’s room, active the Code Blue by pressing the Code Blue button behind the head of the bed. After pressing the Code Blue button, call 4-2999.

  • The ceiling dome lights in front of the resident’s room and zone lights located at the end of each household shall illuminate flashing lights (scrolling of all bulbs).

  ii. If the location of the Code Blue is not in the resident’s room, or occurs in Moran Hall, the Chapel, or Gerald Simon Theater, call 4-2999.

  iii. If an emergency occurs in the Administration building (except Moran Hall, the Chapel, and Gerald Simon Theater), or outside LHH buildings, including outside the Hospital buildings, dial 9-1-1.
iv.iii. Accessing 9-1-1 for Code Blue (see Appendix 3)

- Activate 9-1-1 call from the unit where the emergency is occurring.
- Once the 9-1-1 operator answers, follow the operator’s instructions.
- Stay calm and speak clearly.
- State your name and your role.
  "My name is _____________ and I am a nurse on (state your location) at Laguna Honda Hospital".
- State the nature of the emergency.
  "We have a medical emergency. A patient is in cardiac arrest and is not breathing".
- State the location of the emergency.
  "The patient is located in room ________ or location _______".
- State what interventions are in process.
  "A Code Blue has been called and the nurses are starting CPR".
- Wait for further instructions or questions from the 9-1-1 operator. Have the addressograph or face sheet in your hand in case you need to provide other demographic information.
- If additional information is asked by the 9-1-1 operator, and you do not have the information, it is okay to tell the operator "I do not have that information right now". Ask the operator if she/he would like you to try to get the information.
- DO NOT HANG UP OR DISCONNECT THE CALL. Wait for further instructions from the 9-1-1 operator.

b. Nursing and Medical Staff Response

i. If emergency medical assistance is needed the first responder (personnel who first arrives on scene, or witnesses the change in condition) shall initiate a code.

ii. Staff shall assess for resident's responsiveness, breathing and pulse per BLS Guidelines.
iii. If no pulse, begin Chest Compression, open Airway, and assist Breathing using the bag/valve/mask connected to oxygen (C-A-B).

iv. Apply the defibrillation/STAT pads and use AED function on Zoll Defibrillator.

iv-v. Check for patient's advanced directive code status. If the resident's code status is designated a Do Not Resuscitate (DNR), notify the physician.

v. vi. Resuscitation efforts shall be initiated for all persons experiencing a medical emergency in the Wellness Center.

c. Nursing Office Response

i. Once a Code Blue activation call is received, the Nursing Office personnel shall:

  • Announce the overhead “Code Blue” page three times.

  • Send a text to the Code Blue pagers with the location of the Code Blue.

  • Two staff shall be assigned by the supervising nurse to guide the emergency response team to the location of the emergency.

    • 1 – One to wait near the elevator at the site of the emergency

    • 2 – One to wait at the Pavilion entrance

    • Announce the overhead page “Code Blue All Clear” when notified by the neighborhood or location that the Code Blue has been cancelled.

3. Response/Coverage for the Site of Emergency

a. North and South Building

i. One licensed nurse from each neighborhood in the North and South Tower shall respond to the emergency within that building (i.e., South Tower staff RNs/LVNs shall respond to their own tower).

ii. A licensed nurse from Pavilion shall respond to each code, and bring the 12-lead EKG machine (located in Pavilion Mezzanine Acute).

b. Pavilion (including Wellness Center)

i. One licensed nurse from each neighborhood on North 1, North 2, and South 2 licensed nurses shall respond to the emergency.
ii. When a Code Blue occurs in the Wellness Center, the Pavilion Mezzanine licensed nurses, or Rehabilitation Department personnel shall bring the crash cart to the site.

c. Serenity Park (previously known as Harmony Park)
   i. One licensed nurse on each floor of the North Tower and Pavilion Mezzanine shall respond to the emergency.
   
   ii. The Pavilion licensed nurse shall bring the crash cart to the site.

d. Moran Hall, The Chapel, or Gerald Simon
   i. One licensed nurse from each neighborhood in the South Tower and Pavilion shall respond to the emergency.

   ii. The South 2 licensed nurse shall bring the crash cart to the site.

e. Outside the building (see attachment 9)
   i. One licensed nurse from Pavilion Mezzanine and licensed nurses from each neighborhood carrying code blue pagers will respond to the emergency.

   ii. If enough staff are present, licensed nurse staff will confirm with supervisor if they may return to their assignment. If determined the person in distress is a resident on your unit, remain at emergency to assist and provide any available information.

   i. One licensed nurse from each neighborhood in the South Tower and Pavilion shall respond to the emergency.

   The South 2 licensed nurse shall bring the crash cart to the site.

4. Roles and Responsibilities
   a. Physician: The first ACLS physician to arrive shall:

      i. Be the command physician of the code.

      ii. Announce that they have assumed command of the Code Blue.

      iii. Coordinate the resuscitation efforts.

      iv. Confer with the unit physician, if available, regarding treatment of the patient.
v. Prescribe mode of treatment and medication.

vi. If present, a second physician shall assist the command physician.

vii. Insertion of intraosseous access or central line access, when appropriate. Refer to LHHPP File #24-21 Insertion and Maintenance of Intraosseous Device.

b. Nursing:

i. Performs standard roles, including chest compressions, airway, breathing, obtaining intravenous supplies, preparing medications, administering medications, applying STAT pads to prepare for defibrillation, recording Code Blue events.

ii. Management of the EZ-IO once access is established and placement verified by the physician.

iii. See Appendix 2: Guideline for Code Blue for Nursing Response for further description of nursing roles and responsibilities.

iv. The licensed nurse from the neighborhood with the Code Blue is responsible for ensuring that the crash cart is brought to the site of the emergency.

c. Pharmacy:

i. If present during Monday through Friday, a pharmacist shall assist the RN in preparing medications as ordered by the physician.

d. Respiratory Therapy:

i. If present, the Respiratory Therapist shall assist in maintenance of airway, ventilation, 12-lead EKG, and arterial puncture to obtain arterial blood gas as appropriate.

e. Elevator Access

i. Code Blue team members have keys to call for and to override the elevator in a code blue response.

ii. To use the key to the elevator:

   • From outside the elevator, insert key and turn key to the right to the “ON” position. A period of 90 seconds is given to override the elevator. Remove the key before entering.
Once inside the elevator, insert the same key and turn right to the “ON” position. Press “CLOSE DOOR”. Wait until the doors are completely closed, then press the desired floor number, while continuously pressing the button for the desired floor (i.e., hold your finger on the button). Leave key in the switch until the desired floor is reached. Turn key to left to the “OFF” position and remove key.

5. Post-Code Blue Activities

a. Unit Charge Nurse

   i. Notify Central Supply (CSR) at 759-3349 or 4-2760 that a used crash cart is being exchanged for a fully stocked crash cart.

   ii. If the emergency drug box was used, the Charge Nurse, or licensed nurse designated by the Charge Nurse, shall return it to the pharmacy to be restocked. If the pharmacy is closed, the nursing supervisor shall sign out a replacement emergency drug box from the supplemental drug room.

   iii. Gather staff involved in the Code Blue for a Post Code Huddle (debrief), to discuss what went well during the Code Blue and what areas need improvement.

b. Central Processing and Distribution (CPD)

   i. CPD shall fax a notification to the pharmacy to replace the used medication tray and to lock the cart. If the pharmacy is closed, CPD shall notify the nursing supervisor to sign out a sealed complete tray of crash cart medications from the supplemental drug room to replace the used tray. CPD shall then lock the cart with a temporary lock and fax a notification to the pharmacy to check the cart and relock. (See Appendix 4-A: Crash Cart Supplies and Equipment and Appendix 4-B: Crash Carts Medications)

c. Team Physician

   i. Notifies the family or legal representative, or delegates this responsibility to the attending physician, and shall document this notification/delegation in the medical record.

   ii. If the resident is to be transferred to the acute care hospital, the physician shall notify the emergency department physician regarding the resident’s status.

6. Documentation

a. Designated Recorder (Preferably Registered Nurse):
i. Complete the Code Blue Record (see Appendix 5: Code Blue Record – MR317).

ii. Obtain a printout of the rhythm strip during the Code Blue and place in the resident’s medical record.

b. Physician:

i. Reviews and signs the Code Blue Record and the Post Code Blue Checklist.


c. The Nursing Supervisor, Nurse Manager, or Charge Nurse:

i. Ensures that a designated Registered Nurse is recording the Code Blue events in the Code Blue Record.

ii. Ensures that the Code Blue Record is complete (with EKG strip) and signed by the recording nurse and the command physician.

iii. Ensure that the code blue huddle has occurred, then completes the Post Code Blue Checklist (See Appendix 7).

iv. Scan a copy of the Code Blue Record (place the original in the cart) and Post Code Blue Checklist to a secure drive. Send an email to the Code Blue Committee members informing them when a new Code Blue Record/Checklist has been added. Bring a copy of the Code Blue Record to Nursing Office and place in Code Blue Committee Mailbox.

d. Unit Licensed Nurse:

i. Documents the events leading up to the Code Blue, interventions, and resident outcome in the Integrated Progress Note.

7. Code Blue Drills

a. Each shift shall have a monthly Code Blue Drill coordinated by Nursing Education (3 Code Blue drills per calendar month).

b. At the beginning of the drill, the Nursing Office Personnel shall announce three times “Code Blue Drill” identifying the location and, at the same time, shall activate pagers of the Code Blue team members.
c. After completion of the drill the Nursing Office Personnel shall be notified to announce “Code Blue drill all clear” three times.

d. A nursing educator or other designated observer shall use two checklists developed by the Code Blue Committee to monitor the Code Blue Drill process.

i. One checklist shall be used to monitor the initial neighborhood response.

ii. The Post-Code Checklist / Medical Quality Assurance (see Appendix 7) shall be used to monitor the process after the Code Blue responder arrive.

e. The Code Blue Drill Record (see Appendix 6), along with comments from the staff, shall be used by the Code Blue Committee to evaluate the drill.

8. Quality Review

a. Nursing Education shall summarize the Code Blue drill records and post-code checklists to review the events, analyze trends, identify problem areas, develop corrective plans, and submit to the Code Blue Committee.

b. The Code Blue Committee shall receive copies of Code Blue drill records and post-code checklists to review during the Code Blue Committee meeting to analyze trends, identify problem areas, and develop corrective plans.

c. The Code Blue Committee Chair shall refer Code Blue events to Medical and Nursing QI Committees, Medical Executive Committee, and Performance Improvement and Patient Safety Committee regarding the drills and Code Blue events.

ATTACHMENT:
Appendix 1: Automatic Dysreflexia Protocol
Appendix 2: Guideline for Code Blue for Nursing Response: Roles and Responsibilities
Appendix 3: Accessing 9-1-1 for Code Blue (Script)
Appendix 4-A: Crash Cart Supplies and Equipment (PDF format)
Appendix 4-B: Crash Carts Medications
Appendix 5: Code Blue Record (MR317)
Appendix 6: Code Blue Drill Record
Appendix 7: Post Code Blue Checklist
Appendix 8: Crash Cart Injection Reference Sheet
Appendix 9: Code Blue Outside the LHH Building
Appendix 10: Resident Code Blue Events – Quick Reference

CROSS REFERENCE:
LHHP 24-21 Insertion and Maintenance of Intraosseous Device
REFERENCE:
AHA BLS and
ACLS Manuals 2015
Code Blue Record MR317 (3/86; 4/09)
LHHPP 24-21 Insertion and Maintenance of Intraosseous Device
NPP L 1.0: Emergency Intervention for Choking

Revised: 97/06/01, 00/12/14, 02/10/24, 03/11/04, 10/11/09, 11/11/29, 13/01/29, 13/09/24,
15/01/13, 17/05/09, 17/11/14, 19/03/12 (Year/Month/Day)
Original adoption: 97/06/01 as MSPP Code Blue; 98/11/16 as LHHPP Code Blue Drill
APPENDIX 9 – Medical Emergency on Hospital Grounds, Outside of Hospital Building

- Hospital Building, Moran Hall, the Chapel, or Gerald Simon, follow Code Blue Policy
- Other areas of administration building, call 9-1-1

1. Any medical emergency that occurs outside the building will be a call to 9-1-1.
   a. Any staff that identifies a medical emergency outside LHH building may call 9-1-1 via cell phone, may use the emergency pull buttons, or notify sheriff at nearest desk.
   b. If Sheriff receives a medical emergency call, they will report to the location with the AED and BLS pack stored at the lobby desk.
   c. Sheriff will confirm 9-1-1 has been called and if not already called, they place 9-1-1 call.
   d. Sheriff will also call nursing office at 4-2999 and state “we have a medical emergency outside the building. 9-1-1 has been activated, page a medical emergency to [location].”
   e. Sheriff on scene will assist as needed.

2. Staff first responders on site may institute BLS until help arrives.

3. When nursing office receives call for medical emergency outside the building:
   a. Confirm with caller that 911 has been activated
   b. Overhead page “medical emergency at location” and page the code blue pagers to the location.

4. All responders carrying code blue pagers will report to location.
   a. One licensed nurse from Pavilion Mezzanine and all licensed nurses from units carrying code blue pagers.
      a. Licensed nurse staff will confirm with supervisor if they may return to their assignment.
      b. If determined the person in distress is a resident on your unit, remain at emergency to assist and provide any available information.

5. Any medical emergency that warrants a 911 call must be transferred to acute care unless advanced directive states otherwise.

6. Available staff should be assigned to obtain face sheet and H&P/medical history if person is identified as a resident.

References: Good Samaritan Act
RESIDENT CODE BLUE EVENTS

Quick Reference

Code Blue Occurs in:
- New Hospital Building
- Serenity Park (previously Harmony Park)
- Moran Hall
- Chapel
- Gerald Simon Theater

Activate the emergency response
- Call 4-2999
- State location

Code Blue Occurs Outside the Building:
- Hospital grounds, but not in hospital building.
  - e.g.: Horseshoe
  - Green Fence
  - Parking lot
  - Animal Farm/Meadow

Activate the emergency response
- Immediately notify the Sheriff’s desk & state “We have a medical emergency at (location), call 911”.
- Sheriff to call 911 and immediately after, call 4-2999 to activate internal code blue.
HARM REDUCTION

POLICY:

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

PURPOSE:

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

SCOPE:

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

DEFINITION:

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

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

Unsafe practices: Behaviors that negatively impact the healing environment and recovery of self or others, but are not imminently dangerous. Some examples include: 1) A resident who is HIV positive brings used needles to the unit, increasing the risk of needle stick to others around them; 2) A resident continues attempts to smoke cigarettes inside their room; 3) A resident attempts to smoke, or use lighters, matches, e-cigarettes, and/or other devices that ignite or fuel a flame, in the presence of or near devices that deliver oxygen to persons; 34) A resident (who is not being aggressive) brings alcohol to the unit and gives it to another resident.
Imminently dangerous behavior: Behaviors that if not intervened upon immediately, would cause immediate harm to self or others (e.g.: a resident is agitated and waving around a broken bottle while intoxicated).

RATIONALE:

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

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

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

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

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

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

PROCEDURE:

1. Provision of Services

   a. Service goals shall be determined through collaboration between the resident and resident representatives, the staff, and the program, establishing realistic measurements of success, for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care 42 CFR § 483.40.
b. Providers shall expand service options within existing programs or collaborate with other service agencies to be able to respond to residents and their special needs.

c. As LHH is part of the San Francisco Health Network and a safety net institution, access to LHH services is allowed even for residents who are unable or not yet willing to abstain from unsafe practices on the LHH campus including the designated smoking area, provided that LHH can provide safe and adequate care for the resident.

d. Providers shall not deny services to individuals for exhibiting behaviors for which they seek or need help.

e. Residents shall not be denied access to, restricted from participation in, or terminated from services on the basis of their use of prescribed medications.

f. Provider language shall not reflect bias toward personal behaviors, experiences, ethnicity, sexual orientation, or personal choices.

g. Programs shall broaden their treatment philosophies in order to provide quality, comprehensive care and coordinate care with other health care service providers.

2. Interventions

a. Initiation and Resident Education

i. Clinical interventions shall be individualized based on the safety risk assessment, differentiating approaches for unhealthy practices and unsafe practices.

ii. The provider shall:

   - Meet with the resident to acknowledge and address the resident's unsafe practice(s), as well as how it relates to the resident's recovery goal(s) and goal(s) for that session in particular.
   - Provide and document resident education regarding risk of unsafe practice(s) to increase resident awareness, reduce the risk of negative consequences, and help resident in making an informed decision regarding unhealthy and unsafe habits. Education and training opportunities shall include reference to LHH's harm reduction philosophy as appropriate to the education and training content/topic. Education provided shall be documented in electronic progress notes by the discipline providing the education.
   - Utilize the principles in Trauma Informed System through mindfulness and awareness, and recognize personal trauma and triggers, and its
impact to present behavior and coping skills. Use “what has happened?” perspective in developing plan of care to our residents.

- Include motivational strategies (e.g. motivational interviewing) that reduce the harm for those residents who are unable to or not yet willing to stop unsafe practices.

- Along with the Resident eCare Team (RCT), ensure that clinical interventions and initiated care plans are person-centered and shall take the resident’s own goals and values into consideration.

b. Monitoring and Follow Up

i. Providers shall make a reasonable attempt, within the context of their programs, to follow-up with residents who demonstrate an inability or unwillingness to participate in treatment, and prior to discharge, make a reasonable attempt to find additional or alternative treatment.

ii. Providers shall recognize relapse, or a return to unsafe practices as part of the recovery process, not as a "failure of treatment" or "failure of resident."

iii. Successes shall be measured to include incremental improvement in housing, physical and mental health, finance, employment and family and social support system.

iv. In the event that a resident is so impaired and/or uncooperative to present imminent danger to self or others, the provider shall follow LHH’s safety policies and procedures in managing the situation.

v. Evaluation of risk factors shall be completed by the RCT at a minimum every quarter, and shall be discussed with the resident or representative during the Resident Care Conference.

3. Quality Assurance

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

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

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

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

ATTACHMENT:
None

REFERENCE:
42 CFR Section 483.40 Behavioral Health Services
San Francisco Health Commission Resolution No. 10-00: Adopting a Harm Reduction Policy for Substance Abuse, STD and HIV
LHHPP 01-00: Value, Mission and Vision Statement
LHHPP 20-01: Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units
LHHPP 24-03: Resident Rights
LHHPP 22-10: Management of Resident Aggression

Revised: 19/03/12 (Year/Month/Day)
Original adoption: 18/01/09 (Year/Month/Day)
HIGH RISK – HIGH ALERT MEDICATIONS

PURPOSE:

To identify potential high risk medications at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) and to outline steps to prevent errors.

POLICY:

Laguna Honda will have procedures in place to minimize medication errors and adverse drug events from high risk medications.

DIVISIONS/DEPARTMENTS AFFECTED:

Medicine, Nursing and Pharmacy

OWNER/AUTHOR:

P&T Committee / Med Executive Committee

FUTURE ISSUE:

1. New drugs added to the Hospital Formulary may meet criteria

2. New reports of harmful errors in the literature, within the hospital, and input from practitioners and safety experts

3. New FDA Med Watch warning or Black Box warning

DEFINITION:

High Risk – High Alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error.

PROCEDURE:

1. Identifying High Risk drugs and preventing harm
   
   a. The Medical Staff through the P&T Committee will determine the list of drugs designated as High Risk – High Alert and the corresponding monitoring / response to be used when these medications are prescribed.
   
   b. All staff involved in the medication use process will be educated on these high alert drugs and the monitoring / response associated with each. The education shall
include any specifics involved in procuring, storing, ordering, transcribing, preparing, dispensing, administering and monitoring.

2. High Risk – High Alert Medication list

   i. See Attachment A for a list of medications designated as High Risk – High Alert Medications at Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) and the steps utilized to prevent errors.

3. Steps Utilized to Prevent Errors

   a. See Attachment B for the procedures utilized to prevent errors.

**ATTACHMENT:**
Attachment A: Laguna Honda High Risk - High Alert Medications
Attachment B: Steps Utilized to Prevent Errors

**REFERENCE:**
ISMP’s List of High Alert Medications e.g., "www.ismp.org"

Revised: 07/16/09, 08/13/09, 13/05/28, **19/03/12** (Year/Month/Day)
Original adoption: 2/12/2008
ATTACHMENT A: Laguna Honda High Risk - High Alert Medications

<table>
<thead>
<tr>
<th>Laguna Honda High Risk - High Alert Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulation (enoxaparin, heparin, warfarin)</td>
</tr>
<tr>
<td>Antineoplastic/Cytotoxic agents</td>
</tr>
<tr>
<td>Clozapine (Psych consult required)</td>
</tr>
<tr>
<td>Digoxin intravenous</td>
</tr>
<tr>
<td>Epidural / Intrathecal Agents (e.g. baclofen)</td>
</tr>
<tr>
<td>Haloperidol injection (e.g. Haldol IM, Haldol Dec)</td>
</tr>
<tr>
<td>Insulins</td>
</tr>
<tr>
<td>Lithium</td>
</tr>
<tr>
<td>Morphine Concentrate (e.g. Roxanol)</td>
</tr>
<tr>
<td>Magnesium Sulfate (IV)</td>
</tr>
<tr>
<td>Methotrexate (PO)</td>
</tr>
</tbody>
</table>

NOTE:

Potassium chloride for injection concentrate (2 mEq/mL) is not on the formulary and is not available at Laguna Honda. Safer alternatives exist and are available, including Potassium Chloride 10 mEq/100ml IVPB and 10 - 40 mEq /1000 ml large volume solutions.

See Laguna Honda IV administration guidelines for infusion recommendations.
## ATTACHMENT B: Steps Utilized to Prevent Errors

<table>
<thead>
<tr>
<th>LHH High Risk – High Alert Medications</th>
<th>Anticoagulation (enoxaparin, heparin, warfarin)</th>
<th>Antineoplastic/Cytotoxic agents</th>
<th>Clozapine (Psych consult required)</th>
<th>Digoxin intravenous (Acute only)</th>
<th>Epidural / Intrathecal Agents (e.g. baclofen)</th>
<th>Haloperidol injection (e.g. Haldol IM, Haldol Dec)</th>
<th>Insulins (SQ only; IV not allowed)</th>
<th>Lithium</th>
<th>Morphine Concentrate (e.g. Roxanol)</th>
<th>Magnesium Sulfate (IV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardize ordering, preparation, and administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use standardized drug/dose expressions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispense only in Unit Dose or Unit of Use packaging</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eliminate use of unapproved abbreviations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardize and limit drug concentrations/formulations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pre-printed Order set/panel available</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Use oral syringes for administration of oral products</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limit the total number dispensed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Drug included in LHH IV guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalize or centralize drug preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use commercially available, premixed IV solutions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distinguish or warn with labels, container size, or computer alerts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use TALL man lettering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispensing label includes appropriate warnings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific organizer bin in pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide labeling specifying administration instructions for emergency use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limit or restrict drug access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispense from ADC only</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispense from pharmacy only</td>
<td>✓</td>
<td>✓</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laguna Honda Hospital-wide Policies and Procedures
<table>
<thead>
<tr>
<th>Limit or restrict drug use</th>
<th>√(IV-RN)</th>
<th>√(RN)</th>
<th></th>
<th>√(RN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certify/privilege staff to order, prepare, or administer drug</td>
<td>√(IV-RN)</td>
<td></td>
<td></td>
<td>(RN)</td>
</tr>
<tr>
<td>Formulary decisions / restrictions</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perform independent double-checks</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy double check of drug &amp; drug preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recalculate the dose</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Double-check rate, drug, concentration, and/or line attachments</td>
<td>√(IV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse-Nurse double check prior to administration</td>
<td>√</td>
<td>(warfarin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involve the patient (family) through education</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitor the patient and respond to drug effects</th>
<th>√</th>
<th>√</th>
<th>√</th>
<th>√</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain and communicate laboratory values per policy</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Require close observation/vital sign monitoring (cardiac monitoring, BP)</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have antidotes and/or resuscitation equipment close at hand</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietician notified for potential food-drug interactions</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Side effect information provided to nursing for close monitoring</td>
<td>√</td>
<td>√</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SAFE MEDICATION ORDERS

PURPOSE:
To ensure resident safety by reducing the potential for error or misinterpretation when orders are communicated.

POLICY:
Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal communication of prescription or medication orders is limited to situations in which immediate written electronic communication is not feasible. Medication orders from physicians, dentists, podiatrists, physician assistants, nurse practitioners, and pharmacists are accepted if they comply with the requirements listed below.

PERSONS AFFECTED:
Clinical Staff, including but not limited to Physicians, Nurses, and Pharmacists

PROCEDURE:
1. Medication Orders
   a. All prescription orders must be in writing or electronic and shall contain the following:
      i. Date and time order is written
      ii. Patient name and medical record number
      iii. Medication name (generic preferred)
      iv. Strength or concentration
      v. Dose
      vi. Frequency or time of administration of the medication
      vii. Route, e.g. PO, IM, SC, IV or rectal
      viii. All orders (PRN and scheduled) must include the indication for use of the medication. PRN orders must also include how often the medication may be given.
      ix. Duration of therapy and quantity. Prescribing practitioner signature
   b. Medication orders that have a Banned abbreviation (e.g. QD instead of daily), acronym or symbol may not be used in any hand-written, patient-specific communication. This includes medication and treatment orders, medication and treatment administration records, laboratory and radiology orders, progress notes, etc. Refer to the “Do Not Use Abbreviation List.”
   c. All verbal or telephone orders shall be immediately recorded in the resident’s chart and signed by the prescriber within 48 hours for the acute units and within five days for Skilled Nursing Facility (SNF) units.
d.c. Orders that are incomplete, illegible or unclear shall not be transcribed or processed by nursing or pharmacy. The prescribing practitioner shall be contacted for clarification and a new order shall be written. Making corrections to an existing order (e.g., crossing over an order) shall not be permitted.

2. Requirements for Specific Categories of Medication Orders

a. "As needed" (PRN) orders: Must include dose, frequency, route and indication for use.

b. There shall be no standing orders for medications or treatments. Standing Orders are defined as orders that allow practitioners to automatically & globally implement patient care without a patient specific order.

c. Hold orders: A "hold order" is interpreted as "discontinue" unless it is specified with specific parameters (e.g., Hold if HR < 60). A hold order with specific parameters is held until the next scheduled dose.

d.c. Automatic stop orders: Drugs not specifically prescribed as to time or number of doses must automatically be stopped as outlined in the Policy and Procedure (P&P) for Automatic Stop Orders (PHARM 01.02.02).

e.d. Resume, Renew, Continue orders: Blanket reinstatement of previous medication orders is not acceptable. Resume, renew or continue orders must be written-completed as part of the medication reconciliation process a new order with all specified elements for a medication order as defined by this P&P.

f.e. Titration orders (orders that a medication is to either progressively be increased or decreased for a specific patient response): "Titration orders" must contain criteria for use and clear parameters as to when to increase or decrease the medication.

g.f. Taper orders: "Taper orders" refer to those in which the dose is decreased by a particular amount with each dosing interval. Each dose of a tapering regimen must be clearly written out.

h.g. Range Orders: There shall be no range orders for medications. "Range orders" are defined as those in which the dose or dosing interval varies over a prescribed range. (e.g. instead of Oxycodone 5-10mg PO Q4 hours prn pain prescribe Oxycodone 5mg PO Q4 hours PRN mild pain; Oxycodone 10mg PO Q4h PRN moderate pain).

i.h. Multiple PRN medications written for the same indication: The parameters for use of each medication must be clearly written to specify when it shall be used (e.g., Milk of Magnesia 30ml PO daily PRN constipation; Bisacodyl 10mg PR daily PRN constipation not relieved by MOM). **Prescribers are encouraged to avoid multiple PRN medications for the same indication.**
j.i. Medications written with multiple routes of administration: The parameters for use must be specified (e.g. Famotidine 20mg PO Q12h, give IV if resident unable to take PO).

k.j. Investigational medication orders: Refer to PHARM 02.05.00 on Investigational Drugs.

3. Verbal Orders
   a. Communication of prescription or medication orders is limited to situations in which immediate written electronic communication is not feasible. Verbal orders, when indicated, shall be immediately written documented by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be written documented before it is read back. The resident's allergy status must be discussed. Refer to LHHPP 25-03 Verbal/Telephone Orders.

4. STAT Orders & Pharmacy Response Time
   a. Nursing service and pharmacy (when open) shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered. When the pharmacy is closed, drugs ordered STAT which are available in the emergency drug supply shall be administered immediately. The nursing supervisor shall be notified when access to the supplemental medication room or the on call pharmacist is needed as outlined in the P&P for Emergency and Supplemental Medication Supplies (PHARM 02.03.00).

   b. Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

   c. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

   d. Refills shall be available when needed.

5. Discontinued Medication Orders
   a. By the end of shift during which the medication is discontinued, the nursing unit shall send or fax the order to Pharmacy, and print "DC" on the prescription label. Room temperature medications are to be placed in the drug pick-up box, and unopened, refrigerated medications are to be returned to the pharmacy immediately. This also applies to the medications of residents who expire, are discharged, or transferred to an acute hospital. The pharmacy shall process discontinued orders within 4 hours of receiving.
ATTACHMENT:
None

REFERENCE:
Do Not Use Abbreviation List
LHHPP 25-03 Verbal/Telephone Orders
PHARM 01.02.02 Automatic Stop Order Policy
PHARM 02.03.00 Emergency and Supplemental Medication Supplies
PHARM 02.05.00 Investigational Drugs Policy

Revised: 08/02/12, 15/05/12, 17/07/11, 19/03/12 (Year/Month/Day)
Original adoption: 07/10/20
VERBAL/TELEPHONE ORDERS

POLICY:

1. Verbal communication of prescription or medication orders is limited to situations in which immediate written electronic communication by the prescriber is not feasible.

2. Verbal orders are not indicated when the prescriber is present and the patient's chart is available, except in an emergency situation, in which case a repeat-back is acceptable.

3. Verbal orders are not permitted for chemotherapy.

4. The following job categories are authorized to give verbal orders:
   a. Physician
   b. Affiliated Healthcare Practitioners credentialed by the medical staff
   c. Dentist
   d. Podiatrist

5. The following job categories are authorized to accept verbal orders:
   a. Licensed nurse (RN, LVN, LPT)
   b. Licensed pharmacist
   c. Licensed rehabilitation therapist (physical therapy, occupational therapy, speech therapy)
   d. Respiratory therapist
   e. Clinical dietitian

6. Staff giving or accepting verbal orders are limited to only those orders within their scope of practice.

PURPOSE:

To reduce errors associated with misinterpreted verbal or telephone communications of physician orders.

PROCEDURE:

1. Verbal orders, when indicated, will be immediately documented in the electronic health record or written down by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be documented before it is read back.

2. The recipient will record each verbal order directly into the electronic health record or onto an order sheet in the patient's chart.
3. The prescriber and person accepting the verbal order will discuss the resident’s allergy history when the order is for a medication.

4. Both parties will pronounce numerical digits separately—saying, for example, "one six" instead of "sixteen."

5. For medication orders, the prescriber will spell the name of any unfamiliar medication, if either party feels this is necessary.

6. Prescribers will include the purpose of the drug to ensure that the order makes sense in the context of the patient’s condition.

7. Both parties will express doses of medications by unit of weight (e.g., mg, g, mEq, mMol).

8. Recipients of verbal orders will sign, date, time, and note the order at the time it is written on the order sheet. The electronic health record will time stamp the order.

9. The Prescriber will verify, sign, and date orders within 48 hours for the acute ward and within 5 days for SNF wards. Another physician may not verify and sign for the prescriber.

10. Verbal orders, when spoken and when transcribed, will use only approved abbreviations. (e.g., "daily" written instead of QD, refer to do not use abbreviation list).

11. Verbal medication orders will include the following information:
   a. Date and time order is received
   b. Patient name
   c. Drug name (brand or generic)
   d. Strength or concentration
   e. Dose
   f. Frequency or time of administration of the medication
   g. Route if other than oral, e.g. IM, SC, IV or rectal
   h. All "PRN" orders must include the indication for use of the medication and how often prn medications may be given.
   i. Duration of therapy or quantity
   j. Name of prescriber
   k. Signature of order recipient

ATTACHMENT:
None

REFERENCES:
Nursing Policy and Procedure C 9.0 Transcription and Processing of Orders


Revised: 08/02/12, 10/11/24, 11/03/24, 12/07/31, 14/05/27, 15/05/12, 19/03/12
(Year/Month/Day)
Original adoption: 06/12/22
ADVERSE DRUG REACTION (ADR) REPORTING PROGRAM

POLICY:

1. Suspected adverse drug reactions among Laguna Honda Hospital and Rehabilitation Center (Laguna Honda LHH) residents will be reported, investigated, reviewed, and appropriate action will be taken.

2. Adverse Drug Reaction Reporting is voluntary and non-punitive.

3. Priority for investigation will be given for reactions categorized as severe or necessitating an emergency visit or admission to acute care.

PURPOSE:

1. To assure timely intervention when a resident has an adverse reaction to his/her medication.

2. To identify opportunities to improve drug utilization practices by minimizing the occurrence of preventable adverse drug reactions.

3. To improve resident care by educating all health care providers about potential adverse drug reactions.

DEFINITION:

1. A reportable adverse drug reaction (ADR) is a noxious, unintended or undesirable clinical symptom, sign or laboratory finding, caused by a drug administered for prophylactic, therapeutic or diagnostic purposes.

PROCEDURE:

1. Reporting Requirement:

   a. Any health care provider suspecting an adverse drug reaction will:

      i. Take appropriate action to treat or secure treatment for the reaction; and assure that the suspected reaction and treatment are documented in the medical record.

      ii. Contact the attending physician and supervisor. If the attending physician is not available the covering physician is notified. The attending physician is notified as soon as they are available.

2. Types of Reportable Adverse Drug Reactions:
a. All lethal and severe reactions (e.g. Neuroleptic Malignant Syndrome (NMS) caused by antipsychotic medication such as Haloperidol)

b. Any untoward effects manifesting as a result of excessive dosage (e.g. oversedation or respiratory depression caused by opioid such as morphine sulfate)

c. A reaction due to a direct toxic effect on any organ system (e.g. nephrotoxicity, ototoxicity caused by aminoglycoside such as gentamicin)

d. Hypersensitivity reactions manifesting as an allergic response (e.g. Steven Johnson Syndrome (SJS) or Toxic Epidermal Necrolysis (TEN) caused by sulfad-based antibiotics such as Septra)

e. Rare, unexpected responses to a drug, unrelated to dose (idiosyncratic reactions) (e.g. Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) caused by selective serotonin reuptake inhibitors (SSRI) such as sertraline)

f. A drug interaction that causes an unintended response (e.g. sulfonamide derivatives may enhance the anticoagulant effect of Coumadin)

g. Any suspected ADR to a newly approved drug, regardless of severity (e.g. signs/symptoms of heart failure caused by rosiglitazone such as rapid weight gain, dyspnea, edema)

h. A known, common, but unintended reaction that requires any change in drug therapy (e.g. hypoglycemia caused by insulin or oral antidiabetic agents such as glipizide; extrapyramidal symptoms (EPS) and tardive dyskinesia caused by antipsychotic medications such as risperidone.)

In general, adverse effects which occur routinely as part of the pharmacologic spectrum of drug activity do not need to be reported unless categorized as severe, or necessitating an emergency visit or admission to acute care.

When uncertain about the need to report an ADR, report it anyway.

3. How to Report a Suspected ADR:

a. The health care provider reporting a suspected ADR does not need to be absolutely sure that the reaction is caused by a medication before reporting. All information will be kept confidential.

i. File an Unusual Occurrence form OR call the pharmacy at extension 4-0477.

ii. Provide:

• Resident name
- Resident location
- Resident medical record number
- Date of suspected ADR
- Suspected drug involved
- Description of suspected ADR
- Reporter's professional title (MD, RN, pharmacist, etc.)
- Reporter's name (optional)

iii. If appropriate, the physician will write an order in the chart indicating to add the offending medication to the patient's allergy list in the electronic health record (EHR) - a drug allergy or adverse reaction (to generate a label to be affixed to the front of the chart and to assure that nursing staff will record the adverse reaction on each order sheet).

iv. The health care provider suspecting an adverse drug reaction will so note on an Unusual Occurrence form (e.g., "suspected ADR to ") and/or call the pharmacy. An investigation is not required at this point.

v. The Unusual Occurrence report will be submitted to the Quality Management Department, who will direct it to the clinical pharmacist for investigation. Clinical pharmacists also will investigate all calls to the pharmacy. Priority for follow-up is given to those reactions rated as severe or lethal and probable or definite.

vi. The clinical pharmacist will submit the ADR investigation to the Medication Error Prevention-Reduction Subcommittee of the Pharmacy and Therapeutics Committee (P&T) for evaluation and follow-up.

vii. The clinical pharmacist, after conferring with the chairperson of the P&T, will present a summary of reports and findings from the preceding month at each P&T.

viii. If, after review, the clinical pharmacist determines that there is an adverse drug reaction, he/she will so note as part of the investigation and if recommended by the P&T, will file a report with the Food & Drug Administration (FDA MedWatch) in accordance with government regulations.

4. Trigger Drug Program:

a. Trigger drugs for identifying suspected ADR are defined as drugs used to reverse, mitigate or treat symptoms secondary to administration of another drug.

b. Drugs shall be approved for the Trigger Drug Program by the Medication Error Prevention-Reduction Subcommittee and approved by the P&T Committee.

c. Reports of suspected ADR detected through the Trigger Drug Program will be provided quarterly to the Medication Error Prevention-Reduction Subcommittee.
d. The Department of Pharmaceutical Services will be responsible for carrying out Trigger Drug Program procedures.

   i. A report from the Pharmacy computer systems EHR will be generated and reviewed by a pharmacist.

   ii. If the report shows that a trigger drug was dispensed, the pharmacist will confirm that it was administered to the patient by checking the patient’s MAR (Medication Administration Record.)

   iii. When confirmed that the patient received a dose of the trigger drug, the pharmacist shall report the ADR as above in order to provide for investigation and monitoring.

5. The Chairperson of the P&T Committee:

   a. Will present a quarterly summary of adverse drug reaction reports to the Medical Quality Improvement Committee, which will take action as needed.

   b. Will confer with the attending physician as appropriate and necessary after reviewing the ADR investigation, with the objective of decreasing the potential for future similar ADRs.

ATTACHMENT:
None

REFERENCE:

Revised: 08/02/02, 11/11/29, 19/03/12 (Year/Month/Day)
Original adoption: 00/07/13
PAIN ASSESSMENT AND MANAGEMENT

POLICY:

1. Residents have the right to appropriate assessment and management of pain.

2. Pain is regularly (re)assessed as clinically indicated.

3. When pain is identified, a pain management plan is developed as part of the resident's care plan. Complementary therapies will be implemented first for chronic pain.

4. The Verbal Descriptor Scale is the preferred method for (re)assessing pain intensity for residents/patients able to self-report pain.

5. For residents receiving opioid therapy for chronic non-malignant pain, informed consent and treatment agreements are recommended. (See LHH Forms in Cross Reference)

6. Laguna Honda Hospital and Rehabilitation Center (LHH) continuously monitors and improves its performance in managing residents' pain.

PURPOSE:

1. To enhance the resident's functional ability and quality of life.

2. To identify and eliminate barriers to effective pain management.

3. To comply with licensing and certification requirements.

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions and Other Relevant Information</td>
<td>1-2</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>3</td>
</tr>
<tr>
<td>Pain Reassessment</td>
<td>3-4</td>
</tr>
<tr>
<td>Pain Management</td>
<td>4-6</td>
</tr>
<tr>
<td>Documentation</td>
<td>6-7</td>
</tr>
<tr>
<td>Organizational Performance/Quality Improvement Efforts</td>
<td>7</td>
</tr>
<tr>
<td>Appendix A: Laguna Honda Pain Intensity Scales: Verbal Description and Numeric Rating Scale and Verbal Rating Scale in English, Spanish and Chinese</td>
<td>9-11</td>
</tr>
<tr>
<td>Appendix B: Guidelines for Assessing and Managing Pain in Residents with Severe Cognitive Impairments</td>
<td>12</td>
</tr>
<tr>
<td>Appendix C: Guidelines for Managing Pain in Residents with Substance Use Disorders</td>
<td>13-14</td>
</tr>
<tr>
<td>Appendix D: Guidelines for Managing Pain in Residents who Are Actively Dying</td>
<td>15-16</td>
</tr>
<tr>
<td>Appendix E: CDC Recommendations for Opioid Prescribing for Chronic</td>
<td>17-18</td>
</tr>
</tbody>
</table>
DEFINITION AND OTHER RELEVANT INFORMATION:

1. Pain:
   a. An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (APS, 1999; IASP1994).
   b. There are no biological markers of pain.

2. Acute Pain:
   a. Follows injury or procedures and generally disappears when the injury heals.
   b. Generally associated with autonomic nervous system activation (i.e. tachycardia, hypertension, diaphoresis, pallor and mydriasis).
   c. To defer analgesia until the etiology of acute pain is diagnosed is rarely justifiable (APS, 1999).

3. Chronic Or Persistent Pain (AGS, 2009):
   a. Pain lasting more than 3 months or beyond the expected time for healing which may or may not have an easily identifiable pathologic basis.

4. Addiction:
   a. Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, compulsive use despite harm, and craving (Consensus statement American Academy of Pain Management, American Pain Society and American Society of Addiction Medicine, 2001).

5. Physical Dependence:
   a. Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist. (Consensus statement American Academy of Pain Management, American Pain Society and American Society of Addiction Medicine, 2001).

6. Tolerance:
a. Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time (Consensus statement American Academy of Pain Management, American Pain Society and American Society of Addiction Medicine, 2001).

PROCEDURE:

1. Pain Assessment

a. Nursing staff

   i. For all Skilled Nursing Facility (SNF) admissions, the nurse will complete the SNF Nursing Admission Pain Assessment (MR 361).

   ii. As part of the RAI process, the nursing staff screens/assesses for pain by completing the MDS pain interview for residents able to communicate verbally, at admission, quarterly, annually, and with a condition change. For residents unable to self-report pain, staff observation of possible pain behaviors are recorded.

   iii. For acute units, the nurse will complete the Comprehensive Pain Assessment Form (MR 337).

b. Medical staff

   i. Perform a complete history and physical examination;

   ii. Review medication regimen;

   iii. Evaluate past medical history for conditions commonly associated with pain (e.g., arthritis, orthopedic injuries, peripheral vascular disease, advanced cancer, AIDS etc.); and

   iv. Obtain tests to guide diagnosis and treatment of painful conditions.

   v. Determine if history of substance use disorder and if known, opioid diversion.

c. Other RCT members such as social worker, activity therapist, dietitian and rehabilitation therapist may recognize the presence of pain as part of their initial and ongoing assessment process using some of the following strategies:

   i. Interviewing the resident or family caregiver;

   ii. Inquiring of family caregivers how they recognize the resident is in pain; and
iii. Observing the resident in recreational or therapeutic activities.

2. Pain Reassessment

a. Monitor pain intensity (Verbal Descriptor Scale is preferred) each time vital signs are measured except as noted below.

i. Exceptions: If resident requires frequent V.S. measurement for a procedure (e.g. blood transfusion) or post injury (e.g. post fall with neuro checks), pain is assessed at the beginning and completion of the assessment process.

b. For non-English speaking residents who read in their native language, use the appropriate translated Laguna Honda Pain Intensity Scales (see Appendix A for English, Spanish and Chinese versions). Additional assessment information may require an interpreter to interview the resident.

c. Reassess and document pain location and pain intensity before PRN, and record pain intensity only after each PRN medication administered.

d. Nursing assistants may monitor/record residents’ self-reports of pain intensity and report increased pain scores and possible pain behaviors to the licensed nurse for further assessment and management.

e. For residents able to self-report pain intensity, either the Verbal Descriptor Scale or Numeric Rating Scale, may be used. (Refer to Appendix A.)

f. Use the PAINAD to compute possible pain behavior score for severely cognitively impaired who cannot reliably report pain. (See Appendix B.)

3. Pain Management

a. Principles of Pain Management

i. The goals and interventions developed to manage pain are based on:

   • The nature of the pain
   • The underlying pathophysiologic mechanism
   • Past interventions used
   • The resident’s treatment preferences
   • Available resources
   • Side effect profile and tolerance
• Medical contraindications to specific interventions

• Functional impact of pain and its treatment

ii. A combination of complementary and pharmacological and interventions shall be attempted to manage chronic pain.

iii. The RCT develops a pain management plan whose goal is to help the resident achieve a level of pain relief tolerable to him/her while maximizing the resident's functional ability and quality of life.

iv. If the resident has pain not amenable to routine interventions, pain management consultants, such as the Pain and Healing Center Clinic, are available to assist the RCT to manage the resident's pain.

v. Risks and benefits of opioid therapy for non-cancer pain will be discussed with the resident. Providers may use the opioid informed consent. (See LHH Forms in Cross Reference.)

vi. A treatment agreement may be used to clarify roles and responsibilities of the resident/patient and the care team and consequences for misuse of opioids. (See LHH Forms in Cross Reference.)

vii. For recognizing/ treating pain in special populations see Appendices B, C, and D.

b. Pharmacological Interventions: General Guidelines – refer to pain guidelines from:

i. American Pain Society
(https://americanpainsociety.org/education/guidelines/overview)

ii. Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 (see Appendix E Summary) (https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm)

iii. American Medical Directors Association


c. Complementary Therapies: General Guidelines

i. Complementary Interventions are defined here as therapeutic activities that
holistically address the human suffering and distress associated with living with chronic pain that includes psychological, spiritual, social and emotional and physical pain, and do not include analgesics.

ii. Complementary interventions include caring relationships, support, resident education, animal assisted therapy, movement groups, as well as physical, rehabilitative and psychologically-oriented interventions.

iii. Complementary interventions may include individual and or group psychotherapy to assist the resident in the development of cognitive behavioral skills to improve the resident’s management of the pain experience.

iv. See Appendix F: LHH Resources/Services for Residents with Pain.

v. Resident/family education related to pain includes individual and group activities and includes: importance of reporting uncontrolled pain, self-care complementary techniques, safe use of medications, and reasonable expectations regarding amount of relief possible with chronic pain.

d. Discharge Planning

i. If a resident is being discharged to the community or to another care program on an opioid or other controlled substance for pain:

   • LHH physician must consult with community primary care provider to discuss regimen and problem solve any concerns to ensure that the resident’s continuing care needs are addressed.

   • LHH Pharmacy may provide a limited supply of analgesics and co-analgesics, including controlled substances to manage the resident’s pain, until appointment with community primary care provider is scheduled for ongoing prescriptions.

   • Provide information to the resident and/or caregiver about the pain management plan including non-pharmacologic interventions.

   • Consider prescribing Narcan Nasal Spray kit for resident discharged with opioid doses > 50 morphine milligram equivalents (MME) per day or at risk for overdose.

4. Documentation

a. The licensed nurse completes SNF Nursing Admission Pain Assessment—(MR 361).

b. For acute care patients, the licensed nurse completes the Comprehensive Pain
Assessment (see MR Form 337).

c. Pain intensity is recorded with each set of vital signs except as noted in Pain Reassessment Section.

d. Pain intensity scores are documented electronically in the EHR, or, for downtime procedures on Treatment Administration Record (TAR).

e. Breakthrough pain scores are only recorded on the back of MAR and include location and intensity (reason for PRN) and change in intensity (as response to PRN). Indicate asleep or off unit if unable to evaluate response to PRN medication.

f. The nurse evaluates resident’s response to pain management care plan side effects, analgesic use and other data and progress toward goals (e.g., impact of pain on ADLs or sleep), on the weekly and monthly summaries and on progress notes when appropriate.

g. Pain care plan will include the location (or site) of pain, pain associated diagnoses, and the method use to reassess pain (NRS, VRS or PAINAD).

5. Organizational Performance/Quality Improvement Efforts

a. Convene a Pain Management Performance Improvement Committee to oversee QI efforts and to identify/address barriers to pain assessment and management as indicated.

b. Incorporate pain assessment and management policies and procedures in clinical staff orientation and continuing education programs.

c. Analyze MDS indicators related to pain management at least annually to determine patterns and prevalence of pain at LHH. Compare LHH data with national benchmarks.

d. Collaborate with RCTs of neighborhoods to examine care processes and/or resident population variations.

e. Provide access to pain consultants or pain clinics and complementary therapies for residents with complex pain problems.

ATTACHMENT:
Appendix A: Laguna Honda Pain Intensity Scales: Verbal Descriptor and Numeric Rating Scale and Verbal Rating Scale in English, Spanish and Chinese versions
Appendix B: Guidelines for Assessing and Managing Pain in Residents with Severe Cognitive Impairments
Appendix C: Guidelines for Managing Pain in Residents with Substance Use Disorders
Appendix D: Guidelines for Managing Pain in Residents who are Actively Dying
Appendix E: CDC Recommendations for Opioid Prescribing for Chronic Pain
Appendix F: LHH Resources/Services for Pain Management

CROSS REFERENCE:
LHH Forms:
- LHH Consent for Long Term Controlled Medicines for Chronic Pain
- LHH Patient-Provider Agreement for Long Term Controlled Medicines for Chronic Pain

REFERENCE:
LHH Diversion Prevention Plan

Revised: 92/05/20; 00/10/05; 01/08/23, 10/10/26, 11/11/29, 12/05/22, 17/11/14, 19/03/12 (Year/Month/Day)
Original adoption: 88/01/22
Appendix A: (English version)

Laguna Honda Self-Reported Pain Intensity Scales:

<table>
<thead>
<tr>
<th>Verbal Descriptor Scale*</th>
<th>Numeric Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Preferred</td>
<td></td>
</tr>
<tr>
<td>Very severe, horrible</td>
<td>10</td>
</tr>
<tr>
<td>Severe</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Moderate</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Mild</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
</tbody>
</table>
### Appendix A: (Chinese version)

**拉古纳醫院疼痛强度自我报告量表**
*(Laguna Honda Self-Reported Pain Intensity Scales)*

<table>
<thead>
<tr>
<th>Verbal Descriptor Scale (<em>Preferred</em>)</th>
<th>Numeric Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>非常劇烈可怕的疼痛</strong> <em>(Very severe, horrible)</em></td>
<td>10</td>
</tr>
<tr>
<td><strong>劇烈疼痛</strong> <em>(Severe)</em></td>
<td>9</td>
</tr>
<tr>
<td><strong>中度疼痛</strong> <em>(Moderate)</em></td>
<td>8</td>
</tr>
<tr>
<td><strong>輕微疼痛</strong> <em>(Mild)</em></td>
<td>7</td>
</tr>
<tr>
<td><strong>沒有痛</strong> <em>(None)</em></td>
<td>6</td>
</tr>
<tr>
<td><strong>輕微疼痛</strong> <em>(Mild)</em></td>
<td>5</td>
</tr>
<tr>
<td><strong>中度疼痛</strong> <em>(Moderate)</em></td>
<td>4</td>
</tr>
<tr>
<td><strong>劇烈疼痛</strong> <em>(Severe)</em></td>
<td>3</td>
</tr>
<tr>
<td><strong>非常劇烈可怕的疼痛</strong> <em>(Very severe, horrible)</em></td>
<td>2</td>
</tr>
<tr>
<td><strong>沒有痛</strong> <em>(None)</em></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix A: (Spanish version)

**Escala de LHH para medir intensidad del dolor**

¿Por favor díganos como y cuanto es su dolor para poderle ayudar?

*Preferred*

<table>
<thead>
<tr>
<th>Intolerable</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insoportable</td>
<td></td>
</tr>
<tr>
<td>Peor, horrible</td>
<td>(Very severe, horrible)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fuerte</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucho, severo</td>
<td>(Severe)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderado</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Moderate)</td>
<td></td>
</tr>
</tbody>
</table>

| Leve, poco, un poquito | 3 |
| (Mild)                 |   |

<table>
<thead>
<tr>
<th>Ninguno</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>(None)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B:

Guidelines for Assessing and Managing Pain in Residents With Severe Cognitive Impairments

1. Use PAINAD (see below) to detect pain related behaviors and record pain scores in EHR or TAR as per downtime procedures.
2. Rule out other non-pain causes of behaviors and intervene appropriately.
3. If a resident is sometimes able to self-report pain intensity, use self-report rather than PAINAD.
4. For residents with painful chronic conditions, such as arthritis, assume resident has pain and provide around the clock analgesia, (not PRN) before using psychotropics.
5. Maximize the use of complementary therapies (tub baths, massage, movement activities, and distraction) in addition to pharmacological interventions.
6. Carefully evaluate for medication side effects and adverse effects since resident's ability to notice/report these may be compromised.

Pain Assessment IN Advanced Dementia (PAINAD)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(independent of</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vocalizations)</td>
<td>None</td>
<td>Occasional moan or groan. Low level speech with negative</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or disapproving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expression</td>
<td>inexpressive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No need to</td>
<td>Distracted or reassured by voice or</td>
<td>Unable to console, distract or reassure.</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>console</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Score

REFERENCE:
Appendix C:

Guidelines for Managing Pain in Residents with Substance Use Disorders

1. Residents with Pain Who Are Actively Using Non-prescribed substances or alcohol:

   a. Understand that many patients who use substances do so to feel good or to feel better. Undertreated pain may be a trigger to substance use relapse.

   b. If patient consents, refer patient to STARS for assessment, treatment, and/or medication-assisted treatment (eg. buprenorphine/methadone/etc.)

   c. Educate the resident that the goals of pain treatment are to manage pain and improve functioning, while maintaining safety.

   d. Residents who frequently use opioids (e.g., heroin) often require higher than expected doses because of pre-existing tolerance.

   e. Dose analgesics on a scheduled or an around-the-clock basis for residents with chronic pain.

   f. Minimize PRN dosing for chronic, non-acute, non-cancer pain as this may lead to confrontation with staff about when it is time for medication, how much is needed etc.

   g. Monitor for signs of diversion and develop plan with RCT to address if signs are discovered (this applies to all residents even those without known substance disorder history).

   h. Recognize that many individuals with substance use disorders have: low pain thresholds, possible atypical pathophysiologic pain mechanisms, and increased anxiety related to the adequacy of pain management because of past negative experiences with the healthcare system and providers. Therefore they may be untrusting of your intentions.

   i. Maximize use of non-pharmacologic and complementary interventions (e.g., heat/cold; massage; acupuncture; cognitive-behavioral approaches etc.).

   j. Be aware of drug-drug interactions (e.g., with antiretrovirals, Rifampin-Methadone, benzodiazepines, etc.) that may influence dose of opioid required to control pain and to prevent withdrawal or overdose.

   k. If opiate medications are being decreased, monitor for signs of withdrawal and provide treatment, as withdrawal may increase the resident’s experience of pain and may trigger an increase in substance use.
1. If the resident has acute pain, begin tapering opioids as the underlying condition is healing and counsel resident beforehand regarding this plan.

m. In general, believe the resident's complaints of pain unless you have compelling evidence otherwise. Recall that pain is subjective experience without reliable biological markers.

n. Closely monitor the interaction between pain management plan and substance use disorders.

2. **Residents in Remission/Recovery from Substance Use Disorders**

a. Recognize that some residents may deny pain or refuse treatment for pain because of fear of relapse.

b. Maximize use of non-opioid analgesics and adjuvant agents.

c. Educate resident on the risks, benefits and alternatives for opioid pain medications if these medications are indicated.

d. Maximize use of non-pharmacologic/complementary interventions (e.g., heat/cold; massage; acupuncture; cognitive-behavioral approaches etc.)

e. Closely monitor the effect of the pain management plan on the resident's disease of addiction.

f. Residents on daily methadone maintenance (for opioid dependence) may require more frequent dosing, or additional analgesics for pain control.
Appendix D: Guidelines for Recognizing/Managing Pain and Other Sources of Distress in Residents who are Actively Dying

1. When the resident is able to report symptoms:
   a. Inquire about pain/hurt
   b. Ask about other uncomfortable symptoms: shortness of breath, anxiety, mental confusion, sadness, regret, nausea etc.

2. When resident is non-verbal, observe for behaviors suggestive of discomfort including but not limited to: moaning, groaning, facial grimacing, tense body language, restlessness, confusion, difficulty breathing, etc. Consider family/friend reports of discomfort.

3. If signs or symptoms are present, conduct a comprehensive assessment to understand:
   a. Onset of sign/symptom
   b. Duration (constant, intermittent, related to care procedures, etc.)
   c. Non-pharmacological interventions (repositioning, calm and reassurance, etc.) used.
   d. Pharmacological interventions to be used to relieve distress.
   e. Evaluate effectiveness of the interventions and revise plan as necessary.

4. Assessing/addressing physical symptoms and other sources of suffering provides support and comfort for family, friends and volunteers providing support.

5. For physical symptoms:
   a. Review current medication regimen for PRN medications.
   b. If resident is no longer able to swallow medications consult with MD and pharmacist for alternative routes of administrations and formulations, e.g. parenteral (SQ or IV), suppository, concentrated liquid formulation for sublingual administration.
   c. New medication orders should be obtained STAT to relieve terminal symptoms.
   d. Evaluate effectiveness of medication in relieving symptoms/behaviors
e. For persistent symptoms, scheduled dosing is often necessary rather than PRN.

f. Provide regular oral care to moisten/refresh mouth and lips.

6. For residents being treated for pain orally, who are approaching the end of life, the attending physician may include additional orders with alternate route of administration in advance so there is no delay in obtaining the medication or controlling the symptoms, e.g., if unable to take PO Morphine dose, may give Morphine ___ mg SQ/IV every ___ hours (ATC or PRN) pain/SOB.

7. For evenings, nights, weekends and holidays, when necessary contact on call physician for unrelieved symptoms requiring evaluation/treatment.
Appendix E: CDC Recommendations for Opioid Prescribing in Chronic Pain

**Determine When to Initiate or Continue Opioids for Chronic Pain**

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

**Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation**

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

**Assessing Risk and Addressing Harms of Opioid Use**

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

---

*All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.*
BOX 2. Interpretation of recommendation categories and evidence type

**Recommendation Categories**

Based on evidence type, balance between desirable and undesirable effects, values and preferences, and resource allocation (cost).

**Category A recommendation**: Applies to all persons; most patients should receive the recommended course of action.

**Category B recommendation**: Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

**Evidence Type**

Based on study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects.

- **Type 1 evidence**: Randomized clinical trials or overwhelming evidence from observational studies.
- **Type 2 evidence**: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.
- **Type 3 evidence**: Observational studies or randomized clinical trials with notable limitations.
- **Type 4 evidence**: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

---

**Determining When to Initiate or Continue Opioids for Chronic Pain**

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.**

Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).

Patients with pain should receive treatment that provides the greatest benefits relative to risks. The contextual evidence review found that many nonpharmacologic therapies, including physical therapy, weight loss for knee osteoarthritis, psychological therapies such as CBT, and certain interventional procedures can ameliorate chronic pain. There is high-quality evidence that exercise therapy (a prominent modality in physical therapy) for hip (100) or knee (99) osteoarthritis reduces pain and improves function immediately after treatment and that the improvements are sustained for at least 2–6 months. Previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip (176). Exercise therapy also can help reduce pain and improve function in low back pain and can improve global well-being and physical function in fibromyalgia (98,101). Multimodal therapies and multidisciplinary biopsychosocial rehabilitation-combining approaches (e.g., psychological therapies with exercise) can reduce long-term pain and disability compared with usual care and compared with physical treatments (e.g., exercise) alone. Multimodal therapies are not always available or reimbursed by insurance and can be time-consuming and costly for patients. Interventional approaches such as arthrocentesis and intraarticular glucocorticoid injection for pain associated with rheumatoid arthritis (117) or osteoarthritis (118) and subacromial corticosteroid injection for rotator cuff disease (119) can provide short-term improvement in pain and function. Evidence is insufficient to determine the extent to which repeated glucocorticoid injection increases potential risks such as articular cartilage changes (in osteoarthritis) and sepsis (118). Serious adverse events are rare but have been reported with epidural injection (120).

Several nonopioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are effective for chronic pain. In particular, acetaminophen and NSAIDs can be useful for arthritis and low back pain. Selected anticonvulsants such as pregabalin and gabapentin can improve pain in diabetic neuropathy and post-herpetic neuralgia (contextual evidence review). Pregabalin, gabapentin, and carbamazepine are FDA-approved for treatment of certain neuropathic pain conditions, and pregabalin is FDA approved for fibromyalgia management. In patients with or without depression, tricyclic antidepressants and SNRIs provide effective analgesia for neuropathic pain conditions including diabetic neuropathy and post-herpetic neuralgia, often at lower dosages and with a shorter time to onset of effect than for treatment of depression (see contextual evidence review). Tricyclics and SNRIs can also relieve fibromyalgia symptoms. The SNRI duloxetine is FDA-approved for the treatment of diabetic neuropathy and fibromyalgia. Because patients with chronic pain often suffer from concurrent depression (144), and depression can exacerbate physical symptoms including pain (177), patients with co-occurring pain and depression are especially likely to benefit from antidepressant medication (see Recommendation 8). Nonopioid pharmacologic therapies
### Appendix F: LHH Resources/Services for Pain Management

<table>
<thead>
<tr>
<th>Specific Pain Management Resources</th>
<th>Department</th>
<th>Hours of Service</th>
<th>Evening Hrs. (Y=yes; N=no)</th>
<th>Weekend Hrs. (Y or N)</th>
<th>Referral Process</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complementary Therapies (acupuncture, massage, meditation, music therapy/acutonics, reiki, Medical Qi Gong, hypnotherapy)</td>
<td>Pain and Healing Clinic/ Medicine Service</td>
<td>Thursdays only 9-12PM and 1-3:30PM</td>
<td>N #</td>
<td>N</td>
<td>E-Referral by MD</td>
<td># Clinic Team has trained some PM nurses re. simple complementary therapy techniques</td>
</tr>
<tr>
<td>Heat or Cold Applications</td>
<td>Nursing</td>
<td>24 hours/day</td>
<td>Y</td>
<td>Y</td>
<td>NA</td>
<td>Refer to NPP for contraindications</td>
</tr>
<tr>
<td>Resident Education</td>
<td>Nursing</td>
<td>24 hours/day</td>
<td>Y</td>
<td>Y</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Bedside Pain Assessment &amp; Management Consultation</td>
<td>Nursing</td>
<td>Monday-Friday Days</td>
<td>N</td>
<td>N</td>
<td>Contact Clinical Nurse Specialist</td>
<td>Anyone may contact CNS; if medication related, MD agreement for referral is required</td>
</tr>
<tr>
<td>Medication Consultation</td>
<td>Pharmacy</td>
<td>Monday-Friday Days</td>
<td>N</td>
<td>N</td>
<td>Contact pharmacy</td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>Medicine</td>
<td>Monday-Friday Days (Primary Care MD)</td>
<td>Y - On Call MD for Acute Pain only</td>
<td>Y - On Call MD for Acute Pain only</td>
<td>Physician Monthly Calendar for Coverage</td>
<td>Note: Primary Care MD manages routine pain management regimen; On Call MD should be contacted by</td>
</tr>
<tr>
<td>Specific Pain Management Resources</td>
<td>Department</td>
<td>Hours of Service</td>
<td>Evening Hrs. (Y=yes; N=no)</td>
<td>Weekend Hrs. (Y or N)</td>
<td>Referral Process</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>----------</td>
</tr>
<tr>
<td>• Assessment</td>
<td>Psychiatry</td>
<td>Monday to Friday 8:30A to 5PM</td>
<td>Y - On-call psychiatrist for psychiatric emergencies only</td>
<td>Y - On-call psychiatrist for psychiatric emergencies only</td>
<td>E-referral by PMD. Patients may also self-refer by notifying PMD.</td>
<td>See psychiatry department P+P's for further details regarding services.</td>
</tr>
<tr>
<td>• Medication Support, Psychotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mental Health Counseling (for co-morbid psychiatric conditions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health and Behavior (adjustment to disability, psychological factors related to pain/medical conditions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Neuropsychologic Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assessment</td>
<td>STARS/Psychiat</td>
<td>Monday to</td>
<td>Y - On-call</td>
<td>Y - On-call</td>
<td>E-referral by</td>
<td>See STARS P+P</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Friday</td>
<td></td>
<td></td>
<td>PMD. Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>may also self-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>refer by</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>notifying PMD.</td>
<td></td>
</tr>
</tbody>
</table>

nursing only for acute or severe pain unrelieved by available medications; not for adjustment of routine regimen (to avoid splitting)
<table>
<thead>
<tr>
<th>Specific Pain Management Resources</th>
<th>Department</th>
<th>Hours of Service</th>
<th>Evening Hrs. (Y=yes; N=no)</th>
<th>Weekend Hrs. (Y or N)</th>
<th>Referral Process</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication Support (including methadone/buprenorphine)</td>
<td>y</td>
<td>Friday 8:30A to 5PM</td>
<td>psychiatrist for psychiatric emergencies only</td>
<td>psychiatrist for psychiatric emergencies only</td>
<td>PMD. Patients may also self-refer by notifying PMD.</td>
<td>for further details regarding services.</td>
</tr>
<tr>
<td>• Individual/Group Counseling for co-morbid substance use disorders.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapeutic exercise</td>
<td>Rehabilitation Service (PT/OT)</td>
<td>Mon- Fri 8am-5pm</td>
<td>N</td>
<td>Y (limited &amp; varies)</td>
<td>Referral per MD</td>
<td></td>
</tr>
<tr>
<td>• Stretching / ROM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cryotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Superficial heat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Deep heat (U/S)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapeutic bracing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kinesio taping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapeutic massage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Soft tissue mobilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• E-stim</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• TENS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Traction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aquatherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trigger Point Injection</td>
<td>Physiatrist and/or</td>
<td>Weekday</td>
<td>N</td>
<td>N</td>
<td>Consultation</td>
<td></td>
</tr>
<tr>
<td>Specific Pain Management Resources</td>
<td>Department</td>
<td>Hours of Service</td>
<td>Evening Hrs. (Y=yes; N=no)</td>
<td>Weekend Hrs. (Y or N)</td>
<td>Referral Process</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>• Therapeutic Arthrocentesis</td>
<td>Orthopedic Surgeon</td>
<td>Clinic hours</td>
<td></td>
<td></td>
<td></td>
<td>per MD</td>
</tr>
<tr>
<td>• Therapeutic Joint Injection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Botox Injection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Neighborhood’s Group activities</td>
<td>Activity Therapy</td>
<td>7 days a week Activity Schedule 8:30AM-5PM</td>
<td>Y Monday Evening Program 7:30-8:30</td>
<td>Y (Unit and House wide Activity Schedules Posted on Unit)</td>
<td>Contact Neighborhood’ s Activity Therapist; For Aquatics Program - MD Referral required</td>
<td></td>
</tr>
<tr>
<td>• Neighborhood’s 1:1 activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wellness Land Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wellness Aquatic Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital Wide Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Farm Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1:1 Chaplain Visits</td>
<td>Spiritual Care</td>
<td>7 days/week 8:30-5PM</td>
<td>Y if needed</td>
<td>Y</td>
<td>Call Spiritual Care Office</td>
<td></td>
</tr>
<tr>
<td>• Guided or Silent Meditation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Spirituality Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prayer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Spiritual Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific Pain Management Resources</td>
<td>Department</td>
<td>Hours of Service</td>
<td>Evening Hrs. (Y=yes; N=no)</td>
<td>Weekend Hrs. (Y or N)</td>
<td>Referral Process</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------</td>
<td>-----------------</td>
<td>----------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>----------</td>
</tr>
<tr>
<td>• Religious Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide emotional support</td>
<td>Social Services</td>
<td>5 days/week 8-4:30 PM</td>
<td>N</td>
<td>N</td>
<td>Contact unit MSW on RCT</td>
<td></td>
</tr>
<tr>
<td>• 1:1 counseling regarding pain and mood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Research community resources</td>
<td>Neurobehavioral program Nursing/Psychiatry</td>
<td>7 days/wk 9-4:40 PM</td>
<td>N</td>
<td>Y</td>
<td>Referral by RCT</td>
<td>Distraction from pain by providing therapeutic and healing environment for neurocognitive residents with behavioral expressions including SAMHSA based modules.</td>
</tr>
<tr>
<td>LPC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Therapeutic group and 1:1 activities addressing target symptoms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social interaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral Interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Life Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Cannabis</td>
<td>Resident</td>
<td>7 days/wk</td>
<td>Y</td>
<td>Y</td>
<td>Resident must</td>
<td>Edibles, tinctures,</td>
</tr>
<tr>
<td>Specific Pain Management Resources</td>
<td>Department</td>
<td>Hours of Service</td>
<td>Evening Hrs. (Y=yes; N=no)</td>
<td>Weekend Hrs. (Y or N)</td>
<td>Referral Process</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------</td>
<td>-----------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>----------</td>
</tr>
</tbody>
</table>

be in possession of valid medical cannabis card which has been obtained by a recommendation of an outside physician

Resident must store product in locked bedside cabinet and may not share with others. LHH staff are not permitted to provide support for resident’s ingestion/maintenance.
PALLIATIVE SEDATION

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) provides palliative sedation therapy for terminally ill residents whose refractory symptoms cannot be managed by any other means.

2. Palliative sedation is intended to relieve intractable suffering and not to hasten death. Palliative sedation is not euthanasia and is not physician assisted suicide (See appendix for definition of terms).

3. The decision to provide palliative sedation requires agreement among resident/patient, decision maker and the resident care team (RCT).

4. The use of palliative sedation is limited to South 3 - Palliative Care Unit, except in rare circumstances with the permission of the Chief Medical Officer (CMO) and just in time training provided by the palliative care consultants to the staff.

5. Patients or their decision-makers shall provide informed consent for palliative sedation and shall agree to the Do Not Attempt Resuscitate (DNAR) / Do Not Intubate (DNI) order. Consent may be obtained days or weeks before palliative sedation is initiated.

PURPOSE:

To define the safe and appropriate use of palliative sedation for the relief of refractory symptoms in seriously ill patients at the end of life, for whom no other treatments exist which would alter the course of the disease or provide symptomatic relief (See Appendix A for Definitions of Terms).

PROCEDURE:
(See Appendix B for Palliative Care Checklist)

1. Assessment/Recognition of Intractable Symptoms

   a. Assessment and documentation of distress from intractable physical symptoms (including but not limited to: pain, dyspnea, agitation, delirium, anxiety, vomiting, malignant bowel obstruction, or seizures) shall occur in the Treatment Assessment Record (TAR)/Electronic Health Record (EHR) at a daily minimum.

   b. Interventions/treatments to manage intractable symptoms, pharmacological (e.g., benzodiazepines, neuroleptics, analgesics, anti-emetics, oxygen, bronchodilators, corticosteroids, opioids) and nonpharmacological interventions (complementary therapies, spiritual care, psychosocial support) are implemented, evaluated and documented.
c. Assessment and documentation of symptom intensity is completed using standardized symptom assessment methods.

d. The Physician determines whether palliative sedation may be indicated to manage suffering.

2. Resident/Patient Education and Consent Process

a. The RCT shall meet with resident/patient/decision maker to discuss symptom management efforts and to present the option of palliative sedation. The conference shall be documented.

b. The resident or decision-maker shall be counseled that:

   i. Palliative sedation is a voluntary intervention to manage intractable suffering.

   ii. The level of interaction and intake of food and fluid shall decrease depending on the amount of sedation required to effectively manage symptoms.

   iii. The names of medications used (e.g. Midazolam) and the expected effect (i.e.: sedation and initiation of palliative sedation) shall be based on symptom management. In addition, counseling shall include that the dosage may be increased based on symptoms.

   c. The resident/patient or decision maker shall verbalize understanding and written consent for palliative sedation by signing the Interdisciplinary Team Conference Note.

3. Initiation/Monitoring of Palliative Sedation

a. The Physician shall write the order for palliative sedation and specify patient-specific monitoring parameters.

b. The Licensed nurse shall establish the intravenous or subcutaneous route for medication administration.

c. The Pharmacy shall dispense the palliative sedating agents (e.g.: benzodiazepines, barbiturates, etc).

d. The Licensed nurse shall administer the bolus/loading dose and/or continuous infusion as per physician orders.

e. The Physician and nurse shall evaluate the effectiveness of palliative sedation by a decrease of intractable symptoms. The frequency of monitoring shall be determined based on the clinical condition, but at a minimum during each nurse’s shift.
f. The level of sedation shall be monitored at a daily minimum and as indicated using the Richmond Agitation-Sedation Scale for Palliative Care (RASS-PAL) (See Appendix C).

g. Other symptom management interventions (e.g.: analgesia) shall be continued to promote comfort during palliative sedation.

4. Ethical Consideration and Quality Monitoring

a. The Ethics committee may be consulted if conflicts or disagreements arise regarding initiation of palliative sedation.

b. Staff indicating religious, moral, or ethical objections to palliative sedation may refrain from providing this intervention, assuring that other caregivers are available to assume patient care responsibility.

c. Staff who are involved in the care of residents/patients receiving palliative sedation shall receive training and support.

d. All residents/patients receiving palliative sedation shall be reviewed retrospectively by Medical-Nursing Quality Improvement (QI) Committee to ensure that the intent of the policy is met and procedures are followed. The findings from the review shall be reported at the Medical QI Committee meeting.

ATTACHMENT:
Appendix A: Definition of Terms
Appendix B: Palliative Sedation Checklist
Appendix C: RASS-PAL from Bush et al., 2014

REFERENCE:
LHH Physician Palliative Care Order
LHHPP File 25-06 Pain Assessment and Management
Alberta Health Services Covenant Health – Regional Palliative Care Program – Palliative Sedation Guideline
Cherny, N. 2014. Palliative sedation. UpToDate (Billings, J.A., Editor)
Hospice and Palliative Care Federation of Massachusetts – Palliative Sedation Protocol: A Report of the Standards and Best Practices Committee, Hospice & Palliative Care Federation of MA – April 2004
Pathways Home Health and Hospice – Agency Standards Policies and Procedures (2011)
UCSF Medical Center – Adult Palliative Sedation – Policy 6.07.04. Issued January 2012.

Revised: 17/05/09, 19/03/12 (Year/Month/Day)
Original adoption: 16/03/08
Appendix A  
Definition of Terms

- **Refractory symptoms** - Symptoms that cannot adequately be controlled by other therapies. All other treatments that do not compromise consciousness have been attempted, and failed to treat the symptoms.

- **Conscious sedation** – Ability to respond to verbal stimuli is retained, may provide adequate relief without total loss of interactive function.

- **RASS-PAL** – A version of the Richmond Agitation-Sedation Scale that has been modified for palliative care patients.

- **Euthanasia** – The intentional causing of a person’s death with a lethal dose of medication. Medical therapies have the goal of hastening the patient’s death and not simply treating symptoms.

- **Palliative Sedation** - Measure of last resort to relieve severe symptoms at end of life that are refractory to standard treatment. Aims to reduce patient consciousness to the minimum extent necessary so that suffering is tolerable by inducing and maintaining a deep sleep. Death occurs as a result of the natural course of a patient’s disease, not from sedation or other medical intervention.

- **Physician assisted suicide** – When a physician provides the means for a terminally ill patient to self-administer a lethal dose of medication to hasten death.
Appendix B
Palliative Sedation Checklist

Clinical Criteria: Presence of Refractory Symptoms (check all present)

- Pain
- Agitation
- Shortness of breath
- Nausea
- Vomiting
- Seizures
- Bowel obstruction
- Anxiety
- Delirium
- Other __________________________

Attempted Interventions/Treatments (check all interventions attempted)

- Scheduled opiates
- Scheduled benzodiazepines
- PRN opiates
- PRN benzodiazepines
- PRN antiemetics
- Opioid continuous IV infusion
- Neuroleptics
- Bronchodilators
- Respite sedation
- Fan
- Massage
- Family presence
- Qi gong
- Music therapy
- Reorientation
- Distraction
- Relaxation techniques

Evaluation of previous attempted interventions/treatments:

- Effective
- Ineffective, ________________________________
- Imminent death prohibits trial of additional possible treatments

Additional requirements:

- Transfer patient to palliative care unit or obtain permission from the Chief Medical Officer.
- Patient death is imminent (expected in days)
- Do not resuscitate (DNR) order is in effect
- Informed consent has been obtained
- Implanted cardiac defibrillator, if present, has been deactivated
Appendix C
RASS-PAL from Bush et al., 2014

Reprinted with Permission of: Bush et al.: The Richmond Agitation-Sedation Scale modified for palliative care inpatients (RASS-PAL): a pilot study exploring validity and feasibility in clinical practice. BMC Palliative Care 2014; 13; 1

<table>
<thead>
<tr>
<th>Score</th>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
<td>Overtly combative, violent, immediate danger to staff (e.g. throwing items); +/- attempting to get out of bed or chair</td>
</tr>
<tr>
<td>+3</td>
<td>Very agitated</td>
<td>Pulls or removes lines (e.g. IV/SQ/Oxygen tubing) or catheter(s); aggressive, +/- attempting to get out of bed or chair</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent non-purposeful movement, +/- attempting to get out of bed or chair</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
<td>Occasional non-purposeful movement, but movements not aggressive or vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
<td>Not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (10 seconds or longer)</td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
<td>Briefly awakens with eye contact to voice (less than 10 seconds)</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation</td>
<td>Any movement (eye or body) or eye opening to voice (but no eye contact)</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation</td>
<td>No response to voice , but any movement (eye or body) or eye opening to stimulation by light touch</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation</td>
<td>No response to voice or stimulation by light touch</td>
</tr>
<tr>
<td>-5</td>
<td>Not arousable</td>
<td>No response to voice or stimulation by light touch</td>
</tr>
</tbody>
</table>

Verbal Stimulation

Gentle Physical Stimulation
### TableS2- Procedure for RASS-PAL Assessment

1. Observe patient for **20 seconds**.
   - a. Patient is alert, restless, or agitated **for more than 10 seconds**  Score 0 to +4

   **NOTE:** If patient is alert, restless, or agitated for less than 10 seconds and is otherwise drowsy, then score patient according to your assessment for the majority of the observation period

2. If not alert, greet patient and call patient by name and say to open eyes and look at speaker.
   - b. Patient awakens with sustained eye opening and eye contact (**10 seconds or longer**)  Score -1
   - c. Patient awakens with eye opening and eye contact, but not sustained (**less than 10 seconds**).  Score -2
   - d. Patient has any eye or body movement in response to voice but no eye contact.  Score -3

3. When no response to verbal stimulation, physically stimulate patient by light touch e.g. gently shake shoulder.
   - e. Patient has any eye or body movement to gentle physical stimulation.  Score -4
   - f. Patient has no response to any stimulation.  Score -5

Reprinted with Permission of: Bush et al.: The Richmond Agitation-Sedation Scale modified for palliative care inpatients (RASS-PAL): a pilot study exploring validity and feasibility in clinical practice. BMC Palliative Care 2014; 13; 1
MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center shall implement procedures to safely manage the care of residents identified to be at risk for aspiration.

2. The facility recognizes the resident’s or designated surrogate decision maker’s right to make an informed decision where the resident’s enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration.

PURPOSE:

To promote resident safety and enhance resident quality of life with respect to diet and feeding interventions.

DEFINITIONS:

1. Line of Sight – resident is within view of staff while eating.

2. Close Supervision – one staff sitting with no more than 4 residents during mealtime. Staff shall ensure that recommended aspiration precautions (e.g., standard precautions or individualized precautions recommended in the specialized feeding by speech therapy plan and ordered by the physician) are followed by actively cueing, assisting, and/or observing the resident during meal time.

3. 1:1 – resident needs direct assistance or supervision during oral intake (e.g., impulsive eating behaviors, cues needed, unable to feed self, level of risk for aspiration).

PROCEDURE:

1. Identification of At-Risk Residents

   a. Residents shall be evaluated by the Resident Care Team (RCT) and identified as being at risk for aspiration if they have clinical signs of swallowing difficulty/aspiration, demonstrate unsafe eating behaviors or have other conditions that place them at risk (e.g., reduced alertness, need to be fed in a reclined position, partially or completely edentulous with no dentures). At a minimum, the RCT includes a physician and a nurse.

   b. If the resident is partially or completely edentulous with no dentures:

      i. The RCT shall assess if the prescribed diet is deemed safe;
ii. The physician shall order a dysphagia evaluation if the resident's ability to safely swallow the prescribed diet is in question;

iii. The registered dietitian shall assess the resident's ability to tolerate the prescribed diet;

iv. The physician shall document discussion regarding aspiration risk if the resident is prescribed a diet other than pureed and;

v. The physician shall refer the resident to the dental clinic unless there is documented reason by the physician that the referral is not necessary.

c. Once a resident has been identified as being at risk for aspiration, Nursing shall place a pink dot at the head of the resident's bed, give the resident a pink wristband, and affix a pink ribbon to the clothing of residents who leave the neighborhood unaccompanied by Nursing staff. Staff and volunteers shall be trained on this color coding system and what it means.

d. Residents who are assessed to be at risk for aspiration, excluding those who are unable to eat by mouth (also known as NPO), shall be identified and have a physician’s order for standard aspiration precautions, which include the following:

i. Line of sight supervision when eating, unless documented otherwise in the Medical Record.

ii. Resident shall be positioned as upright as possible when eating/drinking, and the resident's head prevented from tilting back, as possible.

iii. Resident shall be fed/cued to eat slowly, taking small bites.

iv. When feeding a resident, make sure that the resident swallows each bite before continuing feeding.

v. Resident shall remain upright for 20 minutes after a meal.

2. Indications for Referral to Speech Pathology for a Dysphagia Evaluation

a. Residents who fall into one or more of the following categories shall be referred, by physician’s order, to the Speech Pathology Department for a dysphagia evaluation:

i. Those admitted with a known swallowing disorder, or history that is suspicious for dysphagia (unless NPO and not a candidate for oral feeding).

ii. As described under Procedure 1 b (ii).
iii. Those who have clinical signs of dysphagia or aspiration and are candidates for ongoing oral feeding. Indications for referral to Speech Pathology include, but are not limited to, the following: coughing, choking, holding food in mouth, significant pocketing of food, significantly delayed swallow, significant leakage of food or liquid from mouth, food or liquid coming from tracheostomy, and/or recurrent pneumonias. If in doubt about whether or not a referral is indicated, contact the Speech Pathology Department.

iv. Alert residents who are being considered for enteral feeding, unless clinically inappropriate (Refer to LHHPP 26-03, Enteral Tube Nutrition), and those on enteral feeding whose clinical condition has improved sufficiently that they may be candidates for oral feeding.

v. Residents with a known swallowing disorder or clinical signs of dysphagia and/or aspiration who are being considered for a diet upgrade. (If a decision to upgrade a resident’s diet has already been made for quality of life reasons, referral is not necessary, but may be indicated in order for a Speech-Language Pathologist to provide training regarding reducing the risk of aspiration on the upgraded diet. All necessary documentation regarding a resident’s or surrogate decision maker’s understanding of risks vs. benefits of upgrading diet and agreement to accept risks must be in place prior to the Speech Pathologist’s intervention).

b. Referral to the Speech Pathology Department may also be indicated in cases of unexplained weight loss, dehydration, and/or poor oral intake, in order to rule out dysphagia as a contributing factor.

c. Dysphagia evaluation is by physician order only. The physician shall write an order and complete a consult request form. If the evaluation is considered clinically urgent, the physician shall mark the consult order “urgent” and call the Speech Pathology Department.

d. RCT members shall alert the physician when signs of dysphagia, aspiration, or change in swallowing function are observed.

3. Dysphagia Evaluation

a. Dysphagia evaluations shall be carried out by a Rehabilitation Center Policy and Procedure #90-05, Establishment of Treatment Programs and Documentation: Dysphagia.

b. Evaluation of Residents for Upgraded Food/Liquid Consistencies

When a dysphagia evaluation involves upgraded food or liquid consistencies not currently included in the resident’s diet order, the following Tray Precautions shall be taken:
i. The Speech Pathologist shall contact Nutrition Services and ask them to write “Hold for Speech Therapy” on the tray ticket.

ii. The Speech Pathologist shall notify Nursing and request that the tray not be served until the Speech Pathologist arrives.

iii. Nursing staff shall hold the tray for Speech Pathology and shall not give it to the resident.

iv. The Speech Pathologist is responsible for removing any food or liquid items not included in the resident’s current diet order before leaving an unfinished tray with the resident upon completion of the session.

4. Treatment

a. Following a dysphagia evaluation, the Speech Pathologist shall proceed with swallowing therapy, when indicated.

b. If treatment involves upgraded food/liquid consistencies not currently included in the resident’s diet order, follow Tray Precautions delineated in paragraph 3b i-iv, above.

5. Referral to Occupational Therapy

a. Occupational Therapy consultation shall be considered if positioning of the resident during feeding is difficult or body posture increases aspiration risk.

b. Occupational Therapy consultation requires a physician order and a referral form.

6. Management of Residents Who Are at Risk for Aspiration

a. Staff who are feeding or supervising residents designated to be at risk for aspiration are responsible for knowing and complying with the resident’s diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

b. Certified and Licensed nursing staff shall be provided with mealtime competency training by Nursing Education or designated trainers upon hire and annually. Facility personnel shall be trained on choking prevention and intervention upon hire and annually.

c. A sign directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident is located in the Pavilion Lobby and designated areas.
d. Nursing is responsible for ensuring that family members and regular visitors who assist residents with their meals have been trained. If a family or volunteer needs additional training regarding feeding techniques, nursing may recommend referral to Speech Pathology. Staff shall document family or volunteer training in the medical record and resident care plan, including the date of training.

e. Residents with pink wristbands or pink ribbons shall not be given or sold food/liquid by anyone who is not aware of the resident's feeding needs.

f. Diet texture modifications (including thickened liquid) or enteral feeding, may be ordered to reduce the risk of aspiration. These interventions may be suggested by the Speech Pathologist following a swallowing evaluation but shall be implemented only after careful resident assessment by the RCT and orders changed by the physician. Diet texture modification for purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality of life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).

g. For residents whose nutrition is via enteral tube, Nurses shall follow interventions to reduce aspiration risk as per Nursing policies and procedures (Refer to NPP E5.0 Enteral Tube Feeding Management).

7. Specialized Feeding Plans
   Individualized Aspiration Precautions
   a.h. A Specialized Feeding Plan (SFP) Individualized (vs. standard) aspiration precautions may be developed by the Speech Pathologist following a swallowing evaluation; the SFP includes more individualized precautions in addition to those stated above. Examples of SFP precautions include:

   i. Close supervision when eating and drinking
   ii. Provide cues/assist for unsafe eating behaviors
   iii. Thin down thick food
   iv. Small sips of liquid
   v. Alternate liquids and solids
   vi. Do not use straw
   vii. Cut food into small pieces
   viii. Cue resident to tuck chin
   ix. Cue or remind resident to swallow twice
x. Cue to swallow food/liquid before taking the next bite/sip

b.i. The Speech Pathologist shall review the SFP recommended individual precautions with Nursing staff and provide training, as needed.

ej. The Speech Pathologist shall place the SFP list any recommended precautions in the Resident Care Plan (RCP) and notify the diet office regarding specific precautions to be printed on the resident's meal ticket.

d.k. The physician shall include “Specialized Feeding Plan” standard aspiration precautions and/or specific precautions as part of the diet order. Nursing shall include this information when communicating the diet order to Nutrition Services.

e.l. For residents with SFPs, Nutrition Services shall print “SFP” and the list of special individualized precautions recommended by speech therapy on the meal ticket, providing an easy reference for caretakers.

f.m. Residents with SFPs with individualized precautions, whose swallow function appears to have improved or declined, shall be referred to Speech Pathology for re-evaluation and updating of the SFP precautions, as needed. When a re-evaluation is not indicated and Speech Pathology is no longer treating or routinely re-checking the resident, the Speech Pathologist may be invited to attend RCT meetings for that resident's who have SFPs with individualized aspiration precautions.

8. Follow-Up

a. The Speech Pathology Department is available to monitor any resident during a meal who has been seen for a dysphagia evaluation, is on the diet recommended by Speech Pathology, and has not had any change in condition. The request may be made by any member of the RCT. No physician's order is required. The Department shall be contacted directly by phone. A physician’s order for a re-evaluation is required for patients whose diet was either upgraded or downgraded without the involvement of the Speech Pathology Department, when there has been a change in condition, or when re-evaluation for diet upgrade is being requested.

b. When an order for an SFP with aspiration precautions is discontinued without the involvement of the Speech Pathology Department, the reason(s) shall be documented in the medical record by the physician and licensed nurse. The Speech Pathology Department shall be informed that the SFP has been discontinued. The Diet office shall also be notified in order to delete the info from the tray ticket.

9. Documentation on Informed Decision
a. When the resident or surrogate decision maker chooses to accept the risks of a diet upgrade, or not to accept the recommendation/benefits of a therapeutic diet and feeding interventions, documentation of discussion regarding informed decision shall be reflected in the Resident Care Conference meeting notes, advance directives, and the resident care plan.

b. The resident care plan shall include care plan approaches for minimizing the risk of aspiration.

10. Others

a. Regardless of the code status, residents shall be provided with rescue interventions in the case of choking or aspiration events.

b. The Medical Examiner shall be contacted by the physician in the case of choking or an aspiration event that leads to death.

ATTACHMENT:
None

REFERENCE:
LHHPP 24-05 Advance Care Planning
LHHPP 24-10 Close Observation
LHHPP 26-03 Enteral Tube Nutrition
LHHPP 26-04 Resident Dining Services
MSPP C01-04 Death Which Must Be Reported to the Medical Examiner-Coroner
NPP A3.0 Nursing Education Programs
NPP B5.0 Color Codes- Resident Identification
NPP E1.0 Oral Management of Nutritional Needs
Rehabilitation Center P&P 90-05 Establishment of Treatment Programs and Documentation: Dysphagia

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18, 08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12, 17/07/11 (Year/Month/Day)
Original adoption: 98/04/01
ENTERAL TUBE NUTRITION

POLICY:

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

PURPOSE:

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

PROCEDURE:

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

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

      i. Family consult: The attending physician shall evaluate the prognosis for the individual resident and consider the expressed desires of either the resident or the resident’s surrogate decision maker prior to beginning enteral tube nutrition. The decision to insert an enteral tube shall be made after consultation with the resident and/or family and the RCT members, and only after carefully reviewing risks, benefits, and other alternatives. Any advance directives should be carefully reviewed. If it is decided not to begin ETN in a resident for whom other feeding alternatives are not possible, comfort care and palliative interventions shall be considered and provided as appropriate.

      ii. Informed consent: Informed consent for enteral tube insertion shall be obtained from the resident or surrogate decision-maker in accordance with hospital policy (Refer to MSPP C02-01 Patient’s Consent for Treatment and Operation). If the resident has no surrogate decision maker, the RCT may provide consent (Epple procedure) and Ethics Committee consultations shall be obtained if there is lack of consensus among the RCT members. the
physician must promptly notify the resident, orally and in writing, of such determination. In instances where the resident is comatose or in a minimally conscious state, notification is not clinically appropriate, but the physician must document his/her determination and shall notify the resident promptly if the resident’s condition changes (LHHPP 29-08 Unrepresented Residents Lacking Decisional Capacity and Epple Procedure Implementation).

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

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

d. Withdrawal: The resident or surrogate decision-maker (SDM) may request withdrawal of an enteral feeding tube at any time. When withdrawal is not requested by the resident or SDM, or when a resident lacks medical decision making capacity and has no surrogate, consideration of withdrawal of ETN shall follow LHHPP 24-05 Advance Care Planning and LHHPP 29-10 Non-Beneficial Treatment.

2. Care and Management

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

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

3. Replacement of a Dislodged Feeding Tube

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

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

c. A dislodged gastrostomy tube that is 6 weeks or more may be replaced by the registered nurse who has demonstrated knowledge and skill, unless the physician orders state otherwise. A gastrografin study shall be ordered by the physician to
confirm tube placement. The physician shall verify results of the radiology study before resuming orders for ETN.

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

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

4. Monitoring

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

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

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

d. Nutrition reevaluation: The dietitian makes interval assessments of residents on enteral tube nutrition and provides suggestions for changes in nutritional therapy if necessary. During the quarterly RCC, the RCT shall review the nutritional plan and the dietitian’s record-documentation in the EHR for residents receiving ETN.
e. Interaction with medications: Certain medications (e.g., phenytoin) may be affected by enteral nutrition, and others (e.g., extended-release tablet and capsule formulations) should not be crushed or otherwise altered for enteral tube administration. For specific recommendations on medications known to be affected by enteral nutrition, and those with formulations that should not be altered, refer to the Nursing Policy and Procedures or consult the Clinical Pharmacist.

5. Documentation

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

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

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

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

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

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

6. Quality Assurance and Performance Improvement

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

i. Clogged tube

ii. Dislodgement of tube

iii. Aspiration

iv. Leakage around the insertion site

v. Erosion at the insertion site
vi. Abdominal wall abscess
vii. Stomach or intestinal perforation
viii. Peritonitis
ix. Tracheoesophageal fistula
x. Inadequate nutrition
xi. Metabolic complication

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

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-05 Advance Care Planning
LHHPP 29-10 Non-Beneficial Treatment
LHHPP 29-08 Unrepresented Residents Lacking Decisional Capacity and Epple Procedure Implementation
MSPP C02-01 Patient’s Consent for Treatment and Operation
NPP E5.0 Enteral Tube Feeding Management
Clinical Nutrition Department Services Policy and Procedure 1.16 Nutrition Screening and Assessment Charting Documentation in the Electronic Medical Record (EHR)
Nutrition Services Policy and Procedure 1.17 Nutrition Assessment as Part of the Care Plan Process

Revised: 98/11/16; 00/04/27, 13/05/28, 13/09/24, 17/09/12, 18/07/10, 19/03/12
(Year/Month/Day)
Original adoption: 96/09/16
RESIDENT DINING SERVICE

POLICY:

1. Staff shall encourage residents to dine in the common dining area to promote social dining for all meals unless resident prefers otherwise.

2. Staff shall encourage residents who are not on an oral diet to be grouped together in the common dining area to prevent social isolation.

3. Avoid scheduling staff meal breaks during resident meal periods so that all available staff assists with resident meals.

4. Efforts will be made so that resident appointments within Laguna Honda Hospital and Rehabilitation Center (LHH) will be scheduled outside of resident meal times.

PURPOSE:

To describe LHH process of providing an enjoyable dining experience for the resident.

PROCEDURE:

1. Diet Office will print the 48 hour menu for individual neighborhoods and post near the galley. The unit clerk or designated staff will print out the two week menu and place the menu in a designated area.

2. Staff will check the meal against the meal ticket diet order and positively match with the correct resident using positive identification.

   Neighborhood staff will assist the resident as appropriate with the meal. Only trained caregivers may assist in feeding those with Specialized Feeding Plansindividualized aspiration precautions (vs. standard aspiration precautions). All others will assist at the direction of licensed staff. Residents with Specialized Feeding Plansindividualized precautions, as noted on the menu ticket, will be served using a specified colored plate cover.

3. Nursing staff will document meal intake in the chart for each resident at the end of the shift.

4. If a resident is not available for the meal, alternative meal arrangements will be made.

5. Staff will return all dishes, plates, and so forth to the meal cart located in the dining room. Food service worker will pick up the meal cart. For tray that did not make it to the meal cart, meal tray will be place on the rolling shelf inside the galley.
6. Nursing staff will wipe tables using approved disinfectant. Environmental Services (EVS) staff will sweep and mop the dining room and the great room floor as needed. EVS will clean and sanitize around the exterior of the ice machine located in the Great Room.

7. Once a day the food service worker will clean and sanitize the Galley using the three bucket method; this includes the juice and coffee dispensers located in the Great Room.

8. Anyone who uses the Galley must clean and sanitize after each use.

9. Special feeding devices and other personal items will be cleaned by the nursing staff and stored at the resident’s bedside.

10. Food and beverages stored in the galley are for resident use only.

11. To ensure the accuracy of the menu diet ticket with physician orders, host round sheets (resident diet list) are sent from the diet office to the neighborhood for verification.

12. Infection Control in Dining Service:
   a. Staff must wash their hands:
      i. Before and after wearing gloves.
      ii. Before and after serving meals.
      iii. When changing tasks.
      iv. When they are visibly soiled or contaminated.
   b. *Gloves are not required for serving of meals provided the server has washed their hands with soap and water prior to proceeding.
   c. Staff must wear proper hair covering whenever they enter the Galley Area to serve or prepare food such as when making a sandwich or dishing up cold or hot food items.

ATTACHMENT:
None.

REFERENCE:
None.
PREVENTIVE MAINTENANCE PLAN

POLICY:

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

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

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

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

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

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

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

PURPOSE:

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

PROCEDURE:

1. Preventive Maintenance Program

   a. The majority of testing and maintenance of the hospital’s medical and non-medical resident/patient care related equipment is conducted by Facility Services personnel and contracted services.
i. Refer to the Facility Services Policy and Procedure EM-1 Equipment Management Program for a description of procedures carried out.

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

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

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

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

a. Central Processing Department

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

c. Environmental Services

d. Facility Services

e. Food and Nutrition Services

f. Information Technology

g. Nursing

h. Outpatient Clinic (includes Dental services)

i. Pharmacy

j. Rehabilitation Services

k. Vocational Rehabilitation

l. Wellness and Activity Therapy

m. Workplace Safety and Emergency Management

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

b. Each piece of inventored equipment that requires preventive maintenance shall
be labelled with an asset tag and preventive maintenance sticker regardless of
cost. All equipment greater than $200 in cost shall be labelled with an asset tag
and a preventive maintenance sticker or a “No Maintenance Required” sticker.

i. The following table may be used as a guide for determining whether the
equipment requires an asset tag and/or preventive maintenance sticker. See
Attachment A for Asset Tag and Preventive Maintenance Guide.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Asset Tag</th>
<th>Preventive Maintenance Sticker or No Maintenance Required Sticker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment requires PM (regardless of cost)</td>
<td>Yes</td>
<td>Yes (PM sticker)</td>
</tr>
<tr>
<td>Equipment greater than $200 cost</td>
<td>Yes</td>
<td>Yes (PM sticker or No Maintenance Required sticker)</td>
</tr>
<tr>
<td>Equipment less than $200 cost and no PM required</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

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

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

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

ii. “B” and “Q” – Information Technology department

iii. “C” – Facility Services

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

v. “No Maintenance Required” – Any item that does not specify preventive
maintenance required in the owner/user’s manual.
4. When staff identifies hospital equipment without an asset tag, carry out the following steps:

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

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

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

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

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

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

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

5. Departmental Responsibilities

   a. Department managers are responsible for performing the following:

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

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

      iii. Equipment that is not included in Procedure 1a or 1b shall be identified as described in Procedure 3.d.v.
iv. Performing periodic rounds to ensure that equipment used in the department has a preventive maintenance sticker that has not gone past the expiration date.

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

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

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

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

d. Department Managers or designees are responsible for submitting annual reports on preventive maintenance to the Quality Council Committee to assess departmental compliance with facility procedures.

ATTACHMENT:
None

Attachment A: Asset Tag and Preventive Maintenance Sticker Guide

REFERENCE:
Facility Services P & P EM-1 Equipment Management Program
CPD P & P Section 3.21 Biomedical Technical Assistance
CPD P & P Section B5 Equipment Maintenance
LHHPP 31-03 Clinical Product and Device Evaluation
LHHPP 35-04 Inventory and Disposal of Hospital Property
Preventive Maintenance Reporting Calendar to the Quality Council Committee
State Operations Manual Appendix A- Survey Protocol, Regulations and Interpretative Guidelines for Hospitals, Section A-0724 Issued: 02-12-14

Revised: 18/11/13, 19/03/12 (Year/Month/Day)
Original adoption: 18/05/08
**ATTACHMENT A: Asset Tag and Preventive Maintenance Sticker Guide**

Most patient/resident care related equipment have an asset tag, which indicates who has the responsibility for ensuring preventive maintenance (PM) is done. These are the 4 types (A, B/Q, C, and D) of asset tags that are available at LHH:

<table>
<thead>
<tr>
<th>Asset Tag Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Asset Tag Example" /></td>
</tr>
</tbody>
</table>

A tag: PM responsibility is with the contracted biomed vendor, with the responsibility for PM completion coordinated by Central Processing Department.

| ![Asset Tag Example](image2) |

B/Q tag: PM responsibility is with IT

| ![Asset Tag Example](image3) |

C tag: PM responsibility is with Facility Services

| ![Asset Tag Example](image4) |

D tag: PM responsibility is with the Department that utilizes the equipment.
Preventive Maintenance Sticker Examples

No PM Required sticker: This is placed on equipment that has no manufacturer recommended preventive maintenance. This sticker is used in conjunction with the A, C, or D asset tag.
SALES, DISTRIBUTION OF FREE ITEMS, AND SOLICITATION ON THE CAMPUS

POLICY:
1. Sales, distribution of free items, and solicitation on the Laguna Honda Hospital and Rehabilitation Center (LHH) campus must be consistent with the mission, vision, values, and strategic goals of the hospital.
2. Laguna Honda staff and/or volunteers shall not be responsible for communicating information (either written or oral) on behalf of vendor(s) to campus members.

PURPOSE:
To preserve the residents’ safety and health and to ensure that resident care remains the primary focus of the workplace.

PROCEDURES:
1. Approval Process
   a. Individuals or organizations wishing to sell items, solicit memberships, or distribute free merchandise must submit a request form to the Administration Office for review by designated member(s) of the Hospital Executive Committee (HEC). Requests must conform to the guidelines in Sections 2–6 below.

2. Free Merchandise
   a. No vendors, solicitors, or distributors of free merchandise are authorized to be on the Laguna Honda campus unless they:
      i. Have approval from the Hospital Executive Committee (HEC), and
      ii. Provide products or services that are consistent with the mission, vision, values, and strategic goals of the hospital.

3. Merchandise for Sale
   a. Person(s) or organization may not sell or distribute items to residents or staff without first obtaining authorization of the Hospital Executive Committee (HEC) or designee.

      This prohibition is applicable during rest breaks, as well as meal breaks taken anywhere on hospital premises.

   i. Businesses wishing to sell goods or services at Laguna Honda must provide a copy of Seller’s Permit to do business in San Francisco. The permit is due at the same time as the Application for Use of Laguna Honda Campus is completed.
ii. All on-premises transactions involving the transfer of money or goods are covered by this prohibition, whether or not the parties enjoy formal commercial vendor status.

4. Solicitations
   a. No person or organization may solicit residents for membership, donations, business, or for any other purpose without authorization from the hospital executive committee.
      i. Religious organizations must register with the hospital Spiritual Care Director.
      ii. All other organizations must receive approval from the Hospital Executive Committee (HEC).

5. Illegal and Harmful Items
   a. Sales or exchange(s) involving illicit or prohibited drugs, paraphernalia, substances—such as alcohol, cigarettes, tobacco products, products that emit smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, weapons, and illegal items—and substances—that are which either contraindicated by the resident’s care plan, are not permitted on the LHH campus, interfere with the operation of the hospital LHH, or endanger the lives of staff and other residents are prohibited.

6. Exceptions
   a. Not-for-profit corporations with educational or charity status are exempted as follows:
      i. Nothing in this policy is intended to prohibit sales by residents to other residents or staff of small dollar items such as raffle or other event tickets to benefit legitimate not-for-profit organizations that maintain formal charity or educational status under the law.
      ii. Nothing in this policy is intended to prohibit sales by employees to other employees of small dollar items such as raffle or other event tickets to benefit legitimate not-for-profit organizations that maintain formal charity or educational status under the law, so long as such sales take place during regular break times or mealtime and not while the employee is at his or her work post.
   b. This policy is not intended to prohibit regular sales by residents to residents or staff of miscellaneous small dollar items if authorized by the Hospital Executive Committee (HEC). Examples are newspapers and minor creative works by residents.
   c. This policy is not intended to restrict a resident’s right to access to legal products.
d. Commercial vendors to hospital departments that have contracted to deliver products shall be considered by virtue of the sales contract to have authorization.

7. Violations

a. Violation of this policy by a resident shall be treated as a patient care issue and referred to the Resident Care Team for appropriate care planning.

b. Violation of this policy by an employee shall be referred to the employee's department manager for appropriate action.

c. Violation of this policy by a commercial vendor or solicitor shall be referred to the Operations Division for action.

ATTACHMENT:

Attachment A: Part A: Application for Use of Laguna Honda Campus
Attachment B: Part B: Invoice for Use of Laguna Honda Campus

REFERENCE:

LHHPP 35-05 Guidelines for Medical Service Representatives
LHHPP 75-02 Public Access and Night Security
LHHPP 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use by Residents or Visitors
LHHPP 76-02 Smoking Control
LHHPP 90-08 Campus Use for Non-Laguna Honda Groups
Civil Service Rule 118: Outside Employment
Department of Public Health Statement of Incompatible Activities:

Revised: 92/05/20, 10/03/09, 11/05/13, 15/05/12, 19/03/12 (Year/Month/Day)
Original adoption: 92/05/20
INVENTORY AND DISPOSAL OF HOSPITAL PROPERTY

POLICY:

1. All Laguna Honda Hospital and Rehabilitation Center (LHH) hospital departments take responsibility for inventory and tracking of capital and minor equipment.

2. The Information Systems Department (IS) is responsible for the inventory of computer equipment such as desktop and laptop computers, and peripheral devices used by staff throughout the hospital.

3. The Accounting Department is responsible for recording capital equipment.

4. The disposal of hospital property is done in accordance with established procedures.

4.5. Staff shall adhere to the City's reuse program through the Virtual Warehouse online system.

2.6. Reusable items from the Virtual Warehouse are for city-use only and cannot be acquired for personal use.

3.7. Employees may not remove from the premises any hospital property without a Property Pass.

PURPOSE:

1. To ensure the effective utilization of departmental assets and resources.

2. To meet disposal requirements of the City and County of San Francisco for inventoried property.

3. To prevent unauthorized removal from the premises of inventoried Hospital property.

4. To provide a means to remove property from the asset ledger and preventive maintenance schedules when it is purged from inventory.

DEFINITION:

1. Minor Equipment - The larger class of Hospital property, furniture, and other equipment with a purchase value of $200 up to $5000.
2. Capital Equipment – Stand-alone equipment with a purchase price of $5000 or greater and an anticipated life of one year or greater.

4.3. Sticker Identified Hospital Property: Hospital property to which is affixed a CCSF inventory sticker, an Laguna HondaLHH Plant Services preventive maintenance program sticker, or upon which is imprinted or painted any CCSF, DPH, or Laguna HondaLHH identifier.

2. Unmarked Hospital Property: The larger class of Hospital property, other equipment, materials, or supplies which remain unidentified by sticker or otherwise unmarked.

3.4. “DISCARD – Laguna Honda”: Items marked by Materials ManagementCentral Processing Department (CPD) that are defined as “no longer Hospital property.”

4.5. Property Pass: An item-specific document obtained from Laguna Honda Hospital and Rehabilitation CenterLHH’s Materials CPD Manager.

5.6. Virtual Warehouse – City and County of San Francisco’s web-based program to facilitate the reuse of City owned office furniture, electronics, equipment, and supplies.

PROCEDURE:

1. Equipment is received by CPDMM.
   a. Designated staff from MM/CPD affixes an “A” inventory and asset tag to equipment designated as bio-medical.

2. CPDMM contacts Facility Services Department to evaluate equipment covered under the Hospital’s preventative maintenance program (PM).
   a. Facility Services affixes a “C” or “D” asset inventory tag depending on the PM program.

3. IS receives ordered technology equipment from the IT Procurement Storekeeper.
   a. IS affixes a “B” or “Q” asset inventory tag to the equipment used by staff, records the equipment in its database, and deploys the equipment.
   b. IS affixes a red “No Maintenance” “D” asset inventory tag to computer equipment that is used by residents but not supported by IS and facilitates delivery to the appropriate department.

4. Upon receiving minor equipment, not covered by the hospital’s PM program, hospital departments are responsible to affix red “No Maintenance” maintain an inventory and asset tag to that equipment of all equipment with a “D” tag.
5. Donated equipment is included under departmental responsibility for tagging and inventory of the equipment.

6. Each department maintains a listing of identified hospital equipment under its operation. Departments are not responsible for inventory of technology equipment designated for staff use. Technology equipment designated for resident use is included in departmental responsibility for inventory.

   a. The listing includes a general description of the item (i.e. iPad), the number of items and the location of the equipment.

   b. The listing is updated as existing equipment is disposed of, and as new equipment is acquired.

7. Departments shall conduct an inventory count of their equipment on an annual basis by the end of the fiscal year to confirm the accuracy of their equipment lists.

   a. Any equipment missing from the list will be marked either as missing, stolen, or disposed. Departments will attach a report for all missing or stolen equipment detailing the circumstances with a plan to prevent missing or stolen equipment in their departments in the future.

   b. The lists will be forwarded to the Accounting Department by the 31st of July.

8. Materials Management Central Processing Department is responsible to facilitate the disposal of all identified property.

   Department heads are responsible for completing the Virtual Warehouse form and submitting to the Materials Management CPD Manager, the Laguna Honda Hospital LHH Virtual Warehouse Authorized contact.


   b. All reusable items will be posted to the Virtual Warehouse online inventory for other departments and organizations to view. These items must be available for a minimum of 30 days.

   c. Items for disposal must be submitted to the Virtual Warehouse prior to disposal or removal, even if the item is already broken or obsolete.

   d. Broken or obsolete items will not be posted and can be recycled or donated in less than 30 days. They may be donated or recycled to various non-profits per Virtual Warehouse approval and receipts must be submitted.

   e. If after 30 days it is determined that the item is to be disposed, CPDMM will contact Environmental Services Department (EVS) and/or Facility
Services for arrangement. Prior to disposal of any stickered-identified property in a hospital trash bin, Materials Management CPD will coordinate with EVS or Facility Services to place a red tag “Discard – Laguna Honda” in a visible location on the item.

   i. If technology equipment, CPD MM will arrange for e-waste disposal.

f. Any hospital employee or volunteer who wants to remove from the premises any discarded item with red tag “DISCARD – Laguna Honda” must obtain a Property Pass from Laguna Honda Hospital and Rehabilitation Center’s Materials Manager.

9. Materials Management CPD will notify the Accounting Department of all disposed equipment. Information provided to Accounting will include the inventory and asset tag number.

10. The Nutritional Food Services Department shall forward information on disposed food to the Accounting Department at the end of each month.

11. EVS shall report disposed linen to the Accounting Department at the end of each month.

12. The Pharmacy Services Department shall report any incidental disposal of any pharmaceuticals other than the expired drugs to the Accounting Department.

1. Designated staff from Facility Services and Information Services departments are responsible for placing CCSF inventory stickers on Hospital property.

2. Facility Services is also responsible for placing preventive maintenance (PM) cycle stickers on Hospital property for which PM is scheduled.

3. Materials Management is responsible for the disposal of all sticker-identified property.

4. Virtual Warehouse Reuse Process

a. Department heads are responsible for completing one of the following two forms and submit to the Materials Management Manager, the Laguna Honda Hospital Virtual Warehouse Authorized contact.

i. To submit electronics or computers, you must fill out the form found here: [http://warehouse.sfenvironment.org/donate-items/submit-an-item](http://warehouse.sfenvironment.org/donate-items/submit-an-item)

ii. To submit non-electronics, or “Everything Else”, you must fill out this form found here: [http://warehouse.sfenvironment.org/donate-items/donate-everything-else](http://warehouse.sfenvironment.org/donate-items/donate-everything-else)

b. All reusable items will be posted to the Virtual Warehouse online inventory for other departments and organizations to view. These items must be available for a minimum of 30 days.
c. Items for disposal must be submitted to the Virtual Warehouse prior to disposal or removal, even if the item is already broken or obsolete.

d. Broken or obsolete items will not be posted and can be recycled or donated in less than 30 days. They may be donated or recycled to various non-profits per Virtual Warehouse approval and receipts must be submitted.

5. Materials Management will notify the Finance department and Facility Services Safety Engineer by email of the disposal of any item on which a Facility Services Preventive Maintenance Program sticker is affixed. Information Services department will remove their items’ stickers and from their inventory database.

6. Prior to disposal of any stickered-identified property in a hospital trash bin, Materials Management will coordinate with EVS or Facility Services to mark the item "Discard-Laguna Honda" in a visible location on the item.

7. Any Hospital employee or volunteer who wants to remove from the premises any discarded item marked “DISCARD—Laguna Honda” must obtain a Property Pass from Laguna Honda Hospital and Rehabilitation Center’s Materials Manager.

ATTACHMENT:
None, Asset and Preventative Maintenance Sticker Guide

None

REFERENCE:
-LHHPP 31-05 Preventative Maintenance Plan
LHHPP 50-09 Capital Asset Administration Policy

City & County of San Francisco Virtual Warehouse website – warehouse.sfenvironment.org

Revised: 96/07/15, 12/09/25, 19/03/12 (Year/Month/Day)
Original adoption: 96/02/09
RESIDENT TRUST ACCOUNT

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. PATIENT TRUST ACCOUNT:

   a. LHH establishes a Patient Trust Account to assist residents in managing their funds during their stay at LHH. The ADL module system issued to record deposits and disbursements in the individual Trust Account for each resident. At the end of each month, accounting performs a reconciliation to balance ADL.

   b. The Accounting department may consolidate into a single account per admission or multiple accounts over the residents stay at LHH. However, the resident’s Trust Account shall not be co-mingled with facility funds or with the funds of any other person.

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

3. Checks: LHH receives check payments from SSA/SSI, Private Retirement Pensions, or other sources.

   a. Checks received for Share of Cost (SOC) related or a combination or SOC/Personal Need (PN) shall be mailed/sent directly to the Billing Department. The Billing Department shall complete the check log listing the check number, resident’s name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.
b. Checks received by Admissions & Eligibility (A&E) for PN only are sent directly to the Cashiers. A&E shall complete the PN check log listing the check number, resident’s name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.

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

d. A&E does not open checks addressed to residents without approval. They are mailed to the unit, or picked up by the Medical Social Worker (MSW).

e. Checks for residents who have discharged or expired shall be returned to the sender by A&E.

f. All funds received are divided into share of cost and PN. PN allowance for residents receiving Social Supplemental Income (SSI) is posted in the PN account.

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

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

6. **Wire Transfer:** SSA and VA, or other pension plan may send benefits by wire transfer directly to the Bank of America “Patient Trust Account” on a monthly basis. A report detailing the transfer from the CCSF Department of Treasury is emailed to the Accounting Department.

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

7. **Definition:**
a. Medi-Cal current rate: A dollar amount per month that qualified residents may draw. Medi-Cal periodically changes this current rate, which is available from the A&E Financial Counselor. B. SSI Current Rate: A dollar amount per month that qualified residents may draw. SSI periodically changes this current rate, which is available from the A&E Financial Counselor.

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

9. Establishing Resident Trust Account: At the time of the resident’s admission to LHH, the A&E Financial Counselor assists the resident in establishing a patient Trust Account at LHH. The A&E Financial Counselor shall ask the resident to sign the direct deposit form to have his/her funds deposited electronically to the LHH Trust Account.

10. Trust Account Quarterly Statements: The Accounting Department issues a fiscal quarterly “Resident Trust Account Statement” (hereafter Statement) ending September, December, March and June. The Statement shall be delivered thru interdepartmental mail to individual Nursing Neighborhood and the nurse manager or designee of each Nursing Neighborhood shall distribute the Statement to residents. When a legal representative manages the residents’ funds, Accounting Department delivers the Statement to the A&E Department who then in turn distributes by mail to the residents’ legal representative.

11. Distribution Funds after Death: Upon the death of a resident, the A&E Department shall convey within 30 days the resident’s funds and a final accounting of those funds to the individual for probate jurisdiction administering the resident’s estate. It is the responsibility of the A&E Financial Counselor to withhold any overpayment from SSA, VA or retirement system.

a. To avoid negative account balances:

i. A&E shall request that overpayment amounts received electronically be transferred to SS-reserve fund for future electronic reverse payment.

ii. All other funds not identified as overpayment shall be distributed to the family, conservator, or Public Administrator.
b. Over payments received by check shall be returned via US postal service. Funds received after death shall be held until FC receives notice or email confirming that resident has no over payment.

c. Accounting shall provide the SS-reserve balance report quarterly to A&E and A&E shall review the SS-reserve balance report quarterly and cleanup annually when necessary to avoid accumulation.

12. Burial Account:

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

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

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

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

c. **Disposition of Funds when Resident is Discharged:** Title 22 Section(8) Upon discharge of a patient, all money and valuables of that patient which have been entrusted to the licensee and kept within the facility shall be surrendered to the patient or authorized representative in exchange for a signed receipt. Disposition of Burial Funds when resident discharges;

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

   ii. A&E shall notify Social Services if LHH is the Rep Payee; and when patient is discharged and funds are withdrawn and/or forwarded to the new Rep Payee.

   iii. If residents withdraw funds from the burial fund, they shall be informed that the amount may be counted as income and may affect their monthly SSI benefits.

   iv. If the resident or their decision maker withdraws funds, the A&E Financial Counselor shall inform them of the Medi-Cal/SSA requirement to deposit funds into a Burial Trust Account.
13. Funds Transferred to Billing for late SOC payment:
   a. The billing department is responsible for ensuring that the current months SOC is credited to the patient’s account by the 15th of the month.
   b. The biller must contact the A&E Financial Counselor if the SOC payment is for previous months. The A&E Financial Counselor shall verify that funds in the Trust Account are designated as SOC funds for previous months. The A&E Financial Counselor shall inform the biller if money is for PN or SOC payment.

14. Funds Credited from Billing to the Patient Trust Account:
   a. Billing shall contact A&E via email to notify them of overpayment on SOC to be credited back to the trust account.
   b. A&E Financial Counselor shall respond with a date that funds shall be transferred back to the Patient Trust Account.
   c. On the date of transfer, Billing shall notify the Accounting Department via email to proceed with the credit to the Patient Trust Account.

15. Resident Has Financial Decision Making Capacity and Requests Withdrawal of Money from the Patient Accounts/Cashier Window: If the resident wishes to withdraw funds from his/her patient Trust Account, the resident completes the Authorization to Accounting Office form (ATAO). The A&E Supervisor must counter sign authorizations over SSI current rate. The A&E Manager must counter sign authorizations over $300 for discharge only. Refer to 18e for window cash withdrawal over $300.
   a. Cash shall be authorized if resident is being final discharged from LHH.
   b. Any questions regarding an unreasonable request by a resident who may need guidance in managing his/her funds are to be resolved by the members of the resident’s care team.

16. Annual Authorization to Withdraw Monthly Allowance: The resident or MSW may choose to receive monthly allowances (Medi-Cal current rate or SSI current rate) through Annual Authorization by completing and signing the Annual ATAO form. The A&E Financial Counselor writes on the top of the form “Annual Authorization”, and an expiration date. The A&E Financial Counselor forwards the original copy to the Cashier and a copy of the form is filed in A&E file. The Cashier shall file the ATAO original copy to use as reference to verify residents who participate in Annual Authorizations. Annual authorization covers monthly allowance not to exceed the SSI/Medi-Cal current rate. Additional requests for withdrawal requires resident to sign an ATAO form for each request. Annual Authorizations are renewed on December 31, of each year. Residents/MSWs wishing to continue with annual authorizations must complete a new authorization for the upcoming year.
17. **Steps for Authorization of Funds**: The expense of the funds is intended for the resident’s use to provide for his/her comfort and happiness. Included in the legitimate use of resident’s funds, but not limited:

a. The purchase of specially prepared or alternative food that meets the resident’s dietary needs instead of the food generally prepared by LHH;

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

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

d. Flowers and plants; and television/radio/audio appliances for PN.

e. Discretionary (PN) funds may not be used to pay past-due SOC or other hospital bills. Other than current months SOC, transfer of funds to Billing must be approved by the A&E Financial Counselor via email.

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

<table>
<thead>
<tr>
<th>Withdrawal Amount</th>
<th>Amount up to Medi-Cal or SSI Current rate</th>
<th>Amount exceeds Medi-Cal or SSI Current rate</th>
<th>Amount exceeds $300.00</th>
<th>Amount exceeds $1,500.00 w/o Residents signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFS staff signature requirements</td>
<td>A&amp;E Financial Counselor</td>
<td>A&amp;E Supervisor or designee</td>
<td>A&amp;E Manager or designee</td>
<td>Director of PFS, CFO, or designee</td>
</tr>
</tbody>
</table>

The LHH A&E Manager may approve authorization for any amount when funds are intended for:

a. Resident’s Burial or purchase of a burial plan,
b. Resident Discharge or Pending Discharge
c. Distribution of funds to family/estate after resident expires
d. Funds sent to the Department of Human Services, Public Guardian, Public Administrator, or a legal representative or Rep. Payee.
e. Payment of resident’s bills
f. Authorizations approved by the resident or Legal Representative, via email or letter, by signing the authorization form

18. **Authorizations Requested by Resident**:
a. Residents who are capable of managing their own funds shall complete the authorization form for withdrawal of funds:

b. The A&E Financial Counselor reviews Trust Account ledger to verify that funds are available.

c. If authorization is a final liquidation of the resident account due to discharge ADL (1) screen of resident’s account shall be printed and attached to ATAO.

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

e. For withdrawal requests for amounts over $300, A&E shall contact the cashier office two business days in advance to ask if cash is available. If not, resident can arrange to pick up the cash when available or the cashier’s office shall issue a check for amounts over $300.00.

f. For cash requests, the A&E Financial Counselor gives the white copy of the authorization to resident to take to Cashier, the yellow copy is placed in the A&E supervisor’s mailbox for auditing purposes, and the pink copy is placed in resident’s chart along with copies of identification and receipt(s) or invoice to A&E copy of ATAO.

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

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

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

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

j. If a resident lacks capacity to make financial decisions, person identified by the MSW as the person having authority to access the resident’s Trust Account.

k. If LHH is the Rep Payee, the Social Worker must sign ATOA form. Resident may sign the form if he/she has capacity to make decisions.

l. MSW shall provide A&E with name and contact information of person authorized to access the resident’s Trust Account.
i. The A&E Financial Counselor shall enter authorized decision makers, keep a record of the name and contact information for the financial decision maker into Invision Clinical Management System in the A&E file.

ii. The A&E Financial Counselor shall verify that person requesting funds is the authorized decision maker. If not, the person shall be referred to contact the resident's social worker.

iii. If the person is authorized to access funds, the A&E finance counselor shall review the Trust Account ledger to verify that funds are available and ask the person to provide Government identification.

iv. The authorized decision maker must submit a written request for funds indicating amount and reason for the request.

v. Authorized decision makers must submit receipts for resident purchases for reimbursement when the resident lacks financial decision-making capacity.

vi. Refer to item 8a thru 8k for steps on authorization of funds.

19. **Authorization Request by MSW**

a. If in the opinion of the residents’ care team, the resident is unable to manage his/her funds and the resident does not have a legal representative, the hospital or designee shall designate the MSW to manage the resident’s funds. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident’s care team.

b. **Steps for Authorizing Funds to the Medical Social Worker:**

   i. The MSW shall notify the A&E Financial Counselor of request for funds in writing indicating amount and reason for the request.

   ii. The MSW shall submit receipts for purchases to the A&E Financial Counselor within one week.

   iii. The MSW shall maintain a transaction record, which must be signed by the resident whenever money is distributed to the resident. The transaction record shall be forwarded to the A&E Financial Counselor, who shall place the form in the resident’s file.

   iv. MSW signature is required when requesting funds for residents or reimbursement for purchases or services.
v. MSW signature is not required if:
   • Resident is able to sign bill payment
   • Funds sent to Medi-Cal Recovery Unit – California Department of Health Services
   • Funds returned to Social Security
   • Funds used for Burial Plans
   • Funds sent to Public Administrator
   • Funds sent to family/estate after death

vi. Refer to item 8a thru 8h for steps for authorization of funds.

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

ATTACHMENT:
None.

REFERENCE:
Nursing Department Policy for Handling Money Held on the Nursing Neighborhood

Revised: 98/11/16, 00/05/25, 04/12/02, 07/12/18, 10/04/27, 10/08/10, 11/03/24, 16/01/12, 18/03/13, 19/03/12 (Year/Month/Day)
Original adoption: 93/09/01
EMERGENCY PREPAREDNESS

POLICY:

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

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

3. All City and County of San Francisco employees are mandated disaster service workers (DSWs) and are required to return to work during a disaster if called upon to do so. DSWs may be needed for their regular duties, but may also be asked to perform other duties they are trained to perform and they may be asked to report to another location, including alternate care locations set up under an 1135 waiver. Employees are provided with a disaster service worker identification badge that mandates city employee presence in the event of a disaster provides access to alternate locations.

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

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

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

PURPOSE:

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

PROCEDURE:

1. Training and Exercises
   
   a. New employees are introduced to Emergency Preparedness concepts during their orientation.
   
   b. Emergency Preparedness in-service is provided at least annually.
   
   c. Additional training is provided through exercises that include defining and practicing departmental and individual roles with the Incident Command Structure (ICS) and development of next steps based upon exercise evaluation.
d. Training and department specific goals emphasize continuous home preparedness development and maintenance, including keeping an emergency wallet card with an out of area contact in the event that local telephone service is limited during an actual event.

2. Communication and Coordination

a. Each department shall assign a representative to the Emergency Preparedness Committee who is responsible for continuously enhancing and sustaining emergency preparedness.

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

c. Residents are apprised of emergency preparedness and response procedures in the resident handbook, which is reviewed with the resident on admission by a social worker.

d. The department manager shall facilitate continuous updates for the emergency call back lists. The confidential call back lists are kept securely in the HICS Command Center.

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

d. Emergency preparedness updates are communicated to the leadership forum, executive committee, and neighborhood and departmental meetings, community meetings, and residents’ council as necessary.

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

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

3. Re-Assessment and Planning

a. A Hazards and Vulnerability Assessment (HVA) is completed annually to identify emergency incident risks to drive training and exercise development.
b. Opportunities to participate in state wide, city wide, DPH wide and other multi-jurisdictional exercises are incorporated into exercise plans each year for a minimum of 2 exercises annually, no more than 6 months apart. Real incidents requiring HICS activation can substitute for exercises.

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

   i. Earthquake
   ii. Mass Prophylaxis
   iii. Fire
   iv. Spill
   v. Medical Surge
   vi. Water Disruption
   vii. Power Outage
   viii. Heat Emergency
   ix. Active Shooter

d. Emergency Supplies

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

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

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

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

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

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

b. The manual also provides lists of resources and serves as an informational tool for responding to emergencies.

5. Personal Preparedness

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

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

c. Information and links are provided on the WSEM web site on the LHH intranet.

ATTACHMENT:
Attachment A: American Red Cross Emergency Contact Card

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan

Revised: 15/07/17, 15/09/08, 18/07/10, 19/03/12 (Year/Month/Day)
Original adoption: 13/05/28
CONTINUITY OF OPERATIONS PLAN

POLICY

Laguna Honda Hospital and Rehabilitation Center (LHH) is linked to the City and County of San Francisco's Emergency Operations Center (EOC) and the DPH's Department Operations Center (DOC) in accordance with the City and County of San Francisco and DPH Emergency Operations Plans through the Standardized Emergency Management System (SEMS).

LHH's role in emergency preparedness is to respond rapidly and effectively to internal and/or external disasters and continue to provide in-patient services to LHH residents. In the event of a major disaster, LHH is also prepared to expand treatment areas to provide basic first aid and temporary shelter to staff, visitors, and a limited number of additional residents requiring skilled nursing or acute (non-surgical) care. LHH works in partnership with Zuckerberg San Francisco General Hospital (ZSFG) to accept additional residents to make room for incoming casualties at ZSFG during an emergency incident. Evacuation of LHH residents from one area of the hospital to another or to an alternate location on or off-site may also occur.

Essential services must be maintained simultaneously with emergency incident mitigation, response, and recovery during and after a disaster impacting operations.

PURPOSE

The purpose of the Continuity of Operations Plan (COOP) is to ensure that LHH continues to provide essential healthcare services that maintain overall resident and staff safety and well-being in keeping with our mission. The plan outlines a systematic, all hazards approach to ensure the continuity of essential services at LHH during any type of disaster or other emergency that impacts infrastructure, staffing, or other critical resources.

1. LHH Operations

   a. Mission: LHH’s mission is to provide a welcoming, therapeutic and healing environment that promotes the individual’s health and well-being.

   b. Normal Operations: Consistent with its mission, LHH is comprised of 13-14 resident care units or “neighborhoods” providing skilled nursing and rehabilitation care for up to 769 residents and up to 11 residents requiring acute care. The neighborhoods are listed as follows:

      i. Pavilion Mezzanine (11 acute care beds, including one in a negative pressure isolation room; 49 SNF beds)
      ii. North Mezzanine (60 SNF beds)
      iii. North 1 (60 SNF beds)
      iv. North 2 (60 SNF beds)
v. North 3 (60 SNF beds)
vi. North 4 (60 SNF beds)
vii. North 5 (60 SNF beds)
viii. North 6 (60 SNF beds)
ix. South 2 (60 SNF beds)
x. South 3 (60 SNF beds)
xii. South 4 (60 SNF beds, including two in a negative pressure isolation rooms)
xiii. South 5 (60 SNF beds, including two in negative pressure isolation rooms)
xiv. South 6 (60 SNF beds, including two in negative pressure isolation rooms)

c. Services: Services include medical services, behavioral health services, nursing services, activity therapy, pharmacy, rehabilitation, meal service and nutrition consultation, social services, spiritual care, outpatient medical and dental clinics, respiratory therapy, and radiology. LHH also maintains a laboratory staff and courier services to ZSFG for routine and emergency “stat” lab services.

2. Activation: Activation of the LHH COOP shall be considered whenever HICS is activated according to LHHPP 70-03 Emergency Response Plan, and under one or more of the following circumstances:

a. Activation of the DPH Emergency Operations Plan
b. Activation (partial or full) of the DPH Departmental Operations Center (DOC) for an emergency response
c. Staff absenteeism is 20% or more than anticipated staffing for hospital operations
d. When emergency preparedness response activities exceed staffing capabilities
e. Damage or inoperability of key facility/facilities impedes daily operations

3. Leadership Succession: Management of the LHH section is delegated to the following persons in the order of succession in Table 1 below. This table lists, specifically, the people authorized to act on behalf of the Section Director. If the designated person is unavailable, authority will pass to the next individual on the list. The designated individual retains all assigned obligations, duties and responsibilities until officially relieved by an individual higher on the list of successions. These individuals are authorized to assume the role of Continuity of Operations Chief (COOP Chief)

Table 1. LHH Leadership Succession (COOP Chief)

<table>
<thead>
<tr>
<th>LHH Section Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Administrator (CEO)</td>
</tr>
<tr>
<td>Chief Operations Officer (COO)</td>
</tr>
<tr>
<td>Chief Medical Officer (CMO)</td>
</tr>
<tr>
<td>Chief Nursing Officer (CNO)</td>
</tr>
<tr>
<td>Quality Management Director</td>
</tr>
<tr>
<td>Nursing Director</td>
</tr>
<tr>
<td>Operations Nurse Manager</td>
</tr>
</tbody>
</table>
4. **Essential Services:** The COOP supports the execution of essential functions through all circumstances and in particular during emergencies or situations when normal procedures are not possible. The prioritization of essential services provides guidance for the allocation of resources in order of criticality. This may include reassignment of personnel, priority use of alternate facilities, and directed use of administrative and management support.
The tables below describe LHH’s mission critical functions.

Table 2 details Priority 1 activities that must be continued under all circumstances and can be inoperable or delayed for no more than 24 hours. Priority 1 activities include those that must be maintained to protect residents from immediate life safety threats and to comply with regulatory requirements.

### Table 2. Priority 1 Essential Services

<table>
<thead>
<tr>
<th>Essential Service</th>
<th>Systems/Resources Used in Providing Service</th>
<th>Staff (classifications) Required for Providing Service</th>
<th>Department Providing Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>Computers, all medical supplies, medications</td>
<td>2232, 2230</td>
<td>Medical Services</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>Radiology equipment</td>
<td>2468, 2469</td>
<td>Medical Services</td>
</tr>
<tr>
<td>Respiratory Therapy Services</td>
<td>Respiratory therapy supplies</td>
<td>2536</td>
<td>Medical Services</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Laboratory supplies</td>
<td>2430</td>
<td>Medical Services</td>
</tr>
<tr>
<td>Assist residents with ADLS</td>
<td>ADL supplies (towels, soap, shampoo, toothbrush, toothpaste, lotions), EZ Lift, Angel Lift, wheelchairs,</td>
<td>2303, 2302</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>hospital bed, linens, shower gurneys, shower chairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administer Medications and</td>
<td>Omnicell, med carts, IV pumps, feeding pump, wound care supplies, specialized beds and surfaces,</td>
<td>2320, 2312</td>
<td>Nursing</td>
</tr>
<tr>
<td>Treatments</td>
<td>ostomy supplies, glucose machine, alcohol wipes, lancets, test strips, medication refrigerators, QS/1,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ECWEHR (electronic health record)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of Residents</td>
<td>Stethoscopes, BP Machines, Bladder Scans, Thermoscans, Pen Light, Reflex Hammer, Otoscopes, EHR, LCR,</td>
<td>2320, 2322, 2324, 2323</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Assessment Forms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of Resident</td>
<td>Crash carts, emergency supply box, O2 tanks, O2 tubings and supplies, phone</td>
<td>2320, 2323</td>
<td>Nursing</td>
</tr>
<tr>
<td>Conditions</td>
<td>LCR, ECW, EHR, SF GET CARE, Assessment Forms</td>
<td>2312, 2320</td>
<td>Nursing</td>
</tr>
<tr>
<td>Essential Service</td>
<td>Systems/Resources Used in Providing Service</td>
<td>Staff (classifications) Required for Providing Service</td>
<td>Department Providing Service</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Monitoring for Resident Safety</td>
<td>Mobile View, Aeroscout, LC Temprtrak, Spectra-link VolIP Phones, Computers</td>
<td>2320, 2312, 2322, 2324, 2303, 2302, 2323, 2583, 1428</td>
<td>Nursing</td>
</tr>
<tr>
<td>Provide Nursing Staffing</td>
<td>ONE STAFF, Desktop, Phone</td>
<td>2322, 2324, 1429</td>
<td>Nursing</td>
</tr>
<tr>
<td>Provide medication</td>
<td>QS/1; Automed Packager; Omnicell</td>
<td>2450; 2409; 2406; 2454; 2453</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Complete/submit ePASRRs</td>
<td>ePASRR database, LCR, and EHReCW</td>
<td>UM Nurse (2322, 2320, 2312)</td>
<td>QM</td>
</tr>
<tr>
<td>Provide Administrative Services/Administrative Leadership</td>
<td></td>
<td>1406, 18 2742, 1822, 2818, 0931, 0941, 0942, 0943, 1165, 2324, 2322, 2320 (also refer to LHH Staff List)</td>
<td>Admin</td>
</tr>
<tr>
<td>Develop and/or revise the resident menu for appropriate therapeutic management</td>
<td>CBORD, LCR, EHReCW, SFGetCare, PC's, laptops, printers</td>
<td>2626, 2624</td>
<td>Clinical Nutrition</td>
</tr>
<tr>
<td>Provide food and water to residents</td>
<td>Gas, electricity, clean dishes and serving utensils, chemical sanitizers</td>
<td>2604, 2606, 2618, 2650, 2654, 2656</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Clean Patient Rooms</td>
<td>Cleaning supplies</td>
<td>2736</td>
<td>EVS</td>
</tr>
<tr>
<td>Remove Trash/biohazard</td>
<td>Elevators, trash bin</td>
<td>2736</td>
<td>EVS</td>
</tr>
<tr>
<td>Provide essential medical equipment and supplies to Neighborhoods</td>
<td>Elevators, PeopleSoft</td>
<td>2390</td>
<td>MM/CSRCPD</td>
</tr>
<tr>
<td>Provide facilities and utilities essential for safe resident care</td>
<td>Sound building and infrastructure, utility services</td>
<td>3417, 7120, 7203, 7205, 7334, 7335, 7342, 7344, 7345, 7346, 7347, 7524</td>
<td>Facility Services</td>
</tr>
<tr>
<td>Protect residents and staff from security threats</td>
<td>Radios, weapons, vehicles, telephones, computers, cameras</td>
<td>8302, 8304, 8300, 8306, 8308</td>
<td>SFSD</td>
</tr>
</tbody>
</table>
Table 3 details Priority 2 services that can be inoperable or delayed for no more than 72 hours. Priority 2 activities include those that must be maintained to ensure the continuity of government and activated emergency operations (if applicable).

Table 3: Priority 2 Essential Services

<table>
<thead>
<tr>
<th>Essential Service</th>
<th>Systems/Resources Used in Providing Service</th>
<th>Staff (classifications) Required for Providing Service</th>
<th>Department Providing Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash disbursement for residents</td>
<td>ADL system</td>
<td>Cashiers</td>
<td>Accounting</td>
</tr>
<tr>
<td>Purchase of emergency supplies</td>
<td>Cash or credit card (P-card)</td>
<td>CFO, Emergency Manager</td>
<td>Accounting</td>
</tr>
<tr>
<td>Sterile compounding</td>
<td>QS/1; CAI</td>
<td>2450; 2409; 2406; 2454; 2453</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Conduct admission reviews</td>
<td>Database, <strong>EHR</strong>LCR, eCW</td>
<td>UM Nurse <em>(2322, 2320, 2312)</em></td>
<td>QM</td>
</tr>
<tr>
<td>Complete/submit eTARs</td>
<td>Database, <strong>EHR</strong>LCR, eCW</td>
<td>UM Nurse <em>(2322, 2320, 2312)</em></td>
<td>QM</td>
</tr>
<tr>
<td>Notify team, staff and other disciplines of patient's admission and the payor coverage</td>
<td>Email</td>
<td>UM Nurse <em>(2322, 2320, 2312)</em></td>
<td>QM</td>
</tr>
<tr>
<td>Triage UO's</td>
<td>UO system in intranet</td>
<td>RM Nurse</td>
<td>QM</td>
</tr>
<tr>
<td>Infection control surveillance</td>
<td><strong>EHR</strong>LCR, eCW notes</td>
<td>Infection Control Nurse 2320</td>
<td>QM</td>
</tr>
<tr>
<td>Screen &amp; assess residents</td>
<td>CBORD/LCR/EHR/eCW/SFGetCare, PC's, laptops, printers</td>
<td>2624, 2622</td>
<td>Clinical Nutrition</td>
</tr>
<tr>
<td>Provide food and water to staff</td>
<td>gas, electricity, clean dishes and serving utensils, chemical sanitizers</td>
<td>2604, 2606, 2618, 2650, 2654, 2656</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Deliver clean linen</td>
<td>elevators, linen carts</td>
<td>2736</td>
<td>EVS</td>
</tr>
</tbody>
</table>
Table 4 details Priority 3 services that can be inoperable or delayed for no more than one week. Priority 3 activities include those that should be maintained to ensure the continuity of government and that are revenue generating.

**Table 4: Priority 3 Services**

<table>
<thead>
<tr>
<th>Essential Service</th>
<th>Systems/Resources Used in Providing Service</th>
<th>Staff (classifications) Required for Providing Service</th>
<th>Dept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident laundry</td>
<td>Laundry machines, laundry soap, carts</td>
<td>2583, 2303, 2302</td>
<td>Nursing</td>
</tr>
<tr>
<td>Hazardous drug compounding</td>
<td>CACI</td>
<td>2450; 2409; 2406; 2454; 2453</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Complete and store UM worksheets</td>
<td>Network drives</td>
<td>UM Nurse <em>(2322, 2320, 2312)</em></td>
<td>QM</td>
</tr>
<tr>
<td>Milieu management on the neighborhoods</td>
<td>Staff</td>
<td>2320, 2302, 2303, 2583, 2312, 2322, 2323, 2324, 2587, 2588, 2591*No requirement</td>
<td>AT</td>
</tr>
<tr>
<td>Provide food and water to visitors</td>
<td>Gas, electricity, clean dishes and serving utensils, chemical sanitizers</td>
<td>2604, 2606, 2618, 2650, 2654, 2656</td>
<td>Nutrition</td>
</tr>
</tbody>
</table>
5. Systems and Resources Needed for Provision of Essential Services

Table 5 lists the resources & systems that are used in providing the essential services listed in Tables 2-4. Each department who uses these resources and systems for an essential service shall implement downtime procedures when these resources or systems are unavailable or limited. These downtime procedures are incorporated into department emergency response plans.

Table 5: Resources and Systems Critical to Providing Essential Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Resource/System</th>
<th>Department(s) requiring resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment, Software, Utility</td>
<td>LHH Network</td>
<td>All</td>
</tr>
<tr>
<td>Equipment, Supplies</td>
<td>Crash Carts</td>
<td>Nursing, Medical Services</td>
</tr>
<tr>
<td>Equipment</td>
<td>Angel Lift</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Automated Packager</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>BP machines</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>CACI</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>CAI</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>Cameras</td>
<td>SFSD</td>
</tr>
<tr>
<td></td>
<td>Computers</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Elevators (washers and Dryer)</td>
<td>CPDO, EVS, Nutrition</td>
</tr>
<tr>
<td></td>
<td>EZ Lift</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Feeding Pumps</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Glucose Machines</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Hospital Bed</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>IV Pumps</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Laundry Machines (washers and Dryer)</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Linen Carts</td>
<td>EVS</td>
</tr>
<tr>
<td></td>
<td>Med Carts</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Medication refrigerators</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Omnicells</td>
<td>Pharmacy, Nursing</td>
</tr>
<tr>
<td></td>
<td>Printers</td>
<td>Clinical Nutrition</td>
</tr>
<tr>
<td></td>
<td>Radiology Equipment</td>
<td>Medical Services</td>
</tr>
<tr>
<td></td>
<td>Radios</td>
<td>SFSD</td>
</tr>
<tr>
<td></td>
<td>Specialized Beds</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Telephones</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Thermoscans</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Vehicles</td>
<td>SFSD</td>
</tr>
<tr>
<td></td>
<td>Weapons</td>
<td>SFSD</td>
</tr>
<tr>
<td>Supplies</td>
<td>ADL Supplies</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Chemical Sanitizers</td>
<td>Nutrition</td>
</tr>
<tr>
<td></td>
<td>Clean dishes and utensils</td>
<td>Nutrition</td>
</tr>
<tr>
<td></td>
<td>Cleaning Supplies</td>
<td>EVS</td>
</tr>
<tr>
<td></td>
<td>Emergency Supplies</td>
<td>Nursing</td>
</tr>
<tr>
<td>Category</td>
<td>Resource/System</td>
<td>Department(s) requiring resource</td>
</tr>
<tr>
<td>----------</td>
<td>----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td></td>
<td>Laboratory Supplies</td>
<td>Medical Services</td>
</tr>
<tr>
<td></td>
<td>Linens and Towels</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Medical Supplies</td>
<td>Medical Services</td>
</tr>
<tr>
<td></td>
<td>Medications</td>
<td>Medical Services</td>
</tr>
<tr>
<td></td>
<td>Trash Bins</td>
<td>EVS</td>
</tr>
<tr>
<td></td>
<td>Software</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ADL System</td>
<td>Accounting</td>
</tr>
<tr>
<td></td>
<td>Aeroscout</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>ARxiUM (automated medication packaging)</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>CBORD</td>
<td>Clinical Nutrition, Nutrition Services</td>
</tr>
<tr>
<td></td>
<td>EHR</td>
<td>Clinical Nutrition, Medical Services, Nursing, QM, Clinics, Rehab, AT, Social Services</td>
</tr>
<tr>
<td></td>
<td>Email</td>
<td>QM</td>
</tr>
<tr>
<td></td>
<td>JCI (Fire)</td>
<td>Facility Services</td>
</tr>
<tr>
<td></td>
<td>LCR/Invision</td>
<td>Clinical Nutrition, QM, Nursing, Medical Services, Laboratory, Clinics, AT</td>
</tr>
<tr>
<td></td>
<td>McKesson PMM</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>PeopleSoft</td>
<td>CPDMM</td>
</tr>
<tr>
<td></td>
<td>QS/1</td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>PAC (Radiology software)</td>
<td>Medical Services</td>
</tr>
<tr>
<td></td>
<td>SFGetCare</td>
<td>Clinical Nutrition, Nursing, Rehab, AT, Social Services</td>
</tr>
<tr>
<td></td>
<td>Siemens (Fire)</td>
<td>Facility Services</td>
</tr>
<tr>
<td></td>
<td>UO System</td>
<td>QM</td>
</tr>
<tr>
<td></td>
<td>Westcall (Nurse Call)</td>
<td>Nursing</td>
</tr>
<tr>
<td></td>
<td>Utility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electricity</td>
<td>All*</td>
</tr>
<tr>
<td></td>
<td>Generator Power</td>
<td>All*</td>
</tr>
<tr>
<td></td>
<td>Natural Gas Supply</td>
<td>Nutrition</td>
</tr>
<tr>
<td></td>
<td>Water</td>
<td>All*</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td>All</td>
</tr>
</tbody>
</table>

*Downtime procedures for these utilities are addressed in separate hazard-specific plans.

6. Alternative Care Facilities and Emergency Communications
Plans for alternative care locations, emergency transportation, and communications are detailed in [LHHPP 70-01 B1: Emergency Response Plan](#).

**ATTACHMENT:**
Attachment A: Job Classifications and Titles

**REFERENCE:**
## Attachment A: Job Classifications and Titles

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2230</td>
<td>Physician Specialist</td>
</tr>
<tr>
<td>2232</td>
<td>Senior Physician Specialist</td>
</tr>
<tr>
<td>2302</td>
<td>Nursing Assistant</td>
</tr>
<tr>
<td>2303</td>
<td>Patient Care Assistant</td>
</tr>
<tr>
<td>2305</td>
<td>Psychiatric Technician</td>
</tr>
<tr>
<td>2312</td>
<td>Licensed Vocational Nurse</td>
</tr>
<tr>
<td>2320</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>2322</td>
<td>Nurse Manager</td>
</tr>
<tr>
<td>2323</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>2324</td>
<td>Nursing Supervisor</td>
</tr>
<tr>
<td>2326</td>
<td>Nursing Supervisor Psychiatric</td>
</tr>
<tr>
<td>2424</td>
<td>X-Ray Laboratory Aide</td>
</tr>
<tr>
<td>2430</td>
<td>Medical Evaluations Aide</td>
</tr>
<tr>
<td>2468</td>
<td>Diagnostic Imaging Tech II</td>
</tr>
<tr>
<td>2469</td>
<td>Diagnostic Imaging Tech III</td>
</tr>
<tr>
<td>2536</td>
<td>Respiratory Care Practitioner</td>
</tr>
<tr>
<td>2542</td>
<td>Speech Pathologist</td>
</tr>
<tr>
<td>2548</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>2550</td>
<td>Senior Occupational Therapist</td>
</tr>
<tr>
<td>2554</td>
<td>Therapy Aide</td>
</tr>
<tr>
<td>2555</td>
<td>Physical Therapist Assistant</td>
</tr>
<tr>
<td>2556</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>2558</td>
<td>Senior Physical Therapist</td>
</tr>
<tr>
<td>2574</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>2576</td>
<td>Sprv Clinical Psychologist</td>
</tr>
<tr>
<td>2583</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>2920</td>
<td>Medical Social Worker</td>
</tr>
<tr>
<td>2922</td>
<td>Senior Medical Social Worker</td>
</tr>
<tr>
<td>2924</td>
<td>Medical Social Work Supervisor</td>
</tr>
<tr>
<td>2930</td>
<td>Psychiatric Social Worker</td>
</tr>
<tr>
<td>2931</td>
<td>Marriage, Family &amp; Child Cnslr</td>
</tr>
<tr>
<td>7324</td>
<td>Beautician</td>
</tr>
<tr>
<td>P103</td>
<td>Special Nurse</td>
</tr>
<tr>
<td>2604</td>
<td>Food Service Worker</td>
</tr>
<tr>
<td>2606</td>
<td>Senior Food Service Worker</td>
</tr>
<tr>
<td>2608</td>
<td>Supply Room Attendant</td>
</tr>
<tr>
<td>2618</td>
<td>Food Service Supervisor</td>
</tr>
<tr>
<td>2619</td>
<td>Senior Food Service Supervisor</td>
</tr>
<tr>
<td>2620</td>
<td>Food Service Mgr Administrator</td>
</tr>
<tr>
<td>2650</td>
<td>Assistant Cook</td>
</tr>
<tr>
<td>2654</td>
<td>Cook</td>
</tr>
<tr>
<td>2656</td>
<td>Chef</td>
</tr>
<tr>
<td>2736</td>
<td>Porter</td>
</tr>
<tr>
<td>2738</td>
<td>Porter Assistant Supervisor</td>
</tr>
<tr>
<td>2740</td>
<td>Porter Supervisor 1</td>
</tr>
<tr>
<td>3417</td>
<td>Gardener</td>
</tr>
<tr>
<td>7120</td>
<td>Bldgs &amp; Grounds Maint Supt</td>
</tr>
<tr>
<td>7203</td>
<td>Bldg &amp; Grounds Maint Sprv</td>
</tr>
<tr>
<td>7334</td>
<td>Stationary Engineer</td>
</tr>
<tr>
<td>7335</td>
<td>Senior Stationary Engineer</td>
</tr>
<tr>
<td>7342</td>
<td>Locksmith</td>
</tr>
<tr>
<td>7344</td>
<td>Carpenter</td>
</tr>
<tr>
<td>7345</td>
<td>Electrician</td>
</tr>
<tr>
<td>7346</td>
<td>Painter</td>
</tr>
<tr>
<td>7347</td>
<td>Plumber</td>
</tr>
<tr>
<td>7524</td>
<td>Institution Utility Worker</td>
</tr>
<tr>
<td>0922</td>
<td>Manager I</td>
</tr>
<tr>
<td>0923</td>
<td>Manager II</td>
</tr>
<tr>
<td>0931</td>
<td>Manager III</td>
</tr>
<tr>
<td>0932</td>
<td>Manager IV</td>
</tr>
<tr>
<td>0933</td>
<td>Manager V</td>
</tr>
<tr>
<td>0941</td>
<td>Manager VI</td>
</tr>
<tr>
<td>0943</td>
<td>Manager VIII</td>
</tr>
<tr>
<td>1042</td>
<td>IS Engineer-Journey</td>
</tr>
<tr>
<td>1165</td>
<td>Manager, Department Of Public Health</td>
</tr>
<tr>
<td>1204</td>
<td>Senior Personnel Clerk</td>
</tr>
<tr>
<td>1220</td>
<td>Payroll Clerk</td>
</tr>
<tr>
<td>1404</td>
<td>Clerk</td>
</tr>
<tr>
<td>1406</td>
<td>Senior Clerk</td>
</tr>
<tr>
<td>1408</td>
<td>Principal Clerk</td>
</tr>
<tr>
<td>1428</td>
<td>Unit Clerk</td>
</tr>
<tr>
<td>1429</td>
<td>Nurses Staffing Assistant</td>
</tr>
<tr>
<td>1430</td>
<td>Transcriber Typist</td>
</tr>
<tr>
<td>1440</td>
<td>Medical Transcriber Typist</td>
</tr>
<tr>
<td>1630</td>
<td>Account Clerk</td>
</tr>
<tr>
<td>1632</td>
<td>Senior Account Clerk</td>
</tr>
<tr>
<td>1634</td>
<td>Principal Account Clerk</td>
</tr>
<tr>
<td>1635</td>
<td>Health Care Billing Clerk 1</td>
</tr>
<tr>
<td>1636</td>
<td>Health Care Billing Clerk 2</td>
</tr>
<tr>
<td>1652</td>
<td>Accountant II</td>
</tr>
<tr>
<td>1654</td>
<td>Accountant III</td>
</tr>
<tr>
<td>1657</td>
<td>Accountant IV</td>
</tr>
<tr>
<td>1663</td>
<td>Patient Accounts Supervisor</td>
</tr>
<tr>
<td>1664</td>
<td>Patient Accounts Manager</td>
</tr>
<tr>
<td>1708</td>
<td>Senior Telephone Operator</td>
</tr>
<tr>
<td>1820</td>
<td>Junior Administrative Analyst</td>
</tr>
<tr>
<td>1822</td>
<td>Administrative Analyst</td>
</tr>
<tr>
<td>1823</td>
<td>Senior Administrative Analyst</td>
</tr>
<tr>
<td>1824</td>
<td>Pr Administrative Analyst</td>
</tr>
<tr>
<td>1825</td>
<td>Prnpl Admin Analyst II</td>
</tr>
<tr>
<td>1842</td>
<td>Management Assistant</td>
</tr>
<tr>
<td>2105</td>
<td>Patient Svcs Finance Tech</td>
</tr>
<tr>
<td>2106</td>
<td>Med Staff Svcs Dept Spc</td>
</tr>
<tr>
<td>2110</td>
<td>Medical Records Clerk</td>
</tr>
<tr>
<td>2112</td>
<td>Medical Records Technician</td>
</tr>
<tr>
<td>2119</td>
<td>Health Care Analyst</td>
</tr>
<tr>
<td>2785</td>
<td>Asst General Services Manager</td>
</tr>
<tr>
<td>2818</td>
<td>Health Program Planner</td>
</tr>
<tr>
<td>2903</td>
<td>Eligibility Worker</td>
</tr>
<tr>
<td>2908</td>
<td>Hospital Eligibility Worker</td>
</tr>
<tr>
<td>2909</td>
<td>Hospital Elig Wrk Supervisor</td>
</tr>
<tr>
<td>4321</td>
<td>Cashier 2</td>
</tr>
<tr>
<td>5504</td>
<td>Project Manager 2</td>
</tr>
<tr>
<td>1934</td>
<td>Storekeeper</td>
</tr>
<tr>
<td>1942</td>
<td>Asst Materials Coordinator</td>
</tr>
<tr>
<td>1944</td>
<td>Materials Coordinator</td>
</tr>
<tr>
<td>2390</td>
<td>Central Processing &amp; Dist Tech</td>
</tr>
<tr>
<td>2392</td>
<td>Sr Cent Proc &amp; Dist Tech</td>
</tr>
<tr>
<td>2406</td>
<td>Pharmacy Helper</td>
</tr>
<tr>
<td>2409</td>
<td>Pharmacy Technician</td>
</tr>
<tr>
<td>2450</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>2453</td>
<td>Supervising Pharmacist</td>
</tr>
<tr>
<td>2454</td>
<td>Clinical Pharmacist</td>
</tr>
<tr>
<td>2586</td>
<td>Health Worker 2</td>
</tr>
<tr>
<td>2587</td>
<td>Health Worker 3</td>
</tr>
<tr>
<td>2588</td>
<td>Health Worker 4</td>
</tr>
<tr>
<td>2591</td>
<td>Health Program Coordinator 2</td>
</tr>
<tr>
<td>2593</td>
<td>Health Program Coordinator 3</td>
</tr>
<tr>
<td>2622</td>
<td>Dietetic Technician</td>
</tr>
<tr>
<td>2624</td>
<td>Dietitian</td>
</tr>
<tr>
<td>2626</td>
<td>Chief Dietitian</td>
</tr>
<tr>
<td>6138</td>
<td>Industrial Hygienist</td>
</tr>
<tr>
<td>6139</td>
<td>Senior Industrial Hygienist</td>
</tr>
<tr>
<td>7355</td>
<td>Truck Driver</td>
</tr>
<tr>
<td>9910</td>
<td>Public Service Trainee</td>
</tr>
<tr>
<td>9924</td>
<td>PS Aide Health Services</td>
</tr>
</tbody>
</table>
RESIDENT EVACUATION PLAN

POLICY:

In order to provide care for residents in a safe location, Laguna Honda Hospital and Rehabilitation Center (LHH) 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 the any resident care area(s) of the hospital becomes unsafe for residents, HICS will be activated. The residents will be moved out of the area(s) and into an alternate care site. Alternate care sites will be selected by the HICS Team.

2. Horizontal Evacuation

Whenever possible, evacuation shall be done horizontally. The Nurse Manager or designee shall 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.
If anyone is missing, attempt to locate them and notify the command center, the Nursing Office, and the Sheriff’s Department.

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.

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. 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.

ii. If time is of the essence, bed-bound residents may be brought down the stairs using evacuation devices or carriers.

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.

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.

6. Accounting for Residents and Resident Tracking

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 Managers to account for any missing residents.

b-c. For any resident who is evacuated, continuity of care document (CCD) will be made available to providers at the receiving facility via the health information exchange. The document will contain key information including problem list, allergies, medications, recent lab results.

7. Employee Training

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

b. A team of staff from Nursing, Rehab, and Activity Therapy staff shall be trained on the use of evacuation devices on initial hire and annually. This training will include hands on practice using the equipment.

ATTACHMENT:
Appendix A: Alternate Care Sites
Appendix B: Evacuation Devices
Appendix C: Emergency Carriers

REFERENCE:
LHHPP 70-01 B1: Emergency Response Plan

Revised: 18/09/11, 19/03/12 (Year/Month/Day)
Original Adoption: 14/07/29
# APPENDIX A: Alternate Care Sites

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>Electricity (E: power available)</th>
<th>Water</th>
<th>Ease of Transporting Patient (1=Easy, 3=Hardest)</th>
<th>Ease of Transporting Equipment (1=Easy, 3=Hard)</th>
<th>Quality of Space (1=Good, 3= Poor)</th>
<th>Lighting (Y=Yes, N=No)</th>
<th>Protection from Weather</th>
<th>Bed Capacity, est.</th>
<th>Ability to Quarantine</th>
<th>Med Gas Availability</th>
<th>Surface</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic, P1</td>
<td>Y, E</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>12</td>
<td>Y</td>
<td>Y</td>
<td>terrazo</td>
</tr>
<tr>
<td>Rehab Center, PG</td>
<td>Y no E</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>30</td>
<td>N</td>
<td>N</td>
<td>terrazo</td>
</tr>
<tr>
<td>Simon Auditorium, Admin 1</td>
<td>minimal E</td>
<td>N</td>
<td>1</td>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>60</td>
<td>N</td>
<td>N</td>
<td>concrete</td>
</tr>
<tr>
<td>Wellness Hub, H3</td>
<td>minimal E</td>
<td>N</td>
<td>2</td>
<td>2</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>50</td>
<td>N</td>
<td>N</td>
<td>carpet</td>
</tr>
<tr>
<td>Moran Hall, H3</td>
<td>minimal E</td>
<td>N</td>
<td>2</td>
<td>2</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>50</td>
<td>N</td>
<td>N</td>
<td>concrete, carpet</td>
</tr>
<tr>
<td>Esplanade, including Kanaley, P1</td>
<td>minimal E</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>40</td>
<td>minimal N</td>
<td>terrazo</td>
<td></td>
</tr>
<tr>
<td>Cafeteria, P1</td>
<td>minimal E</td>
<td>Y</td>
<td>1</td>
<td>1</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>25</td>
<td>N</td>
<td>N</td>
<td>terrazo</td>
</tr>
<tr>
<td>Outside - Main Entrance (front of Pavilion)</td>
<td>N</td>
<td>N</td>
<td>3</td>
<td>3</td>
<td>minimal N</td>
<td>L inside</td>
<td>N</td>
<td>100</td>
<td>N</td>
<td>N</td>
<td>grass, blacktop, variable</td>
</tr>
<tr>
<td>NW Parking Lot</td>
<td>N</td>
<td>N</td>
<td>3</td>
<td>3</td>
<td>minimal N</td>
<td>N</td>
<td>N</td>
<td>100</td>
<td>N</td>
<td>N</td>
<td>blacktop</td>
</tr>
</tbody>
</table>
APPENDIX B: 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 by 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 Center. 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. Pictorial 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 (7) are available through the Command Center for evacuation down stairs (weight limit 500 lbs). Pictorial 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 C: 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.
FIRE RESPONSE PLAN

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. When You See Smoke or Fire

   a. Follow the R.A.C.E. acronym below for basic fire response steps:

      i. Rescue persons in immediate danger while announcing “Code Red” to nearby staff.

         - **If a person is on fire, the best immediate response is to have them stop, drop and roll. However, if someone cannot drop and roll, you may wrap the person in bedding or clothing to smother the fire or use a fire extinguisher if it is safe to do so.**

      ii. Alarm by continuing to shout “Code Red” to nearby staff and by activating the alarm using the nearest manual pull station.

         - Any person may activate the Fire Plan by pulling a manual pull station. In addition, the fire detection system may be automatically activated via heat sensors and particle (smoke) detectors.

         - **When the fire alarm goes off due to activation of a smoke detector, the annunciator panel at the nurse’s station will display the source of the fire and the light outside the resident’s room will flash red. Check the panel at the nurse’s station to find the fire quickly.**

         - When the alarm activates, chimes will ring and strobes will flash in the building.

         - Once activated, the fire alarm automatically alerts the San Francisco Fire Department, which will respond immediately.

Dial 4-2999. Provide the following information:
• Location of fire

• What is burning

• Your name

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

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

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

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

• Move residents needing oxygen to a safe area to administer it.

• Licensed staff turns off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.

• Turn off electrical equipment in the area.

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

• Pull the pin

• Aim at the base of the fire

• Squeeze the handle

• Sweep side to side

*ABC Dry Chemical Fire Extinguishers contain monoammonium phosphate and ammonium sulfate. Exposure to these chemicals can cause irritation to the eyes, skin and respiratory pathways. Additionally, inhalation of the chemicals can aggravate existing respiratory conditions such as asthma, emphysema or bronchitis. For more information, refer to the safety data sheet available on the WSEM webpage.
Note: If a fire extinguisher is used, restrict access to the area and notify EVS. EVS shall then clean up the residue following standard procedures listed in Appendix D: EVS Fire Extinguishment Discharge Clean-Up Procedures.

b. If evacuation of residents is necessary, follow the procedures in LHHPP 70-01-B3 5—Resident Evacuation Plan

2. Fire Response in the Hospital Buildings

a. Resident Safety

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

i. Move residents needing oxygen to a safe area to administer it.

ii. Turn off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.

iii. Turn off electrical equipment in the area.

b. Fire Door Closure

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

i. Passage through activated fire doors is acceptable after visual check through window and/ or light touch to assure the area is free of smoke, flames, or excessive heat.

ii. Fire alarm activation in the Pavilion Building triggers four automatic accordion fire doors on the Esplanade to close. Any staff member on the Esplanade during accordion door activation is expected to assist residents or visitors who are unsure of what to do. Accordion doors retract if an obstacle is encountered and then re-close automatically. The doors can be opened by pressing a clearly marked green bar after safety on the other side of the door is verified by visual check through the accordion door window.

iii. The Rehabilitation Department (Pavilion ground floor), Art Studio (Pavilion 1st floor, and Pharmacy (Pavilion 2nd floor) have roll down fire screens in addition to fire doors. The roll down doors must be kept clear of obstructions.

c. Stairwell Doors
i. Activation of the fire alarm by a smoke detector will cause exit doors in the neighborhoods of the affected building to automatically unlock to allow for evacuation.

ii. The doors will not automatically unlock during a drill or if the fire alarm is activated using a manual pull station; a heat or smoke sensor must also be activated.

iii. Stairwell doors can also be unlocked from the master lock outside of the medication room on each neighborhood.

iv. Precautions must be taken to prevent residents from inadvertently exiting unaccompanied by staff, as follows:

   - In case of fire activity in the North Mezzanine secure neighborhood, North 1, 2, 3 and 4 will send one staff member to North Mezzanine to monitor the fire stairwell doors to assure resident safety as follows:
     - N1: send staff to monitor NM Cypress household door
     - N2: send staff to monitor NM Redwood household door
     - N3: send staff to monitor NM Cedar household door
     - N4: send staff to monitor NM Juniper household door
   - On all other units, staff must go to the stairwell doors to redirect residents.

   - Relock each of the stairwell doors after the "all clear" is announced over the public-address system. Stairwell doors can also be unlocked from the master lock outside of the medication room on each neighborhood.

   - Never use elevators during a fire.

   - Elevators are equipped with fire screens and systems to bring the elevator to the lowest safe floor automatically in case of fire in the building.

   - If you are in an elevator, to exit the elevator once it reaches the lowest safe floor, and if the fire screen is down, press the clearly marked button in the center of the roll-down fire to open the screen.

   - Elevators will be placed back in service by the Fire Department or the Watch Engineer once “all clear” has been declared.
iv. Never use elevators during a fire.

v. iv. Elevators will be placed back in service by the Fire Department or the Watch Engineer once “all clear” has been declared.

e. Evacuation of Hazardous Area

i. An evacuation of a unit or department area shall take place if the fire cannot be safely extinguished or if smoke or other damage renders the area unsafe for residents.

ii. Residents shall be moved to a safe area 1-2 fire doors away from the fire on the same floor if possible (horizontal evacuation).

iii. Initiate horizontal evacuation in the following order:

• Ambulatory residents
• Semi-ambulatory residents and those in wheelchairs
• Residents who are more dependent/in bed.

iv. During horizontal evacuation, the Nurse Manager or designee shall:

• Coordinate the movement of residents.
• Perform a check of the unit to verify that all persons have been moved out of the hazardous area.

• Remove medical records from the hazardous area if safe to do so.
• Account for residents, staff, and visitors and take steps to locate anyone missing.

v. When vertical evacuation is necessary for the safety of residents, follow the procedures in LHHPP 70-01 B3 5 Resident Evacuation Plan.

f. Post Fire Procedures

i. Ventilate the area to clear any smoke by opening windows or using a fan if needed; do not block any fire doors.

ii. If a fire extinguisher was used, Any electrical equipment or wiring that is contaminated must be shut off and immediately cleaned up following procedures listed in Appendix D. If a fire extinguisher was used.
iii. Staff shall coordinate arrangements with EVS to clean up the discharge residue as soon as possible. If it is after 10 pm and EVS is not present:
Any electrical equipment or wiring that is contaminated must be shut off and immediately cleaned up following procedures listed in Appendix D.

v. Ventilate the area to clear any smoke by opening windows or using a fan if needed; do not block any fire doors.

3. Fire Response in the Administration Building

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

a. Staff Evacuation Procedures

i. When the alarm sounds, building occupants will calmly secure work areas and exit the building via the nearest fire exit. If you are not on ground level, use stairs to reach the nearest exit. Elevators must not be used in a fire.

ii. Once you have exited the building, proceed to the front of the building near the flagpole. If the fire prevents access to this area, the 5th floor parking lot will be the alternate meeting area.

iii. At least three staff members from each of the wings/building areas that are normally occupied are pre-assigned to participate on an Evacuation Team and will keep a red vest and clipboard with a list of staff in their work area.

iv. The Evacuation Team members will put on their red vests, collect their clipboard with attendance sheets, and sweep their assigned areas, knocking on all doors to make sure that all occupants have evacuated.

v. Evacuation Team members will proceed to the meeting area in front of the building where they will take attendance using the lists of staff for each area.

vi. Evacuation Team members will also compile a list of people present at the meeting location whose names are not on the list of building occupants. Attendance sheets will be turned over to the Incident Commander.

vii. If a determination is made by SFFD, SFSD, Engineering, or WSEM that there is no fire in the administration building either because the alarm was triggered in error or only in the Pavilion building, “All Clear” will be announced and occupants may re-enter the building.

viii. If there is an actual fire in the administration building, occupants will not return to the building until the SFFD and/or the Incident Commander declare “All Clear.”
4. **HICS Activation in Response to a Fire**

a. **Designation of an Incident Commander**

   i. As soon as possible after alarm activation, the Nursing Office will notify the Executive Administrator or the Administrator on Duty (AOD) of the Code Red.

   ii. The AOD and the Nursing Officer will:

       • Determine the extent of the fire
       • Activate HICS if a fire leads to a disruption in normal operations
       • Designate the Incident Commander

b. **Incident Commander Responsibilities:**

   i. Learn from the Nursing Office staff/telecommunications operator the LOCATION and NATURE of the fire. Verify that Nursing Office staff/telecommunications operator telephoned SFFD to confirm the automated alarm.

   ii. Ascertain the following from the Fireground Officer (watch engineer initially, then senior fire fighter once SFFD arrives)

       • Immediate danger to residents or staff
       • Arrival of SFFD at scene
       • Any need to consider additional evacuation
       • Resources required

   iii. Coordinate the hospital’s response to the fire emergency, including activation of other HICS roles as necessary.

   iv. Upon receiving clearance from the Fire Department or watch engineer, authorize the announcement of “CODE RED ALL CLEAR (location)” by Nursing Office staff/telecommunications operator.

   v. Authorize initialization of clean up and restoration of the affected area as required. This work should include removal of fire debris and immediate restoration of the rooms (unless arson is suspected, in which case crime scene must be preserved).
vi. Manage the post fire clean-up operation by providing specific direction and resources. Assure the incident is completely documented for required reporting.

vii. Schedule a post-fire debriefing as necessary.

viii. Contact the Nursing Directors and Nurse Managers as needed to arrange for alternate accommodations for residents who may be temporarily displaced due to fire.

ATTACHMENT:
Appendix A: Nursing Operations Procedure
Appendix B: Watch Engineer Procedure
Appendix C: Sheriff’s Department Procedure
Appendix D: EVS Clean-up Procedure

REFERENCE:
LHHPP 70-01 B35 Resident Evacuation Plan
Safety Data Sheet Amerex ABC Dry Chemical Fire Extinguisher

Revised: 09/08/24, 11/09/27, 13/05/28, 14/07/29, 14/09/09, 18/03/13, 19/03/12
(Year/Month/Day)
(Previously numbered as LHHPP 71-02)
Appendix A: Nursing Operations Fire Response Procedures

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

2. Upon alarm activation without a phone call from the affected area:
   a. Expect to receive a call from SFSD regarding the location of the alarm activation. If you do not receive a call, call SFSD at 4-2319 to confirm location of the alarm.
   b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: “Attention, Attention, May I have your Attention Please.” “CODE RED (location)”

3. Upon Notification of a Code Red Drill:
   a. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: “Attention, Attention, May I have your Attention Please.” “CODE RED DRILL (location)”

c. When notified that the drill is all clear by the unit being drilled, or by Engineering staff, announce three times over the paging system: “CODE RED DRILL (location) IS ALL CLEAR.”
Appendix B: Watch Engineer Fire Response Procedures

1. Upon activation of the fire alarm system, the Watch Engineer on duty shall:

   a. Immediately respond to the location of the alarm and become the Fireground Officer if there is an actual fire.

   b. Initial response to fire shall include the following:

      i. Activate nearest fire alarm pull station if not already done.
      ii. Tell others to close doors and windows.
      iii. Tell others to turn off Oxygen cylinders and wall gases.
      iv. Extinguish fire, if small.
      v. Direct firefighting until SFFD arrives.
      vi. If false alarm, locate source detector and possible causes.

   c. If hazardous materials are involved, inform the SFSD to notify 911 responders.

   d. If necessary, go directly to the location of the emergency shut-off breaker of the intake/exhaust fan(s) and shut them off. Immediately return to the fireground.

   e. If HICS has been activated, carry out the Incident Command directives.

   f. Determine whether adjacent areas are at risk and advise Incident Commander. When SFFD arrives, relinquish authority to the senior firefighter and inform Incident Commander of that person’s name.

   g. When the SFFD authorizes a “Code red (location) all clear”.

      i. Notify the Incident Command Center and Nursing Operations of all clear authorization.
      ii. Reset the alarm system.
      iii. Reset the elevators if not damaged by fire.
      iv. Report completion of re-setting to the Command Center.

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

   i. Initiate clean up and restoration of the affected area as required.
Appendix C: San Francisco Sherriff Department Fire Response Procedures

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

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

1. Upon notification of the use of a fire extinguisher requiring clean up, the following steps must be followed immediately:
   
   a. Ask individuals not associated with clean up to leave the area.
   
   b. Wear the following personal protective equipment prior to during clean up:
      
      i. Nitrile or latex gloves
      ii. N95 respirator (employee may voluntarily choose to wear a half face respirator)
      iii. Safety goggles
      iv. Disposable boot covers
      v. Coveralls/Gown
      vi. N95 respirator Use of either an N95 or reusable respirator is optional. (employee may voluntarily choose to wear a half face respirator)
      
   c. Use a HEPA vacuum to collect loose debris large deposits of fire extinguisher ant discharge.
   
   d. For cleaning surfaces with stuck-on residue, prepare a 1:1 mixture of water and baking soda and clean the affected areas using a wet cloth or paper towel rag if necessary.
   
   e. If electrical equipment has traces of residue, clean external surfaces using a HEPA vacuum. However, if equipment is severely damaged, discard the equipment appropriately.
   
   f. All waste generated during the clean-up process shall be disposed in regular trash.
   
   g. After cleaning, wash your hands thoroughly.
   
   h. Return the HEPA vacuum to EVS after use.
      
      Note: This vacuum is solely for cleaning fire extinguisherant residue and must not be used for any other purpose.
OUTBREAK/EPIDEMIC INVESTIGATION PROTOCOL

POLICY:

The Infection Control Committee has ultimate responsibility for investigating outbreaks/epidemics and developing policies aimed at prevention and control of healthcare associated infections. If an outbreak is suspected, the Chair of the Infection Control Committee or their designee will direct the investigation.

CDC DEFINITIONS:

Epidemic refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area. Outbreak carries the same definition of epidemic, but is often used for a more limited geographic area. Cluster refers to an aggregation of cases grouped in place and time that are suspected to be greater than the number expected, even though the expected number may not be known. Pandemic refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.

PURPOSE:

Suspected epidemics, outbreaks and clusters of healthcare associated infections will be investigated completely and uniformly.

PROCEDURE:

1. The Infection Control Chair in collaboration with their Infection Control Nurse will determine whether the situation is an infectious outbreak or epidemic that poses a threat to the health and safety of residents and employees, and/or whether it warrants immediate investigation.

2. If investigation indicates that an epidemic or outbreak exists, the Infection Control Nurse will notify the San Francisco Department of Public Health Communicable Disease Unit and the Risk Management Nurse will notify California Department of Public Health.

3. Key players will be selected to participate in the planning process for control of the outbreak, including the utilization of the Hospital Incident Command System, if necessary. Such individuals may include any or all of the following:
   a. Chair of the Infection Control Committee (ICC)
   b. Infection Control Nurse(s)
   c. Chief Medical Officer (CMO)
d. Chief Nursing Officer

e. Industrial Hygienist/Safety Officer

f. Other Infection Control Committee members

g. Nurse Manager of the involved resident care unit(s)

h. MDPhysician of the involved resident care units

i. Program Director of Nursing or designee

j. Occupational Health Service Director or designee

k. Clinical Microbiology Laboratory manager and personnel

l. Director of Pharmacy or designee

m. Hospital Administrator or designee

n. Department of Public Health representatives from appropriate communicable disease division(s)

4. The Infection Control Nurse(s) may call an immediate meeting of such individuals and disciplines to:

   a. Clarify the nature and extent of the potential problem.

   b. Discuss proposed investigative steps.

   c. Determine and assign responsibility of each department; determine who will–shall collect and record specific data.

   d. Anticipate questions that may arise and develop a frequently asked question (FAQ) fact sheet.

5. Major decisions involving large numbers of residents, personnel, or considerable expense (such as "closing" a unit), will–shall be made in conjunction with the investigating personnel, attending staff and administration.

6. If prophylactic or therapeutic medication is required for residents, the prescribing physicians will–shall be notified by the Infection Control Nurse after consultation with the Chair of ICC, CMO, or designee|ICC Chair.

6. Employee prophylaxis and/or medications will be administered through the Employee Health Services at Laguna Honda Hospital or SFGH at no expense to the employee.
7. Resident care personnel may be requested to assist with data collection, culturing and notification of employees.

8. Educational in-services may be held with personnel to prevent over reaction.

9. Frequent interdisciplinary meetings or "huddles" may be held to review and plan for new developments.

10. The ICN will collaborate with clinical members of the ICC to write the investigation report and distribute the report to involved departments.

11. After the investigation is completed, the Infection Control Committee shall critically review all aspects of the investigation in order to identify problems that could be averted in the future.

ATTACHMENT:
None.

REFERENCE:
CENTERS FOR DISEASE CONTROL (HTTP://WWW.CDC.GOV)
LHHPP File 70-013 B1 Emergency Response Plan
LHHPP 70-01 C5 Emergency Responder Antibiotic Dispensing Plan
LHHPP 72-01 A9 Contact/Exposure Investigation
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 14/11/25, 19/03/12 (Year/Month/Day)
Original adoption: Est. 05/11/01
VISITORS GUIDELINES FOR INFECTION PREVENTION

POLICY:

Visitors shall be provided with infection prevention instructions and or written materials by nursing staff or other health care providers when visiting residents.

PURPOSE:

1. To minimize the potential for bi-directional transmission of infections from visitors to residents and residents to visitors.

2. To assist staff in educating visitors on preventing the transmission of infection.

DEFINITION:

A visitor is defined as anyone who is not a healthcare worker, paid or unpaid; who comes on the Laguna Honda campus to meet, visit, or comes within 6 feet of the resident.

PROCEDURE:

1. Visitors with Illness

   a. Visitors with respiratory or gastrointestinal symptoms of infection shall be asked to refrain from visiting Laguna Honda Hospital until afebrile for 24 hours, without the use of medication and improvement of symptoms.

2. Hand Hygiene

   Visitors shall be encouraged to practice good hand hygiene by staff or through signage placed at the lobby entrance and on the neighborhoods conveying the following information.

   a. Practicing hand hygiene prevents transmission of infections and minimizes environmental soiling.

   b. Hands may be cleaned by using alcohol based hand rub or washing with soap and water.

   c. Visitors shall be asked to practice hand hygiene upon entering and exiting a resident’s room, before and after eating, after using the restroom, and after any potential exposure to body fluids or contaminated surfaces.

3. Transmission-Based Precautions and Isolation
A resident placed on transmission-based precautions and isolation has a sign placed outside the room instructing the visitor to check with nursing staff before entering the resident’s room. Transmission-based precautions and isolation are implemented to protect visitors and staff from exposures to communicable illnesses, and to reduce the potential for transmission to others or the environment.

a. The nurse who is caring for the resident shall explain the transmission-based precautions and isolation requirements to the visitor before s/he enters the room for the first time and any time further clarification is needed.

b. Visitors shall be encouraged to follow the requirements for wearing gloves, masks, and gowns as indicated on the precautions signs outside of the resident's door.

c. Visitors shall be reminded to practice hand hygiene upon entering and exiting resident rooms.

4. Influenza (flu) Prevention

The CDC recommends a yearly flu vaccine for everyone 6 months and older to protect against the flu. Signage regarding the importance of the flu vaccine; respiratory and cough etiquette; and the mandatory masking period during the flu season shall be placed at the lobby entrance and on neighborhoods.

a. During this time, visitors who have not received the current year’s flu vaccine AND visitors vaccinated with the live attenuated influenza vaccine (LAIV) within 7 days shall be asked to wear a mask anytime s/he is within 6 feet of a resident. Masking by visitors is voluntary. (The CDC has determined that those who receive the LAIV or “nasal spray” should avoid contact with immunocompromised persons for 7 days after getting the nasal spray vaccine is not recommended for use due to ineffectiveness.)

b. Visitors shall be asked to cover coughs and sneezes with a tissue. If tissues are not available, cover coughs and sneezes with the sleeve. Clean hands by using alcohol-based hand rub or washing hands with soap and water, immediately after.

c. Respiratory stands that are stocked with masks and tissues will be made available during the flu season.

5. Outbreak/Epidemic

In the event of an outbreak/epidemic in the facility or community, notices shall be posted outside of specific neighborhoods and or at the facility entrances to provide information on restrictions and or guidelines for visitors.
ATTACHMENT:
Attachment A: Visitor Sign
Attachment B: Clean Hands Count – Hand Hygiene
Attachment C: Clean Hands Count for Everyone – Hand Hygiene
Attachment D: Clean Hands Count for Your Protection – Brochure
Attachment E: Cover Your Cough

REFERENCE:
CDC Live Attenuated Influenza Vaccine [LAIV] (The Nasal Spray Flu Vaccine),
https://www.cdc.gov/flu/about/qa/nasalspray.htm

Revised: 16/09/13, 19/03/12 (Year/Month/Day)
Original adoption: Est. 05/11/01
Attachment A: Visitor Sign

ATTENTION

Laguna Honda Visitors, Volunteers, Staff and Students:

If you have a **fever** and **respiratory** or **gastrointestinal symptoms** (cough, runny nose, congestion, sore throat, nausea, or diarrhea), please **refrain from visiting or coming to work**.

The Infection Control Department requests that you stay home until you are fever-free for 24 hours, without the use of medication.

---

**Influenza (Flu) Prevention**

The CDC recommends a yearly flu vaccine for everyone 6 months and older to protect against the flu.

**If you have NOT received the flu vaccine, we ask that you please wear a mask during the mandatory masking period, December 15, 2016 – March 31, 2017.**

*Thank you for your help with keeping Laguna Honda’s residents healthy and preventing health complications.*

Thank you.
Attachment B: Clean Hands Count – Hand Hygiene

HEALTHCARE PROVIDERS, RESIDENTS & VISITORS

CLEAN HANDS COUNT

Healthcare providers and visitors should protect themselves as well as residents from infection.

Be sure you clean your hands the right way at the right times.

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and 50.00.
Attachment C: Clean Hands Count for Everyone – Hand Hygiene

HEALTHCARE PROVIDERS, RESIDENTS & VISITORS

Clean your hands the right way at the right times

CLEAN HANDS COUNT FOR EVERYONE

Many potentially deadly germs are spread from person to person contact.
Consider whether your actions put you or others at risk of infection.

CLEAN YOUR HANDS TO PROTECT RESIDENTS & PROTECT YOURSELF

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and GOJO.
Attachment D: Clean Hands Count for Your Protection – Brochure

YOU HAVE A VOICE
PROTECT YOURSELF BY ASKING QUESTIONS

Clean your own hands and ask everyone to do the same.

It’s important to ask your healthcare providers questions about your healthcare, such as:

“Did you see you clean your hands when you came in, would you mind cleaning them again before you examine me?”

“I’m worried about germs spreading in the hospital. Will you please clean your hands once more before you start my treatment?”

Ask your visitors to clean their hands too.

“You cleaned your hands a while ago when you got here, but could you please clean them again? It would help put me at ease.”

Learn more at: www.cdc.gov/HandHygiene

Contact CDC:
www.cdc.gov/info
800-CDC-INFO
(800-232-4636)
TTY 888-232-6348

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and VCGO.
Attachment E: Cover Your Cough

Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.

If you don’t have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a face mask to protect others.

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.
PEDICULOSIS (LICE) MANAGEMENT

POLICY:
Residents/patients and personnel infected or exposed to lice are evaluated and managed to prevent transmission.

PURPOSE:
To provide information in the evaluation and management of lice/pediculosis infestation.

PROCEDURE:

1. Mode of Transmission

Body lice are spread directly through contact with a person who has body lice or indirectly through shared clothing, beds, bed linens, or towels.

Head lice are transmitted only by:

   a. Direct contact with an infested person.

   b. Objects used on the hair such as combs, brushes, uniforms, or hair ribbons.

   c. Clothing such as hats, scarves, or coats.

   d. Lying on a back, couch, pillow, carpet, or stuffed animal that has recently been in contact with an infected person.

   e. Pubic lice are spread through sexual contact and occasionally by contact with clothing, bed linens, or towels that have been used by an infested person.

2. Description of Lice Infestation

   a. The three types of lice are human parasites: body lice, head lice, and pubic or crab lice. There are three forms of lice:

      i. Nit or head lice eggs;

      ii. Nymph or body louse; and

      iii. Adult louse, about the size of a sesame seed, has six legs and is tan to grayish-white.
b. Body and head lice look similar and are approximately 2-4 mm in length. Only body lice are vectors for human pathogens (typhus, trench fever, relapsing fever), though these are rare.

   i. Body lice are parasite insects that live on the body and in the clothing, especially along the inner seams or bedding infested humans.

   ii. Head lice are parasitic insects found on the heads of people. Head lice are commonly found on the scalp behind the ears and near the neckline at the back of the neck and rarely found on the body, eyelashes or eyebrows.

   iii. Pubic lice, also called crabs are smaller than body lice, only 1-2 mm in length. Crab lice are found in the genital area of humans.

3. Signs and Symptoms

   a. Body lice:

      i. Itching and rash are common; both are your body’s allergic reaction to the lice bite. Long-term body lice infestations may lead to thickening and discoloration of the skin, particularly around the waist, groin, and upper thighs. Sores on the body may be caused by scratching. These sores can sometimes become infected with bacteria or fungi.

   b. Head lice:

      i. Tickling feeling of something moving in the hair.

      ii. Itching, caused by an allergic reaction to the bites.

      iii. Irritability.

      iv. Sores on the head caused by scratching. These sores can sometimes become infected.

   c. Pubic lice:

      ii. Itching in the genital area. Nits (lice eggs) or crawling lice may be seen.

4. Diagnosis and Treatment

   a. Upon admission, the skin and hair of all residents will be carefully inspected for possible infestation before the resident is placed in bed. If questionable symptoms (itching, small white substance (nits) on hair shafts or living lice) are present, the nurse manager/designee and infection control nurse/officer are to be notified immediately.
b. Residents with pediculosis are to have their baths scheduled last, after unaffected residents have received their tub baths.

c. If the licensed nurse strongly suspects pediculosis, the physician will be notified for treatment orders.

d. Disposable gloves and long sleeve gown are to be worn when delousing.

5. Equipment

a. Obtain from Pharmacy:
   i. Pediculicidal medication
   ii. Fine tooth comb
   iii. Small shampoo bottle without conditioner

b. Obtain from unit or Central Processing Department:
   Fine tooth comb

   i. Nail clipper
   ii. Disposable gloves
   iii. Disposable gowns
   iv. Disposable scissors

c. Obtain from Central Supply:
   Disposable gowns

6. Staff Precautions

a. Hand hygiene is the first line of defense.

b. Alert all personnel and resident visitors who may come in contact with the resident.

c. Staff are to self-monitor for signs and symptoms of pediculosis. LHH staff who have symptoms are to report to the nurse manager/designee to determine if further screening is necessary.

7. Procedure for individual residents with probable pediculosis
a. Care of Resident

i. Staff should wear disposable gowns and gloves.

ii. Keep resident’s fingernails short.

iii. Hair should be shampooed without conditioner, rinsed, and dried before medication is applied.

iv. If requested by resident, hair can be cut short by nursing staff using disposable scissors before applying medication.

v. Apply the prescribed medication onto the affected area according to label instructions or as directed by the physician.

vi. Rinse hair thoroughly with water.

vii. Bathe resident per routine bath procedure.

viii. Towel dry hair. Do not blow dry hair.

ix. Part the hair into 4 sections. Work on one section at a time. Longer hair may take more time (1-2 hours).

x. Start at the top of the head on the section you have picked. With one hand, lift a 1-2 inch wide strand of hair. Get the teeth of the comb as close to the scalp as possible and comb with a firm, even motion away from the scalp to the end of the hair. Comb the hair with a fine tooth comb to remove any remaining nits.

xi. Make sure the hair remains slightly damp while removing nits. If the hair dries during combing, dampen it slightly with water. Clean the comb completely as you go. Wipe the nits from the comb with a tissue and throw away the tissue in a sealed plastic bag to prevent the lice from coming back. After combing, recheck the entire head for nits and repeat combing if necessary.

xii. WARNING: Do not wash hair 1-2 days after treatment. If no dead lice are found 8-12 hours after treatment and lice seem as active as before, the treatment may not be working. Notify the physician and follow their treatment instructions. Continue to check all treated persons for 2-3 weeks after there are no signs or symptoms of infestation.

xiii. After treatment, check hair daily every 2-3 days and use a nit comb to remove any nits or lice you see.
The resident does not return to his room until it has been cleaned per procedure.

If live lice are seen 7 days or more after the first treatment, a second treatment should be given or per physician treatment instructions.

Retreat in 7-10 days.

Report any allergic reaction to the physician immediately.

8. Care of Property

If bath tub is used by the resident, nursing shall disinfect the tub with the approved hospital-wide disinfectant and let tub dry for 15 minutes before using again.

Strip linen from resident’s bed. Put all linen into double bags. Close the bags securely and place them in the linen chute.

Disinfect the wheelchair, commode, transport gurney (if used), bed, bedside table and furniture inside and outside the room with the approved hospital-wide disinfectant. Include bed attachments and call lights.

To kill lice and nits, machine wash all washable clothing that the infested person touched during the 2 days before treatment. Use the hot water cycle to wash clothes. Dry laundry using the high heat cycle for at least 20 minutes. Resident’s soiled clothing shall be washed separately from other resident’s. Items that cannot be laundered, shall be sealed in a plastic bag and stored for 2 weeks.

Usually, only a relatively small number of head or pubic lice will occur away from their normal host, the person. Away from their host, they usually die in 3 days or less; therefore, the resident’s personal belongings that cannot be washed or dry cleaned (such as shoes, books, clothing, toilet articles, etc.) should be sealed in a plastic bag for 14 days.

If the resident has a urinary drainage bag or colostomy bag, replace it. Double-bag and discard in a standard waste container.

Double-bag all disposable materials and personal items, including combs, brushes, the water pitchers, cups, toothbrushes, and used gloves. Discard in a standard waste container. Provide new personal itemsa new water pitcher, cup and toothbrush for the resident.
h. Soak personal items such as combs, brushes, hair bands, and barrettes in soapy hot water for one hour.

i. Notify Housekeeping to remove, double bag, and replace privacy curtains.

9. For in-house residents with signs of pediculosis

a. If there are several residents on a neighborhood with pediculosis, the entire neighborhood or household resident and/or staff population may require treatment.

10. Documentation

a. Medical Record: Record procedure, medications used, and description of resident’s skin and reaction of the resident. Record and describe any allergic symptoms.

b. “Unusual Occurrence Record”: Include description of skin observation and medication prescribed. If this is a newly admitted resident, include the name of facility and the unit the resident came from.

ATTACHMENT:
None.

REFERENCE:
CDC Resources for Health Professionals, 2015 @
http://www.cdc.gov/parasites/lice/head/health_professionals/index.html

72-01 E3 Barber and Beauticians
73-11 Medical Waste Management Program

Revised: 16/07/12, 19/03/12 (Year/Month/Day)
Original adoption: Est. 05/11/01
PNEUMOCOCCAL IMMUNIZATION

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) residents who meet the established Centers for Disease Control and Prevention (CDC) clinical criteria will be offered the pneumococcal polysaccharide vaccine (PPSV23) and/or pneumococcal conjugate vaccine (PCV13).

2. Before offering the pneumococcal vaccine, each resident or the resident's legal representative will receive education regarding the benefits and potential side effects of the immunization.

3. The resident or the resident's legal representative has the opportunity to refuse the immunization.

4. The resident’s medical record will include documentation indicating that education was provided and if the resident received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

PURPOSE:

To reduce morbidity and mortality from pneumococcal disease, LHH residents who meet the criteria established by the CDC Advisory Committee on Immunization Practices will be vaccinated with the appropriate pneumococcal vaccine.

PROCEDURE:

1. The physician assesses resident eligibility for vaccination. A reasonable attempt will be made to determine prior vaccination history. Resident with unknown or unsure vaccination status will be considered unimmunized. For those not vaccinated, the reason will be documented.

2. The physician screens patients for contraindications and precautions to PPV-the pneumococcal vaccine:

   a. Contraindication: a history of a serious reaction (e.g., anaphylaxis) after a previous dose of PPV-a pneumococcal vaccine or to any vaccine component.

   b. Precaution: moderate or severe acute illness with or without fever.

3. The licensed nurse shall provide each resident for whom there is no contraindication education using the most current federal Vaccine Information Statement (VIS). Document in the resident's medical record the publication date of the VIS and the date it was given to the resident. Provide non-English speaking residents with a copy of the VIS in their native language (available at www.immunize.org/vis ).
4. **For PPSV23,** the licensed nurse administers 0.5ml PPSV23 vaccine either intramuscularly (22-25g, 1-1½" needle) in the deltoid muscle or subcutaneously (23-25g, 5/8” needle) in the posterolateral fat of the upper arm.

4.5. **For PCV13,** the licensed nurse administers 0.5ml PCV13 vaccine intramuscularly (22-25g, 1-1½" needle) in the deltoid muscle.

5. The physician identifies residents in need of a second and final dose of PPV if five or more years have elapsed since the previous dose of PPV and the resident is:

   a. Age 65 years or older and received prior PPV vaccination before age 65 years.

   b. At highest risk for serious pneumococcal infection or likely to have a rapid decline in pneumococcal antibody levels, including:
      
      i. Functional or anatomic asplenia (e.g., sickle cell disease, splenectomy);
      
      ii. Immunocompromising condition (e.g., HIV infection or AIDS, leukemia, congenital immunodeficiency, Hodgkin's disease, lymphoma, multiple myeloma, generalized malignancy);
      
      iii. Immunosuppressive chemotherapy (e.g., alkylating agents, antimetabolites, long-term systemic corticosteroids);
      
      iv. Organ or bone marrow transplantation; and
      
      v. Chronic renal failure or nephrotic syndrome.

6. The licensed nurse documents each resident's vaccine administration information in the electronic medical record.

   a. Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, the name and title of the person administering the vaccine, and the date VIS was provided.

   b. If vaccine was not given, record the reason(s) for non-receipt of the vaccine.

7. **Staff (physician and/or licensed nurse) will document any unexpected or significant adverse events to the vaccine and report the occurrence to the Laguna Honda Infection Control Practitioner.**
ATTACHMENT:
None
Appendix A: CDPH Pneumococcal Vaccine Timing–For Adults
Appendix B: CDC Pneumococcal Vaccine Timing for Adults

REFERENCE:
CDC Pneumococcal ACIP Vaccine Recommendations. https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

Revised: 11/07/26, 17/09/12, 19/03/12 (Year/Month/Day)
Original adoption: Est. 05/11/01
# Appendix A: Pneumococcal Vaccine Timing—For Adults

DO NOT administer PCV13 and PPSV23 at the same visit.

## Age 65 Years or Older

- If PCV13 was given before age 65 years, no additional PCV13 is needed.

### No history of pneumococcal vaccine

- **PCV 13** Prevnar 13®
- **1 year** (8 weeks for groups B & C as defined below)
- **PPSV 23** Pneumovax 23

### Received PPSV23 before age 65

- **PCV 13**
- **1 year**
- **PPSV 23**

### Received PPSV23 at age 65 or older

- **PCV 13**
- **1 year**
- **PPSV 23**

## Age 19-64 Years With Underlying Condition(s)

- Prior doses count towards doses recommended below and do not need to be repeated.
- If PPSV23 given previously – wait one year before giving PCV13
  - for group B, wait at least five years before giving a second dose of PPSV23.
- No more than two doses of PPSV23 recommended before 65th birthday and one dose thereafter.

### A. Smoker, or Chronic conditions:

- heart disease (excluding hypertension)
- lung disease (including asthma)
- liver disease (including cirrhosis)
- diabetes
- alcoholism

### B. Immunocompromised (including HIV infection),

- Chronic renal failure,
- Nephrotic syndrome,
- Asplenia (including sickle cell)

- **PCV 13** Prevnar 13®
- **8 weeks**
- **PPSV 23**
- **5 years**
- **PPSV 23**

### C. CSF leaks or Cochlear implants

- **PCV 13** Prevnar 13®
- **8 weeks**
- **PPSV 23**

For further details, see: [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html)

California Department of Public Health, Immunization Branch [www.EZIZ.org](http://www.EZIZ.org)

This publication was supported by Grant Number H23/CCH922507 from the Centers for Disease Control and Prevention (CDC)
Appendix B: Pneumococcal Vaccine Timing for Adults

Make sure your patients are up to date with pneumococcal vaccination.

Two pneumococcal vaccines are recommended for adults:
- 13-valent pneumococcal conjugate vaccine (PCV13, Prevnar13®)
- 23-valent pneumococcal polysaccharide vaccine (PPSV23, Pneumovax®23)

PCV13 and PPSV23 should not be administered during the same office visit. When both are indicated, PCV13 should be given before PPSV23 whenever possible. If either vaccine is inadvertently given earlier than the recommended window, do not repeat the dose.

One dose of PCV13 is recommended for adults:
- 65 years or older who have not previously received PCV13.
- 19 years or older with certain medical conditions and who have not previously received PCV13. See Table 1 for specific guidance.

One dose of PPSV23 is recommended for adults:
- 65 years or older, regardless of previous history of vaccination with pneumococcal vaccines. Once a dose of PPSV23 is given at age 65 years or older, no additional doses of PPSV23 should be administered.
- 19 through 64 years with certain medical conditions. A second dose may be indicated depending on the medical condition. See Table 1 for specific guidance.

Pneumococcal vaccine timing for adults 65 years or older

For those who have not received any pneumococcal vaccines, or those with unknown vaccination history
- Administer 1 dose of PCV13.
- Administer 1 dose of PPSV23 at least 1 year later for most immunocompetent adults or at least 8 weeks later for adults with immunocompromising conditions, cerebrospinal fluid leaks, or cochlear implants. See Table 1 for specific guidance.

For those who have previously received 1 dose of PPSV23 at ≥ 65 years and no doses of PCV13
- Administer 1 dose of PCV13 at least 1 year after the dose of PPSV23 for all adults, regardless of medical conditions.
Pneumococcal vaccine timing for adults with certain medical conditions

**Indicated to receive 1 dose of PPSV23 at 19 through 64 years**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPSV23</td>
<td>19-64</td>
<td>1 year</td>
</tr>
<tr>
<td>PCV13</td>
<td>≥ 65</td>
<td>1 year</td>
</tr>
<tr>
<td>PPSV23</td>
<td>≥ 65</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**Includes adults with:**
- chronic heart or lung disease
- diabetes mellitus
- alcoholism
- chronic liver disease
- includes adults who smoke cigarettes

For those who have **not** received any pneumococcal vaccines, or those with unknown vaccination history:
- Administer 1 dose of PPSV23 at 19 through 64 years.
- Administer 1 dose of PCV13 at 65 years or older. This dose should be given **at least 1 year after** PPSV23.
- Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given **at least 1 year after** PCV13 and at least 5 years after the most recent dose of PPSV23.

**Indicated to receive 1 dose of PCV13 at ≥ 19 years and 1 or 2 doses of PPSV23 at 19 through 64 years**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
<th>Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCV13</td>
<td>19-64</td>
<td>8 weeks</td>
</tr>
<tr>
<td>PPSV23</td>
<td>19-64</td>
<td>5 years</td>
</tr>
<tr>
<td>PPSV23</td>
<td>≥ 65</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**Includes adults with:**
- cerebrospinal fluid (CSF) leaks*
- cochlear implants*
- sickle cell disease or other hemoglobinopathies
- congenital or acquired asplenia
- congenital or acquired immunodeficiencies
- HIV infection
- chronic renal failure
- nephrotic syndrome
- leukemia
- lymphoma
- Hodgkin disease
- generalized malignancy
- iatrogenic immunosuppression
- solid organ transplant
- multiple myeloma

For those who have **not** received any pneumococcal vaccines, or those with unknown vaccination history:
- Administer 1 dose of PCV13.
- Administer 1 dose of PPSV23 **at least 8 weeks** later.
- Administer a second dose of PPSV23 **at least 5 years** after the previous dose (*note: a second dose is not indicated for those with CSF leaks or cochlear implants*).
- Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given **at least 5 years** after the most recent dose of PPSV23.
Table 1. Medical conditions or other indications for administration of PCV13 and PPSV23 for adults

<table>
<thead>
<tr>
<th>Medical indication</th>
<th>Underlying medical condition</th>
<th>PCV13 for ≥ 19 years</th>
<th>PPSV23* for 19 through 64 years</th>
<th>PCV13 at ≥ 65 years</th>
<th>PPSV23 at ≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None of the below</td>
<td></td>
<td></td>
<td>Recommended</td>
<td>Recommended</td>
</tr>
<tr>
<td></td>
<td>Alcoholism</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic heart disease†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic liver disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic lung disease§</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cigarette smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes mellitus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cochlear implants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CSF leaks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunocompetent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons with</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>functional or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>anatomic asplenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imunocompromised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This PPSV23 column only refers to adults 19 through 64 years of age. All adults 65 years of age or older should receive one dose of PPSV23 5 or more years after any prior dose of PPSV23, regardless of previous history of vaccination with pneumococcal vaccine. No additional doses of PPSV23 should be administered following the dose administered at 65 years of age or older.

†Including congestive heart failure and cardiomyopathies

‡Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy

§Including chronic obstructive pulmonary disease, emphysema, and asthma

¶Includes B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease)
Additional scenarios: completing the pneumococcal vaccination series for adults

- Adults recommended to receive PCV13 at ≥ 19 years who already received 1 dose of PPSV23 at < 65 years:
  - PPSV23 (at < 65 years) → PCV13 (at < 65 years) → At least 8 weeks apart → PPSV23 (at < 65 years) → At least 5 years apart → PPSV23 (at ≥ 65 years)
  - At least 1 year apart

- Adults recommended to receive PCV13 at ≥ 19 years who already received 2 doses of PPSV23 at < 65 years and 1 dose of PPSV23 at ≥ 65 years:
  - PPSV23 (at < 65 years) → PPSV23 (at ≥ 65 years) → PCV13 (at ≥ 65 years) → At least 1 year apart → PPSV23 (at ≥ 65 years)

- Adults recommended to receive PCV13 at ≥ 19 years who already received 3 doses of PPSV23 at < 65 years and 1 dose of PCV13 at ≥ 65 years:
  - PPSV23 (at < 65 years) → PPSV23 (at < 65 years) → PCV13 (at ≥ 65 years) → At least 1 year apart → PPSV23 (at ≥ 65 years)

- Adults recommended to receive PCV13 at ≥ 19 years who already received 2 doses of PPSV23 at < 65 years and 1 dose of PPSV23 at ≥ 65 years:
  - PPSV23 (at < 65 years) → PPSV23 (at ≥ 65 years) → PCV13 (at ≥ 65 years) → At least 1 year apart → PPSV23 (at ≥ 65 years)

- For those who have already received 1 or more doses of PPSV23, or those with unclear documentation of the type of pneumococcal vaccine received:
  - Administer 1 dose of PCV13 at least 1 year after the most recent pneumococcal vaccine dose.
  - Administer a second dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the previous dose of PPSV23 (note: a second dose is not indicated for those with CSF leaks or cochlear implants).
  - Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given at least 5 years after the most recent dose of PPSV23.

- For those who have already received 1 dose of PCV13, do not administer an additional dose at 65 years or older.
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 who have not received their influenza vaccine may shall not eat in the cafeteria. An additional break room will be provided during the mandatory masking**
period for unvaccinated staff. 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 7:00 a.m. - 4:30 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, 19/03/12 (Year/Month/Day)
Original adoption: 09/12/15
APPENDIX A:

RESPIRATORY VIRAL ILLNESS (including Influenza) SCREENING FOR STAFF

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Stay At Home</th>
<th>Return to Work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEVER</strong></td>
<td>T &gt; 38C or 100.4F</td>
<td>• No fever for 24 hours¹</td>
</tr>
<tr>
<td>• Fever (T38C or 100.4F)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESPIRATORY SYMPTOMS WITHOUT FEVER</strong></td>
<td>Two or more symptoms ²</td>
<td>• 24 hours after onset of symptoms AND</td>
</tr>
<tr>
<td>• Cough</td>
<td></td>
<td>• No fever ¹ AND</td>
</tr>
<tr>
<td>• Sore throat</td>
<td></td>
<td>• Symptoms have significantly improved</td>
</tr>
<tr>
<td>• Nasal Congestion / Runny Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Myalgia (body aches)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza)</strong></td>
<td>T &gt; 38C or 100.4F and at least one symptom</td>
<td>• At least 5 days after onset of symptoms³ AND</td>
</tr>
<tr>
<td>• Fever (T38C or 100.4F)</td>
<td></td>
<td>• No fever for 24 hours¹</td>
</tr>
<tr>
<td>• Cough</td>
<td></td>
<td>• Symptoms have significantly improved</td>
</tr>
<tr>
<td>• Sore throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nasal Congestion / Runny Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Myalgia (body aches)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
CARBAPENEM RESISTANT ENTEROBACTERIACEAE (CRE) MANAGEMENT AND PREVENTION STRATEGIES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) will identify and manage CRE infection according to Centers for Disease Control (CDC), California Department of Public Health (CDPH) and SFDPH Communicable Disease Control and Prevention Unit (CDCU) recommendations.

2. Suspected or confirmed cases of CRE colonization or infection shall receive the same rigorous infection control interventions and shall be placed presumptively on contact precautions in a private room with a private bathroom or an isolation room.

3. Ongoing prevention of CRE shall be addressed through antimicrobial stewardship and specifically includes judicious use of antimicrobials and invasive devices along with a rigorous hand hygiene program.

PURPOSE:

To prevent, identify and manage CRE infection and prevent the spread of CRE infection to others.

DEFINITION:

1. CRE are Enterobacteriaceae that are:

   a. Resistant to any carbapenem antimicrobial

   or

   b. Documented to produce carbapenemase

2. In addition, for bacteria that have intrinsic imipenem nonsusceptibility (e.g., Morganella morganii, Proteus spp., Providencia spp.) resistance to carbapenems other than imipenem is required to qualify as a CRE.

3. Informational Note: Carbapenem resistance among Enterobacteriaceae in the U.S. represents a serious threat to public health and is associated with:

   a. The potential to spread widely.

   b. High mortality rates, particularly for carbapenemase producing CRE (CP-CRE vs non-CP-CRE).
PROCEDURE:

1. Clinicians shall collaborate with the Infection Control Nurse (ICN) for any suspected or confirmed cases of CRE.

   a. CRE is identified in cultures such as urine, wounds, or rectal swabs. The Zuckerberg San Francisco General (ZSFG) lab protocol is to notify the ICN by pager of positive CRE findings so that the resident’s physician can be promptly notified by the ICN.

   b. When CRE is identified by the ZSFG Microbiology lab a secondary modified carbapenem inactivation method (CIM) Hodge Test is automatically done to determine if the enzyme carbapenemase is being produced, as this is a more serious type of CRE infection that may be pan-resistant to antibiotics.

      i. Specimens may also be sent to the CDPH lab for testing via special arrangements as needed for outbreaks and other unusual circumstances.

   c. Admitting clinicians and patient flow coordinator shall anticipate the need for a private room/bathroom and contact precautions when CRE colonization or infection is known to be present prior to admission. Hospitals and SNFs are advised to consistently communicate this information, per the CDC 2015 CRE Toolkit.

2. Infection control shall review current CDC and CDPH recommendations for CRE management and inform clinicians of pertinent changes when a suspected or confirmed case of CRE is identified. CRE information continues to evolve.

   a. Consultation with SFDPH Communicable Disease Control Unit (CDCU at 415-554-2830) and CDPH is also available and commonly accessed by the ICN.

   b. CRE is reportable only if an outbreak is suspected or confirmed. (Two or more cases of epidemiologically linked cases or 3 non epi-linked cases.)

3. Routine screening for CRE by rectal swab shall be considered for residents admitted to the acute unit from a SNF unit if the resident has a chronic tracheostomy or chronically draining wound.

   a. Contact the microbiology lab at ZSFG prior to performing a rectal swab to make special arrangements and instructions for processing and/or contact LHH ICN to assist with the process.

4. Suspected or confirmed cases of CRE shall be placed presumptively on contact precautions in a private room with a private bathroom or isolation room pending laboratory confirmation. Cohorting may be acceptable only if both residents are infected or colonized with the same type of CRE (see definition above).
5. Refer to the following table for details for CRE contact precautions.

<table>
<thead>
<tr>
<th>Core Measure</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meticulous hand hygiene</strong> for any persons entering the room and for the resident.</td>
<td><strong>Instruct / assist resident</strong> to wash hands after using the bathroom, before meals, before and after handling their own invasive devices and before leaving the room or participating in group activities once this is allowed.</td>
</tr>
</tbody>
</table>
| **Personal Protective Equipment (PPE)** including gown and gloves at minimum for all staff and visitors entering the room and additional PPE for care or procedures that may necessitate a mask or face shield. | i. Hand hygiene is done before entering the room and before putting on PPE. Put on PPE in this order: Gown, followed by gloves.  
ii. Remove PPE in this order: Gloves, followed by gown. Perform hand hygiene before leaving the room. |
| **Dedicated equipment** such as BP cuff, thermometer, pulse oximeter, stethoscope, and lift. | Provide dedicated equipment with disposables as much as possible. If equipment must be removed from room, e.g. w/c or lift for repair, clean with facility approved disinfectant. |
| **Incidental non-dedicated equipment** (such as crash cart). | Wipe down with environmental wipes (green top or bleach wipes) before removing from room then usual cleaning, such as return to CSR for usual cleaning with facility approved disinfectant. |
| **Chlorhexidine baths** with 2% solution or 2% chlorhexidine wipes indefinitely. | Bathe / shower with 2% chlorhexidine according to the resident's usual frequency of bathing or more often but at least weekly. Avoid open wounds and face. |
| **Avoid group activities.** | Resident must stay in the room and should not participate in group activities / dining **while acutely ill** and thereafter until restrictions are modified on a case by case basis. Continue to provide in-room activities and support including but not limited to activity therapy and social services. |
| **Precautions for necessary appointments**, such as dialysis, clinic visits or transfer to other units or facilities. | Includes notifying the receiving staff, dressing the resident in clean/ freshly laundered clothing, and containing bodily fluids (through adequate dressings / adult briefs, etc). |
Clean w/c assistive devices before removing from room per usual nursing disinfection process.

Receiving clinic staff don gown and gloves prior to resident contact. Use face shield for procedures with potential for splashes. Usual exam table and room disinfection is adequate.

Document CRE infection or colonization in inter-facility transfer forms under “special considerations” and on the electronic health record.

h. Environmental Cleaning.

Provide usual EVS cleaning using gown and gloves; clean room with dedicated mop head, preferable to clean room last. Usual terminal disinfection prior to a new resident occupying the room.

Provide usual nursing environmental cleaning with the addition of green top or bleach wipes for at least daily cleaning of frequently touched (“high touch”) surfaces, such as call light, bed rails, door knobs/handles.

MODIFICATION OF PRECAUTIONS

i. Contact precautions are continued for confirmed cases while acutely ill and may be appropriate indefinitely.

Modification of precautions is determined in consultation with the Infection Control Nurse (ICN) based on case by case assessment of risk for transmitting CRE. (ICN considerations follow this table.)

j. Standard Precautions And Transmission Based Precautions are used when modification of precautions is determined to be appropriate.

Modified precautions are generally only appropriate for continent residents with no invasive devices and no draining wounds who are able to perform / be assisted with hand hygiene reliably and must include:

i. Document the rationale for modifying precautions in the medical record.

ii. Instruct/assist the resident on hand hygiene after toileting, before leaving the bedroom, before and after meals and before group activities.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>iii.</td>
<td>Assist the resident to dress in clean, freshly laundered clothes when leaving the room.</td>
</tr>
<tr>
<td>iv.</td>
<td>Disinfect the wheelchair/ assistive device at least daily prior to the resident leaving the room.</td>
</tr>
<tr>
<td>v.</td>
<td>Continue the use of dedicated equipment and disinfect equipment before it leaves the room and before it is used with others.</td>
</tr>
</tbody>
</table>

6. Infection Control risk assessment considerations include the following:

   a. Persons with CRE infection or colonization are presumed to be indefinitely colonized, therefore the decision to modify precautions is not based solely upon culture results.

   b. A private room with a private bathroom is strongly preferred for the length of stay. When this is not feasible the resident may be cohorted with resident(s) colonized with the same type of CRE.

   c. Risk factors for transmitting CRE shall be assessed before modifying precautions and generally include how easily body fluids can be contained and how reliable the resident will be with hand hygiene and general hygiene.

      i. Residents with Carbapenemase producing CRE are at higher risk and modification of precautions is unlikely to be appropriate.

      ii. Residents are at higher risk for transmission to others when they are incontinent of bowel or bladder, have open draining wounds or touch multiple surfaces without cleaning their hands (or allowing others to clean their hands).

7. **Communication** shall occur between Nurse Managers/ Charge Nurses and will include Patient Flow Coordinator and ICN to assure that placement in a private room with a private bathroom or cohorting with residents infected or colonized with like CRE organisms is maintained.

   a. Need for contact precautions shall be communicated between units upon transfer between SNF units or between SNF and acute unit and for clinic visits.

      i. Receiving staff, including clinic staff, don gown and gloves for resident contact. Use face shield for procedures with potential for splashes. Usual cleaning of exam table / room in clinic is adequate.
b. Contact precautions for CRE will be documented-communicated to the receiving facility/neighborhood on the nursing Interfacility Transfer form under “Special Considerations” for transfers out.

8. Contact investigation and screening is organized through the ICN according to CDC, CDPH, and SFDPH CDCU recommendations and includes, at minimum, rectal swab screening for roommate(s) and household occupants who have shared the same healthcare providers on a case by case basis, particularly when Carbapenemase-producing CRE have been identified.

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-07 Antimicrobial Stewardship Program
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHH Nursing PP D97.0 Wheelchair and Geriatric Chair Cleaning
CDPH HAIProgram@cdph.ca.gov

Revised: 18/11/13, 19/03/12 (Year/Month/Day)
Original adoption: 16/03/08
EVALUATION OF COMMUNICABLE ILLNESS IN HEALTH CARE WORKERS

POLICY:

Health Care Workers (HCWs) with communicable or potentially communicable disease shall be evaluated for work fitness to prevent the transmission of disease to residents and other health care workers.

DEFINITION:

The term HCWs are defined as persons, paid or unpaid, working in health care settings who have direct contact with residents or who work in resident care areas.

PURPOSE:

To minimize the risk for disease transmission.

PROCEDURE:

1. Staff shall not come to work with potentially contagious illness symptoms of a communicable disease, including influenza or any illness with a fever (until afebrile for 24 hours without the use of medication), uncontrolled diarrhea, vomiting, persistent cough or sputum production consistent with tuberculosis, contagious or suspicious rash, skin lesions or weeping dermatitis that is not easily kept covered with secretions contained, untreated conjunctivitis, or symptoms of hepatitis such as jaundice.

2. HCWs who believe they have been exposed to a communicable disease at work Any illness that may be job-related shall be reported to their supervisor for reporting to SFDPH Occupational Safety and Health at 101 Grove, in accordance with the LHH Injury and Illness Prevention Program (LHHPP 73-01) and be evaluated at ZSFG Occupational Health Services.

3. HCWs who experience symptoms of a communicable disease that is not related to a workplace exposure shall be evaluated by their primary care physician.

4. HCWs shall report any communicable disease diagnoses to their supervisor and the Infection Control Nurse (ICN).
3.5. A health care worker (HCW) with a communicable or potentially communicable disease must avoid resident contact and report illness to infection control and SFDPH Occupational Health Services at ZSFG.

b.a. Refer to Attachments A and B for disease-specific guidance including transmission risk, immunization requirements, definitions for infection and exposure, work restrictions, and reportable illnesses. SFDPH Occupational Health Services has the authority to evaluate health care workers who have been exposed to or have symptoms of a communicable disease.

4. , and implement appropriate work restrictions, exclusions, and referral to TB clinic.

5. SFDPH Occupational Health Services is required to report all exposures and suspected/confirmed cases of communicable disease in personnel to Infection Prevention and Control Officer (IPCOICN) or designee.

6. The ICC Chair, Laguna Honda IPCOICN, or designee is responsible for initiating a Contact Investigations as described in section A9 of the Infection Control Manual.

ATTACHMENT:
Attachment A: Table of Illnesses/Infections and Related Work Restrictions
Attachment B: Sub-table of Diarrheal, Vomiting, and Acute GI Illness with known Enteric Organisms

REFERENCE:
CDC Guideline for Infection Control in Health Care Personnel.
LHHPP 70-01 C6 Pandemic Influenza Plan
LHHPP 72-01 A9 Contact/Exposure Investigation
LHHPP 72-015 C24 Employee Influenza Vaccination(s) Policy and Use of Surgical Masks When Vaccination(s) is Declined
LHHPP 73-01 Injury and Illness Prevention Program (IIPP)
ZSFG (2015) Occupational Health Table of Illnesses/Infections and Related Work Restrictions and Sub-table of Diarrheal, Vomiting, and Acute GI Illness with known Enteric Organisms

Revised: 16/01/12, 19/03/12 (Year/Month/Day)
Original adoption: Est. 05/11/01
**Attachment A: Table of Illnesses/Infections and Related Work Restrictions**

*(Adapted from ZSFG Infection Control / Occupational Health)*

*if highly suspicious or confirmed in accordance with SFDPH criteria;*

Yes (1): Reportable within 1 day  
Yes (7): Reportable within 7 days  
PEP – Post Exposure Prophylaxis  
Contact the Infection Prevention and Control Officer/Control Nurse for information if links fail.

<table>
<thead>
<tr>
<th>Illness/Infection</th>
<th>Transmission</th>
<th>Incubation; Communicability</th>
<th>Reportable*</th>
<th>PEP</th>
<th>HCW Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute febrile illness</td>
<td>Varied; depending on the causative agent</td>
<td>N/A</td>
<td>No</td>
<td>No</td>
<td>May not work until fever resolved without the use of fever-reducing medications. If fever has persisted for 5 days or more, a physician evaluation should be obtained and clearance submitted to Occupational Health Services prior to returning to work.</td>
</tr>
</tbody>
</table>

**Respiratory Illnesses**

<table>
<thead>
<tr>
<th>Illness/Infection</th>
<th>Transmission</th>
<th>Incubation; Communicability</th>
<th>Reportable*</th>
<th>PEP</th>
<th>HCW Restrictions</th>
</tr>
</thead>
</table>
| Cold/Cough | Direct Contact or Inhalation of Respiratory Droplets; Indirect hand contact | Varied | No | No | Exposure: None  
Active Disease: Personnel with cold symptoms may work but are instructed to comply with certain measures to prevent transmission (cover mouth and nose with tissue; wash hands immediately after use of tissue; frequently clean surfaces that may have been contaminated with respiratory secretions); wear a mask and change mask after cough or sneeze. |
| Upper Respiratory Infection (unspecified) | Direct Contact or Inhalation of Respiratory Droplets; Indirect hand contact | Varied | No | No | Exposure: None  
Active Disease: Personnel with Upper Respiratory Infections may work but are instructed to comply with certain measures to prevent transmission (cover mouth and nose with tissue; wash hands immediately... |
### D4: Evaluation of Communicable Illness in Health Care Workers

<table>
<thead>
<tr>
<th>Illness/Infection</th>
<th>Transmission</th>
<th>Incubation; Communicability</th>
<th>Reportable*</th>
<th>PEP</th>
<th>HCW Restrictions</th>
</tr>
</thead>
</table>
| Influenza (link to Influenza policy/ATD) [link to Influenza policy/ATD](http://insfghweb01/lhh/policies/072/72-05.pdf) [link to Influenza policy/ATD](http://insfghweb01/lhh/policies/073/73-07.pdf) | Droplet | 1 to 4 days; 1-2 days before onset to 4-5 days after onset | No. (Unless outbreak) | Possible. (Consult with Employee Health) | Exposure: Varied  
Disease: RTW 24 hours after resolution of fever and respiratory symptoms or 7 days after onset |
| Pertussis [link to Pertussis policy/ATD](http://insfghweb01/lhh/policies/073/73-07.pdf) | Droplet | 4-21 days; ~21 days during the catarrhal period (runny nose, sneezing, low-grade fever, symptoms of the common cold) and 1st 2 weeks after cough onset | Yes (1) | Yes | Exposed personnel should contact OHS and monitor themselves for symptoms. If cough develops, personnel may not return to work until completion of 5 days of appropriate antibiotic therapy. |
| Measles (Rubeola) | Airborne | 10-12 days; 5 days prior to 7 days after onset of rash | Yes (1) | Yes | Exposed: Any unprotected HCW shall be removed from work on day 5 thru day 21 after exposure.  
Active Disease: Any HCW diagnosed with measles shall be relieved from work immediately and for a period of 7 days following the appearance of the rash or for |
<table>
<thead>
<tr>
<th>Illness/Infection</th>
<th>Transmission</th>
<th>Incubation; Communicability</th>
<th>Reportable*</th>
<th>PEP</th>
<th>HCW Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mumps</td>
<td>Droplet or direct contact with saliva</td>
<td>14-18 days (range 14-25 days)  2 days before to 9 days after onset of parotid swelling</td>
<td>Yes (7)</td>
<td>No</td>
<td><strong>Exposure:</strong> If susceptible, personnel may not work from 12 days (after the first exposure date) to 26 days (after the last exposure date).  <strong>Disease:</strong> Personnel diagnosed with mumps are removed from work until 9 days after onset of parotitis.</td>
</tr>
<tr>
<td><strong>Definition of Exposure:</strong> To be considered exposed to mumps, a person must be susceptible to mumps (nonimmune or immunocompromised) and have prolonged (&gt;1 hour) of close contact (w/in) 3 feet with a probable case.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella (German measles)</td>
<td>Droplet</td>
<td>12 to 23 days; 7 days before to 5-7 days after onset of rash</td>
<td>Yes (7)</td>
<td>No</td>
<td><strong>Exposure:</strong> Any person considered exposed will be excluded from work from 7 days after first exposure through 21 days after last exposure.  <strong>Disease:</strong> Personnel who meet the clinical criteria for rubella should be excluded until 7 days after appearance of rash.</td>
</tr>
<tr>
<td><strong>Definition of Exposure:</strong> To be considered exposed to rubella, a person must be susceptible to rubella, and have maintained close contact (w/in 3 feet) with a probable case for 5 minutes or more OR have had any direct contact with an infant diagnosed with congenital rubella syndrome.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSV</td>
<td>Droplet &amp; Contact with respiratory secretions</td>
<td>2-8 days; 3-8 days (infants upto 4 weeks)</td>
<td>No</td>
<td>No</td>
<td>Personnel may work but should comply with certain measures to prevent transmission (cover mouth and nose with tissue; wash hands immediately after use of tissue; frequently clean surfaces that</td>
</tr>
</tbody>
</table>
### Group A Streptococcus
- **Contact with infected secretions or body fluids; Droplet**
- **Incubation:** 1-5 days;
- **Communicability:** No
- **Reportable:** No
- **PEP:** Personnel with GAS infection may return to work 24 hours after treatment with appropriate antimicrobial therapy started and symptom improvement.

### Tuberculosis
- **Transmission:** Airborne
- **Incubation:** 2 to 12 weeks;
- **Communicability:** Yes (1)
- **Reportable:** No
- **PEP:** Exposed: Any personnel exposed may work without restriction, but need to follow-up with OHS.
  
  **Active Disease:** Any employee with signs of active pulmonary TB should immediately refer to OHS. May not return to work until cleared by OHS in consult with TB control.

### Varicella
- **Transmission:** Airborne (primary varicella & disseminated shingles)
- **Incubation:** Direct contact with infected lesions 10-21 days (varicella); 1-2 days before onset of rash until all lesions are crusted over
- **Communicability:** No
- **Reportable:** Yes. (High risk individuals after consultation with their PCP or in absence of PCP, ID/IC medical director)
- **PEP:** Primary varicella/Disseminated zoster: May not work until all lesions are dry and crusted over
  
  **Zoster/shingles:**
  1) face/forearms- may not work until lesions are dry and crusted
  2) chest, back, abdomen, or legs- may works if lesions are covered

  **Exposed HCW:** May not work from days 10 to 21 post exposure

**Definition of exposure:** To be considered exposed to varicella, HCW must be susceptible (non-immune) to varicella, share airspace within the same room for >1 hour with a probable case of chicken pox or disseminated shingles, OR have face-to-face contact for ≥ 5 minutes with a probable case of chicken pox or disseminated shingles, OR have any direct skin-to-skin contact with a probable case of chicken pox or shingle, either form.
<table>
<thead>
<tr>
<th>Illness/Infection</th>
<th>Transmission</th>
<th>Incubation; Communicability</th>
<th>Reportable</th>
<th>PEP</th>
<th>HCW Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningococcal Disease</td>
<td>Droplet</td>
<td>3 to 4 days (Range 2 to 10 days);</td>
<td>Yes (1)</td>
<td></td>
<td>Exposed: None.</td>
</tr>
<tr>
<td><a href="http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po21.pdf?12/4/20158:31:43">http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po21.pdf?12/4/20158:31:43</a> AM</td>
<td></td>
<td></td>
<td>Possible.</td>
<td></td>
<td>Active Disease: Personnel with meningococcal disease will be excluded from work for at least 24 hours after start of effective therapy and until they feel well enough to return to work.</td>
</tr>
<tr>
<td>Definition of exposure: Direct contact with an infectious person's secretions without wearing personal protective equipment. Examples of direct contact include: face-to-face exposure during a coughing attack; physical exam of nose/throat; oral care; suctioning the patient; intubation; bronchoscopy; performing CPR w/o use of protective barriers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjugunctivitis</td>
<td>Contact (Direct or Indirect)</td>
</tr>
<tr>
<td>Enterovirus (Coxsackie virus/ hand, foot and mouth disease)</td>
<td>Direct or Indirect contact with infected respiratory secretions and infected stool; Droplet</td>
</tr>
<tr>
<td>Herpes Simplex</td>
<td>Contact between exposed/broken skin and lesions or virus-containing secretions</td>
</tr>
<tr>
<td>Draining wounds &amp; skin lesions</td>
<td>Possible contact between</td>
</tr>
<tr>
<td>Illness/Infection</td>
<td>Transmission</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Lice (Pediculosis)</td>
<td>Contact with infected person or object used on the hair/clothing</td>
</tr>
<tr>
<td>Scabies</td>
<td>Skin to skin contact (crusted scabies requires shorter contact time)</td>
</tr>
<tr>
<td>Rabies</td>
<td>Bite from infected animal; Contact w/ infected tissue, excretions, secretions</td>
</tr>
</tbody>
</table>

**Definition of exposure:** Personnel have been bitten by a patient or animal with rabies, or if provided care to a person with rabies and have scratches, abrasions, open wounds or mucous membrane splashed with saliva or other body fluid.
### Appendix B: Diarrhea, Vomiting, Acute GI Illnesses

*(Adapted with permission from SFGH Infection Control / Occupational Health)*

<table>
<thead>
<tr>
<th>Illness/Infection</th>
<th>Transmission</th>
<th>Incubation; Communicability</th>
<th>Reportable *</th>
<th>PEP</th>
<th>HCW Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea, Vomiting, or Acute GI Illness (General)</td>
<td>Contact Fecal-oral</td>
<td>Varied</td>
<td>No</td>
<td>No</td>
<td>Personnel may not work if they have acute diarrhea or acute GI illness. RTW when symptoms resolve. If diarrhea lasts 3 or more days, contact OHS for evaluation prior to returning to work. If stool specimen positive for enteric organism (source organism known), click here. [<a href="http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po11.pdf?12/4/20158:31:43">http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po11.pdf?12/4/20158:31:43</a> AM](<a href="http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po11.pdf?12/4/20158:31:43">http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/online/ICManual/Sec5/Sec5Po11.pdf?12/4/20158:31:43</a> AM)</td>
</tr>
<tr>
<td>Hepatitis A (5.16)</td>
<td>Contact Fecal-oral</td>
<td>15-50 Days 2 weeks before to 1 week after symptom onset.</td>
<td>Yes (1)</td>
<td>Yes</td>
<td>Restricted from patient care areas and food handling until 7 days after the onset of jaundice Exposure Definition: Considered exposed if contact with excrements of patient diagnosed with Hepatitis A or if close contact or food preparer diagnosed with Hepatitis A</td>
</tr>
<tr>
<td>Bloodborne pathogens (Link to Bloodborne Pathogen policy: <a href="http://in-sfghweb01/lhh/policies/073/06-01132015.pdf">http://in-sfghweb01/lhh/policies/073/06-01132015.pdf</a>)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Bloodborne</td>
<td>6 weeks to 6 months; 1-2 months before and after onset of symptoms; chronic carriers</td>
<td>Yes (7)</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Bloodborne</td>
<td>2 weeks to 6 months;</td>
<td>Yes (7)</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>HIV</td>
<td>Bloodborne</td>
<td>N/A</td>
<td>Yes (7)</td>
<td>Yes</td>
<td>None</td>
</tr>
</tbody>
</table>
WORKPLACE VIOLENCE PREVENTION PROGRAM

POLICY:

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

3. 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. 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 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 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 worksite, 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.

4. Psychological First Aid: A supportive response to a fellow human being who is suffering and who may need support, including attending to employee needs for information, comfort, and time to process.

PROCEDURE

1. Workplace Violence Prevention Program 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 maintain a log of workplace violence incidents and report incidents involving physical force to the California Department of Industrial Relations Division of Occupational Safety and Health according to CCR Title 8 Section 3342 Violence Prevention in Healthcare 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 LHH residents and for reviewing and for revising plans in response to aggressive behavior. Care plans shall include medically and cognitively appropriate behavioral interventions disciplinary procedures for residents who repeatedly commit acts of workplace violence. 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 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):

   i. 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.

   ii. 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.

   iii. 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 LHHPP 75-01 Security Management Plan.

f. Department Managers and Supervisors:

   As per the 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.

g. All LHH Employees, DPH Employees on Campus, and Tenants:

   All 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 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 LHH staff.

2. Prevention of Violent Incidents

   a. Laguna HondaLHH admissions criteria in LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units preclude the admission of patients with a significant likelihood of unmanageable behavior.

   b. Access to Laguna HondaLHH by visitors and the public is controlled by SFSD according to LHHPP 75-11 Public Access and Defined Restricted Areas and LHHPP 75-02 Public Access and Night Security in order to prevent entrance of persons with no legitimate business at Laguna HondaLHH.

   c. LHHPP 75-03 Disorderly or Disruptive Visitors specifies procedures for the removal of disorderly or disruptive visitors and the Department of Security Services has developed a threat management plan that is incorporated into LHHPP 75-10 Security Services Standard Operating Procedures in order to manage potential threats from anyone entering the facility.

   d. History of aggressive behavior and any incidents of aggressive behavior shall be documented by the RCT and the care plan shall include measures to be taken for prevention and management of these behaviors.

   e. Objects that could be used as a weapon shall be removed from rooms of potentially aggressive residents.

   f. Buddies and/or coaches shall be utilized in the care of residents for whom this is deemed appropriate and effective in preventing aggressive behavior.

   g. Incidents of aggressive behavior by residents shall be communicated to care providers at change of shift.

3. Incident 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 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 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 given immediate feedback including appropriate consequences (as spelled out in the policy), review of expectations and rules, and review of potential consequences of future recurrence of aggressive behavior. Behavioral interventions developed disciplined immediately according to protocols developed by the RCT shall be implemented immediately.

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. Provide Psychological First Aid as appropriate for affected individuals including victim, aggressor, and bystanders.

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

iii. Immediately complete and submit an incident report to DPH OSH according to injury reporting procedures in the LHH IIPP 73-01 Injury and Illness Prevention Program. A copy of the report shall also be scanned to the WSEM Director by the end of the shift for logging and reporting to Cal OSHA as appropriate.

iv. Consult with appropriate resources via HRS, EAP, WSEM, SFSD, and/or LHH Administrator on Duty (AOD).

v. 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:
1. Notification, if necessary, of the Director of Human Resources if the incident involves Type 3 violence.

2. Notification of LHH, SFSD, or Psychiatry Department Consultant for evaluation, treatment, and follow up recommendations and/or counseling of involved resident(s), as indicated.

3. Notification of the SIRT SFSD leader for further follow up as appropriate if there is imminent danger or a possible crime has been committed.

4. Notification of DPH Security Services if an incident involves an aggressor for whom a threat assessment is appropriate.

5. The SIRT Leader will:
   a. If appropriate, deploy the SIRT, which will provide LHH employees involved in the incident with initial incident defusing.

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

   e. 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 shall be notified and a threat assessment will be completed according to the Threat Management Plan and the Security Services Standard Operating Procedures (LHHPP 75-10 Security Services Standard Operating Procedures). 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 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 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. LHH 73-01 Injury and Illness Prevention Program (IIPP)

   ii. The details of this Workplace Violence Prevention Program

   iii. 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 LHH

c. All other employees also receive annual training on workplace violence appropriate to their responsibilities.

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.

e. The Managers and Supervisors shall be provided with training in Psychological First Aid by Employee Assistance Program staff annually at Leadership Forum.
(800) 759-2351 is also available to provide educational sessions to LHH departments/services regarding recognition and prevention of violence in the workplace.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units
LHHPP 22-08 Threat of violence to residents by an external party
LHHPP 22-10 Management of Resident Aggression
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 Calls for SFSD Assistance
LHHPP 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. Violence Prevention in Healthcare

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, 19/03/12 (Year/Month/Day)
Original adoption: 05/12/20
ILLICIT OR PROHIBITED DRUGS AND PARAPHERNALIA
POSSESSION/USE BY RESIDENTS OR VISITORS

POLICY:

1. As in the greater community, the use, possession, solicitation and/or distribution of
   illicit or prohibited drugs or paraphernalia at LHH Laguna Honda Hospital and
   Rehabilitation Center (LHH) or on Hospital or campus grounds is prohibited.

2. Staff shall take steps to prevent illicit or prohibited drugs or paraphernalia use or
   access, and shall promote and support resident efforts to minimize the health
   consequences of illicit or prohibited drug or paraphernalia use.

PURPOSE:

1. To ensure the Hospital’s capability to deliver effective health care to its
   residents by:
   a. Minimizing the presence and use of illicit or prohibited drugs at LHH;
   b. Eliminating the presence of illicit or prohibited drug paraphernalia;
   c. Minimizing disease progression related to illicit or prohibited drug use;
   d. Maximizing therapeutic impact and safety of prescribed medication;
   e. Maximizing the safety of the resident and other residents, staff, volunteers, and
      visitors; and
   f. Complying with community State and City laws and City regulations.

DEFINITIONS:

1. Illicit or illegal drug: A drug or substance that cannot be obtained legally or by
   prescription, or any substance prohibited by code or statute.

2. Prohibited drug: A medication that has not been currently prescribed or authorized for
   the possessor.

3. Paraphernalia: Medical apparatus or over-the-counter items that are commonly used
   in illicit drug activity such as syringes, needles, drug pipes, hemostats, and so forth.

4. STARS: LHH Substance Treatment and Recovery Services

PROCEDURE:
1. Illicit or Prohibited Drug Possession/Use by Residents

a. On admission to LHH, the Admissions and Eligibility Department representative shall inform the resident of the Illicit or Prohibited Drug or Paraphernalia Possession/Use policy and shall request that the resident acknowledge notification. The resident, or the resident’s legal representative, affirms by his/her signature on the House Rules and Responsibilities that s/he understands and agrees to abide by the policy and procedure.

b. If the resident has a substance use disorder or a history of substance use, the admitting or attending physician shall recommend to the resident that s/he receives an assessment by a STARS clinician in addition to medical management. The referral for STARS can be made through LHH Psychiatry e-referral. STARS providers shall offer specialized services including group therapy, individual counseling, and recommendations about Medication Assisted Treatment (MAT) for substance use. For details on STARS service, see MSPP D08-07 (LHH Substance Treatment and Recovery Services).

c. The Resident Care Team (RCT) shall identify the team member who shall address safety issues around substance use, once identified, with the resident whose behaviors related to substance use are negatively impacting their own care and/or affecting others. This is to ensure safety for all. Intervention options shall be reflected in the resident’s care plan, which may include (but are not limited to) Medication Assisted Treatment (MAT), participation in STARS treatment, peer counseling, 12 Step groups, other psychosocial treatment and interventions, and San Francisco Sheriff’s Department (SFSD) assistance in case of safety crisis.

i. The attending physician shall offer MAT, as indicated.

ii. STARS and/or other LHH Psychiatry providers shall offer behavioral intervention recommendations. For details on LHH Psychiatry service on behavioral management, see MSPP D08-10 (Behavioral Management Services by LHH Psychiatry).

iii. RCT team members shall orient the resident to LHH safety rules, and address issues related to substance use through the care planning process. Clinical interventions may include limiting access to illicit or prohibited drugs (passes, access, visitors, etc.).

iv. When any hospital LHH staff member has reasonable grounds to conclude a resident is using illicit or prohibited drugs in violation of hospital LHH policy, he/she/they shall inform the resident’s attending physician or assigned physician coverage and the RCT.
• If the physician determines reasonable grounds exist, urine or blood toxicology screens shall be obtained, consistent with the signed Conditions of Admission.

• If the resident refuses testing and is competent to refuse, (a) the refusal shall be considered the same as a positive result, and (b) further hospitalization may be conditional upon the resident’s desire to comply with hospital-LHH policy.

• If the RCT determines reasonable grounds exist, a designated team member may conduct a clinical safety check of the resident’s person, room, bed and belongings for the safety of the resident, other residents and staff as outlined in LHHPP 22-12 Clinical Search Protocol (see Appendix A: Contraband Clinical Search Protocol). All contraband found during a clinical safety check shall be turned over to the SFSD for appropriate legal disposition. If the resident becomes aggressive or poses a safety risk, unit staff shall request the SFSD to standby during the clinical safety check.

• The employee who discovers or suspects the illegal use, possession, solicitation and/or distribution shall complete an Unusual Occurrence report.

v. Hospital-LHH staff may request the SFSD to consider a legal search.

• If warranted, the SFSD shall evaluate the circumstance and shall determine if legal “probable cause” exists to permit a deputy to conduct a legal search.

• If probable cause exists, hospital-LHH staff shall inform the resident of the need for the SFSD to search in order to protect the resident, as well as others from the health/safety implications of substance use in the hospital-LHH.

• The SFSD shall conduct the legal search.

• The SFSD shall seize all contraband found during a legal search and shall proceed with appropriate and legal disposition.

• Any resident or visitor in possession of illegal substances is subject to detention and possible citation or physical arrest by the SFSD.

vi. Substance use (lab documented and/or reasonable grounds), possession, solicitation and/or distribution shall result in progressive interventions for the resident.
• A determination shall be made of the resident’s decision-making capacity to enter into a treatment plan.

• If resident has no decision-making capacity regarding substance treatment:

  • The RCT, in conjunction with the surrogate decision maker (if any), shall initiate or increase behavioral interventions intended to limit resident access to illicit or prohibited drugs; and

  • Staff shall document reason(s) for treatment decision(s).

• If resident has decision-making capacity regarding substance treatment:

  • Further treatment at LHH shall require that the resident adhere to a substance use related behavior plan developed by the RCT.

    • The behavioral plan may include (but not be limited to) interventions such as: random laboratory (preferably urine) toxicology testing, attendance at substance use treatment groups, restricted community or hospital-LHH access, room observation and visitor check-in.

    • Refusal to enter into a treatment contract or violation of the predetermined terms of the behavior plan shall be considered a decision by the resident to end the treatment and may result in discharge.

    • In the event of discharge, the resident shall be offered a referral to community outpatient services.

    • In the event that discharge from hospital-LHH would constitute a medical emergency (risk to life, limb or function within 48 hours), the RCT shall initiate or increase behavioral interventions intended to limit resident access to illicit or prohibited drugs and may implement other behavior plan conditions.

vii. Upon presentation to LHH of a resident previously discharged for violation of policies or contract(s), a readmission to LHH shall require the resident to re-engage in a substance use treatment plan. If two LHH admissions have resulted in substance use-related discharges, the resident shall be considered to have refused LHH services and, in conjunction with LHH Screening Committee, the resident shall not be readmitted without review and demonstration of change from the resident (for example, successful completion of community residential substance treatment program).

2. Paraphernalia Possession/Use by Residents
a. When any LHH staff member has reasonable grounds to conclude a resident may have possession and/or use of drug paraphernalia, the RCT shall be informed.

i. Assigned nursing staff and other available members of the RCT may initiate a clinical safety check of the resident’s person, room, bed and belongings for the safety of the resident, other residents, and staff as outlined in LHHPP 22-12 Clinical Search Protocol. (see Appendix A: Contraband Clinical Search Protocol). If the resident becomes aggressive or poses a safety risk, unit staff shall request the SFSD to standby during the clinical safety check.

ii. The RCT may request the SFSD to consider a legal search, and to proceed, if warranted, as outlined in paragraph 1.C.IV.

b. If staff find illicit or prohibited drug paraphernalia in a resident's possession and/or use:

i. Staff shall confiscate the illegal or prohibited drug paraphernalia and turn it over to the SFSD. Syringes not placed into evidence by the SFSD shall be disposed of in accordance with appropriate disposal procedures.

ii. The staff person who directly observed the drug paraphernalia shall report the incident to the SFSD.

iii. The clinical staff person who directly observed the drug paraphernalia, or her/his immediate supervisor, shall document the incident in the resident’s medical record and complete an Unusual Occurrence report.

iv. If the staff member who directly observed the drug paraphernalia is not a clinician, he/she/they/he should report to an RCT member and also complete an Unusual Occurrence report.

v. Depending on the type of intervention (legal search or clinical safety check), the SFSD or assigned nursing staff with other available members of the RCT, may perform further checks of the resident’s person, room, bed, and belongings.

vi. If the resident remains at the Hospital and the physician determines reasonable grounds exist, the physician may order urine or blood toxicology screens which shall be obtained from the patient, consistent with the signed Conditions of Admission.

vii. Residents who are found with illegal or prohibited drug paraphernalia, including unauthorized syringes, are subject to detention and/or citation or physical arrest by the SFSD.
viii. Unauthorized syringes found on or near a person may be seized by the SFSD and may result in criminal charges.

ix. Found illicit or prohibited drug paraphernalia, including unauthorized syringes, are grounds for discharge.

x. If the RCT determines that the resident is unable to be immediately discharged because such discharge might constitute a medical emergency (i.e., risk to life, limb or function within 48 hours), the resident shall not be discharged. In lieu of discharge, hospital LHH staff shall take appropriate steps to limit resident access to drug paraphernalia by creating a behavior plan that may include:

- Restriction to room and/or neighborhood.
- Restriction of visitors.
- Transfer of room assignment for increased safety.
- Removal of other personal containers where syringes could be stored (e.g., toothbrush holder).
- Search and removal of contraband as outlined in LHHPP 22-12 Clinical Search Protocol, (see Appendix A: Contraband Clinical Search Protocol).
- Close observation by staff (refer to LHHPP 24-10 Close Observation).
- Limitations of pass privileges.
- Toxicology screens and resident clinical safety checks shall be performed upon return to care unit from pass, as indicated.

c. A resident who was previously discharged for drug paraphernalia possession who then requests readmission to the Hospital LHH and agrees to abide by hospital rules LHH policies:

i. Shall be screened and may be considered for readmission based on his/her current condition.

ii. May be asked to sign a behavioral plan as a condition of admission.

3. Illicit or Prohibited Drug or Paraphernalia Possession/Use by Visitors

a. If a visitor is observed, or reasonably suspected, to be in possession and/or use of illegal or prohibited drugs or paraphernalia, the staff who directly observed the
event shall immediately report the incident to the SFSD for immediate response and investigation.

b. A visitor found to be in possession and/or use of illicit or prohibited drugs or paraphernalia may be referred by the RCT or hospital LHH staff to Administration for administrative review, which may include restriction or removal of visitation privileges at LHH.

c. A visitor found to be in possession and/or use of illegal or prohibited drugs or paraphernalia is subject to detention, removal from hospital LHH grounds and/or possible citation or physical arrest by the SFSD.

ATTACHMENT:

None Appendix A: Contraband Clinical Search Protocol.

REFERENCE:

LHHPP 20-01 Admission to LHH and Relocation Between LHH SNF Units
LHHPP 20-10 Management of Resident AggressionTransfer and Discharge Notification
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident’s Property and Prevention of Theft and Loss
LHHPP 22-12 Clinical Search Protocol
LHHPP 24-10 Close Observation
LHHPP 20-14-24-25 Harm Reduction
LHHPP 60-04 Unusual Occurrences
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHMSPP D08-07 LHH Substance Treatment and Recovery Services
LHHMSPP D08-10 Behavioral Management Services by LHH Psychiatry

Revised: 98/04/01; 00/05/25, 12/09/25, 14/05/27, 17/06/01, 17/09/12, 19/03/12
(Year/Month/Day)
Original adoption: 96/07/15 (drugs only)
APPENDIX A: CONTRABAND CLINICAL SEARCH PROTOCOL

PURPOSE:

To outline the process of contraband search at Laguna Honda Hospital and Rehabilitation Center (LHH).

OVERVIEW:

LHH acts to ensure the safety of residents and staff and provide necessary care so that each resident can attain or maintain their highest practicable physical, mental, and psychosocial well-being. Active substance use, drug dealing, unsafe smoking and use of dangerous items objects endangers the safety of residents and staff, and does not promote a resident's well-being. To further safety of residents and staff and resident well-being, dangerous objects, illegal drugs, non-prescribed medications, cigarettes, alcohol and/or drug paraphernalia are prohibited at LHH. When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors as described below.

DEFINITION:

- **Contraband**: Illegal or prohibited items, such as dangerous objects, prohibited drugs and drug paraphernalia, alcohol, and smoking or tobacco products/materials/paraphernalia.

- **Dangerous objects**: Items which can be used to inflict harm to self or others (sharps, knives, firearms, lighters, matches etc.).

- **Prohibited drug**: A medication/alcohol or substance that is illegal or is not prescribed or otherwise authorized for the resident by a LHH provider.

- **Drug paraphernalia**: Medical apparatus or over-the-counter items that are commonly used in illicit drug activity such as syringes, needles, drug pipes, hemostats etc.

- **Smoking or tobacco paraphernalia**: lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame, etc.

PROCEDURE:

Indications for Searches
a. Property of all newly admitted residents shall be inventoried when the resident arrives to the unit.

b. Packages brought into the unit that clinical staff reasonably suspects contain contraband shall be searched in the presence of the resident before giving the package to the resident.

c. A Staff may search a resident, and their property, and their resident's room and property may be searched when clinical staff believes there is a potential risk and/or reasonably suspects suspicion that the resident is in possession of contraband.

d. Staff may search a resident, their property, and their room when upon reasonable belief by clinical staff that the resident is assessed as being suicidal, or homicidal, or necessary to prevent serious harm to themselves or to others, searches of their person, property and room may be conducted, as indicated.

e. Residents who return from pass privileges may be asked to empty their pockets and their packages may be searched if contraband is reasonably suspected.

f. Staff may search a resident's property and their room when staff reasonably suspects that a resident has taken another person's property, searches of the resident's person, property, and room may be conducted and if the property is found, the property may be returned to the owner.

g. Staff may conduct unit-wide searches when there is a potential risk and/or reasonable suspicion exists that drug using/dealing may be occurring on a unit or multiple units, unit-wide searches may be conducted.

h. Staff may search a resident, their property, and their room when a resident exhibits a change in mental status or behavior and substance use is suspected, searches of their person, property and room may be conducted. Staff may search a resident, their property, and their room while on, or near an delivery device

Search Procedures

Neighborhood staff may initiate searches to ensure the health and safety of residents and staff. shall

Searches are to be conducted in a reasonable manner that respects the individual's dignity and privacy. A search should be conducted only to the extent required to assure contraband is not present. The method and purpose of the search shall be explained to the resident.
To the extent possible, residents shall be present while their property (including intended packages) and rooms are being searched.

The permission of the resident should be secured requested prior to any search (except in cases of danger to self or others). If the resident refuses to be present for the search or is unable to be present, staff shall contact the Sheriff (X 42319) to witness the clinical search of the resident’s belongings. It is recommended that a Sheriff’s deputy be present for searches that involve a resident who may display behavioral escalation during the search.

Repeated searches of resident’s rooms and property are permitted when there is a potential risk and/or reasonable suspicion that they are in possession of contraband. Examples include but are not limited to:

i. Resident appearing to be under the influence of drugs or alcohol;

ii. Reasonable suspicion that contraband is in a resident’s possession; (Risk factors may include the Resident’s having history of bringing and/or selling alcohol, street drugs or other contraband in the facility.)

iii. Resident having current suicidal or homicidal ideation or expressed feelings of inflicting serious harm to themselves or others;

iv. Reasonable suspicion of theft. (Risk factors may include resident history of theft while on the unit, credible witness report, etc.) or near an oxygen delivery device

Staff shall take Universal Precautions such as wearing gloves when handling resident belongings or suspected contraband. Staff shall avoid reaching into any pockets. Staff should pour out the content of bags, boxes, packages, or other personal belongings, asking the resident to empty the pockets, or gentle patting is recommended instead.

A minimum of two staff shall be present during a search.

Whenever a search is conducted the following information shall be documented in the resident’s medical record:

i. The facts constituting a reasonable suspicion to conduct the search

ii. The scope of the search:
   - Who conducted the search;
   - Manner in which it was conducted; and
• Who was present during the search.

iii. The results of the search:

• Items found and seized; and

• Disposition of items found and seized.

iv. Resident’s response and any pertinent clinical information.

v. If a resident is not present during the search, staff’s action to advise the resident on regarding the basis for the search and the outcome of the search process.

New Admissions:

i. All newly admitted residents shall be informed that admission procedures require a routine inventory of his/her property by LHH Hospital staff.

• The resident shall be asked to empty his/her pockets, purse, suitcase and other belongings.

• Any contraband shall be removed from the resident’s possession.

• Any weapons or dangerous items objects shall be given turned over to the Sheriff’s deputy.

• Illicit drugs shall be given turned over to the Sheriff’s deputy.

• A notation shall be made in the progress note (see II.8 above) and the resident shall be given a property receipt for items that are being held by staff.

When a resident is assessed as suicidal or homicidal, or has a history of drug use or violent behavior or is suspected of having contraband, a search may be initiated. Staff shall notify the Sheriff’s Office of search and request stand-by for support, if needed. Types of searches which may be conducted by staff include:

i. Pocket Searches—resident shall be asked to empty his/her pockets and contents shall be inspected by staff for contraband.

ii. Pat Down or Frisk Searches shall be conducted by treatment clinical staff who are of the same sex as the individual being searched in the presence of a witness. If in the course of a pat-down search a suspicious object is
discovered which reasonably could be, for example, a weapon, pills or other contraband—staff may remove the object for closer inspection.

iii. Clothing Searches – the resident shall be escorted to a private area accompanied by two staff members, at least one staff member of the same sex whenever possible and requested to change into a hospital gown. The clothing shall be checked for contraband. Once contraband objects are removed, the clothing can be returned to the resident.

iv. Room Searches – The resident’s room and furniture/belongings in the room shall be inspected by staff.

Unit Searches of the Resident Rooms and Common Areas

Preparation

i. Neighborhood

ii. Staff shall notify Sheriff’s Office of the search and request stand-by for support.

iii. Staff review basic safety search procedures before proceeding, including SMART principles as needed.

iv. Search teams should be identified (2 staff per household).

v. One staff should be assigned to monitor the unit entrance/exit.

vi. A LHH Sheriff’s deputy shall be stationed outside the entrance/exit for support as needed.

vii. Staff may request canine search assistance as needed from the Sheriff’s Office ahead of time (see Section 4 below).

viii. A mandatory community meeting should be called to announce the safety search and instruct the residents to wait in the Great Room until called to their bedside for the search.

During the Search

i. Two staff are to provide support for each neighborhood being searched. The duties include escorting residents from the Great Room to the residents’ rooms, working with agitated residents, collecting confiscated substances and paraphernalia, communicating with staff at entrance/exit, etc.
ii. At least one staff is to observe the residents in the Great Room. If available, AT may run an activity group during the wait.

iii. Residents who have been searched may leave the unit however they shall not be able to return until the search is concluded, or be asked to wait in a separate dining room.

iv. All confiscated substances and paraphernalia shall be bagged, labeled and secured in med-room until search is completed.

v. Staff shall help with de-escalation and provide support as needed.

vi. LHH Sheriff’s deputy may provide support as needed.

After the Search

i. All confiscated substances shall be cataloged then turned over into SFSD for disposal with the exception of cannabis from a resident with a valid cannabis card, alcohol and cigarettes:

   • Confiscated cannabis from a resident with a valid cannabis card shall be disposed of by 2 staff members (including one supervising nurse) using the smart sink in the supplemental drug room.

   • Confiscated alcohol shall be poured down the sink while witnessed by another staff, and the container shall be discarded in the recycle bin.

   • Confiscated cigarettes shall be held or disposed of based upon the resident’s care plan for smoking.

   • Confiscated e-cigarettes, lighters, matches, and other devices that ignite, light, or fuel a flame shall be bagged, labeled and secured by nursing staff.

   All other confiscated substances shall be cataloged then turned in over to SFSD for disposal.

ii. Confiscated sharps shall be disposed in the sharps container while being witnessed by another staff. Other paraphernalia or dangerous items shall be cataloged then turned in over to SFSD for disposal.

iii. Disposal of all confiscated substances and items shall be documented in the resident’s medical record.

iv. UO’s and Focused Progress Notes are to shall be completed by the unit staff.
The RCT shall be informed when searches were conducted. The RCT shall review the incident and assess for the need to modify the resident's care plan. The resident's care plan shall be modified.

Canine Searches

LHH has access to canine assistance for drug searches when needed.

- A request by LHH administrative staff can be made to the Sheriff's Office SFSD for random unit-wide or hospital-wide searches.
- The search dog shall be handled by a professional handler only.
- Staff shall be sensitive to those residents who may have negative reactions when they are around dogs.

Staff and residents shall be instructed about proper ways to interact with the dog, such as no petting or feeding.

Visitors

All visitors shall be informed that LHH strives to be a safe, drug-free healing environment, that all contraband and illegal activities are prohibited. If a visitor is suspected of bringing in contraband, LHH staff may implement interventions, including but not limited to: inspection of packages the visitor brings to the unit, restricting visits, and/or calling SFSD for support.

CROSS REFERENCE:

LHHPP 22-03 Residents’ Rights and Responsibilities
LHHPP 22-05 Handling Resident’s Property and Prevention of Theft and Loss
SMOKE and TOBACCO FREE ENVIRONMENT

POLICY:

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

2. Smoking and tobacco products are prohibited on the LHH campus, with the exception of smoking in the designated smoking area as described below.

3. Lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame are not permitted and shall be collected from residents by staff for safeguarding.

2.4. This policy applies to smokable and any tobacco product, any product that emits smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the users, including nicotine and non-nicotine e-cigarettes, nicotine, non-nicotine cigarettes, cigars, pipes, pipe tobacco, or and chewing tobaccos.

3.5. Buying and selling of smokable and tobacco products, any products that emit smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user between residents any individual is prohibited.

4.6. The prohibition of smoking on the LHH campus applies to staff, vendors, volunteers, and visitors.

7. Residents may only smoke in the designated smoking area when on the LHH campus, in accordance with their individual care plan. Smoking or ingesting cannabis is not permitted in the designated smoking area.

8. Residents with an oxygen tank or concentrator are prohibited from smoking or being within 6 feet of the designated smoking area.

5.9. 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 LHH campus refers to means the areas that include the buildings, grounds, parking spaces owned, operated,
maintained, or leased by the City, bordered by Laguna Honda Boulevard, Woodside, Idora and Clarendon and includes all buildings, grounds, parking spaces, and all vehicles owned or operated by the Hospital, LHH or the City-operated vehicles.

Smoking means inhaling, exhaling, burning, or carrying any lighted, heated, or ignited cigar, cigarette, cigarillo, pipe, hookah, electronic device, or any other device that delivers nicotine or other substances to a person.

Tobacco Product means (1) any product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, snuff; or

(2) any electronic device that delivers nicotine or other substances to the person inhaling from the device, including, but not limited to, an electronic cigarette, electronic cigar, electronic pipe, or electronic hookah.

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 LHH is a smoke and tobacco free facility-campuss shall be posted at the hospital’s public entrances.

   a.b. Signs that advise that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are prohibited shall be posted at the hospital’s entrances.

   b.c. 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 LHH is a smoke and tobacco free facility campus with a designated smoking area for LHH residents.

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 House Rules and Responsibilities 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 Resident Care Team (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 are placed on oxygen. This shall include a search of the resident’s room and/or belongings to collect lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame for safeguarding.

vii-viii. Clinical care plan interventions shall be developed for those residents who have violated the smoking-smoke and tobacco free environment policy, and may include,

- Search of a resident’s belongings and resident room for, and confiscation safeguarding of, smoking or tobacco product materials.
- Meeting with RCT members to discuss the violation with resident and outline care plan to prevent further smoking or tobacco product violations, which may include repeat searches, engagement in smoking cessation activities referral to SATS and/or MD.

viii-ix. 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 LHH is a smoke and tobacco free facilitycampus.

ii. Employees, volunteers, including trainees and students, shall be notified during orientation that smoking is not permitted on the hospital-LHH campus. Staff, vendors, volunteers 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.

iii.iv. Volunteers shall be notified that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are not permitted at each visit when asked to sign-in with the volunteer kiosk.

c. Visitor Notification

i. Visitors, including contractors, vendors and outpatients, shall be informed that LHH is a smoke and tobacco free facility campus, and that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are not permitted through signage at entrances, applicable agreements, and hospital brochures and by staff. The designated smoking area is only for resident use.

3. Compliance & Safety

a. Employee Obligations

i. The entire LHH community is responsible for complying with the Smoke and Tobacco Free Environment policy, which may include respectfully informing the smoker that LHH is a smoke and tobacco free facility campus with a designated smoking area for resident use only.

ii. The Smoke and Tobacco Free Environment policy is part of the new employee orientation and annual in-service.

iii. An employee who observes a smoking-violation of this policy by a resident is to report the incident to the respective neighborhood nurse manager/charge nurse.

iv. An employee who observes a smoking-violation of this policy by a staff member is encouraged to report the incident to the responsible manager for corrective action.

v. An employee who violates this policy may be subject to disciplinary action.
vi. 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 individual for violation of municipal or state codes.

b. Safety Obligations

i. The RCT shall complete and/or review smoking assessments on admission, re-admission, quarterly, annually, when there is a significant change in condition, when a resident is placed on oxygen, and/or when a resident who did not smoke at admission begins to smoke.

ii. The RCT shall ensure that residents whose assessments or care plans indicate a need for assisted or supervised smoking have a written plan that assists, supervises, and monitors their smoking. The RCT shall also ensure that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are collected from such residents.

iii. The Resident Care Team (RCT) 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.

iv. The smoke patrol shall report smoking violations to the Nursing Office.

v. RCT will address resident’s non-compliance by assessing and implementing appropriate interventions.

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

d. 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.

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

f. RCT will address resident’s non-compliance by assessing and implementing appropriate interventions.

ATTACHMENT:

Reference:

LHHPP 22-12 Clinical Search Protocol
LHHPP 35-01 Guidelines for Sales, Distribution of Free Items, and Solicitation on the Campus
LHHPP 75-05 Illicit or Prohibited Drugs and Paraphernalia Possession/Use By Residents or Visitors
CDPH Program Flexibility, Requested 01/13/2014
Laguna Honda House Rules and Responsibilities
Smoking Cessation Assessment (MR 161T)
California Labor Code Sec. 6404.5
California Health and Safety Code Sec. 11362.3
San Francisco Health Code Art. 19F

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, 19/031/1208 (Year/Month/Day)
Original adoption: 92/10/30
CAMPUS USE FOR NON-LAGUNA HONDA GROUPS

POLICY:

1. The Laguna Honda Hospital and Rehabilitation Center (LHH) campus may be used as a resource for educational, cultural, civic, recreational and other non-political activities.

2. Persons or organizations applying for use of meeting or event space at Laguna HondaLHH shall (a) comply with policies and activities compatible with the mission and policies of the Department of Public Health (DPH) and Laguna HospitalLHH, and City, State, and Federal laws; and (b) not use public resources for campaign activity, personal purposes, or other purposes not authorized by law.

3. Any Laguna–HondaLHH staff may be a sponsor of a non-Laguna–HondaLHH group/event.

PURPOSE:

To provide a systematic process for application and use of the Laguna–HondaLHH campus for meetings and events.

PROCEDURE:

1. Application

An application to be reviewed by designated members of the Executive Committee or designee must–shall be submitted at least four weeks prior to the event. All applications submitted less than four weeks prior to the event will–shall only be considered at the discretion of the Executive Administrator or designee. Reservations are not considered confirmed until the application has been signed by all approvers listed on the application and a copy is received by the applicant.

Requests for campus use on a recurring schedule will–shall be considered individually and is dependent on availability of rooms. All requested campus use dates shall not exceed more than 90 days from date of application. After 90 days, a new campus use request application will–shall need to be completed.

2. Employee Sponsor

Applicants requesting use of the campus must–shall work with a Laguna–HondaLHH employee sponsor who will manage the application process and coordinate event needs. The sponsoring staff member, or a designee, is required to be present during the event. If there is no employee sponsor, the applicant will work with a Laguna–HondaLHH administrative assistant.
3. Approval

a. The Hospital Executive Committee (HEC) shall have the final determination if event requests are consistent with the mission of the organization and the well-being of residents.

b. In the event of conflicting requests, priority of use will be given as follows:
   i. First priority will be given to hospital-sponsored activities and meetings.
   ii. Second priority will be given to other branches of the Department of Public Health (DPH) and other city agencies.
   iii. Third priority will be given to non-profit, community-based, or private sector organizations.

4. Termination

a. Laguna Honda (LHH) shall have the option, in its sole discretion, to terminate an event at any time for convenience and without cause.

b. Notification of termination shall be made orally or in writing by the Executive Administrator or his/her designee.

c. In the event of termination, the City and County of San Francisco shall not be responsible for costs incurred by applicant as a result of the termination.

5. Use of Laguna Honda (LHH)

a. An on-site orientation by Facilities, Environmental Services, Administration Services staff, and/or event sponsor about building use, security and maintenance is required for the contact person from groups using the campus for the first time at least two weeks prior to the event.

b. The event contact person from the campus use application must be present throughout the event.

c. All rooms come as described in Attachment C. Additional fixtures and equipment, if requested and available, may be supplied in rooms at the request of the contact person during the application process. Any additional requested fixtures and equipment shall need to be set up by the event contact person, unless determined otherwise by Laguna Honda.

d. Fixtures and equipment cannot be altered without the express approval from the Executive Administrator or the Chief Operating Officer. Any destruction or
alteration of the premise, equipment, furniture or other LHH property will result in charge(s) in any and all remedial actions taken for correction(s).

6. Costs

a. Individuals and organizations shall pay a daily $100.00 for a standard facility usage. Meetings and/or events that require a commitment of LHH resources greater than $100.00 may be subject to additional fees.

b. Any and all payment(s) to LHH shall be made no less than 10 business days in advance of the event.

c. The Chief Executive Officer, Chief Financial Officer, or Chief Operating Officer may waive or reduce cost(s) may be waived or reduced for government agencies, non-profit organizations, and entities providing resident services.

   i. The CEO or designee shall indicate the total amount waived on the Campus Use Application.

c-d. The filming fees charge will be no less than those recommended by the San Francisco Film Commission.

d. Meetings and events that require a commitment of Laguna Honda resources greater than $100.00 may be subject to higher fees.

e. A W-9 form, Request for Taxpayer Identification Number and Certification, may be required by LHHLaguna-Honda resources for events and/or meetings that consist of more than 25 persons.

f. Businesses wishing to sell goods or services at LHHLaguna Honda shall provide a copy of the Seller's Permit to do business in San Francisco. The permit is due at the same time as the Application for Use of Laguna Honda Campus is completed.

g. Organizations may supply third-party housekeeping and security personnel to assist Laguna HondaLHH with coordination and security of the event. LHHLaguna Honda and the San Francisco Sheriff's Department shall have final authority in decision making with all third-party housekeeping and security personnel.

h. Fees shall be deposited into LHH's operating budget.

   i. Any and all payment to Laguna Honda must be made in advance of the event no less than 10 business days.

ATTACHMENT:
Attachment A: Part A: Application for Use of Laguna Honda Campus
Attachment B: Part B: Invoice for Use of Laguna Honda Campus
Attachment C: Meeting Rooms Information and Pictures
Attachment D: Campus Use Process Map

REFERENCE:
Laguna Honda Special Events, Filming and Photography Use Agreement (Rider to Film Commission Use Agreement)
LHHPP 01-07 Posting Notices, Hanging Artwork, and Caring for the Buildings
LHHPP 35-01 Sales, Distribution of Free Items, and Solicitation on the Campus

Revised: 11/09/27, 15/05/12, 16/03/08, 19/03/12 (Year/Month/Day)
Original adoption: 02/05/20
1. Receive Room Request (Phone, Email, Etc.)

2. LHH Staff Screens Request Using Standard Screening Questions.

   Is This Request Campus Use?

   Yes → 3. LHH Staff Will Email Screening Info to EVS Clerk and Back-up

   NO → 2a. LHH Staff Will Book Room (Criteria: within DPH, only need room, no set-up or additional tech.)

3. LHH Staff Will Follow-up With Requestor Within Two (2) Business Days

4. EVS Clerk Will Follow-up With Requestor Within Two (2) Business Days

5. EVS Clerk Sends Campus Use Application to Requestor Via DocuSign

6. EVS Clerk Reviews Application Upon Receipt

   6a. EVS Clerk Creates EVS and/or Facilities Work Orders as Needed

7. EVS Clerk Confirms Completed Application and signs in DocuSign

8. Application Is forwarded Via DocuSign to Admin Clerk for Equipment and Parking Approvals

   8a. Admin Clerk Adds Approved Equipment Requests to LHH Admin Calendar and Approves Parking as Needed

9. Application forwarded to Sponsor Via DocuSign For Sign-off

10. Application Forwarded Via DocuSign to Facilities Director for Sign-off

11. Application Forwarded Via DocuSign to Sheriff for Sign-off

12. Application Forwarded Via DocuSign to CFO for Sign-off

13. Application Forwarded Via DocuSign to COO for Sign-off

14. Application Forwarded Via DocuSign to CEO for Sign-off

15. Application Is Routed Back to EVS Clerk Via DocuSign for Finalization

16. EVS Clerk adds reminders and invites self to event in LHH Events Calendar

17. Requestor and Signatories Receive completed Application Via DocuSign

18. EVS Clerk Sends Reminder Form to Requestor

19. Sponsor Is On Site to Trouble Shoot

20. Support Person (Admin or EVS) Available to Assist with Set-up

Five Business Days Prior to Event

Day Of Event
Revised Activity Therapy
Policies and Procedures
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: 42CFR 483.00, Department of Health and Human Services Centers for Medicare & Medicaid Services F248 and F680, and California Code of Regulations, Title 22.

PURPOSE:

Provide information regarding residents that relate to their leisure interests and lifestyle and improve continuity of care.

Comply with State and Federal Regulations.

PROCEDURE:

1. The assigned RAI Coordinator creates and distributes a schedule which includes due dates for the 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 electronic healthcare record (EHR).
      ii. Minimum Data Set 3.0 (MDS) is electronically completed and signed, within 7 days of ARD.
      iii. Minimum Activities Care Plan Template MR353i which corresponds with the assessment shall be saved in the L drive and printed for the care plan book.

3. Annual assessments, care plans and MDS are repeated each year (annual), on readmission and in the case of significant change, and are to be complete within 7 days of the ARD. The ARD is determined by the MDS coordinator.

4. Progress Notes are written in the EHR, 3 times per year. At the same time, the care plan is reviewed and modified if necessary.

5. In the event staff is unable to complete the Wellness & Activity Therapy Assessment (602) within 48 hours of admission, a note shall be written to justify the cause for delay.
6.8 In the event of EHR 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 rack 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: 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
             8/29/2014, 8/10/2014
**Adopted:**  6/1/1999
QUARTERLY PROGRESS NOTE FORMAT

POLICY:

Every three months, a quarterly progress note is required for each resident, in accordance to 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.

PURPOSE:

The note demonstrates a plan has created and monitoring is occurring.

PROCEDURE:

1. **Resident quarterly Progress Notes** written in the Integrated SF-GetCare Progress Notes section of their electronic medical record.

2. The progress notes are written on or 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. **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 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. Activity Therapy staff write progress notes more frequently to document something of significance related to the resident’s plan of care.

6. The note may document something positive such as an accomplishment.

7. The note may document an issue or situation that is impacting or may have impact on the residents overall plan of care.

8. 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. 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 F68079, and California Code of Regulations, Title 22.
<table>
<thead>
<tr>
<th>ATTACHMENT:</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent review</td>
<td>7/2/2015</td>
</tr>
<tr>
<td>Revised:</td>
<td>11/15/2018, 12/12/2012, 8/29/2013, 8/29/2014</td>
</tr>
<tr>
<td>Adopted:</td>
<td>September, 2013</td>
</tr>
</tbody>
</table>
Revised Medical Staff Policies and Procedures
PRIMARY CARE PHYSICIAN SERVICES

Policy: Physicians will comply with the following procedures, protocols and common practices.

Purpose: To assure consistency in procedures and provide continuity of medical care that meets or exceeds community standards.

APPENDIX A – General Information

Hours

Working hours are 8:00 a.m. to 5:00 p.m. or as assigned by the Chief Medical Officer. If delayed or ill, please contact the Medical Services Office at 415-759-2388.

Physician assignments

- In general, each full time primary care physician will be assigned to a neighborhood of 60 residents. Part time physicians may share one or more neighborhoods.
- Specialty units such as Positive Care, Acute Medicine and Rehab may require a higher physician to resident ratio.
- Physician assignments are made at the discretion of the Chief Medical Officer and Chief of Medicine. To the extent possible, consistency will be maintained in physician assignments, and assignments will be made with consideration for physician interest and area of expertise; however physician assignments are made at the discretion of the Chief Medical Officer and Chief of Medicine.
- In addition to regular neighborhood assignments, each physician will be assigned daytime pager coverage as needed to provide coverage for other physicians who are absent. For scheduled absences, physicians may be assigned short term coverage of additional neighborhoods.
- When covering a neighborhood, the physician will check in with the charge nurse upon arriving in the morning to be apprised of any problems or issues that may require attention, and to notify the nursing staff of the physician coverage for the day.
- The primary care physician is a member of the Resident Care Team on each neighborhood, and as such contributes to developing a holistic plan of care for each resident including rehabilitation potential and discharge planning.
Daytime pager

All physicians will be assigned to the SNF pager (415-327831-4912) on a rotating basis to provide coverage for sick call and/or to cover when the primary physician is not available.

- The pager coverage is divided into 3 time slots: 8 a.m. - 11 a.m., 11 a.m. – 2 p.m., and 2 p.m. – 5 p.m.
- The physician assigned to the am SNF pager shall be in the Medical Staff Lounge by 8:00 a.m. for sign out and pager hand off.
- When assigned to 11:00 a.m. – 2:00 p.m. SNF pager coverage, contact the physician you are relieving by 11:00 a.m. to arrange transfer of the pager.
- When assigned to 2:00 p.m. to 5:00 p.m. pager coverage, contact the physician you are relieving by 2:00 p.m. to arrange transfer of the pager, and come to the Medical Staff Lounge by 5:00 p.m. for sign out. All issues requiring night/weekend follow up should be entered in the physician sign out log.
- The physician assigned to PM Acute pager (415-327831-4914) shall come to the Medical Staff Lounge for sign out and pager transfer at 8:00 a.m. and 5:00 p.m.

Vacation/Leave Requests

Requests for vacation or changes in scheduling must be submitted to the Medical Services office by the first day of the month preceding the month of which the request is made. For example, an August vacation request must be submitted by July 1.

Medical Staff Lounge

The Medical Staff Lounge is located on Pavilion 2, at the north end. Physician sign out occurs daily at 8 a.m. and 5 p.m. in the Medical Staff Lounge. All primary care physicians are expected to attend.

Primary Care Neighborhood Physician

- Evaluate residents as needed for medical necessity on skilled nursing units
- Complete monthly progress notes on each resident, unless an alternate (every 60 day) note schedule has been approved by the Chief Medical Officer.
- Participate weekly and as needed in resident care conferences.
- Complete annual assessment on each resident.
- Assist other physicians as the need arises.
- Complete admission H&Ps, progress notes, and discharge summaries in accordance with regulations and Medical Staff Policies and Procedures.
- Follow up on all ordered labs, x-rays, consultations and other tests and interventions with documentation in the medical record and appropriate patient management.
- Participate in discharge planning for each resident.
**Code Blue**

1) All code blues are announced overhead. Physicians carrying the 327-4912 and 327-4914 pagers will also receive a code blue page with the location of the code.

2) Every physician should respond immediately to every code blue. The physician with the most ACLS experience should run the code.

3) The code blue team nurse will transport the crash cart to the code blue location.

4) All residents who survive a respiratory or cardiac arrest should be discharged via 911 ambulance.

5) Termination of resuscitation efforts is at the discretion of the code blue team leader.

6) Residents with “Do Not Resuscitate” orders who choke will have a code blue called and interventions initiated.

7) Documentation after a code blue includes completion of the code blue record which is reviewed and signed by the physician, and a detailed code blue/progress note. If the resident expires, the death note should be dictated or typed in the LCR and no encounter form is submitted. If the resident survives the resuscitation, documentation should be done in the EHR.

8) The resident’s family, surrogate decision maker (SDM) or conservator should be notified.

**Progress Notes**

Progress notes must be documented on all residents evaluated for new or ongoing medical issues.

**Medical Acute Unit**

The acute medical unit is licensed as an acute care unit. Patients admitted for acute care must be discharged from their SNF units, and require a discharge order and dictated discharge summary. If there is a disagreement about whether a patient requires admission to the medical acute unit, the decision will be made by the Chief of Medicine or Chief of Staff. A complete history and physical must be documented on admission to the medical acute unit. Upon discharge from the acute unit a discharge order and dictated discharge summary must be done, as well as a complete admission history and physical to the SNF unit. Patients on the acute care units require daily evaluation and progress notes. (Medical Acute Admission Criteria – Appendix D)

**Discharge to outside acute care hospital**

Residents who have acute illness or change in condition that cannot be managed at LHH will be discharged to an acute care hospital, generally SFGH/SFG. Medically unstable
residents will be transported to UCSF which is the nearest hospital. When transferring a resident to an outside facility, an Interfacility transfer form must be completed and sent with the resident, along with pertinent information from the medical record such as the H&P, Advanced Directives, MAR, Face Sheet and contact number for the covering and primary physician. Prior to transfer the provider at the receiving hospital must be contacted and given sign out. Notify the resident’s family, SDM or conservator of the transfer.

**Sentinel Event**

Notify the Chief Medical Officer or designee and the Administrator on Duty (AOD) in the event of a sentinel event (Appendix B)

**Death**

All residents who expire must be pronounced by a physician. The Medical Examiner’s Office must be contacted for any death that meets criteria listed on the “Expiration Check List” Appendix C

Any possible aspiration event or trauma (even very remote trauma) that may have contributed to the death must be reported to the Medical Examiner’s Office, even for patients on end of life or comfort care. If the case is declined, the deputy’s name and badge number should be documented on the expiration check list.

The physician must notify the next of kin, SDM or conservator and document notification. Ask the family if they would like to come in to view the body and notify the nursing staff if they intend to come.

*The Primary Care Physician shall, when possible, contact the family/surrogate decision maker within 48 hours one week of the resident’s death to offer condolences and answer questions.*

The organ donor network must be called within one hour for any patient who expires in the acute medical or acute rehab unit (180055DONOR). Tissue donation forms must be completed for all deaths occurring on the acute medical or acute rehab units.

**Medical Emergencies for non-residents (staff, visitors or volunteers)**

When an employee, visitor or volunteer has a potentially life threatening emergency, 911 and a code blue should be called immediately, and the first physician to arrive will evaluate the victim and provide appropriate emergency medical care until the emergency medical crew arrives. The physician will contact the receiving hospital provider. Documentation shall be done on an Unusual Occurrence form. Physician response is intended only for provision of emergency medical care and stabilization. Physicians should not provide routine care for non-residents.
Notification of Family/Conservator

The physician will notify the resident’s family, surrogate or conservator for any significant change in clinical condition, transfer to outside facility or discharge to acute care.
Radiology

Radiology services are available from 7:30 a.m. to 4:00 p.m. Monday through Friday and Sunday. Plain films done at Laguna Honda are transmitted to SFGHZSFG to be interpreted by the radiologists, and results are placed in the LCREHR. Films can also be viewed on IMPAX on all computer terminals. Other radiology studies such as CAT scans, ultrasounds and MRIs are scheduled by e-referral at SFGHZSFG. For urgent studies call SFGHZSFG radiology department at 206-8855, or transfer the patient to the emergency department if unable to schedule the study urgently or if the patient is unstable.

ECG

ECGs are ordered by completing the request form and are done by respiratory therapists, or, when they are not available, by the nursing staff. ECGs are transmitted daily to SFGHZSFG for formal interpretation, and results are available in the LCREHR.

Respiratory Therapy

Respiratory Therapists are available 7 days a week, from 8 a.m. to 4:30 p.m. They will assist with respiratory emergencies, codes blues, perform ABGs, sputum inductions and nasal swabs for viral screens.

Laboratory Services

Phlebotomy services are available from 6:00 a.m. until 6:00 p.m. Monday through Friday, and from 10:00 a.m. to 2:00 p.m. on weekends and holidays. At other times, the nursing staff will obtain blood specimens. All specimens are transported to SFGHZSFG for analysis. Results are available on the LCREHR. Turnaround time for STAT labs is 2 to 3 hours. Scheduled courier service pick up times are:

Monday through Friday 8:30 a.m., 11 a.m., 2:30 p.m., and 6 p.m.
Saturday, Sunday and Holidays 11:30 a.m. and 2 p.m.
A courier is available to take STAT labs to SFGHZSFG at times other than scheduled if needed.

Pharmacy

The pharmacy is open from 8:00 a.m. until 6:00 p.m. on weekdays and 8:00 a.m. until 4:00 p.m. on Sundays, and closed on Saturdays. A supply of the most commonly used medications is kept in the night closet for new medication orders when the pharmacy is closed. The nursing operations director should be called if these meds are needed. After hours, if an ordered medication (or accepted substitute) is not available, the nursing director may contact the on call pharmacist. This should only be done if initiation of therapy cannot reasonably wait until the pharmacy is open again, and after a review of the available medications.
Outpatient Clinics

There are multiple specialty clinics available for evaluation and treatment of residents by appointment in the Outpatient Clinics. All Outpatient Clinic referrals are done by e-Referral. The clinic is located on the first floor Pavilion, near the South Building.

There are also consultation rooms available for Psychiatry, Substance Use Treatment, and Neuropsychology.

Psychiatry, Neuropsychology, Substance Use Treatment, Nephrology, Neurology, Physiatry, Ethics, Pain Management and Palliative Care are also available as bedside consultations.

Physical Therapy, Occupational Therapy, Speech Therapy and Audiology are also available by completing a rehab consult form. Residents may also be referred for the Aquatics Program, for Restorative Care, or to the Laguna Honda Premier Club, a neurobehavioral day program.

APPENDIX B – 2232 Senior Physician Specialist Job Description
APPENDIX C – Sentinel Events, HWP&P 60-12
APPENDIX D – Acute Medical Unit Admission Guidelines, MSP&P 001-03
APPENDIX E – Billing and Coding, MSP&Ps 003-03, 003-04, 003-05, 003-06
NIGHT AND WEEKEND PHYSICIAN SERVICES

Policy:  Physician services will be provided to Laguna Honda Hospital residents with onsite physician coverage 24/7.

Purpose:  To provide continuity and consistency of physician services that are evidence based and meet or exceed community standards.

Procedure:  As needed night and weekend physicians provide hospital coverage during off hours in compliance with the hospital procedures and protocols outlined in Appendix’s below.

Appendix A – General Information

Hospital coverage – two physicians are scheduled for off hours coverage. One physician is assigned to the North Tower, PM SNF, and PMA medical unit, (pager 327-4914) and the other to the South Tower and PMA rehab unit (pager 327-4912). On Sundays there is an admitting physician (pager 327-0754) scheduled for 4 hours to do new admissions from ZSFG or readmissions from ZSFG or UCSF. If there are no admissions, the admitting physician will assist the North and South tower physicians.

In person sign out and pager transfer is required. Daily sign out will take place in the Medical Staff Lounge at the start and end of each shift, at 8am and 5pm, and will consist of verbal sign out with review of the physician sign out log. The nursing supervisor will also attend sign out.  Appendix F

Logistics

1) There are 2 on call rooms, one on Pavilion Mezzanine (extension 4-5755) and one on South 4 (extension 4-1272).
2) Lab, Respiratory and Radiology are located on Pavilion 1.
3) The Medical Staff Lounge is located on Pavilion 2, at the north end of the hall.
4) The cafeteria is on Pavilion 1, and is open from 7am until 2pm. Vending machines are located on Pavilion 1 and can be accessed 24/7. There is an ATM in the vending machine area. An evening snack is delivered to the Medical Staff Lounge each evening. The Medical Staff Lounge has a coffee machine and hot/cold water. Weekend physicians are entitled to a free lunch in the cafeteria, and physicians working overnight are entitled to a free breakfast the following morning. Inform the cashier in the cafeteria that you are the on call physician.
5) Keys to the call room, Medical Staff Lounge, exam rooms on each neighborhood and elevator code blue keys are kept in the nursing office on the north end of the Pavilion Building. Keys must be signed out and returned at the end of each shift; if passed on over the weekend, keys must be returned to the nursing office on Monday morning.

6) Parking is in designated areas – please arrange through Medical Services office. Blue decal can park anywhere except Red and Visitor parking spots.

Schedule

The night and weekend schedule for each month is finalized and distributed no later than day 20 of the preceding month. While as needed physicians will not be guaranteed any specific shifts or minimum number of shifts, a template will be maintained that identifies shifts routinely covered by specific physicians. After the schedule is finalized, it will be the responsibility of the physician to arrange any needed shift changes.

Weekend back up schedule – this is covered by a rotating pool of daytime primary care physicians who also work nights and weekends. The back up coverage begins Friday at 5pm and ends Monday at 8am. Back up physicians must be available to come in within 2 hours of being called. Back up is used when the scheduled physician is ill, or if a shift is uncovered. Back up should not be used for the admitting shift or a second overnight physician shift. There is no back up provided for holiday coverage or weeknight coverage.

Clinical Responsibilities

Follow up on any issues identified at sign out.

Daily evaluation and progress notes for any patient on PM Acute, either medical or rehab admissions to acute medical unit as needed; these require full H&P and admission orders.

Evaluate residents as needed for medical or behavioral issues that arise and follow up on evolving issues. Document each resident visit and complete an encounter form for each visit. All EHR notes must be locked and all dictations and verbal orders must be signed by the end of each shift.

Pages must be answered promptly, within 10 minutes. Patients requiring evaluation should be seen within 30 minutes, or sooner if they are unstable.

Conditions including (but not limited to) the following need in person physician evaluation:

1) Fever over 100.5 F/38 C
2) Shortness of breath/hypoxia
3) Change in mental status
4) Chest pain
5) Seizure
6) Fall with injury
7) Syncope
8) Unstable vital signs
9) Vomiting more than twice in shift
10) Abdominal pain
11) Visual changes
12) Unrelieved or persistent pain despite interventions
13) Resident to resident altercation or resident to staff physical altercation
14) Emergent use of psychotropic medications

Orders – all medications except topical medications are ordered in the EHR. Labs, x-rays, topical medications and nursing orders are ordered on the paper physician order sheet. All verbal orders must be signed by the end of the shift.

Pharmacy

The pharmacy is closed weekdays after 5pm and on Saturdays, but is open on Sundays from 9am to 4pm. The pharmacy is open from 8:00 a.m. until 6:00 p.m. on weekdays and 8:00 a.m. until 4:00 p.m. on Sundays, and closed on Saturdays. A supply of the most commonly used medications may be accessed by the nursing supervisor if needed from the supplemental drug room. A pharmacist is available on call on off hours and may be contacted by the nursing supervisor if a medication is urgently needed that is not available in the supplemental drug room. Review the supplemental drug list carefully before calling in the pharmacist.

Psychotropic medications

OBRA guidelines and Laguna Honda Hospital policy require that all new medication orders being used for psychoactive effects, including sleeping agents, have a signed consent prior to administration of the medication. Include diagnosis and specific target symptoms when ordering a psychotropic medication. For example “Seroquel 250 mg q 12 hours for schizophrenia, target symptoms auditory hallucinations resulting in refusal of dialysis”. When ordering an emergent one time psychotropic medication, the patient must be evaluated and the emergent psychotropic order form must be reviewed and signed by the physician. Clearly and specifically document the behavior requiring emergent psychotropic use, make sure to re-evaluate in a timely manner and document your follow up evaluation.

Respiratory Therapy
Respiratory Therapists are available 7 days a week, from 8am to 4:30pm. They will assist with respiratory emergencies, code blues, perform ABGs, sputum inductions and nasal swabs for viral screens.

**Radiology**

Radiology is available on weekdays and Sundays from 7:30am to 4pm. If x-rays are urgently needed at other times arrangements should be made to have them done at ZSFG. Radiology results are available in the LCR-EHR and images can be reviewed on IMPAX on all computer terminals. Radiology is not available on Saturdays or holidays.

**ECG**

ECGs are ordered by completing the paper form and are done by the respiratory therapists, or, when they are not available, by the nursing staff. ECGs are transmitted daily to ZSFG for formal interpretation, and results are available on the LCREHR. Covering physicians will do preliminary ECG interpretations.

**Laboratory Services**

Phlebotomists are available from 6am to 6pm on weekdays and from 10am to 2pm on weekend days. When phlebotomists are not available, the nursing staff will obtain the blood specimen. All specimens are transported to ZSFG to be analyzed in there. Results are available on LCREHR. Turnaround time for STAT labs is 2 to 3 hours. Scheduled courier service pick up times are:

- Monday through Friday - 8:30am, 11am, 2:30pm and 6pm
- Saturday/Sunday/Holidays 11:30am and 2pm

A courier is available to take STAT labs to ZSFG at times other than scheduled if needed.

**Code Blue**

1) All code blues are announced overhead. The on call physicians will also receive a code blue page with the location of the code.
2) Every on call physician should respond immediately to every code blue. The physician with the most ACLS experience should run the code.
3) The code blue team nurse will transport the crash cart to the code blue location
4) All residents who survive a respiratory or cardiac arrest should be discharged via 911 ambulance.
5) Termination of resuscitation efforts is at the discretion of the code blue team leader.
6) Residents with “Do Not Resuscitate” orders who choke will have a code blue called and interventions initiated.

7) Documentation after a code blue includes completion of the code blue record which is reviewed and signed by the physician, and a detailed code blue/progress note. If the resident expires, the death note should be dictated or typed in the LCR EHR and no encounter form is submitted. If the resident survives the resuscitation, documentation should be done in the EHR.

8) The resident’s family, surrogate decision maker (SDM) or conservator should be notified.

Discharge to LHH Acute Medical Unit

Review advanced directives prior to discharge to acute care. LHH PMA is licensed as an acute care hospital, separate from the skilled nursing facility. All patients admitted to PMA require discharge from SNF (including note in the EHR documenting evaluation and reason for discharge and discharge order) and admission to acute (including H&P typed or dictated into the LCR documented in the EHR). Documentation on patients in the acute unit is done directly into the LCR or dictated into WebMedx, not in the EHR. The SNF discharge summary will be completed by the primary care physician.

Discharge to outside acute care hospital

Residents who have acute illness or change in condition that cannot be managed at LHH will be discharged to an acute care hospital, generally ZSFG. Medically unstable residents will be transported to UCSF which is the nearest hospital. When transferring a resident to an outside facility, an Interfacility transfer form must be completed and sent with the resident, along with pertinent information from the medical record such as the H&P, Advanced Directives, MAR, Face Sheet and contact number for the covering and primary physician. Prior to transfer the provider at the receiving hospital must be contacted and given sign out. Notify the resident’s family, SDM or conservator of the transfer.

Sentinel Event

Notify the Chief Medical Officer or designee and the Administrator on Duty (AOD) in the event of a sentinel event (Appendix B)

Death

All residents who expire must be pronounced by a physician. The Medical Examiner’s Office must be contacted for any death that meets criteria listed on the “Expiration Check List” Appendix C
Any possible aspiration event or trauma (even remote trauma) that may have contributed to the death must be reported to the Medical Examiner’s Office, even for patients on end of life or comfort care. If the case is declined, the deputy’s name and badge number should be documented on the expiration check list.

The physician must notify the next of kin, SDM or conservator and document notification. Ask the family if they would like to come in to view the body and notify the nursing staff if they intend to come.

The organ donor network must be called within one hour for any patient who expires in the acute medical or acute rehab unit (180055DONOR). Tissue donation forms must be completed for all deaths occurring on the acute medical or acute rehab units.

**Medical Emergencies for non-residents (staff, visitors or volunteers)**

When an employee, visitor or volunteer has a potentially life threatening emergency, 911 and a code blue should be called immediately, and the first physician to arrive will evaluate the victim and provide appropriate emergency medical care until the emergency medical crew arrives. The physician will contact the receiving hospital provider. Documentation shall be done on an Unusual Occurrence form. Physician response is intended only for provision of emergency medical care and stabilization. Physicians should not provide routine care for non-residents.

**Psychiatric Emergencies**

A psychiatrist is available at all times for psychiatric emergencies. The psychiatry on call schedule is posted on the Intranet under “Psych/Calendars/Current Calendar Year”. The psychiatrist on call can be paged directly. The on call psychiatrist can provide telephone consultation, come in to do an evaluation in person, and/or facilitate transfer to inpatient psych unit or psych emergency department (PES). **Requests for on call psychiatry services are only to be made by the on call physician.** Covering physicians should not accept return of any patient who has been sent for psychiatric evaluation prior to assessment by LHH psychiatry.

**Weekend Admissions**

All weekend admissions are arranged by the proceeding Friday by 3pm. Weekend admissions are only accepted on Sundays, and only if an admitting physician is scheduled. New admissions are accepted from ZSFG only, readmissions may be accepted from ZSFG or UCSF. Admissions or readmissions from other hospitals cannot be accepted on weekends. Readmissions from within LHH (PMA to SNF unit) do not require prearrangement, and should be done as soon as the patient no longer requires acute care.
The admit shift hours are 11am to 3pm on Sundays. The admitting physician is responsible for the H&P, admitting orders, and initial management of Sunday admissions from ZSFG or UCSF. There will be a maximum of 2 admissions on Sundays. If there are no admissions scheduled, or if the admitting physician has free time, s/he will assist the other weekend physicians as needed.

Appendix B – Night and Weekend Physician description of duties

1) Assess, diagnose, treat and follow up on residents with new or evolving medical or behavioral issues.
2) Arrange discharge to acute care when appropriate level of care cannot be provided on SNF unit, consistent with resident's advanced directives and goals of care. Appendix E
3) Respond immediately to all code blue and medically urgent situations.
4) Pronounce death and contact Medical Examiner’s Office when indicated. Notify family, SDM or conservator in the event of resident expiration.
5) Evaluate and write daily progress notes on all patients on acute medical and rehab units.
6) Complete a H&P and admission orders on newly admitted or readmitted patients.
7) Perform special procedures as needed and in keeping with delineated privileges. Obtain consent for any invasive procedure performed and for blood transfusions.
8) Communicate with residents and/or families, surrogate decision makers or conservators regarding change in resident condition or plan of care.
9) Communicate with consultants as needed.
10) Review all signed out, urgent, STAT or critical lab reports, document interpretation of results and appropriate treatment plan.
11) Maintain a complete, accurate and legible medical record.
12) Sign verbal orders, lock EHR notes, and review, edit and sign all dictations prior to the end of each shift.
13) Accurately complete an encounter form for each resident/patient encounter. Ensure the billing is supported by level of service and documentation. Appendix D
14) Address concerns or questions of the nursing staff, including clarification of orders and evaluation of residents.
15) Conform to the Medical Staff Bylaws and Rules and Regulations, and adhere to all hospital policies and procedures.

Appendix C - Sentinel Events, HWP&P 60-12
Appendix D - Billing and Coding, MSP&P 003-03, 003-04, 003-05, 003-06
Appendix E - Acute Medical Unit Admission Guidelines, MSP&P 001-03
Appendix F - Sign Out
PSYCHOTROPIC MEDICATION MANAGEMENT

POLICY:
Laguna Honda Hospital and Rehabilitation Center provides psychotropic medications for LHH residents as clinically indicated.

PURPOSE:
To provide appropriate care to residents and to conform to State and Federal regulations relating to the use of psychotropic medications in skilled nursing facilities.

DEFINITION:
1. Psychotropic medications are drugs that affect brain activities associated with mental processes and behavior. They are divided into four broad categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic medications (“Psychotropic Drug Use in Nursing Homes,” Department of Health and Human Services, Office of Inspector General, November 2001 OEI-02-00-00490). For the purpose of this policy, psychotropic medications also include any other drugs used for the purpose of effecting mental status or behavior.

2. LHH providers of psychotropic medications include all LHH Medical Staff members with prescribing authority as defined by the State of California.

PROCEDURE:
1. ASSESSMENT PRIOR TO PRESCRIBING
   a. The resident shall receive proper clinical assessment prior to being prescribed psychotropic medications.

   b. The assessment may be performed by the Primary Care Physician or by a LHH consulting psychiatrist. For initiating services by a LHH consulting psychiatrist including timeline, please refer to MSPP D08-03, Access to LHH Psychiatry Services.

   c. The assessment shall include documentation of the medical indication for prescription of psychotropic medications.

   d. If the assessment is performed by a LHH consulting psychiatrist, the psychiatrist will discuss the findings of the assessment with the referring physician including diagnosis, medical necessity for specific behavioral health services (Specialty Mental Health, Non-specialty Mental Health, Substance Treatment And Recovery Services - STARS, Primary Care Behavioral Health - see MSPP D08-02 Attachment 1, Behavioral Health Medical Necessity), and the suggested treatment plan. In general, the referring physician and the consulting psychiatrist will determine whether the referring physician or the psychiatrist will assume responsibility for prescription of psychotropic medication,
but for residents whose mental health conditions meet medical necessity for Specialty Mental Health, psychotropic medication management shall be assumed by the psychiatrist, with the consent of the resident or surrogate decision maker. This is to ensure that the resident’s clinical needs can be met by direct psychiatrist services and other mental health services under the Specialty Mental Health program of LHH Psychiatry Service.

2. RESPONSIBILITIES RELATED TO PSYCHOTROPIC PRESCRIBING
   a. The LHH prescriber of psychotropic medications, whether primary care provider or psychiatrist, will follow all LHH documentation practices related to psychotropic medications including, but not limited to, review and use of:
      i. PLHH psychiatric medication consent forms and procedures
      ii. Physician Quarterly Psychotropic and Sedative/Hypnotic Regimen Review
      iii. Behavioral Monitoring Record
      iv. Licensed Nurse Weekly Behavior Summary
      v. Gradual dose reduction implementation and documentation
      vi. Regulatory guidelines regarding use of psychotropic medications in skilled nursing facilities
   b. LHH psychiatrist prescribers of psychotropic medications will also follow documentation guidelines of San Francisco Health Network Behavioral Health Services (SFHN BHS) including, but not limited to, guidelines in “SFDPH, Community Programs Outpatient Services Documentation Manual” and instructions for relevant electronic health record (EHR). LHH psychiatrists will document in the designated EHR per documentation procedures and ensure that necessary BHS EHR documents are uploaded to the patient’s LHH electronic health record. LHH Psychiatry will ensure appropriate storage of any necessary hard copy documents related to Specialty Mental Health and STARS.
   c. For psychotropic medications the prescriber will review the regulatory guidelines for use (Attachment A) to ensure that the use of the medication is clinically appropriate and only after inadequate response to non-pharmacologic interventions. Use of antipsychotic medications for dementia-related behaviors should be avoided unless there is a strong clinical indication, and in those instances, should be used at the lowest possible doses, for the shortest possible period of time, and with clearly documented discussion of risk versus benefit.

3. INFORMED CONSENT
   (Refer to MSPP C02-01 Patient’s Consent for Treatment and Operation.)
   a. Resident with decision making capacity or resident without decision making capacity with a surrogate decision maker (SDM):
      i. The resident or SDM will be informed by the prescribing physician about the reasons for the medication, the goals of therapy, the probable and potential
side effects and the reasonable alternative treatments. The resident or SDM will be informed about the right to accept or refuse the proposed treatment and informed that consent may be withdrawn at any time. The resident or SDM may state their desire to withdraw consent to any member of the treating staff.

ii. The type of medication, frequency of administration, dosage amount, method of administration, and duration of taking the medication will be described.

iii. The resident or SDM and the physician will sign the informed consent form for psychotropic medications.

iv. Informed consent may be obtained from the SDM over the phone, in which case “telephone consent” should be noted on the informed consent form.

v. Informed consent is required for sedative hypnotics used to aid sleep.

vi. An written electronic copy of the consent form will be maintained in the medical record. If a resident verbally consents to the medication but does not wish to sign the form, the unsigned form will be placed in the medical record with a note indicating that the resident understands the nature & effect of the medication, consents to the administration of the medication, but does not wish to sign.

vii. Any time a psychotropic medication is increased beyond the limit set in the consent, a new consent must be obtained.

viii. Informed consent must be obtained by the prescriber prior to the administration of the first dose for all new orders, except in an emergency situation as described in Section 5.

b. Resident without decision making capacity, without a surrogate decision maker, and unable to understand the proposed treatment. Per California Health and Safety Code Section 1418.8:

i. Prior to the initiation of psychotropic medications, attempts should be made by the Resident Care Team to identify a person with legal authority to make health care decisions for the patient.

ii. If no SDM can be identified, the attending physician will convene a meeting of the RCT that prior to the administration of the medication, except in an emergency situation as described in Section 5. The RCT shall includes the attending physician, the nurse responsible for the resident and other appropriate staff as determined by the resident’s needs. A patient representative must be included on the RCT, where practicable. This patient representative may be a family member or friend who is unable to assume decision-making responsibility, or another person authorized by law such as the public guardian or ombudsman. The RCT must:

• review the resident’s medical condition;
• discuss the reason for use of a psychotropic agent;
• discuss the resident’s desires, if known;
• discuss the type of psychotropic medication planned, including the probable impact on the resident’s condition with and without the medication, and the probable frequency and duration; and
• discuss reasonable alternative interventions considered or utilized and reasons for their discontinuance or inappropriateness.
The prescribing physician will note on the resident’s medical record, which may include on the informed consent form itself, that the resident does not have capacity to make decisions concerning his or her health care, that there is no person with legal authority to make those decisions on behalf of the resident, consent for the use of psychotropic medication was approved by and that the resident’s interdisciplinary team reviewed the prescribed medical intervention. File: MSPP D01-05

iii. If a different perspective is desired, a second medical opinion may be obtained at this time. The resident may seek judicial review of the RCT decision to provide the resident with such psychotropic medication(s).

iv. The RCT will evaluate the use of the psychotropic drug at least quarterly or upon a significant change in the resident’s medical condition.

v. The determinations required to be made pursuant to this section 3(b), as required under California Health & Safety Code Section 1418.8 (l), and the basis for those determinations shall be documented in the patient’s medical record and shall be made available to the patient’s representative for review.

c. When the identified SDM cannot be reached within a reasonable period of time, the RCT may provide consent as described in section 3b above. Attempts to reach the SDM must be continued.

d. Informed consent must be obtained by the prescriber prior to the administration of the first dose for all new orders. (Exception: Emergency Use -- refer to Procedure 4 below).

e. The consent form will indicate that the elements in a. ii – a. v. were discussed with the resident or SDM. The medication name, and maximum dose to be used (up to XXX mg/day) must be noted on the consent form. A written copy of the consent form will be maintained in the medical record. If a resident verbally consents to the medication but does not wish to sign the form, the unsigned form will be placed in the medical record with a note indicating that the resident understands the nature & effect of the medication, consents to the administration of the medication, but does not wish to sign.

f. Any time a psychotropic medication is increased beyond the limit set in the consent, a new consent must be obtained.

4. Family Notification Regarding Antipsychotic Medications for Residents with Decision Making Capacity

The prescribing physician shall seek the consent of the resident to notify the resident’s interested family member, as designated in the medical record. If the
resident consents to the notice, the physician or psychiatrist shall make reasonable attempts, either personally or through a designee, to notify the interested family member, as designated in the medical record, within 48 hours of the prescription, order, or increase of an order. Notification of an interested family member is not required if any of the following circumstances exist:

- There is no interested family member designated in the medical record.
- The resident has not consented to the notification.

As used in this section, the following definitions shall apply:

- “Resident” means a patient of a skilled nursing facility who has the capacity to consent to make decisions concerning his or her health care, including medications.
- “Designee” means a person who has agreed with the physician or psychiatrist to provide the notice required by this section.

5. EMERGENCY USE OF PSYCHOTROPIC MEDICATIONS

a. In an emergency situation, psychotropic medications may be ordered by the physician electronically or in writing when necessary to ensure the physical safety of the resident, other residents, or members of the staff. This shall be done in accordance with all applicable state and federal regulations.

b. There should be appropriate documentation in the chart of the specific circumstances for which the medication is prescribed.

c. The resident will be monitored by the nursing staff for the effectiveness of the medications and any adverse reactions.

d. Emergency orders will be continued only as required to treat the emergency situation.

e. Before continuing psychotropic medications which were initiated on an emergency basis, informed consent must be obtained.

f. When psychotropic medications have been used as a chemical restraint in an emergency situation and the resident is unable to consent and there is no surrogate, informed consent must be obtained through the RCT.
g. The form, Nursing Assessment and Progress Note: Potential Emergent/Unplanned Psychotropic Drug Use, will be completed by nursing and signed by the prescribing physician when psychotropic medications are used in emergency situations.

6. ONGOING MONITORING

   a. The prescribing physician will review the psychotropic medications at least quarterly and document in the chart the review of psychotropic medications, noting efficacy and possible side effects.

   b. In accordance with regulatory guidelines, an attempt shall be made for gradual dose reduction of all psychotropic medications. Tapering shall be attempted in conjunction with the RCT quarterly meeting and documentation shall be placed in the chart when there are strong clinical indications for not tapering. If gradual dose reduction is clinically contraindicated, the resident’s physician shall provide a justification as to why the continued use of the drug and the dose of the drug are clinically appropriate.

   c. For all resident on psychotropic medications, the nursing staff shall monitor resident behavior, observe for drug side effects according to nursing procedure and notify the primary physician as indicated.

   d. The electronic copy of the written consent form must be kept in the resident’s active chart. A new consent form for the same medication need not be completed when a resident is discharged and re-admitted; however, changes in medication dosing should be discussed with the resident or SDM.

ATTACHMENT:
Appendix A: Guidelines for Psychotropic Medications

REFERENCES:

- Psychotropic Drug Use in Nursing Homes, Department of Health and Human Services, Office of Inspector General, November 2001 OEI-02-00-00490
- MSPP C02-01 Patient’s Consent for Treatment and Operation
- MSPP D08-02 Attachment 1, Behavioral Health Medical Necessity
- MSPP D08-03 Access to LHH Psychiatry Services
California Health and Safety Code Section 1418.9
HWPP 25-10 Use of Psychotropic Medications

Most recent review: 19/02/07
Revised: 19/02/07
Original adoption: 12/03/27

Psychotropic Drug Use
LHH PSYCHIATRY DOCUMENTATION AND BILLING GUIDELINE

POLICY:
LHH Psychiatry providers document all clinical services and submit billing in accordance with pertinent LHH policies, SFHN CBHS policies, and state and federal regulations.

PURPOSE:
To ensure that LHH Psychiatry clinical documentation and billing practices meet regulatory and compliance requirements.

PROCEDURE:

1. General Requirements
   a. Documentation is part of the clinical work of all LHH Psychiatry providers. All clinical encounters must be documented.
   b. All clinical documentation by LHH Psychiatry providers are entered in the designated Electronic Health Record (EHR) AVATAR.
   c. There are four behavioral health service programs in LHH Psychiatry three Reporting Units (RUs) in AVATAR for cases under different payer criteria:
      - RU 38KJOP: Specialty Mental Health services
      - RU 8912ODF: Substance Treatment and Recovery Services (STARS)
      - RU LHNSPC: Non Specialty Mental Health services
      - and Primary Care Behavioral Health services
      - Substance Treatment and Recovery Services (STARS), (specialty substance treatment services)
   d. Different services in different RUs are provided and documented based on payer, staff service and billing privileges.
   e. Notes under the RUs 38KJOP and LHNSPC are uploaded to eCW according to established protocol. Notes under the RU 8912ODF are NOT uploaded to eCW.
   f.e. Documentation timeliness
      Documentation for all encounters should be at least drafted at the end of the business day. All draft notes are to be finalized and submitted within the timeline per EHR 72 hours of the encounter, and submitted in AVATAR. For staff/trainees who require supervision/co-signatures, the documentation must be fully finalized and submitted, including the supervisor’s review/signature, within the timeline per EHR 72 hours of the encounter, and submitted in AVATAR. Notes under the RUs 38KJOP and LHNSPC are to be saved for upload within 72 hours of the encounter as well.
g.f. Billing Codes and LHH Psychiatry Service Encounter Forms
   i. All LHH Psychiatry providers shall choose the billing codes in the designated EHR AVATAR that are appropriate for the program and services provided.
   ii. In addition to entering billing codes in AVATAR, psychiatrists will use the LHH Psychiatry Service Encounter Form for Psychiatrists, and choose the proper LHH Service Codes for encounters under the RU LHNSPC.
   iii. In addition to entering billing codes in AVATAR, psychologists will use the LHH Psychiatry Service Encounter Form for Psychologists, and choose the proper LHH Service Codes for encounters under the RU LHNSPC.
   iv. When implemented, in addition to entering billing codes in AVATAR, licensed psychiatric social workers will use the LHH Psychiatry Service Encounter Form for Psychiatric Social Workers, and choose the proper LHH Service Codes for encounters under the RU LHNSPC.
   v. Encounter forms shall only be submitted for encounters with finalized documentation in AVATAR. All encounter forms shall be submitted to the LHH Psychiatry Behavioral Health Program Director or designee on weekly basis.
   vi. Counselors shall choose billing codes in AVATAR only. No encounter form submission is necessary for counselors.

h.g. It is each provider’s responsibility to ensure that their documentation for each clinical encounter meets the regulatory requirement for the billing code used.

2. Registering New Resident in EHR AVATAR
   a. Registration of all new residents for LHH Psychiatry Services shall follow the appropriate standards and procedures for pertinent behavioral health program. Should be registered in AVATAR within one business day of the first clinical encounter.

   a.
   b. At the first encounter, the clinician will search AVATAR to see if the patient already has a chart/BIS number in AVATAR:
      i. If yes, but no current LHH Psychiatry episode is opened, the clinician will open a new episode in the appropriate RU.
      ii. If no, the clinician will open a new chart and a new episode in the appropriate RU.

   e.b. The clinician will inform the designated clerical staff for LHH Psychiatry about initiating the new services episode/RU/new chart so that the clerk can complete the proper clerical tasks in the designated EHR. AVATAR registration and enter financial information.

3. Paper Record Requirements (Specialty Mental Health and STARS)
   a. When indicated, designated clerical staff will prepare a new set of paper forms required for initiating new services encounter for each resident with a new
AVATAR episode. These will be available at a designated location for LHH Psychiatry Staff. They include, but are not limited to:

i. HIPPA Notice of Privacy Practices
ii. Grievance Process Description
iii. Consent for treatment forms
iv. Authorization to Release Information forms, as appropriate
v. Resident Acknowledgement of Receipt of Materials

Upon completion, the LHH Psychiatry provider will submit to the designated clerical staff all required paper forms for processing with required signatures and the encounter form for filling.

The designated clerical staff for LHH Psychiatry is responsible for processing and filing per program procedures, the paper records, and for forwarding paper records on closed AVATAR episodes to CBHS Medical Records.

4. The “Golden Thread” of clinical documentation
All behavioral health clinical documentation for each resident in each episode must follow the “Golden Thread” steps for documentation, which is a concept in best practice documentation where:

a. the initial screening/assessment provides diagnosis, the information and direction for the treatment plan, then
b. the treatment plan provides direction for service delivery, then
c. the progress notes document the planned services that link to and are ordered by the treatment plan.

This best practice demonstrates a coherent clinical “story” about the care received from the provider that is logical and organized, as well as the resident’s response.

Each of the three components of the Golden Thread must be documented under the three RUs, whether or not a specific AVATAR form or code for each is required by a particular RU, for all service programs per documentation guidelines.

Crisis services are by definition an unplanned service, and not ordered on a treatment plan. Documentation for crisis services are usually located in a single progress note but should contain elements of the “Golden Thread,” i.e. assessments, diagnosis, plan and intervention.

5. Admitting vs Attending Practitioner in AVATAR
a. The admitting practitioner is responsible for the initial and annual assessment and Treatment Plan of Care (TPOC). The admitting practitioner can be the psychiatrist, psychologist, social worker or counselor.

b. The attending practitioner can only be a psychiatrist. The attending practitioner is responsible for providing input into the TPOC developed by the admitting practitioner and the resident. For STARS services the attending or an MD with privilege under AVATAR RU 8912ODF must also sign the substance TPOC.
c. In some cases, the admitting practitioner and the attending are the same. This can only happen with a psychiatrist. In this case, the psychiatrist is solely responsible for the initial assessment and TPOC, and the annual assessment and TPOC.

d. Any changes in attending or admitting practitioner status should be changed using the AVATAR Attending Practitioner Form. It is the provider’s responsibility to do this to ensure the accuracy of his or her caseload by updating the admitting/attending practitioner status in AVATAR.

6.5. Assessment

a. The initial services for all residents referred to LHH Psychiatry should result in an assessment of and determination of their needs and willingness to engage in services. These initial services can include pre-admission Initial Risk Assessment, behavioral screening, triage, screening, and clinical assessment along with motivational visits. Additional assessment tools ANSA (e.g. ANSA) rating must be completed in Avatar along with the Assessment per program requirements.

b. All payers have specific requirements regarding the content and complexity of the initial assessment. LHH Psychiatry providers shall complete the appropriate EHR forms per program requirements.

i. For Specialty Mental Health and STARS services, specific forms in AVATAR are to be used.

ii. For Non-Specialty Mental Health services, the Specialty Mental Health assessment in AVATAR should be used.

iii. For Primary Care Behavioral Health, the Progress Note form in AVATAR should be used to document the assessment. See coding manual for required elements.

c. For billing purposes, a separate progress note must accompany each finalized assessment form in AVATAR. The content of the note only needs to record the completion of the form. Any efforts to gather additional background from LHH staff, family, medical records, etc. for this assessment should be billed in a separate progress note that states “Administrative Time for completing assessment”. All information gathered in this administrative time should be included in the body of the assessment.

d. Timeliness:

The clinician shall determine and document medical necessity for services through screening within 5 business days of the case referral to LHH Psychiatry. Within 15 business days of medical necessity determination, the clinician shall complete and finalize a full assessment, a treatment plan (see below) and initiate planned treatment.

e. Signature Requirement

Signatures from both the provider and the resident/representative (electronic or wet) are required on the Treatment Plan for POC (Specialty Mental Health).
This is a minimum requirement for demonstrating resident participation in creating the TPOC. Best practice is that the provider assesses the resident goals for treatment in every session and document them. The goal is to formulate treatment objectives in the early sessions and document those in the assessment notes, which is the high-quality evidence of resident participating in development of goals. **LHH Psychiatry providers shall obtain the required signatures per program requirements.**

Provider signature is required on Assessment Form (Specialty Mental Health and STARS). See LHH Psychiatry Coding Manual.

**f. Updates and required intervals**

For mental health services, **Assessments** [(with required assessment tools (e.g., new ANSA) and updated Diagnosis) form] and **Treatment PlanPOC**e (with required signatures) must be done at least annually no earlier than 30 days prior to and no later than the episode opening anniversary date, with signatures from both the provider and the resident on the TPOC, and from the provider on the Assessment. See LHH Psychiatry Coding Manual.

### 7.6. Diagnosis

The resident’s diagnosis(es) shall be documented in the designated EHR AVATAR using the Diagnosis Form, in addition to documentation in progress notes and assessments. Time spent recording the diagnosis in the AVATAR form should be counted along with the time spent completing the AVATAR assessment form.

First diagnosis should be entered at the time of episode opening in an AVATAR RU. Non-specific diagnoses can be used to bill for screening, triage, and initial assessment visits. (See LHH Psychiatry Coding Manual.)

A specific and complete diagnosis is required at the time the assessment is finalized.

### 8.7. Treatment Plan of Care

**a.** For all residents who need ongoing treatment services from LHH Psychiatry providers, a **Treatment Plan**shall be developed according to requirements of the behavioral health program for all residents who need ongoing treatment services from LHH Psychiatry providers.

i. For each RU a resident is registered in, a TPOC is required that covers all planned services in that RU.

ii. Within the same RU, multiple providers should coordinate and produce a single comprehensive TPOC.

**b.** All payers have specific requirements regarding the content and complexity of the **Treatment Plan**.

**c.** For Specialty Mental Health and Non-Specialty Mental Health and STARS, the **Adult/Older** the proper form in the designated EHR shall be used. Additionally,
A separate progress note must accompany each finalized TPOC form. The content of the note needs to record the completion of the form, and efforts to obtain the resident’s signature (if the resident is not able/willing to sign the TPOC initially).

d. Timeliness:
In cases where the resident is willing and able to receive services, the clinician shall complete a full assessment, finalize a Treatment PlanTPOC and initiate planned treatment within 15 business days of medical necessity determination.

In cases where the resident is unwilling/unable to receive services, the clinician shall make attempt to re-approach the resident as clinically indicated, and complete a full assessment, finalize a Treatment PlanPOC and initiate planned treatment as soon as possible, but no later than 60 days from—the episodeAVATAR episode opening. If the resident remains unwilling/unable to receive services within those 60 days, the serviceAVATAR episode is closed. The resident may be referred again for services at a later time.

In cases where the resident is deemed to not meet medical necessity for services through the assessment process, a Treatment PlanPOC is not required. The Psychiatry provider shall communicate the medical necessity determination to the referring primary care physician and close the serviceAVATAR episode within 60 days from the episode opening.

e. Signature Requirements
LHH Psychiatry providers shall follow service program requirements for
i. --- signatures and co-signatures. For Specialty Mental Health and Non-Specialty Mental Health, both the provider and resident signatures are required. See LHH Psychiatry Coding Manual.

ii. For STARS, an MD must sign the Treatment Plan of Care, in addition to the provider and the resident. See LHH Psychiatry Coding Manual.

f. Updates and required intervals
Treatment Plans POCs must be updated at least annually, more frequent if needed, no earlier than 30 days prior to and no later than the episode opening anniversary date. Signatures from both the provider and the resident are required. See LHH Psychiatry Coding Manual.
9.8. Progress Notes
A progress note should be completed for every clinical encounter either with the resident or with others about the resident’s clinical care (e.g. family members, other providers and members of the RCT).

A separate progress note must accompany each completed Assessment and Treatment PlanPOC forms. The content of these notes only need to record the completion of these forms.
Behavioral consultations and Behavioral Plans shall be documented using a Progress Note form.

10.9. Discharge and Closing the service AVATAR episode
a. Upon the resident’s discharge from the LHH Psychiatry service, the provider shall complete the AVATAR-Closing documentation per service program requirements in the designated EHR, which may include additional tools (e.g. ANSA) form for the appropriate RU:

i. Specialty Mental Health (38KJOP):
   A Closing Summary with a new ANSA is required in Avatar for residents who have received more than 5 services in the episode.

ii. Substance (8912QDF):
   - A discharge plan with required elements must be completed within 30 days prior to the last face-to-face treatment.
   - For unplanned discharge, a discharge summary with required elements is required within 30 days after the last face-to-face treatment.

b. The clinician will inform the designated clerical staff for LHH Psychiatry about the resident’s discharge so that the clerical staff can complete closing task of the AVATAR episode.

11.10. The following best practices for documentation must be followed:

a. Individualized: Each note must be individualized. Notes which contain the same content from visit to visit or from one resident to the next are called “cloned” notes. Cloned notes should NOT be submitted for billing as they do not meet medical necessity criteria.

b. Stand alone: Each progress note must “stand alone” for auditing purposes. That is the auditor must be able to look at the note alone and determine that the service provided is medically necessary. This is usually done by linking the note and its contents to the Treatment PlanPOC. That linkage provides the evidence that the service provided has been ordered on a plan of care as determined by a licensed provider.
e. Timely completion: Best practice for finalization of documentation is on the same day of the clinical encounter. If documentation cannot be completed on the same day, it is required to be completed within the timeline of the designated EHR. 72 hours of the encounter. After the timeline passes, 72 hours, the note shall be labeled “[Late Entry]” at the beginning of the text.

c. Timely submission of encounter forms: Best practice is to complete and submit encounter forms at the end of each work day. Encounter forms are required to be submitted at least weekly. Encounter forms should only be submitted if the documentation is complete and finalized in AVATAR.

12.11 The following practices must be avoided:
   a. Cloning of documentation: see above under individualized
   b. Submitting encounter forms before the services are documented or notes finalized
   c. Failure to submit an encounter form after the services are documented
   d. Use of “prn” or “as needed” in the interventions section of the Treatment Plan.POC

13.12 Quality Assurance
   The LHH Psychiatry Behavioral Health Program Director oversees documentation and billing compliance in consultation with the Chief of Psychiatry. The Program Director/designee shall monitor LHH Psychiatry clinicians’ documentation and billing practices as well as provide feedback to clinicians on a regular basis, in order to ensure that documentation and billing practices meet compliance standards. Monitoring reports will be made to appropriate LHH Compliance Committee as needed.

ATTACHMENT:
None

REFERENCE:
CBHS Provider Documentation Manual
CBHS Substance Treatment Documentation Manual
LHH Psychiatry Coding Manual
LHH Psychiatry Encounter Forms

Most recent review: 2017/01/05
Revised: 2018/11/07
Original adoption: 2017/01/05
Revised Nursing
Policies and Procedures
RESIDENT IDENTIFICATION AND COLOR CODES

POLICY:

1. Each resident is to wear a legible wrist identification band with resident name, hospital number and have a photograph on the Medication Administration Record (MAR). Any member of nursing staff may change wrist bands as needed.

2. Residents requiring designated ongoing precautions and safety monitoring are assessed by the Resident Care Team (RCT) and identified using a consistent system of color-coded wristbands, with adhesive dots for associated precautions. For residents that are unable to wear a wrist band or non-adherent with use of a wrist band, a color coded ribbon shall be used as an alternative to identify aspiration risk, elopement risk, and special approach.

3. The nurse manager, charge nurse or nursing team leader will designate the use of color coding interventions based on a thorough assessment of individual resident needs and risks.

PURPOSE:

To promote resident safety by ensuring quick and accurate identification of high-risk diagnoses and problems, and special needs approaches.

-------------------------------------------------------------------------------

PROCEDURE:

A. Color Coding Grid Table

<table>
<thead>
<tr>
<th>Colors</th>
<th>Wristband / ID Bracelet / Adhesive Sticker Placed on ID Wristband</th>
<th>Ribbons</th>
<th>Bed card stickers</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>No precautions</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Red</td>
<td>Allergies</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Yellow</td>
<td>Diabetic</td>
<td>n/a</td>
<td>Diabetic</td>
</tr>
<tr>
<td>Blue</td>
<td>Seizure</td>
<td>n/a</td>
<td>Seizure</td>
</tr>
</tbody>
</table>
Resident Identification and Color Codes

<table>
<thead>
<tr>
<th>Hot Pink</th>
<th>Aspiration Precaution</th>
<th>Aspiration Precaution</th>
<th>Aspiration Precaution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purple</td>
<td>n/a</td>
<td>Unpredictable, aggressive behavior, uses special or cautious approach</td>
<td>Unpredictable, aggressive behavior, uses special or cautious approach</td>
</tr>
<tr>
<td>Orange</td>
<td>n/a</td>
<td>Resident who:</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a) wanders</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>b) are cognitively impaired with history of or new episode of wandering behavior.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c) are identified at risk for elopement and are given resident locator tag</td>
<td></td>
</tr>
</tbody>
</table>

B. Wristbands

1. Obtain wristbands from central supply and colored adhesive tapestickers from central supply.

2. Apply associated colored stickers onto label that will be printed.

3. To print wristbands:
   - Log onto LCR
   - Select Resident’s name
   - On the left frame, scroll down then click “Clerical Fxns” link
   - Click “Print/Send Pt Info” link
   - Click “Print Patient Info” link
   - From the list of cases, click “Next Page” until you see the resident current Hospital Service Code with no Discharge Date.
   - Click “Resident Current Hospital Service Code”
   - Click “LHH Wristband Printing”
   - “Wristband Generated” will be displayed.

4. Use colored dot stickers - coded wristbands for the following precautions (Refer to Procedure A: Color Coding Grid Table)

2. If more than one precaution is needed, use the color coded wristband for the primary problem and wrap appropriate colored plastic tape around the band to identify secondary problems or use multiple color-coded wristbands. Is this being done? If not, what is current practice if there are multiple color codes?

3. Use the addressograph name plate to imprint the resident’s name, hospital number and birth date on the label. Use permanent markers to write the neighborhood location. Are we actually doing this (permanent markers to write the neighborhood location)? What is the actual practice on the units if there are multiple color codes?
C. Colored Ribbon Identification

1. Obtain colored ribbons from central supply.
2. Use colored ribbons as a means of identification to promote resident safety (Refer to Procedure A: Color Coding Grid Table)
3. Colored ribbons being used to identify a problem are to be pinned or sewn onto the resident’s clothing.

D. Care Plan Front Card Documentation

Document precautions in Electronic Health Record (EHR) on the Front Card of the Resident Careplan under precautions. Are staff putting stickers on the Front Card?

E. Medical Record Binder Are all units doing the following in this section?

1. Red Medical Record Binders are used for all residents who have an HMO health plan.
   a. Contact the Nursing Office to obtain a binder for a new admission.
   b. When an HMO resident is discharged, return the binder to the Nursing Office.
2. Allergy: Red and white “ALLERGIC” tape is placed on the front cover of the medical record binder. Write identified allergies on the tape.
3. Medicare: For residents receiving Medicare, a sticker is placed on the medical record binder spine and a second sticker indicating reason for coverage are placed on the front of the binder.
4. Do Not Resuscitate (DNR): A DNR sticker is placed inside the front of the medical record binder cover when DNR is ordered.

CROSS REFERENCE:

LHH Policies and Procedures: 26-02 Management of Dysphagia and Aspiration Risk


Reviewed: ___________2019/01/18

Approved: ___________
How To Print ID Band

1) Select Resident name.

2) On the left frame, scroll Down then click “Clerical Fxns” link
3) Click “Print/Send Pt Info” link.
4) Click “Print Patient Info” link.
5) From the list of cases, click “Next Page” until you see the resident current Hospital Service Code with no Discharge Date. In this case it is LHG ex LHG, LSA, LRH, LAR, LAM, LHP, LRE, LSS

6) Click “Resident Current Hospital Service Code”

7) Click “LHH Wristband Printing”

8) “Wristband Generated” will be displayed
NURSING CARE OF THE RESIDENT WITH SEIZURES

POLICY:

1. Code blue shall be called in the event of seizure, unless an anticipated emergency plan has been put in place to address seizure.

2. The Registered Nurse (RN) and Licensed Vocational Nurse (LVN) are responsible for observing, reporting, monitoring, and documenting seizure activity.

PURPOSE:

To provide safe and effective nursing care to the resident experiencing a seizure, and to minimize the risk for harm to the resident.

PROCEDURE:

A. Preventive Safety and Anticipatory Measures

1. Assess the newly admitted or relocated resident within eight hours to determine seizure risk. Risk factors include but are not limited to medical diagnosis of seizure disorder, known history of seizure activity, and anticonvulsant therapy (excluding when administered for behavioral management or neuropathic pain management).

2. When a resident is assessed at risk for seizure activity:
   a. Note seizure risk in the precautions section of the Front Card of the Resident Care Plan Electronic Health Record (EHR).
   b. Coordinate development of an interdisciplinary care plan entry.

3. Administer anticonvulsants as prescribed and monitor side effects, lab results, and effectiveness of medications. (If resident is concurrently on enteral feedings, see NPP J 1.0 Medication Administration policy for special considerations).

4. Care plan and initiate individualized seizure precautions as appropriate to the resident’s seizure type and pattern, which may include consideration of the following:
   a. Applying side rail pads to the side rails that resident utilizes.
   b. Use of a Joerns bed (low bed).
   c. Use of a floor pad placed next to the resident’s bed.
   d. Keeping bedside clutter free.
   e. Suction set-up at bedside.
   f. Padding edges of furniture at resident’s bedside.
   g. Helmet (e.g., history of TBI, craniectomy)
   h. Hip protectors

B. Acute Seizure Management
1. Pre-Ictal Phase (period immediately before the seizure)
   a. Monitor the resident for signs and symptoms of impending seizure (aura).
   b. If possible, when signs of impending seizure are reported or observed, and before seizure activity has begun, take the resident to a quiet and safe environment, as indicated by historical seizure type, severity and characteristics.
   c. Provide calm reassurance to the resident.

2. Ictal Phase (period of seizure activity)
   a. Initiate Code Blue (call 42999).
   b. Stay with the resident and provide reassurance.
   c. When possible, keep the resident in a lateral side-lying position.
   d. As the seizure progresses, provide supportive care including the standard C-A-Bs of basic life support (i.e., circulation, airway patency and protection, breathing), and protect against skeletal and soft tissue injury. Consider the following:
      i) Oximetry and oxygen as needed
      ii) Vital sign monitoring
      iii) Check blood glucose
      iv) Oral or nasal suctioning
      v) Neurological monitoring
      vi) Prepare for intravenous or intraosseous access per MD order
      vii) Cardiac monitoring (i.e., especially when administering intravenous antiepileptic medications such as Dilantin)
   e. Do not attempt to force anything into the resident’s mouth. Do not try to hold the resident down.
   f. Due to the possibility of urinary and/or bowel incontinence during a seizure, cover the resident’s lower abdomen and groin to provide privacy.
   g. Observe and document the following:
      i) how the seizure started,
      ii) location and duration of motor activity,
      iii) resident’s report of sensory changes,
      iv) pattern, duration and intensity of seizure development,
      v) any other pertinent details

3. Post-Ictal Phase (after the acute seizure)
   a. Maintain resident is a lateral side-lying position until resident is able to maintain airway and secretions.
   b. Do not offer anything to eat or drink until fully awake and able to swallow safely.
   c. Assess the resident’s post seizure status, carefully noting vital signs, neurological findings and changes, presence of injury, and resident’s emotional response to the event.
   d. Report seizure activity and resident status to the physician.
   e. Provide incontinence care as appropriate.
   f. As appropriate to the resident’s cognitive status, explain to the resident the circumstances of the seizure and provide reassurance.
   g. Encourage periods of rest after the seizure.
   h. Offer support to the resident, family and friends, addressing issues of embarrassment, anxiety, depression, and helplessness as they arise.
   i. During regularly scheduled or special Resident Care Team conferences, present information regarding seizure control, frequency, pattern and effectiveness of interventions.
C. Documentation

1. **Resident Care Plan** (Electronic Health Record): Identify seizure type and characteristics associated with the resident’s seizures, related safety problems, and individualized interventions for monitoring, ensuring safety, managing seizure activity, and providing support and education (see Appendix 1).

2. **Interdisciplinary Progress Notes:**
   a. Document the following: presence, pattern and duration of prodromal symptoms, duration of seizure, pattern of progression, vital signs, loss of consciousness, associated behaviors, incontinence, skin pallor, injuries sustained, and neurological findings during the ictal and post-ictal phase.
   b. Evaluate resident response to specific interventions.
   c. Document physician notification and subsequent interventions.

REFERENCES:


CROSS REFERENCES:

Nursing P&P B5.0 Color Codes – Resident Identification
Nursing P&P C4.0 Notification of Change in Resident Status
Nursing P&P G2.0 Neurological Status
Nursing P&P J1.0 Medication Administration

LHHPP File: 24-16 Code Blue

ATTACHMENT/APPENDIX:

Appendix 1: Nursing Seizure Clinical Practice Guideline
Appendix 2: Classifying Seizures: A Quick Reference Guide

Revised: 2005/01, 2010/01, 2014/08, 2017/03/07
Reviewed: 2017/03/07
DOCUMENTING/REPORTING RESIDENT ALLERGIES/ADVERSE DRUG REACTIONS

POLICY:

Licensed nurses and other clinicians who learn of a resident’s allergies and/or adverse drug reactions (e.g., medication, food, environmental, other) are responsible for reporting and documenting this information so as to ensure patient/resident safety.

PURPOSE:

To communicate residents’ allergies and/or adverse drug reactions.

PROCEDURE:

A. Upon admission and for the duration of the resident’s stay, identified allergies and/or adverse drug reactions are documented in the following places:

1. **Medical Record Chart:** Electronic Health Record (EHR):
   - a. Place "allergy" tape on front of the chart and record identified allergies and/or adverse drug reactions.
   - b. The physician writes allergy and/or adverse drug reactions into the orders.
   - c. At bottom of Physician’s Order Sheet print outs and TAR.
   - d. For new allergies, for an established resident, the physician will document the allergy in EHR and writes on the Physician’s Order Sheet.

2. **Resident Care Plan:** Write allergies and/or adverse drug reactions in **red** ink.

3. **Medication Administration and Treatment Assessment Records:** Record on each page, Electronic Medication Administration Record and Treatment Administration Records will indicate any known allergies.

4. **Admission Nursing Assessment:** On admission, state what specifically causes allergic reactions, or indicate that there are “NONE KNOWN DRUG ALLERGIES” or “NKDA”.

5. **Allergy Color Code Color:** RED is the code for allergies. Write resident’s name and ward location on a red name strip.

6. **Resident Identification Band:** Red **band-sticker** indicates allergies.

7. **Allergy and/or adverse drug reactions information is also recorded in the EHR by clinicians at Laguna Honda Hospital and throughout the San Francisco Department of Public Health.**

B. Residents should be observed for allergic reactions and adverse drug reactions throughout their stay.

CROSS REFERENCES:
LHHPP File: 25-04 Adverse Drug Reaction (ADR) Reporting Program

Nursing P&P B 5.0 Color Codes – Resident Identification
Nursing P&P C1.0 Admission and Readmission Procedures
Nursing P&P C 1.2 Relocation Procedures
Nursing P&P C 1.3 Discharge to Acute
Nursing P&P J 1.0 Medication Administration

Revised: 12/2004, 1/2010, 09/24/2013; 07/14/2015

Reviewed: 07/14/2015

Approved: 07/14/2015
Nursing Guidelines for Relocation Between Laguna Honda SNF Neighborhoods

POLICY:

1. The resident will be processed as “Relocation” when the resident is moved from one SNF unit to another SNF unit, or, one bed to another bed in the same unit.

2. The decision to relocate a resident is made by the Resident Care Team (RCT) based on the resident’s clinical needs

PURPOSE:

To outline Nursing Policies and Procedures for resident relocation and to provide a smooth resident transition within Laguna Honda.

PROCEDURE:

A. Sending Neighborhood

1. 1 to 2 days before the relocation
   a. Licensed Nurse (LN) obtains Relocation Order from the physician
   b. LN or Social Worker (SW) or designee Informs the resident/family/SDM of the relocation
   c. LN or SW or designee offers tour of receiving neighborhood
   d. LN completes a Transfer Notification form.

2. On the day of relocation, the Licensed Nurse (LN) or designee will:
   a. Gather all resident’s medical records (old and current) including the addressograph cards, medications, personal belongings, and other special equipment to be sent to the receiving neighborhood.
   b. Check all personal belongings that are listed in the property inventory sheet to ensure all resident’s belonging are accounted for prior to relocation.
   c. Complete a new inventory / property sheet by reviewing current personal belongings.
   d. Complete LHH Relocation Checklist – Sending Unit section.
   e. Complete the Chronological Sheet.
   f. Inform the receiving neighborhood for any future clinic appointments, if indicated.
   g. Notify Food Services to cancel meals.
   h. Notify the dialysis transportation if applicable.
   i. LN will write document a brief summary of resident’s physical and mental condition including vital signs, time of relocation, mode of transportation.
   j. The LN from both the sending and receiving units will complete the LHH review resident’s skin condition Body Diagram (MR 539) together and update on EHR if needed.
   k. Notify EVS to clean the room.

3. The MDS Coordinator will inform the receiving neighborhood MDS Coordinator the status of any MDS assessment.

B. Receiving Neighborhood
1. Upon arrival, the receiving staff will welcome the resident to the neighborhood. Staff will introduce resident to the Nurse Manager, other nursing staff and Resident Care Team (RCT), roommates and other residents in the neighborhood.

2. The LN or designee must orient the resident to his room, review meal time, activities offered, and pass policies.

3. The NM or designee will tour the resident and/or Surrogate Decision Maker (SDM) in the neighborhood per request.

4. The LN or designee will:
   a. Notify the physician and update the PCP section in LCRupdate electronic health record.
   b. Verify the identification wristband is in place and legible, change ID wrist when appropriate.
   c. Call Admission and Eligibility for a new addressograph cards and to update LCR electronic health record.
   d. Notify Food Services as soon as the relocation has occurred to ensure resident will receive meal tray on time.
   e. Place name card over the resident’s bed and outside the room.
   f. Complete LHH Relocation Checklist – Receiving Unit section.
      g. Arrange the medical records in the medical chart, DNCR binder, and medication and treatment record binders.
      h. Arrange medications on the medication cart cassette drawer with label.
      i. Inform the SDM of the new room of the resident.
      j. Complete the Chronological Sheet.

5. Documentation:
   a. LN will document in the Interdisciplinary Progress Note electronic health record the notification of physician and SDM of relocation, orientation to the neighborhood, resident’s status and response to neighborhood relocation, and complete the LHH Body Diagram (MR 539).
   b. LN or designee will update the Property Inventory Sheet.
   c. For the next 72 hours, LN will document assessment of general condition and adjustment to the new environment at least once per shift; then weekly for at least one month. Then progresses to monthly summary.
   d. LN or designee document vital signs and pain score for the next 72 hours if stable in the LCR electronic health record.
   e. If applicable, LN will complete a Behavior Risk Form (MR 340) Assessment, initiate a care plan if needed.

6. Inform resident and/or SDM about the Resident Care Conference schedule and encourage for the resident and/or SDM to attend and participate with plan of care.

ATTACHMENT:

Appendix 1: Transfer Notification Form
Appendix 2: LHH Body Diagram (MR 539)
CROSS REFERENCES:

Nursing P&P C 5.0 Maintaining Accurate Neighborhood Census

LHHPP File No: 20-01 Admission to Laguna Honda and Relocation between Laguna Honda SNF Units
LHHPP File No: 22-05 Handling Residents Property & Prevention of Theft and Loss
LHHPP File No: 50-02 Residents’ Trust Funds

Reviewed: 2017/09/12
Approved: 2017/09/12
A. Transfer Notification and Information:

For reason(s) explained below, a decision has been made to transfer

_______________________________________________________________________

Name of Resident

From Unit/Room: _____________ To Unit/Room: ____________ on _______________

Date and Time of Notification: __________________ By: _________________________

Name/s of legal representative/family member notified of transfer:

_______________________________________________________________________

Reason(s) for Room Transfer (check multiple boxes as appropriate):

☐ Resident/Family request
☐ Resident has completed rehabilitation services
☐ Resident needs long term skilled nursing facility care
☐ Resident does not require specialized care
☐ Resident no longer needs isolation
☐ The health of individuals would otherwise be endangered (need for an isolation or private room, or to cohort residents secondary to communicable disease)
☐ The safety of individuals is endangered
☐ To accommodate the resident’s language/cultural needs
☐ Transfer from private room to a semi-private room
☐ Benefit from specialized care needs provided by the neighborhood
☐ Other: ________________________________________________________

Date and Time of Notification: __________________ By: _________________________

☐ Copy of Page 1 Hand Delivered to Resident
☐ Copy of Page 1 Provided to Legal Representative by LHH Staff via ☐ mail ☐ email ☐ fax. ____________

(LHH Staff signature)
B. Care Planning *(indicate if resident expresses concern about transfer)*:

- [ ] Resident has no concern, agrees with room transfer as scheduled.

<table>
<thead>
<tr>
<th>Check applicable concern</th>
<th>Areas of Concern</th>
<th>Intervention to Address Concern/s</th>
<th>Date Resolved/Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room Mate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom Set Up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedroom Set Up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Resolution *(check appropriate box)*:

- [ ] All above concerns have been resolved, and resident agrees with room transfer as scheduled.
- [ ] Resident agrees to room transfer with same day notification.
- [ ] Resident has unresolved concern(s) and agrees to file a Resident Complaint/Grievance Form.

D. Checklist Prior to/on transfer:

- [ ] Resident has toured new neighborhood and bedroom. Indicate Date/Initials: ______
- [ ] Resident introduced to new roommate/s. Indicate Date/Initials: ________________
- [ ] Resident introduced to new care team members. Indicate Date/Initials: __________

E. Day of Transfer

- [ ] Resident was transferred as scheduled.
- [ ] Resident was not transferred.
- [ ] Resident was transferred on a different date ________________________________

Completed by: ___________________________ Date and Time: _______________________

(Sending Unit Staff)

(Note: Reasonable notification is defined as 1-day notice for room transfers on the same neighborhood and 2-day notice for transfers to another neighborhood)
Laguna Honda Hospital Body Diagram
PLEASE LEAVE IN FRONT OF THE CHART
This form will serve as a reference for accurate documentation of the location of resident's ulcer. Plastics/MD/CNS to initiate form.

<table>
<thead>
<tr>
<th>Date</th>
<th>Wound location</th>
<th>Wound type</th>
<th>If PU, stage</th>
<th>Plastics MD signature</th>
<th>Unit MD signature</th>
<th>Unit RN signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd.
San Francisco, CA 94116

MR 539 (REV 09/11)
DOCUMENTATION OF RESIDENT CARE/STATUS by the LICENSED NURSE

POLICY:

The Licensed Nurse (LN) is responsible for recording assessments, findings, data in writing or electronically, such as the resident’s health status, developing of a care plan based on identified needs, implementing or supervising of nursing interventions, and evaluating and revising the Resident Care Plan (RCP).

PURPOSE:

To communicate relevant information regarding assessment, interventions, and outcomes to Resident Care Team (RCT) to promote continuity and quality care for our residents.

BACKGROUND:

Documentation of resident care includes the resident's physical, emotional, spiritual, recreational status, functional capabilities, attainment of care plan goals and/or other changes in status and reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.

PROCEDURE:

A. Refer to Appendix 1 Obtaining Nursing Forms, Medical Records and Chart Order

B. Refer to LHHPP File: 21-05 Medical Record Documentation

C. Frequency of Nursing Documentation

Documentation frequency varies as the resident’s condition changes. The licensed nurse is responsible for ensuring that documentation in the progress notes, electronic health record reflecting assessment, planning, interventions, outcomes, and evaluation are completed in a timely manner. Any written documentation must be legible with licensed nurse name and title.

1. Pavilion Mezzanine Acute

Document as warranted by patient condition with a minimum of once per shift. Documentation includes assessment data, interventions implemented, and evaluation of patient’s response to interventions.

2. Skilled Nursing Neighborhoods

   a. Admissions, relocations, and post procedures – document a minimum of once per shift for at least 72 hours until condition is stable and resident has made the adjustment to the new environment. Weekly summaries are completed for at least 4 weeks and may be extended based on the resident’s condition.
b. Medicare designation – Document a daily note at minimum, for the duration of coverage as indicated by Medicare sticker on the spine of the chart. Nursing documentation will specifically describe aspects of skilled nursing care designated as the focus of coverage in addition to routine physical assessment data. When no longer covered by Medicare, progress to monthly documentation scheduled.

c. Unanticipated Change in resident condition or potential/actual decline – Document a minimum of once per shift for 72 hours and as often as clinically indicated depending on the nature of the change. Then document daily until condition stabilizes or resolves. Some examples of changes in resident condition may include but not limited to, change in cognitive function or unusual behavior, abnormal vital signs, meal intake of less than 50%, infectious processes requiring antibiotics, loss of functional ability, new incontinence, and exacerbation of a chronic condition.

d. Pavilion Mezzanine SNF – Document a minimum of once weekly for duration of rehabilitation. Documentation should reflect detailed description of the outcome of interventions, with an emphasis on degree of independence, resident education, and progress towards discharge planning goals.

e. Long Term SNF residents - Comprehensive monthly summaries will be documented for all residents. This summary is an evaluation of the resident’s response to care provided. Data collection for the monthly summary includes physical assessment, review of the care plan, Daily Nursing Care Record (DNCR) activities of daily living, progress notes in medical electronic health record, vital signs, height and weight, medication and treatment records. If the resident has an unanticipated change in condition, frequency of documentation will increase as often as condition warrants and until stabilized.

f. Discharge – refer to NPP C 1.3 Discharge to Acute and LHHPP 20-04 Discharge Planning.

g. The Care Area Assessment (CAA) - documentation will be done after completion of a comprehensive MDS assessment and care planning.

D. Documentation other than Progress Notes

1. Admission documentation (Refer to Admission-Relocation-Discharge Procedures).

2. The Assessment section of the medical record contains the Nursing Admission Assessment and other nursing assessment forms. Please refer to table of chart orders for location of other nursing forms (Appendix I).

3. Licensed nurse documentation includes completion of specific assessment and evaluation tools. See Appendix 1 for Nursing Assessment Forms.

4. Medication and Treatment Administration Record Documentation

   a. Documentation on medication record sheets includes name of drug, dosage, route, time and site for parenteral drugs, frequency and nurse’s initials.

   b. Documentation on treatment record sheets includes the time, the treatment as ordered, pertinent observations and nurse’s initials.
c. When PRN medications or treatments are administered, the reason and result of intervention are documented on the reverse side of the page.

d. Initials are identified by the nurse signing initials and full name printed legibly in "Initial" and "Signature" box.

e. Physician’s orders, medication and treatment administration forms used by nursing must be reviewed for accuracy before being filed into the medical record. This procedure may be delegated to a licensed nurse on any shift.

5. Daily Nursing Care Record (DNCR)

a. Licensed Nurse is responsible for individualizing DNCR with resident specific interventions (e.g. restorative interventions or assistance during meals).

b. Licensed Nurse will document in the DNCR if the LN provides direct assistance with resident’s ADL.

c. Refer to NPP C 3.2 Documentation of Resident Care by Nursing Assistant.

d. Licensed Nurses are responsible for reviewing the documentation on the DNCR to ensure that care is provided as per care plan.

6. Medication orders, vital signs, height, weight, labs, immunization, allergies, and point of care testing are documented electronically.

E. See Appendix 2 for Charting/Documentation/Reporting Expectations

APPENDICES:

Appendix 1: Obtaining Nursing Forms, Medical Records, and Chart Order
Appendix 2: Charting/Documentation/Reporting Expectations

REFERENCES:

Health Information Services Universal Chart Order
RAI/MDS Manual

CROSS REFERENCES:

NPP B 5.0 Color Codes
NPP C 1.0 Admission and Readmission Procedure
NPP C 1.2 Relocation Procedure
NPP C 1.3 Discharge to Acute
NPP C 3.2 Documentation of Resident Care by Nurse Assistants
NPP C 4.0 Notification and Documentation of a Change in Resident Status

LHHPP 20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna
Honda SNF Units
LHHPP 20-04 Discharge Planning
LHHPP 21-05 Medical Record Documentation

Adopted: 8/2002

Revised: 9/2009; 06/16/2015; 09/08/2015

Reviewed: 09/08/2015

Approved: 09/08/2015
APPENDIX 1: Obtaining Nursing Documentation Forms, Medical Records, and Chart Order

Medical Records

1. Obtain blank chart forms from neighborhood supply or commissary.

2. Call HIS one day in advance for chart requests.

3. New and closed medical records are delivered from 9:00 A.M. to 4:00 P.M., Monday through Friday, except holidays.

4. Requests for same day deliveries of closed medical records are accepted when residents are readmitted, or when needed for a unit or clinic physician's review. HIS requests notification as early as possible in the day, preferably before 8:00 A.M. Be sure to specify when a chart is requested for readmission.

5. All charts obtained from HIS are to be returned within 72 hours.

6. All residents discharged within house, home or to outside facilities must have their records forwarded to HIS the day of discharge.

7. Nursing forms chart order:

   Progress Notes Section
   1. Integrated Progress Notes
   2. Focused Progress Notes
   3. Nursing Weekly/Monthly Summary

   Assessment Section
   1. Nursing Admission Assessments
   2. Resident Comprehensive Pain Assessment
   3. Nursing Assessment for Behavioral Risk
   4. Pressure Ulcer Risk Initial Post-Admission
   5. Wound Assessment Records (W.A.R.)
   6. Ongoing Pressure Ulcer Risk
   7. Continence Assessment
   8. Post-Fall Assessment
   9. Self-Administration of Medication: RCT Assessment
   10. Neurological Assessment Section
   11. Behavioral Monitoring Record

   MDS Section
   1. MDS Admission Assessment
   2. MDS Face Sheet Information
   3. MDS Discharge Tracking Form
   4. MDS Correction Request Form
   5. RCT Meeting Note

   DNCR Section
   1. DNCR

   Medication/Treatment Section
   1. Medication Administration Record
   2. I.V. Flow Sheet
   3. Treatment Administration Record
   4. Behavioral Summary Sheet
DOCUMENTATION OF RESIDENT CARE by NURSING ASSISTANT

POLICY:

1. Nursing Assistant (CNA and PCA) documents activities of daily living (ADL) in the ADL section of the electronic health record (EHR).

2. Daily Cares Nursing Care Record (DNCR) are to be completed near the end of each shift by nursing assistant (CNA and PCA) unless documenting in the "Supplemental Notes".

3. Nursing Assistant documents intake and output in the I/O Flowsheet of the EHR. (Reference I&O Policy)

2.4. Nursing Assistant reports documented change in condition documented in the "Supplemental Note" in the Notes section of the EHR section and notifies the charge nurse or the licensed nurse.

PURPOSE:

Concise and accurate documentation and monitoring of daily care provided.

PROCEDURE:

A. GENERAL GUIDELINES:

1. Nursing Assistant documents in the DNCR form electronic health record using selecting the correct coding as listed on the DNCR form (MR 343).

2. Activities of Daily Living (ADL) self-performance indicates the actual resident performance, not resident capability.

3. ADL support indicates the highest level of support and number of staff provided during the shift as listed on the form.

4. Definitions are as follows:

   Self-Performance:

   a. Independent — No help or staff supervision required oversight anytime.

   b. Supervision — Oversight, encouragement or cueing provided.

   Support Provided:

   • Limited Assistance — Resident highly involved in the activity, staff provide guided maneuvering of limbs or other non-weight bearing assistance.

   • Extensive Assistance — Resident involved in activity, staff provide weight bearing support
• **Total Dependence** – Full staff performance of the activity for the entire shift. Complete on-participation by the resident in ALL aspects of the ADL definition.

• **Activity did not occur** – The ADL activity was not performed by the resident of the staff during the observation period. The activity did not occur at all.

  c. **Limited Assistance** – Resident highly involved in the activity, received physical help in the guided maneuvering of limbs or other non-weight bearing assistance.

  d. **Extensive Assistance** – While the resident performed part of the activity, he/she required weight bearing support in order to complete the activity.

  e. **Total Dependence** – Full staff performance of the activity for the entire shift. Complete non-participation by the resident in ALL aspects of the ADL definition.

  f. **Activity did not occur** – The ADL activity was not performed by the resident or the staff during the observation period. In other words, the particular activity did not occur at all.

2. **ADL support** indicates the highest level of support and number of staff provided during the shift as listed on the form.

3. The AM shift or designated nursing staff will prepare the blank forms and the Restorative and Rehabilitative sheets before the beginning of each month.

4. The designated nursing staff reviews the previous month’s DNCR forms for completion. Afterwards, HIS clerks will file the DNCR in the resident’s chart.

---

**B. C. CODING**

See Appendix 1 for data

**C. NOTES**

Use the Notes section to document any supplemental data not noted in other areas (e.g., licensed nurse notifications, changes in condition).

**D. VITAL SIGNS**

Use Vital Signs section to document resident’s Vital Signs and height/weight.

**E. I/O Flowsheet**

Use the I/O Flowsheet section to document resident’s intake and output.

**F. ADLs**

Use ADLs section to document resident’s activities of daily living (including eating, dressing, toilet use, personal hygiene, bathing, bed mobility, transfer, walk in room, walk in hall, locomotion on unit, locomotion off unit).

**G. DAILY CARES**
Use Daily Cares section to document any additional interventions (e.g., skin care, restorative, hygiene, risks). See Appendix I DNCR Coding Tables.

D. SIGNATURE AND TITLE
The Nursing Assistant initials and signs in the “Caregiver’s Initial” section.

E. SUPPLEMENTAL NOTES
Use the supplemental notes section to document when there is a change in condition.

F. INTERVENTIONS
Use the “Interventions” section to document special instructions for resident’s care.

G. RESTORATIVE CARE LEVEL II
Use the “Restorative Care Level II” section to document nursing-based rehabilitative/restorative care.

1. Daily ward ambulation with single-point cane with supervision assist (staff walks w/ resident side by side), enter # of minutes.
2. Training for personal hygiene/grooming/dressing twice a day, enter # of minutes.
3. PROM to right upper extremities at least 15 repetitions 2x/day, enter # of minutes.

REFERENCES:
RAI/MDS Manual

APPENDIX I: DNCR Coding Tables

Authorized from Policy Number Changed from C 3.1 to C 3.2, September, 2009
Revised: 08/2002; 03/2009; 07/22/2014
Approved: 07/22/2014
APPENDIX I:  
**DNCR ADL CODING TABLES**

<table>
<thead>
<tr>
<th>Coding for the following areas only:</th>
<th>DID NOT TOUCH RESIDENT</th>
<th>TOUCHED RESIDENT</th>
<th>ACTIVITY DID NOT HAPPEN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Performance</strong> (white boxes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O = Independent – no help provided</td>
<td>L = Limited Assistance – only GUIDED or did not bear weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S = Supervision or Cueing</td>
<td>E = Extensive Assistance – beared the resident’s weight or used your weight to assist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T = Total – resident did not help out at all for the entire 8 hour shift</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support Provided</strong> (Gray Boxes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O = No set-up or physical help needed from staff – use only if independent or supervision above</td>
<td>1 = 1 person physical assist – use if limited, extensive or total assist above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S = Set up help only – use only if independent or supervision above</td>
<td>2 = 2 person physical assist – use if limited, extensive or total assist above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X = Activity did not occur for the entire 8 hour shift</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BATHING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 = Independent</td>
<td>2 = Physical help only for transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 = Supervision or Cueing</td>
<td>3 = Physical help in part of bathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X = Bathing did not occur at all for the entire 8 hour shift</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Code the highest level of support provided.

(If more than 2 person, list # of staff who assisted)

(DO NOT INCLUDE THE ASSISTANCE PROVIDED WITH WASHING HAIR & BACK)
### Support Provided (Gray Boxes)

**NOTE:**
Code the highest level of support provided

<table>
<thead>
<tr>
<th>Support Provided</th>
<th>0 = No set-up or physical help needed from staff</th>
<th>1 = 1 person physical assist</th>
<th>2 = 2 person physical assist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S = Set up help only</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(If more than 2 person, list # of staff who assisted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X = No support provided for the entire 8 hour shift</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### APPENDIX I
DNCR CODING TABLES CONTINUED

#### BOWEL
(If have colostomy, write “Col” on the side of “Bowels” but still code as below)

<table>
<thead>
<tr>
<th>TOP ROW</th>
<th>X = No BM</th>
<th>C = Continent (Include colostomy did not leak)</th>
<th>I = Incontinent (skin was wet with BM – can be a little or a lot; include if colostomy leaked)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOTTOM ROW</td>
<td>0 = Zero # of BM</td>
<td>#of BM / SM = Small</td>
<td>M = Medium</td>
</tr>
</tbody>
</table>

#### BLADDER
If NO catheter

<table>
<thead>
<tr>
<th>TOP ROW</th>
<th>C = Continent – (skin is not wet)</th>
<th>I = Incontinent – (skin is wet)</th>
<th>X = Did not void</th>
</tr>
</thead>
</table>

If catheter present

<table>
<thead>
<tr>
<th>TOP ROW</th>
<th>C = Continent – (skin is not wet)</th>
<th>I = Incontinent – (skin is wet)</th>
<th>X = Did not void</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOTTOM ROW</td>
<td># of times voided as continent or incontinent</td>
<td># of times catheter leaked</td>
<td></td>
</tr>
</tbody>
</table>

#### MEAL INTAKE:
R (<25%), 25%, 50%, 75%, or 100%
If ate less than these, code for the lower percentage.
(don't code any % if on tube feedings ONLY)
TRANSCRIPTION AND PROCESSING OF ORDERS

POLICY:

1. Licensed nurses (RN, LVN) are responsible for the review, transcription and processing of orders written prescribed on their shift. Transcription and processing of orders may be delegated to the unit clerk under the supervision of the licensed nurse. If the unit clerk transcribes and processes the order, the entry is verified and countersigned by the licensed nurse.

2. Incomplete, questionable or confusing orders are clarified with the prescriber and if appropriate, pharmacy, prior to implementation or processing in the interest of resident/patient safety. The Nurse Supervisor/Manager on duty should be called if the clarification has not remedied the licensed nurse’s concern.

3. Medication orders are accepted electronically, in writing, and by telephone or verbal order directly from an authorized prescriber as outlined in LHHPP 25-03 Verbal Telephone Medication Orders [link](http://in-sfghweb01/LHH/policies/Policies.htm).

4. Telephone and verbal orders are used only when absolutely necessary, written down and then read back by the recipient, and confirmed or corrected by the prescriber. Refer to LHHPP 25-03 Verbal Telephone Medication Orders [link](http://in-sfghweb01/LHH/policies/Policies.htm).

5. The following providers are authorized to give verbal orders:
   a. Physician
   b. Affiliated Health Care Practitioner credentialed by the medical staff
   c. Dentist
   d. Podiatrist

6. The following job classes are authorized to accept verbal orders:
   a. Licensed Nurse (LN)
   b. Licensed Pharmacist
   c. Licensed Rehabilitation Therapist
   d. Respiratory Therapist
   e. Clinical Dietitian

7. Licensed nurses (LN) and unit clerks will write nursing order to reference electronic orders.

8. Each resident’s orders are reviewed monthly by the physician and the licensed nurse.

9. All residents’ charts are reviewed nightly by A.M. (night) shift LN to verify that all orders for the previous twenty four (24) hour period have been noted and processed.

PURPOSE:

To assure that orders are accurately and appropriately transcribed and processed.
PROCEDURE:

**A. Processing of Orders**

1. All documentation in the Physician’s Order Sheets (POS), Medication Administration Record (MAR), Treatment Administration Record (TAR), and Interdisciplinary Progress Notes will be recorded in black ink using Meridian time (24-hour clock).

2. Note the order processing by writing in red ink the date, Meridian time (24-hour clock) and signature following the physician’s order. Electronic orders will be noted in the electronic health record (EHR).

3. Following review, and if necessary, clarification of the order, the LN or unit clerk transcribes the order exactly as written to the appropriate form (e.g., MAR or TAR).

**BA. Nursing Orders**

1. To initiate a nursing order record the date, time and the phrase “nursing order” or “N.O” followed by the order and legible signature and title.

2. Note and transcribe in the same way as physician orders.

**C. Telephone or Verbal Orders**

1. See Hospital wide Policy 25-03 for Verbal/Telephone Orders

2. For verbal order recorded electronically the licensed nurse or unit clerk will write an order on the physician order sheet to “See eCW for ________.”

**D. Processing Orders to Pharmacy**

1. E-prescription by the physician will be sent electronically by the EHR to the Pharmacy.

2. Fax or deliver new and discontinued medication orders to pharmacy.

3. Fax or deliver nursing orders related to medications to the pharmacy.

**E. “STAT” Orders & Pharmacy Response Time**

1. Nursing and pharmacy shall process stat orders immediately during regular pharmacy hours. Outside of pharmacy hours STAT orders are obtained by Operations Nurse Manager/Supervisor refer to Pharmacy Policy 02.03.00 Emergency and Supplemental Medication Supplies.

2. Medications shall be ready for administration within one hour of the time ordered. Drugs ordered “STAT” which are available in the unit emergency drug box shall be administered immediately.

3. New orders for anti-infectives and medications that are used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.
4. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

F. Discontinued Medication Orders

1. By the end of shift during which the medication is discontinued, the LN will send or fax the order to pharmacy.

2. Refer to NPP J1.1 for Obtaining, Handling, Storing of Medications.

3. If the medication is discontinued electronically, the licensed nurse or unit clerk will write a nursing order on the physician order sheet referencing the discontinued medication order and will fax the nursing order to pharmacy.

4. Highlight in yellow the entire entry of the discontinued medication or treatment in the respective MAR or the TAR and record date of discontinuation.

G. Monthly review of Printed Physician’s Order Sheets:

1. The physician reviews medication orders monthly and documents the review in the EHR.

2. Nursing staff (unit clerk or LN) while processing orders routinely pull the pink and yellow copies when the order sheet is full and place the copies in the HIS pick-up box.

3. The LN will draw a line across the blank remaining space of the single original sheet once the copies (colors) have been removed so that no further orders can be written on that page.

4. A new, blank POS is to be inserted for writing the new orders after the copies have been pulled.

5. The following month’s orders, MAR and TAR are printed and delivered to each unit before the end of the month.

6. Orders written on POS or in the EHR after the copies have been pulled and sent to pharmacy may not appear on the new printouts and must be transcribed by the unit clerk or LN onto the new MAR or TAR sheets.

7. Licensed nurses on all shifts are responsible for checking transcription accuracy of newly printed POS, MAR, and TAR. Transcription accuracy is checked by comparing new physician orders on POS, and in EHR, MAR/TAR, against last month’s printed orders on the date they were noted and against all subsequent orders that were hand written during the month.

8. To correct an incorrectly printed order on the printed POS, draw a single line through it and LN signs with their initial. Write the date and the correct order just below the incorrect order or on a blank physician’s order form.

9. When a discontinued order appears on the printed POS, the LN will cross out, date and initial the discontinued order.

10. After reviewing and making corrections on the new monthly orders, MAR and TAR, the reviewing LN signs and dates the order sheet on the line designated "Above orders reviewed by". This means that the orders are correct and current as they appear on paper and in EHR.
11. In order to correct an error on the Medication or Treatment Administration Record, the licensed nurse will rewrite the entire corrected order in a new box. The entry box in error will be completely highlighted in yellow and marked with a “DC” and the date. The LN will submit an HIS correction form for errors on the MAR/TAR and place the form in the HIS box.

12. When the physician reviews monthly orders and wants to discontinue an order, the D/C order is to be fully written out on the POS.

13. When the physician has signed the printed POS, the LN signs and dates the line designated “Above orders noted by”. After this review, there should be no changes to printed POS.

14. On the last day of the month, the P.M. (evening shift) licensed nurse will remove the current MAR and TAR from the binders and insert the new sheets. Set aside completed sheets for the HIS technician to file into the resident’s chart. Documentation on new sheets will begin at 0001 (12:01 A.M.) on the first day of the month.

H. Nightly Verification of Order Processing and Transcription by A.M. Shift Licensed Nurse

1. Licensed Nurses will review both the EHR progress note and POS for each resident for new orders in the past 24 hours.

2. The LN verifies that each order in the POS and EHR in the past 24 hour period was noted and transcribed in the MAR/TAR, etc.
   a. If the order has not been noted, the A.M. LN will transcribe and carry out the order.
   b. If the LN is unable to carry out an order, s/he will consult with the Nursing Operations Manager/Supervisor about any necessary remedial action. The Operations Nurse Manager/Supervisor will determine if physician notification can wait until morning.

3. If the A.M. LN discovers an error in the transcribing of the order, s/he must immediately discontinue the erroneous entry on the MAR by using the “Discontinuing an Order” as per above. Then the LN rewrites the entry accurately per the MD order. If a medication error has been made, Operations Nursing Manager/Supervisor must be contacted and an Unusual Occurrence completed. The Operations Nurse Manager/Supervisor will determine if physician notification can wait until morning.

4. Once the LN confirms that all orders have been accurately transcribed and carried out from both the EHR and the POS, the LN:
   a. For the Physician Order Sheet uses the stamp, “24 hour order check completed by_________ (signature, title) at ___(time, date)”, immediately below the last order. S/he then signs and dates in red ink in the appropriate places.
   b. For EHR, the LN signs/notes in the EHR that the 24 hour check was completed.

CROSS REFERENCE:

NPP J 1.0 Medication Administration
NPP J 1.1 Obtaining, Handling and Storing of Medications
LHHPP File 25-02 Safe Medication Orders
LHHPP File 25-03 Verbal Telephone Medication Orders
Pharmacy Policy 02.03.00 Emergency and Supplemental Medication Supplies
RESIDENT ACTIVITIES OF DAILY LIVING

POLICY:

1. Registered Nurse assesses the functional ability of each resident to perform the activities of daily living (ADL) upon admission, quarterly, annually and when a significant change in condition occurs.

2. The Licensed Nurse in collaboration with the resident care team (RCT) develops a plan of care to meet the resident’s ADL needs, while promoting as much functional independence as possible.

3. All nursing staff except Home Health Aides may be assigned to provide assistance with ADL care.

4. Under the supervision of the Licensed Nurse, the Home Health Aide may assist with feeding.

5. Each resident’s personal hygiene supplies are to be labeled with resident’s initials and bed room/number and kept by the resident’s bedside.

6. When an unanticipated significant decline in ADL function is noted, the RCT will meet to review the plan of care.

PURPOSE:

1. To promote resident comfort and hygiene.

2. A program of ADLs is provided to residents to maintain or prevent disability, decrease in functional status and/or return resident to a maximum, their highest level of independence.

PROCEDURE:

A. Preparation of Resident – The resident’s care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident’s dignity, privacy, safety and confidentiality.

1. Gather all anticipated hygiene and grooming supplies before approaching the resident.

2. Knock before entering the room and introduce yourself to the resident.

3. Explain care activities to the resident and enlist engagement in cooperation and participation.

4. Maintain privacy during care and keep the resident warm and covered as much as possible during care.

5. Engage the resident in a manner that is appropriate to their cognitive and communication abilities using appropriate language, and communication aids as needed.

6. The individualized resident care plan is followed by all nursing staff, and updated as needed.

B. Activities of Daily Living – Activities of daily living are those tasks related to personal care needed for self-care: bed mobility, ambulation, locomotion, bathing, dressing, eating, mobility, toileting, eating, and transferring, personal hygiene, and bathing. Basic nursing care procedures are to be followed utilizing Mosby’s Textbook for Nursing Assistants and related nursing and hospital-wide procedures as a guide.
1. **Personal Hygiene**
   
a. Individualized restorative nursing programs for dressing / grooming are implemented as indicated on the care plan to maintain or improve resident’s abilities.
   
b. Resident is positioned at the sink or bedside with all necessary equipment within reach.
   
c. Equipment and instruction provided to maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excluding baths and showers).
   
d. Skin care routinely includes teaching and assisting the resident to gently cleanse under breasts, chest, back, buttocks and genitals, thoroughly patting dry and application of lotion to back and buttocks.

2. **Dressing**
   
a. Residents are encouraged to participate in putting on, fastening, and removing all items of clothing (includes donning/removing prosthesis or TED hose).
   
b. Residents are encouraged to choose their clothing.
   
c. Adaptive equipment is provided and used as needed.
   
d. Alternative methods of dressing are taught as needed.
   
e. Occupational therapy consultation is requested as needed through the primary physician.

3. **Eating**
   
a. Food preferences are to be respected to the extent possible and are brought to the attention of dietary staff as needed.
   
b. Residents are encouraged to eat preferably in the dining room.
   
c. Residents are to be in an upright 90-degree position for eating unless contraindicated or refused and so documented on the care plan.
   
d. Specialized feeding plans, standard precautions, and restorative eating programs are to be followed. Refer to related procedures as needed.
   
e. Dentures and adaptive devices are provided and utilized as needed.
   
f. Oral care after each meal is strongly encouraged. When residents do not want oral care the reasons are explored and the team is consulted to negotiate the best possible oral care under the specific circumstances. The dental hygienist and dentist are consulted as needed. Mouthwash and lemon glycerin swabs are not to be used in place of good oral care with a toothbrush and toothpaste.

4. **Toilet Use**
   
a. Cognizant residents are instructed on the purpose and use of diet, exercise, and medications in the elimination process by licensed nurses. Nursing Caregiver may reinforce this information within their scope of practice and related policies.
   
b. Privacy and comfort during elimination must be maintained.
   
c. When placing resident on the toilet or commode, the employee is to ensure resident safety until resident is ready to leave, then assist resident to stand and walk or transfer as needed.
   
d. Incontinent residents are cleaned promptly with soap and water, rinsed thoroughly and patted dry. Sensitivity to related discomfort and embarrassment is to be provided.
e. Use of incontinence products such as pads, briefs, and barrier creams is based on individual resident need. Factors such as skin condition and ability to retrain are to be considered and related policies followed.

f. Residents with indwelling urinary catheters receive perineal care each shift and as needed.

5. **Transfer, Ambulation**

   a. Follow related procedures, including transfers, ambulation, range of motion and Restorative Nursing.

   b. Follow basic safety principles for transfer and ambulation such as coaching the resident to rise slowly to gain balance, providing non-skid footwear, obtaining adequate assistance and providing adaptive devices as prescribed.

   c. The minimum frequency of range of motion requiring staff coaching or physical assistance is noted on the front card of the care plan and is to be followed.

6. **Bed Mobility**

   a. Nursing standards for every two-hour turning/ repositioning of dependent residents are to be followed.

   b. Exceptions to the above-noted standard related to resident preferences not to be disturbed during hours of sleep are to be discussed with the Resident Care Team (RCT) members in relation to individual skin condition and other factors with care decisions noted on the care plan.

   c. Resident may be taught and assisted to shift their weight, particularly when seated and when turning is limited by existing pressure areas, unless the resident has limited weight bearing status.

C. **Organization of Resident Care Assignments**

   1. **Call lights** are to be kept within reach and periodic rounds are to be done to facilitate prompt identification of needs, including incontinence or toileting needs.

   2. **Initial Rounds** are done by the nursing caregivers at the start of each shift on all assigned residents on the neighborhood to let each resident know who is caring for them and to identify priorities for care based on immediate safety and comfort needs.

      a. Rounds are to include the resident’s rooms, bathrooms, and other areas on the neighborhood where residents are residing.

      b. Immediate interventions during rounds frequently include repositioning for comfort, toileting/incontinent care, and providing water and call lights within reach.

      c. To ensure safety, reassure dependent residents to request for assistance to move or get up.

      d. Before beginning a lengthy procedure with a resident, it is usually appropriate to check on the other residents first to promote regular monitoring of residents.

   3. **Time preferences:** Check in with residents for preference of bathing time. Refusals of care or resident requests that place an undo burden on the staff are negotiated to achieve a reasonable compromise with RCT members’ support as needed.

D. **Environment of Care**
1. **Personal supplies** are labeled with permanent ink marker pen with resident's initials. Personal supplies or items may include, but not limited to, oral hygiene equipment, washbasins, adaptive eating utensils, brush, combs, electric shavers, bedpans and urinals.
   a. Each personal supplies or items such as oral hygiene equipment, washbasins, and adaptive eating utensils are rinsed after each use, allowed to air dry and returned to resident's bedside stand.
   b. Clean urinal, bedpan, and bedside commode with facility-approved disinfectant.
   c. Clean bedpans or urinals are kept in the lower drawer of bedside cabinet. If resident prefers, clean urinals may be kept within reach of resident.
   d. Oral hygiene equipment, bedpans or urinals are changed as needed.

2. **Combs and brushes** are to have hair removed and are to be cleaned as needed and replaced when broken or worn.

3. **Resident's area** is to be kept orderly and clean including:
   a. Overbed tables are wiped off with facility-approved disinfectant after use during bathing or incontinence care and as needed, and weekly as part of bed stripping and room cleaning.
   b. Spills or unclean floors are brought to the attention of EVS staff. Nursing shall clean the spill, then EVS shall mop and disinfect spill area.
   c. Resident preference to keep their private area cluttered with belongings is to be negotiated with sensitivity to the resident's feelings about the loss of their usual environment with RCT assistance as needed. Allowing for personal preferences in a way that does not impede safety and infection control is preferable to restricting residents unnecessarily, for example:
      i. Provide containers for non-perishable food.
      ii. Offer regular snacks and provide a realistic means for able residents to obtain nutritious snacks independently.
      iii. Offer assistance in tidying up with the resident/family/responsible party.
      iv. Offer assistance in prioritizing items if resident feels strongly about having items at the bedside versus those that can be stored in the wardrobe or sent home.
      v. Communicate regularly with residents regarding which items they value so that items are not inadvertently discarded as trash.
      vi. Unsafe or prohibited items such as spoiled food, drug paraphernalia, or weapons are not permitted and related policies are to be followed, (i.e. Infection Control, STAT notification of Institutional Police, and Prohibition of Illicit Drugs or Paraphernalia Possession / Use by Residents / Visitors.)

4. Resident's **personal clothing** is laundered in the neighborhood or on site. See Cross References to Nurse Guidelines and Facility Services Equipment Management Program.

5. **Linen** and other **personal care items** are not to be brought to another resident's area once such items are brought into a resident's room.
   a. The linen is to be handled with appropriate infection control precautions including keeping the clean linen room door closed, hand washing before handling clean linen and discarding contaminated linen in the hamper.
   b. The soiled linen hamper is to be covered at all times and is to be emptied before it is more than ¾ full or when it is malodorous.
c. Linens carts are distributed to each neighborhood by laundry staff once a day. Staff is to gather supplies needed for each resident prior to beginning care.
d. Gather supplies needed for each resident prior to beginning care.
E. Instrumental Activities of Daily Living (IADLs)

1. IADLs include activities that occur in addition to basic hygiene and grooming procedures and include activities of choice, use of the telephone, and other functions that are usually done at home and the community, such as housework, shopping, and meal preparation.

2. Nursing collaborates with other disciplines, such as Activity Therapy, Occupational Therapy, and Social Services, to support IADLs and to specifically plan and provide activities that are interesting and satisfying to individual residents.

3. IADL programming that specifically supports resident comfort and hygiene and may be provided in whole or in part by nursing may include:
   a. Manicures
   b. Make-up application
   c. Walking, including walk to dine programs
   d. Exercise programs
   e. Practice folding garments or linen
   f. Grooming activities
   g. Off neighborhood visits, strolls, and activities

F. Reporting and/or Documentation

1. **Daily Nursing Care Record (DNCRElectronic Health Record (EHR):)**
   CNA or PCA: Record level of function for each ADL as indicated on the DNCR form. Report any physical or behavioral changes to the charge nurse and document in the narrative notes section of the DNCR.

2. **Progress Notes**
   Licensed nurse: Record and report any changes in condition to physician, supervisor, family and charge nurse of oncoming shift. Review resident ADLs and DNCR-additional entries and document resident status on the monthly/weekly summary, as directed by the documentation policy.

3. **Records**
   Record and report as per related policies.

ATTACHMENTS/APPENDICES:

None

REFERENCES:


CROSS REFERENCES:

Hospitalwide Policy and Procedure
22-03 Resident Rights

Nursing Policy and Procedure
B 5.0 Color Codes – Resident Identification
C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
C 3.2 Documentation of Resident Care Nursing Assistant
E 1.0 Oral Management of Nutritional Needs
Section F: Elimination Procedures

Facility Services Policy and Procedure
EM-6 Laundry Equipment Repairs and Clean Up


Document reviewed: 4/2010
**BATHING ALTERNATIVES/BED BATH**

**POLICY:**

1. Laguna Honda Hospital shall recognize and integrate resident’s past experiences in all aspects of resident’s care.

2. Residents who do not receive tub baths or showers are provided with bathing alternatives.

3. Registered nurses in collaboration with the care team are responsible for assessing and planning for the bathing needs and preferences of residents.

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.

**PURPOSE:**

To provide resident’s hygiene through alternative bathing techniques.

**DEFINITION:**

Bathing alternatives 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 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 Resident Care Team (RCT). (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.
   b. Report to licensed nurse changes in resident preferences.

2. Licensed Nurse
   a. Update the Resident's Care Plan and pertinent problems as needed.

APPENDIX:

Appendix 1: Alternative Bathing and Hair Washing Techniques

REFERENCES:


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 D2 3.0 Tub Baths and Showers

Revised: 07/2006; 05/27/2014; 09/08/15; 09/11/18
Reviewed: 09/11/18

Approved: 09/11/18
TUB BATHS AND SHOWERS

POLICY:

1. Licensed Nurse in collaboration with the Nursing Assistant, and if appropriate Rehabilitation Staff, and/or Resident Care Team (RCT) are responsible for assessing, planning, meeting bathing needs, and accommodating preferences of residents.

2. Bathing includes nail care, hair care, shaving, and cleansing of skin surfaces.

3. Bathing alternatives will be offered if resident finds a tub bath or shower distressing or unacceptable.

4. A resident who requires assistance shall not be left unattended for safety reasons.

5. Nursing staff are responsible for cleaning and disinfecting the shower chair and tub. All care equipment used for bathing are cleaned and disinfected after each resident’s use.

PURPOSE:

To meet resident’s hygiene needs.

PROCEDURE:

A. Preparation

1. Gather all equipment prior to bathing the resident.

2. Check with the Licensed Nurse for any preparation needs.

B. Bathing the Resident using the Tub

1. Use appropriate transfer technique per resident Front Card RCP.

2. Resident has a preference to use a regular tub or portable tub. For guidelines using these tubs, please refer to:
   a. Attachment 1: Operating and Cleaning of Tub (Arjo Parker Tub), or
   b. Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)

3. Refer to NPP D 6 1.1 Battery-Operated Lift Transfer and LHHPP 24-19 The C-625 Battery-Operated Ceiling Lift. Slings used for bathing are labeled per individual resident.

4. Follow recommendations for bathing in the RCP.

5. If the resident has a bowel movement in the tub, take resident out of the tub. Put the resident in a wheelchair or commode chair for cleaning; and cover the resident to keep warm.
   a. Remove feces and deposit in the toilet if possible.
   b. Disinfect the tub with facility approved cleaning agent. Follow directions.
   c. Refill the tub with water and check the temperature.
d. Return the resident to the tub and continue with the bath.

D. Bathing Resident using the Shower

1. Shower can be provided to a resident using an appropriate shower chair based on function and resident preference. For guidelines using these shower chairs, please refer to:
   a. Attachment 3: Operating and Cleaning of Shower Chair Commode
   b. Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair

2. Use appropriate transfer technique per resident Front Card RCP.

3. Resident who is independent in showering:
   a. Teach resident about safety precautions such as having all necessary materials within reach, applying all brakes to shower chair if used, and to test water temperature prior to showering.
   b. Instruct resident to call for assistance using nurse call system when needed.
   c. Periodically check resident for any assistance needed.

E. Grooming

1. Gently apply lotion on resident's back, legs, and feet.

2. Dress resident or assist with dressing as needed.

3. Clip toenails straight across and shape fingernails. Refer to NPP D5 1.0 Foot Care.

4. Comb hair. Handle hair gently when combing, brushing, or styling to avoid damage.

5. Assist the resident to shave facial hair.

6. Apply makeup with resident's consent according to her preference.

F. Reporting / Documentation

1. Report any abnormal skin changes or any discomfort shall be reported to the Licensed Nurses and documented in the medical record.

2. Bathing preferences and needs are indicated in the Front Card of the Resident Care Plan (RCP) of the electronic health record and are included as a care plan problem as needed.

G. Environmental Infection Control

1. Refer to Infection Control Manual

2. The nursing staff are responsible for cleaning and disinfecting the shower chair and tub.

3. Wash nail clippers and soak in approved germicide before using for another resident.
REFERENCES:


CROSS REFERENCES:

LHHPP File: 24-19 The C-625 Battery Operated Ceiling Lift  
Nursing P&P D5 1.0 Foot Care  
Nursing P&P D6 1.1 Battery Operated Lift Transfer  
Nursing P&P D2 2.0 Bathing Alternative and Bed Baths

ATTACHMENTS/APPENDICES:

Attachment 1: Operating and Cleaning of Tub (Arjo Portable Tub)  
Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)  
Attachment 3: Operating and Cleaning of Shower Chair Commode  
Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair  
Attachment 5: Shower Tilt Chairs (Combi Tilt Chairs)

Revised: 8/2002, 2/2010; 05/12/2015; 2016/09/13
Reviewed: 05/12/2015
Approved: 05/12/2015

2016/09/13
05/42/2015 2016/09/13
05/12/2015 2016/09/13
ATTACHMENT 2 - OPERATING THE PORTABLE TUB (Shower Trolley)

A. General Guidelines

1. As part of orientation, the competency of all bedside nursing staff to use portable tub (Shower Trolley) is validated; and annually thereafter as part of their performance appraisal.

2. Requires 2 care givers to operate the equipment for safety.

3. Lifting capacity of the equipment is 330 lbs.

4. The portable tub has leveling stretcher platform that allows overlapping on the bed to allow safe, ergonomic lateral transfer which can be use as transport from room to the shower and vice versa.

5. The portable tub has a steering device for smooth transport. Resident must be placed in the middle of the portable tub prior to transport to prevent the tub from tipping over. Check the portable tub is locked in the horizontal position prior transport using the horizontal adjustment lever.

B. Operating Portable Tub During Shower

1. Activate the all portable tub brakes (all 4 wheels) and adjust it to a convenient working height.

2. Adjust the water temperature from the shower control panel.

3. The portable tub provides room to turn the resident for better access during the showering process.

4. The head pillow is helpful when washing the hair.

C. Draining of Water from the Portable Tub

1. Use the horizontal adjustment lever to slope the portable tub gently to allow the water to drain during the shower.

2. The mattress has drain and run-off channels that also speed water drainage.

3. The portable tub has a flexible drain hose which can be placed next to a floor drain or toilet.

D. Cleaning and Disinfecting

1. Use protective gloves and protective eyewear when using a concentrated disinfectant.

2. Rinse, clean and disinfect the portable tub with facility approved disinfectant before and after use.

3. Tilt the stretcher facilitate cleaning of its underside.

4. Hang the mattress over the stretcher to dry.

E. Storing Portable Tub

1. The portable tub stretcher tilts to the side for easy storage in the unit’s tub room or storage room.

F. Emergency First-Aid in Case of Disinfectant Contamination Exposure

1. Consult MSDS binder which is available in every neighborhood.

2. In case of contamination, follow first-aid treatment for the following:
a. Eyes: Flush with running water for at least 15 minutes.
b. Skin: Remove contaminated clothing and wash affected skin area with running water and soap for at least 15 minutes.
c. Ingestion: Give 4 glasses of milk (water if milk is not available). Do not induce vomiting. If vomiting occurs, give milk or water again.

3. Notify your supervisor immediately to get appropriate medical attention.

REFERENCES:


Arjo Concerto Manual

Adopted from D2 4.6 created on 10/2010

Revised: 2015/05/12, 2016/09/13

Reviewed: 2016/09/13

Approved: 2016/09/13
REMOVAL OF FACIAL HAIR

POLICY:

1. The decision to remove facial hair is based on resident preference or by the decision maker.

2. Any nursing staff except for Home Health Aide can perform and/or assist resident with removing removal of facial hair.

3. Each resident will have his/her their own individual electric or disposable razor and which is replaced as needed and kept and stored at the bedside.

4. An electric razor is preferred for residents who are on anticoagulant therapy or have bleeding tendencies.

PURPOSE:

To promote safe removal of facial hair.

PROCEDURE:

1. Review Resident Care Plan (RCP) for resident’s preference.

2. Encourage resident to participate with self-grooming if able.

3. Disposable razors must be discarded in a sharps container.

4. Documentation:

   The CNA or PCA is to report to the charge nurse if skin is nicked. Record on the DNCR Supplemental Note section the skin area(s) that was nicked, any note for excessive or prolonged bleeding, and resident’s reaction.

REFERENCES


Revised: 3/2001; 2/2010; 07/22/2014

Reviewed: 04/10/15, no changes 10/11/2018

 Approved: 07/22/2014
Care of an Artificial Prosthetic Eye (Artificial Eye)

**POLICY:**

1. On admission, the licensed nurse (LN) will request a physician referral to the Eye Clinic (Ocularist) for consultation of resident’s who have a prosthetic eye, then refer at least yearly, and as needed, to assist in proper care, maintenance, and function.

2. The Medical Clinic nurse is responsible for scheduling and notifying the neighborhood of the Eye Clinic appointments, assessment and care of the artificial eye.

3. Any nursing staff, Any Licensed Nurse LN, can provide routine care of a prosthetic eye.

4. The Registered Nurse is responsible for assessment of resident’s routine in the care of management for a resident with the artificial prosthetic eye, and ongoing condition of the eye socket.

2. Refer resident at least yearly, or as needed, to Eye Clinic for proper maintenance of prosthesis. The Medical Clinic nurse is responsible for scheduling and notifying the unit neighborhood of the appointments.

3. The eye prosthesis should remain in place in the eye socket unless there is a circumstance a problem which necessitates treatment by a physician or for cleaning, or per resident’s preference.

4. Like any other prosthetic device, the prosthesis must be protected from loss or damage. Nursing staff is responsible for entering prosthesis on the property sheet [moved to documentation]

**PURPOSE:**

To ensure that residents receive proper care of the artificial prosthetic eye.

**BACKGROUND**

**CHARACTERISTICS of ARTIFICIAL EYE: GENERAL INFORMATION ABOUT THE PROSTHETIC EYE:**

The artificial eye is made of glass and plastic and must be handled with care.

1. Some prostheses are permanent implants.

2. Removing the prosthesis may irritate the mucosa, increase the tendency for the socket to get smaller and make it harder for the prosthesis to fit. So, it’s encouraged that residents wear the prosthesis and remove it only if necessary for cleaning or procedures. Wearing the prosthetic eye may also enhance the resident’s appearance and promote dignity.

3. Care of the prosthesis is a clean procedure.

4. Cleaning helps ensure that the prosthetic eye remains comfortable.
PROCEDURE:

A. General Artificial Prosthetic Eye Care

1. The Licensed Nurse LN will check the affected eye daily, and as needed, for any abnormalities (e.g., pain, discomfort, redness, discharge) and report any abnormal findings to the attending physician.

2. The artificial prosthetic eye will be cleaned as determined by physician order and resident preference.

3. The resident may perform his/her own prosthetic eye care if determined by the Licensed Nurse LN as being functionally able to perform cleaning and care of the prosthesis. For residents requiring assistance, the nursing staff will assist the resident with, or perform, the prosthetic eye care.

4. The nursing staff will consult with the eye clinic regarding the obtain the necessary prosthetic eye care equipment.

B. Equipment

- 2 x 2 gauze sponges
- Bulb syringe
- Normal saline/warm water with or without mild soap
- Curved small curved basin
- Soft cloth or tissue
- Warm water with or without mild soap
- Gloves
- Rubber suction tip device—usually comes with resident, or may use gloved hands

** (Medical Clinic can obtain a prescription for a new rubber suction tip one and submit it to an outside vendor)

C. Removal, Cleaning and Irrigation

1. Removing and Cleaning Prosthesis and Irrigation of Eye Socket

   a. Perform hand hygiene and have the resident perform hand hygiene if they are assisting with the procedure.
   b. Apply clean gloves
   c. Ask/Assist the resident to turn head to prosthesis side.
   d. Inspect the tissues around the affected eye for signs of inflammation and/or infection and report any abnormal findings to the physician.
   e. Pull the lower lid down to expose the lower rim of the prosthetic eye. Push slightly below the lower eyelid to break the suction and tip the lower rim of the prosthetic out of the orbit of
The eye. Insert fingertip under the lower rim and slide prosthetic out. If prosthetic eye does not slide out, use the bulb suction syringe device to apply direct suction to the prosthesis (see Attachment 1).

e. Place prosthetic eye in the palm of your hand and wash with mild soap and water or saline, gently scrubbing/wiping the prosthesis with a soft cloth.

f. Rinse prosthesis well.

g. Place prosthetic eye on a clean tissue.

h. If there is a physician order to irrigate the eye socket then hold a curved basin below the affected eye, and irrigate the eye socket with warm water or saline using a bulb syringe until secretions have been cleared. Dry around eyes with 2X2 or 4X4 gauze.

i. Insert prosthetic eye back into affected orbit as needed (see Attachment 1 - Inserting Prosthesis).

j. If resident is temporarily unable to wear prosthesis, store it in a labeled (resident name and bed number) closed container filled with water or saline solution, and place container by the resident’s bedside stand. Label container with name and bed number. Notify the physician immediately for any changes in tolerance to wearing the prosthesis.

Irrigation of the Eye Socket per physician’s order

- Hold curved basin below eye.
- Irrigate socket of eye with warm saline using bulb syringe until secretions have been cleared.
- Dry around eyes with 2x2 gauze.

2. Daily Eye Care without Removing Prosthesis

   a. Perform hand hygiene. Wash hands before and after cleaning the eye.
   b. Use a soft cloth, tissue, or 2 x 2 gauze dampened with sterile saline solution or water to gently wipe the eye toward the nose (to avoid the prosthesis from dislodging).
   c. Do not stretch the eyelids.

D. Inserting the Prosthetic Eye(s) (See Attachment 1)

1. Assist/ask resident to sit up and prepare the affected eye for prosthetic insertion by washing the eyelids with mild soap and water from inner to outer canthus. Remove crusts as needed.

2. Moisten the prosthetic eye with water or saline.

3. With non-dominant hand, lift resident’s upper eye lid with thumb and forefinger.

4. With dominant hand, hold the prosthetic eyes so that the notched or pointed edge is positioned towards the nose or inner canthus.

5. Slide the prosthetic eye under the upper lid as far as possible without forcing it, then push down the lower lid allowing eye to slip into place.

6. Gently wipe away any excess fluid with clean gauze from outer to inner canthus to prevent dislodgment of artificial eye.

E. Resident Teaching
1. **Encourage** the resident to participate in their care of the prosthetic eye, and care of the eye socket, as much as functionally possible, including:
   a. Teaching how to remove and insert the prosthesis, Teach resident to remove
   b. Teaching how to clean and store the prosthesis,
   c. Teaching how to clean the eye socket,
   d. Signs and symptoms to report to the LN, Insert and care for own prosthesis if possible.

**A.F. Recording and/or Documentation** The nursing staff Licensed Nurse will check the affected eye daily and as needed for any abnormalities (e.g., pain, redness, and discharge) and report any abnormal findings to the attending physician.

Nursing staff is responsible to document the presence of the prosthetic eye when inventorying the resident’s belongings on admission and document in the Electronic Health Record (EHR) for entering prosthesis on the property sheet.

1. Document on the front card of Resident Care Plan (RCP) the presence of the prosthetic eye in the EHR.

   The Registered Nurse (RN) will initiate a resident care plan on the use of the prosthetic eye and the resident’s routine for prosthetic eye care, and initiate care plan for care of the resident with an artificial eye.

3. Nursing staff will document the daily care of the prosthetic eye is documented in on the Treatment Administration Record (TAR), the EHR.

4. The RN will document changes or unusual findings in the Interdisciplinary Progress Notes EHR.

The artificial eye will be cleaned as determined by physician order, as needed. The resident may do perform his/her own eye care if determined by the Licensed RN as being able to do perform daily cleaning and care of the prosthesis while it is in the eye socket. The nursing staff will furnish the necessary equipment.

**A. Removal, Cleaning and Irrigation**

1. Gather equipment:
   - 2 x 2 gauze sponges
   - bulb syringe
   - normal saline
   - small curved basin
   - soft cloth or tissue
   - warm water, mild soap
   - gloves
   - rubber suction tip—usually comes with resident, or may use gloved hands
   ** Medical clinic can obtain a prescription for a new rubber suction tip one and submit it to an outside vendor.

2. Removing and Cleaning Prosthesis
   a. Explain the procedure.
b. Wash hands thoroughly before handling prosthesis eye. Don clean gloves.
c. Ask/Assist the resident to turn head to prosthesis side.
   Report any abnormal findings to the physician.
d. Depress lower lid so prosthesis slides out and down onto a soft cloth or on the gloved hand.
   May use suction tip as needed. Pull the lower lid down to expose the lower rim of the prosthesis eye. Push slightly below the lower eyelid to break the suction and tip the lower rim of the prosthesis out of the orbit of the eye. Insert fingertip under the lower rim and slide prosthesis out. Use the bulb syringe to apply direct suction to the prosthesis.

e. Place prosthesis eye in the palm of your hand and wash with mild soap and water or saline, gently scrubbing the prosthesis. Do not wash the prosthesis in the sink.
f. Rinse well. Insert prosthesis eye back into affected orbit as needed (see Inserting Prosthesis).
g. If resident is temporarily unable to wear prosthesis, store it in closed container filled with water or saline solution, in and place container by the resident’s bedside stand. Label container with name and bed number. Notify the physician immediately.

3. Irrigation of the Eye Socket per physician’s order
   a. Hold curved basin below eye.
   b. Irrigate socket of eye with warm saline using bulb syringe until secretions have been cleared.
   c. Dry around eyes with 2 x 2 gauze.

4. Daily Eye Care without Removing Prosthesis
   a. Wash hands before and after cleaning the eye.
   b. Use a soft cloth, tissue, or 2 x 2 gauze dampened with sterile saline solution to gently wipe the eye toward the nose (to avoid the prosthesis from dislodging).
   c. Do not stretch the eyelids.

Inserting Prosthesis

Assist/ask resident to sit up and prepare the affected eye for prosthesis insertion by washing the eyelids with mild soap and water from inner to outer canthus. Remove crusts as needed. Moisten the prosthesis eye with water or saline

With nondominant hand, lift resident’s upper eye lid with thumb and forefinger.

With dominant hand, hold the prosthesis eyes so that the notched or pointed edge is positioned towards the nose or inner canthus. The iris of the the prosthesis eye should be facing outward.

Moisten rubber suction tip with normal saline if used.

Slide the prosthesis eye under the upper lid as far as possible without forcing it, then depress push down the lower lid allowing eye to slip into place.
Gently wipe away any excess fluid with clean gauzes from outer to inner canthus to prevent dislodgment of artificial eye.

**Resident Teaching**

Teach resident to remove, insert and care for own prosthesis if as possible

**Recording and/or Documentation**

Nursing staff is responsible for entering prosthesis on the property sheet.

Care of the prosthesis is documented on the front card of RCP and initiate care plan for care of the resident with an artificial eye. (Care Plan: Residents Needs) of the Resident Care Plan.

Care of the prosthesis is documented Daily care of the prosthesis is documented in on the DNCR if CNA or PCA does performs the care; if Licensed Nurse, document on the treatment sheet/administration record (TAR).

Document removal, special cleaning and/or irrigation done by licensed staff on treatment sheet.

Document changes or unusual findings in the Interdisciplinary Progress Notes.

**REFERENCES:**

Elkin, Perry, and Potter, Nursing Interventions and Clinical Skills, 2nd Edition, 2000
Ebsco, Artificial Eye: Insertion and Removal, 2014


Reviewed: __________

Reviewed by ________ Elaine and no revision recommended at this time.

Approved: __________
ATTACHMENT 1: REMOVING AND INSERTING THE PROSTHESIS

**Removing the Prosthesis**

*Without a Suction Cup*
Pull down the lower lid with your index finger, look up and allow the prosthesis to slide out over the lower lid.

*With a Suction Cup*
Wet the cup, squeeze the stem, and press it against the prosthesis. Relax the squeeze and confirm the cup grips. Hold down the lower lid as you tilt the prosthesis out and over the lower lid.

**Inserting the Prosthesis**

Wash the prosthesis between your hands with a non-abrasive, fragrance and moisturizer free soap and hot water. Hold the prosthesis between your thumb and middle finger. Lift the upper lid with your other hand.

Gently slide the top of the prosthesis under the upper lid. Hold the prosthesis in place with your index finger as you pull down the lower lid with your other hand.

FOOT CARE

POLICY:
1. Nursing assistants, are responsible for inspection of the resident's feet/foot daily, routine nail and toenail trimming and reporting of any unusual findings to the licensed nurse.

2. The Licensed Nurse is responsible for documenting and observing the unusual findings and informing the physician of possible need for podiatry referral. Consider requesting wound care consult and/or podiatry referral.

3. Each resident will be provided with individual nail and toenail clippers.

3.4. Residents with diabetes, peripheral vascular disease, peripheral arterial disease, immobility or other foot disorders (but not limited to such as corns, neuromas, calluses, bunions, hammertoe, heel spurs) refer to physician for podiatry referral.

PURPOSE:
To describe the process for routine foot care.

PROCEDURE:

A. Routine Foot Care

1. Inspect skin condition of resident's feet, including between and under the toes to check for cuts, blisters, redness, swelling, irritation, discoloration, or any other unusual skin condition. Observe for any new deformity changes to nails, changes in range of motion or new loss of sensation. Report any unusual findings to the Licensed Nurse.

2. Use soap or foam cleanser to clean feet and toe nails.

3. Rinse and gently dry feet, paying attention to the areas between and under the toes then apply moisturizer.

4. Apply socks or stockings before applying shoes or before resident stands and ambulates.

5. Shoes should be well-fitting and non-compressive. Check the inside of the shoes to make sure that they do not have any protrusions, rough spots or bumps.

6. When the resident is in bed,
   a. Heel protectors may be applied as warranted.
   b. Foot cradle may be placed at the foot of the bed to prevent weight of top bedding from exerting pressure on the toes and to provide support for the feet.

B. Toenail trimming **as needed, considering safety and resident preference**:

1. Trim toenails straight across.
2. Never cut or dig out corner of nails. Do not trim skin.
3. Smooth rough edges with an emery board as needed.
4. Inform Licensed Nurse if unable to trim nails.

C. Documentation

1. Nursing Assistants will document on the DNCR- electronic health record for any unusual foot issues and report to the Licensed Nurse.

2. Licensed Nurse will document any skin changes and physician notification in the Integrated Progress Notes.

2.3. Nursing will document and update care plan.

REFERENCES:


CROSS REFERENCES:

NPP D2 2.0 Bathing Alternatives and Bed Baths
NPP D2 4.0 Operating and Cleaning Jacuzzi Tub
NPP K 2.0 Wound Management and Assessment

Revised: 8/2000; 2/2010; 07/22/2014; 07/14/2015
Reviewed: 07/14/2015
Approved: 07/14/2015
LIMB CARE FOLLOWING AMPUTATION

POLICY:

1. The Licensed Nurse (LN), Certified Nursing Assistant (CNA), or Patient Care assistant (PCA) may perform and/or assist residents with limb care.

2. Registered nurses are responsible for assessments of residents with recent amputations.

3. The LN is responsible for resident education when indicated.

PURPOSE:

To prevent complications after an extremity amputation and to optimize prosthetic fit in the residual limb when indicated.

PROCEDURE:

A. Care of the Residual Limb following a recent amputation

1. Lower Extremity Amputations
   a. Positioning
      i. For transtibial (BKA: below the knee) amputations, when seated, have resident/patient avoid dangling or hanging limb. If ordered, use an "amputee board" or "stump protector" to position the residual limb in extension at the knee. These devices are not necessary for amputations at or proximal to the knee.
      ii. Encourage the resident/patient to move the residual limb to prevent stiffness, spasms, contractures, skin breakdown, and thromboembolism.
      iii. If resident/patient is unable to reposition self, turn and reposition the resident/patient regularly to prevent spasms.
      iv. Turn the resident/patient to a prone position to help prevent contractures in lower extremity amputations per physicians order and as tolerated.
      v. For transtibial amputations, keep the knee straight.
      vi. If a residual limb present, keep the limb flat and extended.
   b. Residual limb shrinker sock use
      i. Don the shrinker sock (see Appendix A).
      ii. The patient is to wear the shrinker sock at all times except for twice daily skin checks and bathing.
      iii. Keep the shrinker sock clean.
         i. Wash the shrinker sock by hand and let air dry
      iv. Ensure that each patient has 2 socks (one to wear and one to wash)

2. Upper Extremity Amputations
   a. Muscle stretching and strengthening
      i. Follow exercises as ordered or recommended by a rehabilitation specialist.
ii. Educate and encourage the resident/patient to perform these exercises independently if appropriate.

b. Touch and Desensitization
   i. Follow the physician's orders and rehabilitation therapists’ recommendations regarding gentle massage, tapping and rubbing to the residual limb in preparing the limb for prosthesis.

c. Residual limb shaping
   i. To manage swelling and prepare the residual for prosthetic fit, a residual limb stocking (“stump” shrinker or compression stocking) may be obtained from orthotics clinic.
   ii. The stocking is washed regularly and when soiled with soap and water and must be thoroughly dried before being applied to the limb.
   iii. Stockings should be used daily unless otherwise specified.
   iv. If a wound is present, skin should be checked q shift.

3. **DO NOT** elevate or prop up knee or hip after 48 hours post-op.

B. **Daily care of the residual limb**

1. Examine the limb daily after the prosthesis is removed for redness, swelling and impaired skin integrity.

2. Assist the resident/patient with washing the residual limb with warm water and mild soap.

3. Rinse and dry thoroughly.

4. While limb is in the process of shrinking for prosthesis fit, do not apply moisturizers and do not shave the limb.

5. Unless otherwise ordered, stump shrinker stockings should be worn daily for comfort and skin protection.

C. **Care of Prosthesis**

1. Clean the interior socket daily with mild soap and water using a soft cloth. Leave to dry overnight.

D. **Reporting and/or Documentation:**

1. In the [DNC Record](#), the licensed nurse, the CNA or PCA will document any redness, abrasions, blisters, boils or edema. Report any skin changes to LN in charge of resident/patient.

2. In [Interdisciplinary Progress Notes/Acute Nursing Flow Sheet](#), the LN will document assessment in the EHR and report any changes to physician.

**ATTACHMENTS/APPENDICES**

Attachment I: Donning the Shrinker Sock
REFERENCES:


CROSS REFERENCES

Nursing Policies & Procedures
D 1.0 Restorative Nursing Program


Reviewed: __________
APPLICATION AND MANAGEMENT OF BRACES

POLICY:

1. The Licensed Nurse, in collaboration with Rehabilitation Services, is responsible for monitoring the correct application of braces by Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) and resident.

2. Braces require a physician order.

3. Obtain Physical Therapy or Occupational Therapy consultation for residents who used a brace prior to admission.

PURPOSE:

To support proper application and management of braces.

PROCEDURE:

A. EQUIPMENT

   Brace with label for resident’s name
   Other devices as necessary (i.e., socks or stockings, shoehorn, etc.)

B. CARE OF RESIDENT WITH BRACE

   1. Review brace application with Rehabilitation if unfamiliar with device.

   2. Nursing staff will check braces for any missing or loose screws or loose or worn-out straps or buckles prior to putting leg brace to resident.

   3. CNA or PCA will check skin at least every shift, and before and after applying brace, for any redness, irritation, or breakdown.

   4. Refer to Physical Therapist if brace is worn-out or ill-fitting. Have the brace checked periodically by the orthotist in conjunction with the Physical Therapist.

   5. Consult with Wound Care Specialist for complex skin conditions.

   6. Consult with Rehabilitation Services, ZSFG or LHH Clinic to obtain a replacement brace if necessary.

D. REPORTING /DOCUMENTATION

   1. Electronic Health Treatment Administration Record:
      a. Document brace application and removal.
      a. Document skin checks every shift.
      b. Document teaching in care of appliance and safety of use.
      c. Document brace application and removal.
      d. Document skin checks every shift.
e. Monitor and document any redness, irritation, or breakdown and report skin changes to Licensed Nurse.
b-f.

2. Resident Care Plan:
   a. Obtain and initiate a Resident Care Plan

   2. Interdisciplinary Progress Notes:
      a. Record resident level of skill and progress toward self-care and use of brace.
      b. Record teaching in care of appliance and safety of use.

   3-2. DNCR:
      a. Monitor and document any redness, irritation, or breakdown and report skin changes to Licensed Nurse.

ATTACHMENTS/APPENDICES:

None

REFERENCES:


Reviewed: __________
ELASTIC OR ANTI-EMBOLIC STOCKINGS

POLICY:
1. A physician’s order is required for elastic compression or anti-embolic stockings.
2. Any nursing staff member may measure and/or apply these stockings.
3. A licensed nurse is responsible for assessing pedal pulses and for evaluating for potential complications.

PURPOSE:
To correctly apply and remove elastic stockings, to promote optimal therapeutic effect and to avoid potential complications.

PROCEDURE:
A. Equipment
   Tape measure (follow manufacturer’s measuring & sizing instructions)
   Order 2 pairs anti embolism stockings, size and type as prescribed by MD

B. Assessment by Licensed Nurse
   1. Licensed nurse will assess for the presence or absence, and quality of pedal pulses and document the findings in the integrated progress note before initial application of elastic stockings. Re-measure or resize stockings for worsening edema or weight loss.
   2. Inspect the toes regularly during the time elastic stockings are worn.
   3. Note skin irritation, temperature, sensation, swelling, circulation, and change.
   4. If complications occur, i.e., skin lesions, remove the stocking and notify the physician.
   5. Remove stockings daily and wash when necessary.
   6. Educate resident who are alert & verbal to report any complications.

C. Documentation
   1. Resident Care Plan (RCP)
      a. Front Card RCP: Document Type, size and length of stockings.
   2. Daily Nursing Care Record (DNCR) / Treatment Administration Record (TAR)
      a.b. Date and time stockings are applied.
Elastic or Anti-embolic Stockings

Revised: 09/2006; 03/25/2014
Reviewed: 03/25/2014
Approved: 03/25/2014
BATTERY OPERATED LIFT TRANSFER

POLICY:

1. The licensed nurse or designee will assess each resident to be transferred by the EZ Lift to determine the most appropriate material, style and size of sling. The results of their assessment will be entered on the front card of the care plan and EZ Lift Sling Assessment Form electronic health record (EHR).

2. Residents will be reassessed for appropriate slings after a change of condition including but not limited to ability to control the head, an amputation, leg sores, significant weight change, difficulty or refusal to follow directions.

3. For residents with aggressive behavior, lacking the ability to follow directions, or whenever otherwise clinically indicated, additional nursing staff will assist with lift transfer (see also #2).

4. Each resident will have his/her own sling(s) which will be identified with his/her name.

5. All nursing staff will receive training and demonstrate competency in the safe use of the equipment prior to transferring a resident at a minimum during new employee orientation and annually thereafter.

6. EZ Lift slings should only be used for the EZ Lift.

PURPOSE:

To provide safe transfers.

PROCEDURE:

A. The licensed nurse or designee will assess each resident prior to the first transfer and reassess as needed to determine the most appropriate sling for the battery operated lift.

1. Resident factors to be considered regarding type of sling:
   a. Resident’s weight
   b. Resident’s measurements:
      i. Length of Trunk: maximum distance 2 inches from resident’s tailbone to base of neck.
      ii. Resident’s girth / width of shoulders – resident’s body should not overlap the sides of the sling
   c. The resident’s ability to support and control his/her head
   d. If the resident has an amputation(s) above the knee or contractures
   e. If the resident has large fleshy thighs or delicate skin or sores on the legs
   f. Difficulty or refusal to follow directions

2. Determining type of sling (See Attachment 1b: EZ Way Sling Sizing Chart)
   a. Regular
      i. Without padded legs
      ii. Made of canvas or mesh for bathing and quick drying
   b. Deluxe (standard)
      i. Have padded legs for comfort and support
      ii. Made of canvas
   c. Multi-purpose
Battery Operated Lift Transfer

i. Made of canvas with padded legs or mesh
   ii. Use for persons with –
       ▪ Lower body contractures
       ▪ With amputation
       ▪ Large fleshy thighs
       ▪ Delicate skin
   iii. Special Head Support slings are available on special order for residents with weak head control

3. Determining the sling size

   a. Select size of sling based on: (See Attachment 1b: EZ Way Sling Sizing Chart):
      i. Weight of the resident, and/or
      ii. Measurement from maximum distance from resident's tailbone to base of neck (see attachment 1).
         **Not applicable with belted mesh or multipurpose slings**
   iii. When determining the appropriate sling size, based on resident's measurement, it is important to evaluate the width of the resident's shoulder in relation to the width of the sling and no portion of the resident's body should overlap the sides of the sling.

   *Note: The size/weight designations stated by the manufacturer are merely estimates and basic guidelines. A proper and safe fit will depend on factors in addition to weight measurement including the height and girth of a resident.

   b. How to measure resident:
      i. The base of the sling must be positioned 2 inches below the tailbone and top of the sling parallel with the top of the shoulder (base of neck). See attachment 1.

B. Documentation

1. Front Card of Resident Care Plan
   a. Document the type of transfer technique used.

2. EZ Lift Sling Assessment Form (See Attachment 1a: EZ Lift Assessment Form)
   a. Complete prior to use of sling and EZ lift, and include in RCP.
   b. Licensed Nurse to update any sling changes based on significant change in resident's condition (Refer to Procedure A: Section 1 “Resident factors to be considered when selecting a sling”).

C. Prior to transfer

1. Check the resident's care plan.

2. Inspect the lift for damage and the sling for fraying or other signs of wear.

3. Identify the resident's sling by name and check style and size using the information in the resident's care plan.

4. Prepare the surface the resident is being transferred to and lock all the wheelchair gurney brakes.

5. Positioning the sling:
   a. Position sling under the resident with the handles facing outward from the resident's skin.
   b. Check that the resident is centered on the sling:
      i. The sling wraps around the shoulders like a shawl.
      ii. Is not more than 3 inches below the coccyx.
iii. The resident will not be sitting on the sling.
iv. The resident’s body and arms fit and remain in the sling during transfer.
c. Lift the resident’s left thigh; and pull the left wing of the sling under the thigh. Then place it on top of the left thigh. Repeat for the other leg. You may choose to do the right leg first, using the right wing and placing it over the right thigh.

6. Positioning the lift:
   a. Wheel must be unlocked during the transfer.
   b. Position the green nosecone 2 inches above the abdomen.

7. Attaching the Regular and Deluxe Sling to the lift:
   a. First attach the two shortest loops at the shoulders. (The other loops are used to move from a reclining position to a reclining position).
   b. Take the wing lying on the left thigh and using the middle loop attaches it to the right lift hook. Repeat for the other leg. You may choose to do the right leg first attaching the loop to the left lift hook.

8. Attaching the Multipurpose Sling to the lift:
   a. Check that the center of the commode hole is one inch below the tailbone.
   b. The wings of the sling are threaded through each other.
   c. The middle or longest loop may be used depending upon the resident’s comfort and sense of comfort.

9. Moving the resident to the chair:
   a. Ensure that the resident’s arms are in the sling.
   b. Push the “Up button” on the hand control.
   c. Once there is tension and the resident is 1 inch off the mattress:
      i. Check that loops are secure in the hooks
      ii. The sling is smooth under the resident
   d. Move the lift to the chair and standing behind the chair use the handles to guide the resident.
   e. Push the “down” button.

10. Emergency Lowering:
    a. If the hand held controls or the controls on the lift fail:
       i. Pull up on the emergency button 1-3 times
       ii. Pull up on the emergency lowering handle until the resident is placed on the desired surface.

REFERENCES:


CROSS REFERENCES:

Nursing P&P D6 2.0 Transfer Techniques
Nursing P&P D6 4.0 Positioning and Alignment in Bed and Chair
ATTACHMENTS/APPENDICES:

Attachment 1a: EZ Lift Sling Assessment Form
Attachment 1b: EZ Way Sling Sizing Chart
Attachment 2: EZ Lift Operating Instructions
Attachment 3: Competency Check List for Battery-Operated Lift


Reviewed: 09/23/2016

Approved: 09/23/2016
### EZ LIFT SLING ASSESSMENT FORM

<table>
<thead>
<tr>
<th>Assessment Date:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident condition (check all that applies)</td>
<td>Indicate reason, if sling size selected does not fall within weight range per sizing chart (see back page)</td>
</tr>
<tr>
<td>☐ Lift &amp; Transfer</td>
<td>☐ Based on resident’s girth / width of shoulders (resident’s body overlaps the side for sling size).</td>
</tr>
<tr>
<td>☐ Bathing</td>
<td>☐ Based on resident’s length of trunk</td>
</tr>
<tr>
<td>☐ Amputee</td>
<td>☐ Multi-purpose sling</td>
</tr>
<tr>
<td>☐ Large thighs</td>
<td>☐ Deluxe Sling</td>
</tr>
<tr>
<td>☐ Delicate skin</td>
<td>☐ Deluxe Mesh Sling</td>
</tr>
<tr>
<td>☐ Needs extra head support</td>
<td>☐ Deluxe Head Support Sling</td>
</tr>
<tr>
<td>☐ Contractures</td>
<td>☐ Small</td>
</tr>
<tr>
<td>☐ Has skin lesions</td>
<td>☐ Med</td>
</tr>
<tr>
<td>☐ Difficulty or refusal to follow directions</td>
<td>☐ Large</td>
</tr>
<tr>
<td></td>
<td>☐ XL</td>
</tr>
<tr>
<td></td>
<td>☐ XXL</td>
</tr>
<tr>
<td></td>
<td>☐ XXXL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Sling</th>
<th>Sling Size Selected</th>
<th>Loops</th>
<th># of persons needed for transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Multi-purpose sling</td>
<td>☐ Small</td>
<td>Upper loop</td>
<td>☐ 1 person-assist staff</td>
</tr>
<tr>
<td>☐ Deluxe Sling</td>
<td>☐ Med</td>
<td>___</td>
<td>☐ 2 person-assist staff</td>
</tr>
<tr>
<td>☐ Deluxe Mesh Sling</td>
<td>☐ Large</td>
<td>Lower loop</td>
<td></td>
</tr>
<tr>
<td>☐ Deluxe Head Support Sling</td>
<td>☐ XXL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ XXXL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Licensed Nurse Signature:**

**Date:**

Please refer to “EZ-Way Sling Sizing Chart” (back page) in selecting sling appropriate size of sling.
BATTERY-OPERATED CEILING LIFT (C 625)

POLICY:

1. All staff required to use the lift will receive training and demonstrate competency prior to transferring a resident. Competencies will be established during employee orientation and annually thereafter.

2. Two nursing staff members are always required for operation of the Battery Operated Ceiling Lift.

3. The Licensed Nurse assesses each resident to determine safe transfer techniques, type and size of sling according to resident's height and weight.

4. Each resident should have their own labelled sling.

5. Ceiling lift is to be charged when not in use to prolong battery life and assure readiness for use at any time.

6. Each staff using the sling must inspect sling’s seams, loops, straps, and fabric for any loose threads, fraying, and holes prior to use and after laundry. Do not use damaged slings (such as lift straps that are frayed, emergency raising or lowering feature is not working) must be tagged and reported to Facility Services as soon as identified. The ceiling lift must not be used until repair and inspection is completed.

7. Never use damage or broken of the ceiling lift or slings.

8. Weight restriction for C-625 ceiling lift model is less than or equal to 625 pounds.

9. Ceiling lift slings should only be used for ceiling lifts.

PURPOSE:

To provide dependent residents with safe transfers with privacy and dignity.

BACKGROUND:

The C-625 is a battery operated ceiling lift which lifts, positions and transfers residents. The C625 is a fixed lift and can carry up to 625 lbs. Lift tracks are securely mounted to the ceiling of the resident’s rooms, in the bathroom, in the tub rooms, and in the therapy areas of the ground floor Pavilion. The ceiling lift can move a resident from bed to chair, bed to toilet, chair to tub, and vice versa; or from floor to bed. In some rooms, a ceiling turn table changes track lift directions.

Components of the Ceiling Lift System:

1. Tracks
2. Lifting straps
3. Emergency stop/Lowering feature
4. Carry bar
5. Pneumatic hand control

PROCEDURES:

Follow manufacturer’s instruction.

A. Prior to Resident’s Transfer
Battery-Operated Ceiling Lift (C 625)

1. Check resident’s care plan.
2. Explain the transfer and how the ceilings lift works to the resident.
3. The staff needs to ensure that resident’s weight does not exceed 625 pounds.
4. Each resident will have his/her own sling (bathing or regular transfer sling).
5. Provide privacy. All residents are to be completely draped before using the ceiling lift.

B. Resident’s Transfer Using Ceiling Lift

1. Prepare the chair/bed/gurney to which the resident is to be transferred. Position the chair against a solid surface. Ensure that all bed and chair brakes are locked.
2. Move the lift away from the charging station close to the resident who is being transferred. Move the lift along the tracks using the bar.
3. Prepare the resident being transferred with the appropriate sling. Make sure the sling is correctly fitted and adjusted on each side of the individual so that maximum comfort and safety are achieved prior to transferring.
4. Once the resident is fitted with the sling, move the lift so that it is positioned directly over the resident. Lower the carry bar to a height so that the straps of the sling can be easily attached to the carry bar. Check to ensure that the lift is correctly positioned directly above the resident to be lifted.
5. Attach the straps of the sling to the hooks of the carry bar. The straps on each side of the sling are generally attached to the corresponding side of the carry bar. Double check to ensure that the straps are properly attached to the carry bar and that the resident being lifted is properly positioned in the sling prior to lifting.
6. Raise the resident by pressing the UP button of the hand control. Always use caution when lowering/raising a resident who is on the sling of the lift and when moving the lift along the tracks. Watch out for and avoid any obstructions that may cause injury to the resident, or damage to the lift.
7. Once at the correct height the resident can be moved along the track to the desired location.
8. Once at the desired location the resident in the sling can be lowered / raised to the correct height in order to complete the transfer. Prior to removing the straps of the sling from the carry bar, be sure to check that the resident being lifted is securely supported in the final desired position.
9. Lower the carry bar sufficiently to allow the straps of the sling to be easily removed from the carry bar. Ensure that the carry bar does not come in contact with the resident in the sling. Remove the straps from the carry bar. Raise the carry bar and move it away so it does not interfere with the removal of the sling from the resident.
10. The sling can now be gently removed from the resident and stored.
11. The lift can now be moved to a safe location or its original location. It is recommended that the lift be left on charge position when not in operation.

Key points to consider:
Emergency stopping - This allows the staff to shut off the power completely. To activate this feature, the red cord is pulled once. The lift immediately stops and its functions will be disabled. To restore the power back to the lift, the white plastic tab that popped out when the cord was pulled, needs to be reinserted into the lift and pushed back in to turn the lift on.

Emergency lowering – In the event that the DOWN button on the hand control does not function or in the event of power failure, the carry bar can be lowered by pulling down and holding the RED emergency cord. Continue to pull down the cord until the carry bar (or resident) is safely lowered to the desired position. The unit will continue to beep as long as the cord is pulled down and it will not stop until the cord is released. The EMERGENCY lowering button does not provide a raising function.

Emergency manual raising and lowering – When the above emergency procedures do not work, contact Facility Services to perform the manual emergency interventions.

C. Types of Sling and Application

1. Sling Selection and Sizing Guidelines

   a. Slings are sized based on the resident's height, weight, and includes resident's comfort. The process of selection of sling does not stop once appropriate size is selected and continues during the lifting process, evaluating the resident's safety, comfort and position.

   b. Sizing Guide

      | Size   | Height   | Weight      |
      |--------|----------|-------------|
      | (Grey) | Junior <4’ | <110 lbs    |
      | (Red)  | Small 4’-5’6” | 95 lbs-150 lbs |
      | (Yellow) | Medium 5’-6’ | 150 lbs-250 lbs |
      | (Green) | Large 6’-7’ | 250 lbs-400 lbs |
      | (Blue)  | X-Large 6’-7’ | 400 lbs-480 lbs |
      | (Black) | XX-Large >6.5’ | >480 lbs |

2. Different Types of Slings and Application

   a. Hammock Sling - provides total body support including head and neck; distributes body weight through the thighs and back area and is well suited for a double leg amputee. Allows toileting but not recommended for this use due to the small opening size. The sling comes with leg, side and head straps. Available in mesh or quilted material.

      How to apply:
      i. The resident should be rolled onto the sling with his/her spine aligned with the stripe facing the bed.
      ii. The top of the sling should start in the area between the top of the resident’s head and top of his/her ear and ends at the resident’s tailbone.
      iii. Cross the long leg strap through the short strap.
      iv. The straps on the sling should be attached to the carry bar starting from the middle straps, then the outside straps.
      v. Always use the long loops for the legs/thighs and the short loops for the shoulders.
      vi. For a bilateral lower extremity amputee, the short leg straps can be crossed in between the resident’s thighs. The long leg straps are then crossed through the shorter leg straps and hooked to the carry bar.
      vii. Hold the carry bar away from the residents face until it is higher than his/her head.
      viii. Ask the resident to hold onto the legs straps while being lifted.
b. **Universal Sling** - Multi-purpose sling that provides toileting access as well as good back and thigh support. The sling comes with leg, hip, and shoulder straps and features loops to accommodate various seating positions.

Types of Universal Slings:
- Universal mesh sling – use for bathing.
- Universal quilted – use for transfer.
- Universal padded with a head support - use for transfer.

How to apply:
- The resident should be rolled onto the sling with his/her spine aligned with the stripe facing the bed.
- The sling can also be applied while the resident is sitting up in chair or head of the bed is raised up. The sling needs to be placed behind the resident with the stripe of the sling aligned with the center of the resident’s back – label facing the bed.
- The top of the sling should start at the shoulders and it should end at the resident’s coccyx.
- Gently pull the inside leg loops until the sling’s bottom is underneath the resident’s thighs. Then cross the inner leg loops between the resident’s thighs. The right leg strap should connect to the left hook and vice versa.
- When attaching the sling to the carry bar, first hook the leg, then the thigh loops, and finally the shoulder loops. By using this order, it prevents the carry bar from hitting the resident in the face.
- Always use the longest loop for the legs and thighs.
- Use the short loop for the shoulders (for a 90 degree position).
- Before lifting, ask the resident to hold on to the cross straps that come up through the legs.
- Lift the resident straight up before moving.
- Position the resident to the desired location/bed.
- Raise the head of the bed before lowering the resident into the bed or chair.
- Remove the sling from the carry bar and pull the sling up from the back of the resident.

Universal slings can be used for pericare:
- When the resident is in bed, unhook the shoulder straps and leg straps.
- Un-cross the leg straps and the hook them back onto the carry bar, right strap to the right hook and left strap to the left hook.
- Slowly raise the resident’s legs to spread the legs for perineal care. Check that the buttocks remain in bed to promote safety.

c. **Positioning Sling** – It is intended to be permanently in place on the bed, either under a sheet or incontinent pads, to turn a resident from side to side. The sling has four pairs of straps. The sling is also used for transfers to other horizontal surfaces and repositioning in bed.

Use for Lifting:
- The white stitching down the middle of the sling should be aligned with the resident’s spine.
- Two pillows must be always be used with this sling. The first pillow should be placed lengthwise under the resident’s head to support head and neck. The second pillow should be placed under the knees for support.
- Depending on resident’s width, the carry bar can be aligned widthwise or lengthwise, parallel to the resident.
- For this sling, always use the long loops when attaching the sling to the carry bar.
- Attach the sling to the carry bar starting with the middle straps and then out to the head and feet.
Use for Positioning:
   i. With the sling already under the resident in the bed, attach the loops from only one side of the sling to the carry bar.
   ii. Raise the side rail on the opposite side of the attached sling.
   iii. Raise the sling, allowing the resident to turn towards the raised side rail.
   iv. When turning a resident the nurse can either support the position with pillows or leave the sling attached to the ceiling lift.

Use for Back Care & Pericare:
   i. Hook the loops of the head, shoulder, and waist on one side of the positioning sling to the carry bar.
   ii. Raise the side rail on the opposite side of the attached sling.
   iii. Place a pillow between the resident’s knees and lift the sling to turn the resident.

d. Band Slings – They come in pairs (long and short) and can be used to lift a resident’s thighs for pericare or Foley catheter placement, and to lift a leg for foot-care or dressing changes. This sling will aid in tilting the pelvis and spreading the legs. Band Slings can be used with the EZ lift.

Use for Foot Care:
   i. Place band sling under the calf and lift to desired height. Do not lift too high or the sling will slip under the knees.

Use for Pericare:
   i. Lower the head of the bed.
   ii. Place one band sling under each thigh and lift.
   iii. The pads also support and hold the thighs away from the perineum.

e. Ambulation Slings – specialized slings used by resident in the Therapy Gym. This walking sling is designed to ambulate resident during therapy.

f. Pool Slings – sling designed to lower and raise residents in and out of the pool during Fitness and Aquatic Therapy.
   i. Residents being lowered into the pool require one person operating the sling mechanism and a second person placed in the pool to guide the resident.

D. Documentation [Procedure]

1. Resident Care Plan (RCP): Indicate in the Front Card of RCP Care Plan if ceiling lift is used for transfers and document in electronic health record the type and size of sling.

E. Charging Lift Battery

1. The battery has to be charged or returned to charger at the end of the track to sustain the longest life for the batteries. The lift can remain on the charger until the next time it is needed.

2. In the event of power outage a fully charged batteries will last between 80-100 lifts.

3. If the batteries are low, the light will turn orange on the underside panel. The display screen will indicate a low battery & a slow audible beep will alarm. If the battery is low and in the middle of transfer, complete the lift in progress, and then move the lift to the end of the track where the charger is located.

4. The light indicator will turn red on the underside panel and the fast beeping alarm will sound indicating that the batteries are fully drained and UP function will be disabled. The DOWN and the
batteries **EMERGENCY LOWERING** function along with traversing will continue to operate. The lift requires four (4) hours of charging when batteries are depleted.

5. The light on the charge turns **green** when the batteries are fully charged and will indicate 100% on the LCD screen on the underside panel.

### F. Care and Maintenance of Ceiling Lift and Sling

1. The carry bar must only be cleaned and disinfected by facility-approved disinfectant after each resident use. Wipe the carry bar lift and hooks after each use.

   a. Visually Check the Equipment for the Following
      - Lifting tape shows no signs of fraying or breaking along its entire length.
      - The stitching of the lifting tape where it connects to the carry bar shows NO signs of fraying or breaking.
      - The slings that will be used show no signs wear and tear. The straps of the sling that connect to the carry bar of the lift shows NO sign of fraying and breaking.
      - The airline tube that connects the hand control to the lift is not kinked, twisted or knotted, cut or damaged.
      - All the functions of the control work correctly (UP and DOWN buttons).
      - The brackets that hold the track in place on the ceiling are secure and do not move or appear loose.
      - There are no cuts, dents or sharp edges on the carry bar that may damage the straps of the sling.
      - The lift has no unusual sounds when the carry bar is moved UP/DOWN or the lift is moved Left/Right.
      - Check that there are end stops installed at each end of the track.

   b. Sling Care
      - When laundering slings, the temperature of the water is 175 degrees. Hang to air dry.
      - Check all seams, loops, straps and fabric for any damage from laundering.
      - Check the loops if damaged, torn or frayed.
      - Check for loose stitching.
      - Check for heat damage (puckering or crumpling).
      - Check for significant staining.
      - Check for tears in the fabric.
      - Replace sling as necessary.

### REFERENCE:


### CROSS REFERENCES:

Nursing P&P D6 2.0 Transfer Techniques  
Nursing P&P D6 4.0 Positioning and Alignment in Bed and Chair

### ATTACHMENTS/APPENDICES:

Attachment 1: Competency Check List for Ceiling Lift for Nursing Staff
TRANSFER TECHNIQUES

POLICY:

1. The Licensed Nurse and/or Rehab staff assesses the resident’s ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. All residents who require battery-operated lift transfer must have their own assigned sling for transfer and bathing. Each sling must have resident’s name and room number.

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. Any member of nursing staff (LN, CNA, or PCA) may perform transfer procedure. Check care plan for required number of staff assistance during transfer.

PURPOSE:

To ensure resident’s and staff’s safety when moving the resident from one surface to another.

PROCEDURE:

A. Prior to Transfer

Review Front Card of Resident Care Plan prior to transfer of resident

B. Transfer Techniques

1. **Slide Transfer Technique** (Gurney to Bed and Vice Versa)
   
   a. Place the gurney parallel to the bed.
   b. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.
   c. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.
   d. Set all brakes on all equipment in a “locked” position after the equipment is positioned. Lock all bed brakes.
   e. Use a draw sheet or slider sheet to assist with transfer.
   f. Always have drainage bags lower than the area being drained.

2. **Pivot transfer Technique**

   a. At the time of transfer, resident should have shoes and socks on.
   b. Position wheelchair or chair at head of bed, parallel to the bed. If the resident has one non-functioning upper or lower extremity, place the chair on the resident’s unaffected side.
   c. Lock all bed and wheelchair brakes and fold wheelchair footrests back.
   d. Adjust height of the bed to what is appropriate for the resident.
   e. Help the resident sit on the side of the bed with feet touching the floor.
   f. Use a gait belt as needed.
   g. If transferring resident without the gait belt, support the resident by placing your hands under the arms and around the shoulder blades of the resident.
h. During transfer, block resident’s feet and knees with your feet and knees to prevent falling.

3. **Sliding Board Transfer Technique**

   a. Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.
   b. Lower the bed to the same height as the seat of the chair or wheelchair.
   c. Assist the resident in a seated position.
   d. Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.
   e. Slide the resident along the board to reach the chair.
   f. Lock all bed and wheelchair brakes and fold wheelchair footrests back.

4. **Transfer Techniques using Mechanical Lift** (Refer to NPP D6 1.1 Battery Operated Lift Transfer and NPP D6 1.4 Battery Operated Ceiling Lift)

C. **Reporting and/or Documentation**

1. Reporting

   All care team will communicate to the physician and rehab staff when further transferring training is warranted.

2. Documentation

   a. **Electronic Health Record (EHR)Daily Nursing Care Record (DNCR)**

      i. The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer.
      ii. The Licensed Nurse documents on weekly or monthly summary any change in functional level.

   b. **Interdisciplinary Progress Notes**

      The Licensed Nurse documents on weekly or monthly summary any change in functional level.

   c. **Resident Care Plan (RCP)**

      i. The Licensed Nurse documents in the RCP Front CardCare Plan the type and level of assistance needed for transfer.
      ii. All residents who require battery-operated lift transfer must be documented on the Front Card of Resident Care Plan indicating what type of lift is used, type and size of slings used, and number of persons required to assist in transfer.
      iii. For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry.

**REFERENCES:**


CROSS REFERENCES:

LHHPP File: 24-19 The C-625 Battery Operated Ceiling Lift
Nursing P&P D1 1.0 Restorative Nursing Program
Nursing P&P D6 1.1 Battery Operated Lift Transfer
Nursing P&P D6 1.4 Battery Operated Ceiling Lift
Nursing P&P D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

None

Reviewed: 2016/09/13
Approved: 2016/09/13
AMBULATION

POLICY:

1. The Registered Nurse assesses the resident's ability to ambulate and need for adaptive devices in collaboration with resident care interdisciplinary team members upon admission and any change of condition.

2. Any member of the nursing staff except Home Health Aides (HHA) may ambulate resident as indicated on the Resident’s plan of care.

PURPOSE:

To prevent complications of immobility & deconditioning.

PROCEDURE:

A. Assessment

1. Upon completion of the initial & on-going assessment the RN will communicate to the care team members regarding the resident’s ambulation needs and assistive/adaptive devices required.

2. See Restorative Policy and Procedure (NPP D0 1.0)

B. Documentation

1. Resident Care Plan

   a. Include ambulation needs, devices, and preferences on the Front Card of Resident Care Plan.

2. Interdisciplinary Progress Notes, Electronic Health Record

   a. At minimum, include documentation addressing declines from baseline when ambulation is written only on the front card and not part of a restorative program.

REFERENCES:

CMS Long -Term Care Resident Assessment User’s Manual (2007)

CROSS REFERENCES:

Nursing Policy and Procedure C1.0 Admission and Readmission
Nursing Policy and Procedure C1.2 Relocation
Nursing Policy and Procedure C1.3 Discharge
Nursing Policy and Procedure D5 2.0 Amputation and Prosthesis Care
Nursing Policy and Procedure D5 5.0 Braces - Leg
Nursing Policy and Procedure C3.0 Documentation of Resident Care by Licensed Nurse
Nursing Policy and Procedure C3.1 Documentation of Resident Care by CNA and PCA
Nursing Policy and Procedure D01 1.0 Restorative Nursing Programs

LHH Policy and Procedure 23-01 Resident Care Plan, Resident Care Team, and Resident Care Conference

Revised: 12/2004; 01/2008; 03/25/2014
Reviewed: 03/25/2014
Approved: 03/25/2014
BED MAKING

POLICY:

1. Any nursing staff including Home Health Aides (HHA) may make the resident’s bed and perform this procedure.

2. Beds will be routinely stripped and wiped and all linens changed once a week as scheduled by the neighborhood.

2. For residents who are total bed rest and incontinent, linen change is performed daily and as needed for residents who are total bed rest and incontinent.

3. Gloves will be worn to remove linen soiled with body secretions.

PURPOSE:

To provide the resident with a clean bed.

EQUIPMENT:

- 2 large sheets (1 fitted, 1 flat)
- 1 linen draw sheet
- 1 bed pad
- 1-2 pillow cases
- 1 bed spread
- Facility-approved disinfectant wipes
- Dirty linen hamper

PROCEDURE:

A. Change wet, damp and soiled linens right away (Refer to Bed Stripping Policy).

A. Equipment

- 2 large sheets (1 fitted, 1 flat)
- 1 linen draw sheet
- 1 bed pad
- 1 blanket
- 1-2 pillow cases
- 1 bed spread
- Facility-approved disinfectant wipes

B. Bring only the linens needed.

C. Raise bed to a comfortable working height and keep bed flat.

D. Reposition bed as needed to ensure proper body mechanics.

E. Refer to Mosby’s Textbook for Nursing Assistants. Maintain proper body mechanics at all times.
F. Follow Standard Precautions.

G. Place clean linens on a clean surface.

H. Place fitted sheet on mattress, applying one side of the bed first, then folding over to the other side to cover mattress pad.

I. Apply open draw sheet on top of fitted sheet using same procedure as fitted sheet. Tuck both sides of draw sheet under mattress.

J. Apply flat sheet on top of fitted sheet and draw sheet using same procedure as fitted sheet.

K. Place blanket on the bed. Tuck in top linens together at foot of bed and make a mitered corner.

L. Straighten all top linen.

M. Apply pillow case to pillow(s) and place pillow(s) on bed.

N. Straighten loose sheets, blankets and bed spreads.

O. Keep bed at low position, return bed to desired position and lock all wheels when done.

C.P. Immediately Report defective equipment to the nurse manager/charge nurse who will order a replacement or submit a work order to Facility Services by telephone or online.

CROSS REFERENCE:

NPP D9 3.0 Bed Stripping and Bedside Cleaning

REFERENCE:


Review: 09/09/2014

Approved: 09/09/2014
BED STRIPPING AND BEDSIDE TERMINAL CLEANING

POLICY:

1. The charge nurse schedules and assigns the nursing staff to perform weekly bedside cleaning.

2. The entire bed and corresponding bedside area is to be routinely cleaned with facility-approved disinfectant, and allowed to air dry.
   This includes the bed frame, headboard and siderails, mattress platform, if needed, mattress, castors, over bed trapeze, footboard, bedside call system, bedside lamp, over bed table, bedside table, bedside chair, and any other equipment or furniture in the resident's bedside.

3. Any part of the bed or bedside area that becomes soiled between the scheduled cleaning is to be cleaned at that time.

4. Terminal cleaning of the bedside unit is to be performed when resident is discharged, transferred or has expired.

PURPOSE:

To maintain a clean environment for the resident.

PROCEDURE:

1. Raise the bed to a comfortable working height and keep bed flat

2. Reposition bed as needed.

3. Maintain proper body mechanics at all times.

4. Strip linen from beds to be washed and place in dirty linen hamper. *(For residents on hazardous drugs, refer to HWPP 25-05 Hazardous Drugs Management for linen care).*
   a. Follow Standard Precautions, unless additional precautions are necessary (e.g., chemotherapeutic precautions, contact precautions).
   b. Do not shake linens. When removing linen, roll linen away from you.
   c. Hold dirty linens away from your uniform and do not put linens on the floor or on clean linens.
   d. Discard dirty linens into the dirty linen hamper.
   e. Remove and discard dirty gloves, perform hand hygiene.

4. Raise the bed to a comfortable working height.
2.5. Clean bed frame, headboard and bed rails, mattress platform, if needed, mattress castors, over bed trapeze, footboard, bedside call system, bedside lamp, over bed table, bedside table, bedside chair, and any other equipment or furniture in the resident’s bedside.

3. Clean the entire bed and bedside with facility-approved disinfectant products; allow to air dry.

4. Clean the entire surfaces of the mattress including the top, bottom, and sides.

5. Once the bed has air-dried, clean linens are applied. Refer to Bed Making P&P.

6. Terminal cleaning [follow bed stripping procedures and remove all personal items].
   a. Inventory, box and label property of previous resident.
   b. Wipe headboard from top to bottom and clockwise.
   c. Remove headboard and wipe underneath. Replace headboard when dry.
   d. Clean mattress top, bottom and sides.
   e. Clean under mattress.
   f. Clean inside and outside bed rails.
   g. Make sure bed is unplugged. Remove footboard and carefully wipe between electrical connections. Replace footboard when dry.
   h. Wipe bottom of the bed.
   i. Once the bed has air-dried, clean linens are applied. Refer to Bed Making P&P.
   j. HHA/PCA/CNA notifies Charge Nurse that the room is ready for EVS cleaning
   k. HHA/PCA/CNA initials Room Readiness Checklist located in the White Board in the Resident’s room once work has been done.
   l. Licensed Nurse signs off on the HHA/PCA/CNA work.
   m. Check bed and call light functions.

6.7. Reporting
   a. Report broken or defective bed or equipment and cracks in the mattress cover to the licensed nurse and ensure a work requisition is completed and followed up.

CROSS-REFERENCE:

NPP D9 2.0 Bed Making

HWPP 25-05 Hazardous Drugs Management
WATER PITCHERS

POLICY:

1. Water pitchers with liners are provided to all residents unless contraindicated.

2. Water pitchers are to be labeled with the resident’s initials and date changed.

2.3. Water pitchers and water pitcher liners are changed weekly and as needed.

PURPOSE:

To provide fresh water and clean drinking supplies for each the resident.

PROCEDURE:

1. Equipment:

   Water pitcher with lid
   Water pitcher liner
   Straws
   Disposable drinking cups

2. Wash hands before beginning to replace new liners and pitchers.

3. Replenish water pitcher every shift or and as often as necessary. Consider resident’s preference when refilling water.

4. Change pitcher liners weekly or as needed; and Change disposable drinking cups or straws as needed.

5. Discard and replace broken water pitchers and liners.

Reviewed: 09/14/2014; 10/11/2018
Approved: 09/09/2014
ORAL MANAGEMENT OF NUTRITIONAL NEEDS

POLICY:

1. Physician orders are required for diets, nutritional supplements, swallowing evaluation, and standard aspiration precautions (standard precautions and specialized feeding plans, any additional individualized precautions recommended by speech therapy).

2. Nursing staff is responsible for monitoring residents’ safety related to eating as well as adequate nutritional intake.

3. Nursing staff will inform the dietitian and physician regarding unintended weight loss or gain.

4. Family, volunteers, and visitors will be educated regarding permitted food and beverages.

5. Standard aspiration precautions will be documented in the resident care plan.

PURPOSE:

To promote adequate and safe nutrition and hydration.

PROCEDURE:

1. On admission and throughout the resident’s stay, the Licensed Nurse (LN) will monitor all residents for ability to eat safely and for any signs or symptoms of swallowing difficulties or changes in the resident's ability to eat/swallow.

2. The physician and dietitian will be notified of any nutrition and/or swallowing difficulties.

3. The nurse reports unintended weight loss or gain to the dietitian and physician:
   a. 5% or greater over 30 days
   b. 7.5% or greater over 90 days
   c. 10% or greater over 180 days

4. Nursing staff will verify that the meal/snack is consistent with the resident's diet as ordered by the physician.

5. Nourishment is to be served by nursing staff between meals, at bedtime and upon resident’s request.

6. All family, volunteers and other visitors will be instructed to speak with the nurse prior to offering the resident any food or beverages.

7. Refer to LHHPP 26-02: Management of Dysphagia and Aspiration Risk.

8. Nursing staff assigned as Line of Sight staff during meals, will have the following responsibilities:
   a. Designated staff will wear a designated pink vest.
b. Designated staff will stay in the great room during meals (from beginning to end; until the last resident in the great room is finished eating).

c. Designated staff will ensure that residents are seated at an appropriate table/seat.

d. Designated staff will continuously scan the area of the Great Room to monitor that standard aspiration precautions (see LHHPP 26-02) are being followed.

e. Designated staff will monitor that staff assisting resident who are on a specialized feeding plan, are following the plan. Precautions are printed on the resident's tray ticket for easy reference and the meal tray has a pink plate cover.

f. Designated staff will monitor and intervene as necessary when patients are eating unsafely or showing signs/risk of aspiration (e.g., excessive coughing, excessive throat clearing, impulsive eating behavior, etc.).

9. The designated Line of Sight staff will not be assigned other responsibilities during meal time nor assist individual residents during meal time as he or she will not be able provide adequate supervision to the other residents.

10. After the meal is completed, the Nursing Assistant will clean the resident's hands, face and clothing as needed. Keep resident sitting upright for at least 20 minutes after the meal. If residents must lie down, position on the side.

11. Food Storage

a. All foods stored in the refrigerator are to be covered, labeled, and dated. Unopened items will have a stamped expiration date. Opened items will be dated with the date the item was opened.

b. Uneaten food from the meal tray should be discarded or sent back to kitchen for disposal.

c. Milk should be discarded after one hour at room temperature.

d. Nourishment refrigerators are to be kept secured. Galley refrigerators are secured behind a locked door. Great room refrigerators will be locked.

12. Documentation

a. Nursing Assistant will calculate and document in the Daily Nursing Care Record (DNCR) the resident’s meal intake. Report to Licensed Nurse if meal intake is less than 50%.

b. If a supplement is given per physician’s order, the amount of the supplement consumed is documented in the Treatment Administration Record (TAR).

c. Resident’s diet, standard aspiration precautions, adaptive equipment used for eating, and dining preferences are documented in the Front Card of Resident Care Plan.

d. In addition to standard aspiration precautions, the speech pathologist may develop a Specialized Feeding Plan (SFP) for some of the residents who are at risk for aspiration (Refer to LHP26-02: Management of Dysphagia and Aspiration Risk). These specific precautions, once ordered by the physician, will be listed on the resident's tray ticket for easy reference by nursing staff. A copy of the SFP will be placed by the speech pathologist is the RCP. They will also be recorded in the resident's care plan.

e. If resident is on fluid restrictions, fluid intake is documented in the TAR-Intake and Output section of the electronic health record and tallied by P.M. shift nightly.

REFERENCES

NONE

CROSS REFERENCES:
LHHPP File: 26-02 Management of Dysphagia and Aspiration Risk
LHHPP File: 26-04 Resident Dining Service

Nursing P&P B 5.0 Color Codes- Resident Identification
Nursing P&P G 3.0 Intake and Output

ATTACHMENT/APPENDIX:

NONE

Reviewed: 2017/05/09
Approved: 2017/05/09
TOTAL PARENTERAL NUTRITION

POLICIES:

1. A Registered Nurse (RN), who is trained and competent, may administer and maintain Total Parenteral Nutrition (TPN) infusions upon written physician order utilizing the EHR Parenteral Nutrition Order Set recorded on the LHH Physician Orders Adult Parenteral Nutrition Order Form MR 160.

2. TPN infusions will not hang longer than 24 hours and the rate is regulated by a pump.

3. Total Parenteral Nutrition (TPN) solution including greater than 10% dextrose cannot be abruptly discontinued.

4. Laguna Honda only provides TPN and administration is limited to neighborhood Pavilion Mezzanine and South 2.

PURPOSE:

To provide safe delivery and maintenance of Total Parenteral Nutrition.

BACKGROUND INFORMATION:

Parenteral Nutrition (PN) is the intravenous (IV) administration of nutrients in residents/patients without a functional or accessible gastrointestinal (GI) tract and provides protein in the form of amino acids, carbohydrates as dextrose, fats, vitamins, minerals, and trace elements (Weinstein, M.E. & Hagle, 2014). The two types of PN are; Total Parenteral Nutrition (TPN), Partial or Peripheral Parenteral Nutrition (PPN).

TPN is a formula that contains complete nutrition, and due to the high osmolality and dextrose content it must be given via CVAD (i.e., PICC, implanted portacath or other subclavian catheter). The term “3 in 1 PN” refers to the combination of a 24-hour supply of dextrose, amino acids, fat emulsion (lipids), electrolytes, trace elements and vitamins in one TPN bag.

Complications related to PN can include: catheter-related infection, non-catheter related infection, hyperglycemia, hypoglycemia, electrolyte imbalance, elevated liver function tests (i.e., AST, ALT, Alkaline Phosphahtase), non-ketotic hyperosmolar state, air embolism, fat embolism, subclavian vein thrombosis, peripheral vein thrombosis.

PROCEDURES:

A. Equipment: Obtained From:

<table>
<thead>
<tr>
<th>Equipment</th>
<th>LHH Pharmacy</th>
<th>LHH Pharmacy</th>
<th>CSR</th>
<th>Nursing Unit</th>
<th>Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hour TPN solution (may include lipids if ordered)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubing with in-line filter (if solution does not contain lipids)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid tubing, 1.2 micron in-line filter (if lipids included)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infusion pump</td>
<td></td>
<td></td>
<td>CSR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luerlock connections</td>
<td></td>
<td></td>
<td>CSR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preprinted PN Physician Order Sheet (MR 160T)</td>
<td></td>
<td></td>
<td>Nursing Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mask</td>
<td></td>
<td></td>
<td>Nursing Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
<td></td>
<td>Nursing Unit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. Preparation:

1. Remove the TPN solution from the refrigerator 1 hour before use.

2. Explain procedure to resident/family and organize equipment.

3. Obtain baseline vital signs (blood pressure, temperature, heart rate, and respiratory rate) on initiation of TPN and repeat every 8 hours for 48 hours.

4. Obtain blood glucose per MD orders on Adult Parenteral Nutrition Order Form.

5. Inspect TPN solution for cloudiness or precipitate. Notify Pharmacy Services immediately if present and do not hang bag.

6. Two RNs will double check the TPN bag prior to administering, comparing the solution label with the physician’s order for correct components, checking expiration date, and checking the bag number on the TPN bag regarding proper sequence of bags.

7. Pharmacy will number the TPN bags in sequence due to the prescription of the contents changing.

8. TPN Infusion Procedures

   a. Follow procedures/guidelines outlined in NPPs (J 7.0 Central Venous Access Device (CVAD) Management and J 7.1 Peripherally Inserted Central Catheters (PICC) Management) to attach TPN tubing with in-line 0.22 micron filter to CVAD/PICC using aseptic technique. 1.2 micron filter is used when TPN is mixed with lipids.

   b. If multiple lumen catheter, remember to use DISTAL LUMEN for TPN only.

   c. Luerlock all tubing junctions to avoid accidental disconnection and air embolus.

   d. Change TPN bag and tubing every 24 hours and label with date and time.

   e. Label the port dedicated for TPN purposes only.

   f. Always use infusion pump to monitor rate of infusion as ordered.

   g. No other infusions, solutions, or medications shall be piggybacked into a Total Parenteral Nutrition line.

C. Monitoring:

1. Vital Signs: After the first 48 hours monitor daily for the next 5 days, then whenever clinically indicated. Notify MD for temperature T > 100.4 °F. See Preparation Section # 3.

2. Input and Output (I&O): Record I&O every shift.

3. Weights: Monitor and record weights weekly at a minimum, or more frequently per MD orders on the Adult Parenteral Nutrition Order Form in the EHR Adult Parenteral Nutrition Order Set.


5. Laboratory Monitoring: frequency of monitoring per MD orders in the EHR Adult Parenteral Nutrition Order Set on the Adult Parenteral Nutrition Order Form.

6. Observe for, and instruct resident when appropriate, to report, signs and symptoms such as CVAD site pain, redness, swelling, feeling febrile, chills, shortness of breath, headache, change in mental status, thirst, increased urination, sweating, and etc. Notify MD as indicated.
7. Encourage and provide frequent mouth care each shift and PRN.

8. Encourage activity as tolerated.

D. **Discontinuation of TPN**

1. TPN must be weaned per MD order and cannot be discontinued abruptly.

2. Follow glucose monitoring orders per MD order during weaning process.

3. Teach resident/patient to report symptoms of hypoglycemia and monitor for signs of hypoglycemia.

4. Discuss with MD whether the need for intravenous fluids will be required after the discontinuation of TPN.

E. **Documentation:**

1. **Integrated Progress Notes Electronic Health Record (EHR)**
   a. Every shift for the first 7 days, and when clinically indicated, document the following:
      i. Resident’s tolerance (e.g. elevated temperature, abnormal vital signs, nausea/vomiting, elevated blood glucose) and response to TPN
      ii. Physician notification if required
      iii. Resident/patient education if provided

2. **Medication Administration Record Bar Code Administration Record (MAR)**
   a. Record the solution used, flow rate and administration times
   b. Double check with 2 RNs
   c. Change of bag and tubing

3. **Treatment Administration Record (TARElectronic Health Record (EHR))**
   a. At end of shift, chart the amount of TPN intake during the shift on the IV flow sheet and the PN solution balance remaining.
   b. Intake and Output
   c. CVAD/PICC site inspection daily
   d. CVAD/PICC dressing change (Refer to CVAD policy)

4. **Electronic Health Record (LCR)**
   a. Vital Signs
   b. Weight

5. **IV Flow Sheet**
   a. At end of shift, chart the amount of TPN intake during the shift on the IV flow sheet and the PN solution balance remaining.

**REFERENCES:**


Lexicomp – Total Parenteral Nutrition
ASPEN – Guidelines for the use of parenteral and enteral nutrition in adult and pediatric patients 2002

CROSS REFERENCES:

LHHPP File: 25-08 Management of Parenteral Nutrition

Nursing P&P J 6.0 Intravenous Infusion
Nursing P&P J 7.0 Central Venous Access Device (CVAD) Management
Nursing P&P J 7.1 Peripherally Inserted Central Catheter (PICC) Management

ATTACHMENTS/APPENDICES:

None


Reviewed: 2016/09/13

Approved: 2016/09/13
PHYSICIAN ORDERS
ADULT PERIPHERAL PARENTERAL NUTRITION (PPN)

**DATE:** [ ] Initial Order ; [ ] Renewing Order (PPN order form need to be renewed once a week)

Indication for Nutritional Support: ____________________________________________

Venous Access Device for PPN infusion: [ ] PICC Line [ ] Other CVAD (e.g. subclavian etc.); [ ] Peripheral IV Line

PPN bag may not hang for >24 hours, drip rate to be regulated on pump

PPN tubing must be changed each 24 hours

**STANDARD SOLUTION**

<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>STANDARD SOLUTION</th>
<th>SUGGESTED RANGES</th>
<th>CUSTOMIZED SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dextrose 10%</td>
<td>Dextrose 10%</td>
<td>Dextrose 10%</td>
<td></td>
</tr>
<tr>
<td>Amino Acids: 4.25%</td>
<td>Amino Acids: 2.5%, 4.25%, or 5%</td>
<td>Amino Acids: %</td>
<td></td>
</tr>
<tr>
<td>Na: 60 mEq/L</td>
<td>Na: 0-140 mEq/L</td>
<td>Na: mEq/L</td>
<td></td>
</tr>
<tr>
<td>K: 20 mEq/L</td>
<td>K: 0-40 mEq/L</td>
<td>K: mEq/L</td>
<td></td>
</tr>
<tr>
<td>Ca: 5 mEq/L</td>
<td>Ca: 4.5-9 mEq/L</td>
<td>Ca: mEq/L</td>
<td></td>
</tr>
<tr>
<td>Mg: 8 mEq/L</td>
<td>Mg: 8-12 mEq/L</td>
<td>Mg: mEq/L</td>
<td></td>
</tr>
<tr>
<td>P: 12 mM/L</td>
<td>P: 0-20 mM/L</td>
<td>P: mM/L</td>
<td></td>
</tr>
<tr>
<td>Cl: 60 mEq/L</td>
<td>Cl: 0-140 mEq/L</td>
<td>Cl: mEq/L</td>
<td></td>
</tr>
</tbody>
</table>

(Leave blank if max or min acetate)

Acetate: balance

<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dextrose 10%</td>
<td>60 mEq/L</td>
</tr>
<tr>
<td>Amino Acids: 4.25%</td>
<td>0-140 mEq/L</td>
</tr>
<tr>
<td>Na: 60 mEq/L</td>
<td>0-140 mEq/L</td>
</tr>
<tr>
<td>K: 20 mEq/L</td>
<td>0-40 mEq/L</td>
</tr>
<tr>
<td>Ca: 5 mEq/L</td>
<td>4.5-9 mEq/L</td>
</tr>
<tr>
<td>Mg: 8 mEq/L</td>
<td>8-12 mEq/L</td>
</tr>
<tr>
<td>P: 12 mM/L</td>
<td>0-20 mM/L</td>
</tr>
<tr>
<td>Cl: 60 mEq/L</td>
<td>0-140 mEq/L</td>
</tr>
</tbody>
</table>

Acetate: balance

**FAT EMULSION:** 20% (2 kcal/mL) check one: [ ] 250 mL [ ] 500 mL [ ] Other ____________

Frequency: _____________________ (Recommendation: daily)

**OPTIONAL ADDITIVES:**

<table>
<thead>
<tr>
<th>ADDITIVE</th>
<th>AMOUNT DAILY (units, mg, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multivitamins:</td>
<td></td>
</tr>
<tr>
<td>Trace Elements:</td>
<td></td>
</tr>
<tr>
<td>Vitamin K: 10mg Q Monday</td>
<td></td>
</tr>
</tbody>
</table>

**INFUSION RATE:** _____________ mL/hr

If **Lipid** is ordered, the TOTAL INFUSION RATE (PPN rate + lipid rate to be filled in by pharmacist) : _____________ mL/hr

Orders must be received by 10:00 am in the Pharmacy for a new bag to be delivered to the units by 5:00 pm.

For orders received after 10:00 am, PPN will be delivered the following day between 12 noon to 5:00 pm. If needed, use D10W for nutrition until the PPN arrives.

Recommendations for supplemental monitoring orders and miscellaneous information are located on the back of this page.

Physician: ______________________ / ______________________ CHN ID # __________ Pager: __________

Registered Nurse: __________________________ Date: __________ Time: __________

MR 160 (11/02)

Original- Medical Record Yellow- Pharmacy
### Average Nutritional Goals:

<table>
<thead>
<tr>
<th>Maintenance</th>
<th>Repletion</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-30 kcal/kg/day</td>
<td>30-35 kcal/kg/day</td>
</tr>
<tr>
<td>1 gm protein/kg/day</td>
<td>1.5-2 gm prot./kg/day</td>
</tr>
</tbody>
</table>

Average fluid requirement: 30-35mL/kg/day

### kCalorie Content:

<table>
<thead>
<tr>
<th>Component</th>
<th>kcal/gm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dextrose</td>
<td>3.4</td>
</tr>
<tr>
<td>Protein</td>
<td>4.0</td>
</tr>
<tr>
<td>Lipid</td>
<td>10.0</td>
</tr>
</tbody>
</table>

### I.V. Fat Emulsion

<table>
<thead>
<tr>
<th>Fat Emulsion</th>
<th>kcal/L</th>
<th>Volume (mL)</th>
<th>Total kcal</th>
<th>Total gm</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>2</td>
<td>500</td>
<td>1000</td>
<td>50</td>
</tr>
<tr>
<td>20%</td>
<td>2</td>
<td>250</td>
<td>500</td>
<td>50</td>
</tr>
</tbody>
</table>

Standard PPN: 500 mL daily of 20% lipid = 1000 kcal/day

### Maximum Dextrose/ Amino Acid Combinations

**Peripheral:**

<table>
<thead>
<tr>
<th>Dextrose</th>
<th>Amino Acid</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Recommended Monitoring Guidelines

**Baseline:** (within 72 hrs prior to, or 24 hrs after PPN is started)

- Na, K, Cl, HCO3, PO4, Ca, Mg, Albumin, TGs, BUN, Cr, ALT, AST, AlkPhos, T. bili, Glucose

**Weekly:** weight, chemistry panel, comprehensive metabolic panel, TGs*, LFTs, albumin

* Draw TGs at least 8-12 hours after end of lipid infusion

### Maximum Allowable CALCIUM AND PHOSPHATE Concentrations in Amino Acid Solutions (applies to all dextrose concentrations)

#### 2.1-3.0% Amino Acids

<table>
<thead>
<tr>
<th>Ca (mEq/L)</th>
<th>Phos (mM/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>40</td>
</tr>
</tbody>
</table>

#### 3.1-4.0% Amino Acids

<table>
<thead>
<tr>
<th>Ca (mEq/L)</th>
<th>Phos (mM/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>40</td>
</tr>
</tbody>
</table>

#### 4.0% Amino Acids

<table>
<thead>
<tr>
<th>Ca (mEq/L)</th>
<th>Phos (mM/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>40</td>
</tr>
</tbody>
</table>

Calcium and Phosphate precipitation may also be influenced by pH, temperature, and presence of other additives.

* If the amount of Ca or Phos to be added to any solution is between two numbers, choose the corresponding amount at the next lower level.

### Composition of MVI-12 (per 10 mL)

<table>
<thead>
<tr>
<th>Component</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (retinol)</td>
<td>1 mg</td>
</tr>
<tr>
<td>B (ergocalciferol)</td>
<td>5 mcg</td>
</tr>
<tr>
<td>C (ascorbic acid)</td>
<td>100 mg</td>
</tr>
<tr>
<td>B1 (thiamine)</td>
<td>3 mg</td>
</tr>
<tr>
<td>B2 (riboflavin)</td>
<td>3.6 mg</td>
</tr>
<tr>
<td>B6 (pyridoxine)</td>
<td>4 mg</td>
</tr>
<tr>
<td>Niacinamide</td>
<td>40 mg</td>
</tr>
<tr>
<td>Dexamphenol</td>
<td>15 mg</td>
</tr>
<tr>
<td>E</td>
<td>10 mg</td>
</tr>
<tr>
<td>Biotin</td>
<td>60 mcg</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>400 mcg</td>
</tr>
<tr>
<td>B12</td>
<td>5 mcg</td>
</tr>
</tbody>
</table>

### Multi-Pak 5 (trace elements) per 1 mL

<table>
<thead>
<tr>
<th>Trace Element</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zinc</td>
<td>1 mg</td>
</tr>
<tr>
<td>Copper</td>
<td>0.4 mg</td>
</tr>
<tr>
<td>Chromium</td>
<td>4 mcg</td>
</tr>
<tr>
<td>Selenium</td>
<td>20 mcg</td>
</tr>
<tr>
<td>Manganese</td>
<td>0.1 mg</td>
</tr>
</tbody>
</table>
ASSISTANCE WITH ELIMINATION

POLICY:

1. All nursing staff, including Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA), except Home Health Aide (HHA), may assist residents with elimination needs.

2. Residents who require assistance with toileting will be supervised when using the bathroom and/or commode.

3. Perineal care is provided to all residents who are incontinent and unable to perform toileting self care.

4. Each bedpan or urinal will be labeled with the resident’s last name and first name initial.

PURPOSE:

1. The resident will be clean, dry, comfortable and odor-free.

2. Assistance with elimination will be provided in a manner that conveys respect, promotes dignity, functional independence, and safety.

PROCEDURE:

A. Assistance with Toileting

1. Refer to current reference text for Nursing Assistants for procedural information about use of bedpan, commode and urinal.

2. Bedpans, urinals, and bedside commodes are cleaned when soiled and replaced when needed. A urinal may be kept within the resident’s reach.

3. See Cross-References below for nursing-related procedures with management of incontinence and restorative programs.

B. Documentation

1. The CNA or PCA completes the Daily Nursing Care Record (DNCR) documentation in the electronic health record (EHR).

2. The licensed nurse (LN) documents any unusual physical or behavioral observations related to elimination. Interventions implemented to address these will be included in the interdisciplinary-EHR progress notes.

3. The LN records resident specific elimination interventions for the CNA or PCA to implement on DNCR the health record.

4. The LN documents the effectiveness of the resident care plan in meeting elimination needs in the nursing summary Resident Care Plan.
REFERENCES:


CROSS REFERENCES:

NPP D01.0 Restorative Nursing Program
NPP F 2.0 Assessment and Management of Urinary Incontinence
NPP F 3.0 Assessment and Management of Bowel Function

Reviewed: 07/22/2014
Approved: 07/22/2014
Assessment and Management of Bowel Function

POLICY:

1. License Nurse shall evaluate all residents for bowel function at admission and whenever clinically indicated.

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

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

PROCEDURE:

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

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

DOCUMENTATION:

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

4. The CNA or PCA records bowel function in the Daily Nursing Care Record (DNCR)/Activities of Daily Living section each shift.

5. Licensed nurse develops, evaluates and revises related care plans when indicated for actual or potential bowel problems.

CROSS REFERENCES:

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

REFERENCES:


Revised: 2006/07, 2008/09, 2010/10, 2016/12, 2018/07/10
Reviewed: 2018/07/10
Approved: 2018/07/10
APPLICATION AND MANAGEMENT OF CONDOM CATHETER

POLICY:

1. Any nursing staff member (CNA, PCA, LVN, or RN) may apply a condom catheter when indicated.

2. Condom catheters are checked at least every shift and changed at least once a day and as needed, and a new catheter and new drainage bag reapplied after skin care using standard precautions.

PURPOSE:

To keep the skin dry and prevent skin breakdown in males who have urinary incontinence.

BACKGROUND:

Evidence suggests a benefit of using external catheters over indwelling urethral catheters in male patients who require a urinary collection device, but do not have an indication for an indwelling catheter such as urinary retention or bladder outlet obstruction (HIPAC, 2009).

PROCEDURE:

A. Equipment

- External condom catheter package
- Connecting tube and extension tubing, if needed
- Bedside drainage bag or leg bag
- Catheter securing device (avoid tape)

B. Consult with manufacturer’s instructions for information about condom catheter sizing and application.

C. Application of External Condom Catheter

1. Perform hand hygiene.

2. Place the absorbent pad or bath towel under the resident.

3. Wash the penis rinse, and dry the penis carefully. Inspect the penis to make sure it does not have any broken or reddened skin.

4. You may want to clip the hair or shave the area near the base of the penis.

5. Hold the penis at a 90 degree angle from the body. Gently roll the condom over the penis. Leave 1 to 2 inches of the condom catheter at the end of the penis.

6. Wrap the sheath holder around the condom at the base of the penis. Do not wrap the sheath holder too tightly because this may stop blood from going to the penis.

7. Attach the condom catheter to the appropriate drainage bag.

D. Management of the Condom Catheter
1. Keep the drainage bag below the level of the bladder to prevent backflow of urine.

2. Change the condom catheter once per day and PRN.

E. Documentation

1. **DNCREElectronic Health Record (EHR):** Record date and time of catheter application and removal; note any changes in skin condition such as redness, skin breakdown, or pain.

2. **Front Card of RCPDocument presence of condom catheter in the resident’s Care Plan**

3. Progress Notes: Note alterations in skin condition, problems with condom management, or any symptoms of UTI.

REFERENCES:


CROSS REFERENCES:

NPP F 1.0 Assistance with Elimination
NPP F 2.0 Assessment and Management of Urinary Incontinence
NPP F 5.0 Management of Urinary Catheters

Revisions: 7/2006; 09/24/2013; 07/22/2014

Reviewed: 07/22/2014

Approved: 07/22/2014
OSTOMY MANAGEMENT

POLICY:

1. The licensed nurse is responsible for the management of ostomy.

2. Licensed nurse is to consult the Wound Care CNS for peri-stomal skin irritation that is not improving with routine care.

3. The certified nursing assistant (CNA) or patient care assistant (PCA) is responsible for emptying or changing the pouch/bag every shift and as needed.

4. Residents who have demonstrated ability to manage their own ostomy may change or empty their own ostomy pouch/bag.

PURPOSE:

To provide appropriate ostomy management.

BACKGROUND:

Ostomy care includes containment of excrement, urinary drainage, skin protection, patient education, and patient support.

PROCEDURE:

A. Equipment

Select appropriate ostomy product {Attached as Appendix Formulary (Coloplast)}

B. Emptying or Changing Ostomy

1. An ostomy pouch/bag should be checked for leakage at least every shift and pouches changed PRN. The pouch/bag should be emptied when 1/3 full to prevent dislodgement of the appliance.

2. Resident with a urostomy may wear a urinary leg bag during daytime. During night time, connect the urostomy pouch to a Foley drainage bag.

C. Ostomy Maintenance for Aquatic Services

1. Ensure that ostomy site is cleaned.

2. Empty/dispose of ostomy pouch.

3. Securely place a new/empty ostomy pouch.

4. Check for leakage and patency.

5. Cover resident with a robe provided by the Wellness Center.
D. Documentation

1. **Electronic Health Record (EHR)** (DNCR) - the CNA/PCA records output every shift in the I/O section.

2. Interdisciplinary Progress Notes (Licensed Nurse)
   a. Any change in appearance, discharge, bloody drainage or discoloration of stoma and peristomal skin
   b. Resident and family education when provided

3. Treatment Record Assessment (TAR)
   a. Record date of change of the ostomy wafer (change at least every 7 days or as needed) and check condition of peristomal skin.
   b. Use new pouch once/day (2-piece pouch). 1-piece pouch – change up to Q 3-7 days or as needed

4. **Resident Care Plan (RCP)**
   a. Front Card of RCP 1st page—Document type of ostomy product(s) and indications for use

ATTACHMENTS:

- One-piece Ostomy (SenSura® - 1 Piece Pouch Colostomy)
- Two-Piece Ostomy (SenSura® Flex – 2 Piece Pouch Coloplast)
- Types of Colostomies and Accessories

REFERENCES:


Original Document: September 30, 2008
Revised: 2015/03/10, 2017/03/14
Reviewed: 2017/03/14
Approved: 2017/03/14
NEUROLOGICAL STATUS ASSESSMENT

POLICY:

1. Assessments are to be performed by the Registered Nurse and recorded in the Electronic Health Record (EHR), by a Licensed Nurse and recorded on the Neurological Assessment Record (MR 315).

2. Frequency of assessments following head injury or other related conditions is to be based upon the resident's condition, but no less often than the schedule below for the first 72-hours unless ordered otherwise by the physician.

   First – 24-hour: every 2-hours for the first 12 hours, then every 4-hours for the second 12 hours;
   Second - 24 hour: every 8 hours;
   Third – 24 hour: every 12 hours, then daily until stable.

   After the initial 72 hours, if neurological assessments indicate status has stabilized, resume the pre-injury vital sign monitoring intervals or if not stabilized, continue to monitor every day as often as needed unless ordered otherwise by the physician.

3. The physician is to be notified immediately if there is a decrease of one or more points in the total score of the Glasgow Coma Scale or when there are sudden or subtle changes in level of consciousness, vital signs or pupil reactions.

PURPOSE:

To assess neurological status following head injury or other related conditions.

CHARACTERISTICS:

A. Neurological assessment includes:

   1. Level of consciousness (eye opening, verbal and motor response).
   2. Vital signs (respiration, blood pressure, apical pulse counted for one minute, and temperature).
   3. Pupil size and reaction to light.

B. Know the resident's baseline vital signs. In the aging resident, minor changes in level of consciousness or vital signs may indicate major problems.

C. Decrease in level of consciousness is the earliest, most sensitive indicator of deterioration. Be alert to detect increasing drowsiness, lethargy and slower verbal or motor response.

D. Symptoms of head injury may occur rapidly or over a longer time. Keep an ongoing alert for changes in neurological status which may be related to even minor head injury. For example, symptoms may be manifested in acute subdural hematomas, usually within 24 to 48 hours; subacute hematomas, anywhere from 48 hours to 2 weeks; and chronic subdural hematomas, the most common in the 60 to 70year age group, weeks, months, and possibly years after injury.

PROCEDURE:
A. Preparation of Resident

1. Wake the resident to the extent possible.
2. Explain the procedure to the resident.
3. Instruct resident to notify the nurse, if able to communicate, if headache, change in speech, sensorium or breathing develop.

B. Signs & Symptoms of Increased Intracranial Pressure

1. Level of consciousness decreases.
2. Changes in vital signs.
   Classic changes are increased systolic blood pressure with widening pulse pressure, bradycardia and slow respiration. However, be alert for any changes, such as irregular respiratory patterns, tachycardia or other arrhythmia.
3. Pupil changes.
5. Vomiting.
6. Changes in sensation or ability to move.

C. Neurological Assessment Procedure

Glasgow Coma Scale

A standardized system to assess level of consciousness after head injuries. Eye opening and verbal and motor responses are evaluated, numerically ranked and totaled after each assessment.

1. Level of Consciousness
   a. Eye Opening
      To perform this test, first observe for spontaneous eye opening without stimulus. If resident does not open eyes, approach closely and command clearly to open eyes. If still no response, apply painful stimulus (sternal rub or pressure to skin) to stimulate eye opening. If still no response, record none

<table>
<thead>
<tr>
<th>Score</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>3</td>
<td>To voice command</td>
</tr>
<tr>
<td>2</td>
<td>To pain</td>
</tr>
<tr>
<td>1</td>
<td>None</td>
</tr>
</tbody>
</table>

b. Best Verbal Response
Ask the resident to tell you their full name and where they are to establish orientation. If unable to respond, ask resident to name a common object (bed, light, pillow) to determine ability to use appropriate words. If unable to identify objects, ask to make any verbal response even if only incomprehensible sounds. If no verbalization at all, mark none.

<table>
<thead>
<tr>
<th>Score</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Conserves, oriented</td>
</tr>
<tr>
<td>4</td>
<td>Converses, disoriented</td>
</tr>
<tr>
<td>3</td>
<td>Inappropriate words</td>
</tr>
<tr>
<td>2</td>
<td>Incomprehensible sounds</td>
</tr>
<tr>
<td>1</td>
<td>None</td>
</tr>
</tbody>
</table>

c. **Best Motor Response**

Evaluate voluntary or involuntary movement of extremities.

<table>
<thead>
<tr>
<th>Score</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Obeys commands. Ask resident to perform some activity (raise arms, extend tongue, etc).</td>
</tr>
<tr>
<td>5</td>
<td>Localizes pain. Apply painful stimuli, (sternal rub). Observe response. (Hand attempts to move stimulus away).</td>
</tr>
<tr>
<td>4</td>
<td>Withdrawal. Apply pressure to extremity. (Observe for attempt to pull away).</td>
</tr>
<tr>
<td>3</td>
<td>Abnormal flexion. (Posturing of upper extremity in decorticate posture with arms adducted and flexed with wrists and fingers flexed on chest).</td>
</tr>
<tr>
<td>2</td>
<td>Abnormal extension. (Posturing of upper extremity in decerebrate posture with arms adducted and extended with wrists and fingers flexed).</td>
</tr>
<tr>
<td>1</td>
<td>None (No movement or abnormal posture).</td>
</tr>
</tbody>
</table>

d. **Glasgow Coma Scale**: Total the scores for eye opening, best verbal and motor responses after each assessment.

For example:
- Eye opening 3
- Verbal response 4
- Motor response 4
- Total Score 10

Score totals range from 3 (no response) to 15 (best possible response). A total of seven (7) or less is defined as coma.

Total scores reflect stability of resident's condition. Changes in total score indicate improvement (score increases) or deterioration (score decreases).

Note: Evaluations that cannot be made because resident unable to open eyes, speak or follow commands before the immediate trauma due to pre-existing condition.

2. **Vital Signs**

a. **Blood pressure**: Widening pulse pressure with increase in systolic reading and diastolic reading remaining the same is a sign of increased intracranial pressure.

b. **Pulse rate**: monitor and watch for changes in apical rate, rhythm and volume.

c. **Respiratory rate**: monitor for quality, rate and rhythm to detect abnormal breathing patterns.
d. Temperature: an increase in intracranial pressure may not cause a change in body temperature. However, an elevated temperature of one (1) degree may cause a further increase in intracranial pressure. It is important to know the resident's baseline temperature and prevent hypothermia or hyperthermia with nursing measures.

3. Pupils

a. Pupil size is measured in millimeters. For accuracy use the sample sizes on the neurological assessment record.
b. Inspect pupils with a flashlight to evaluate size and reaction to light. Compare both eyes for similarities or differences.
c. Reaction to light is measured as to how quickly pupils decrease in size when light is directed into them. For consistency use the coded responses on the neurological assessment record.

D. What to do if neurological status declines 1 number or more

1. Notify physician stat and report the decline.
2. Keep resident on bedrest.
   a. Elevate head of bed 30 degrees.
   b. Position resident supine without turning head to either side.

E. Documentation

1. Document neurological assessment record: at each periodic assessment, record the results. Vital signs do not need to be recorded on the graphic sheet and vital signs in the EHR.
2. Electronic Health Record Integrated Progress Notes: record observations and comment on the resident's level of consciousness every shift, or as the resident's condition warrants.
3. Physician notification:
   a. Record the time notified, name of the physician, information reported to the physician and response.
   b. Record time of physician's visit.
   c. Record nursing action to carry out physician's orders.

REFERENCES:

Nettina, S. The Lippincott Manual of Nursing Practice (9th Ed, 2010)


Reviewed: 1/2010
INTAKE AND OUTPUT (I & O)

POLICY:

1. In addition to when ordered by the physician, intake and output (I&O) may be initiated by the Licensed Nurse (LN) when clinically indicated.

2. Intake and output are measured for residents at risk for fluid imbalance; while receiving intravenous therapy including peripheral parenteral nutrition (PPN) and total parenteral nutrition (TPN).

3. Intake is measured for resident receiving enteral nutrition and on fluid restrictions; output are measures based on clinical indication.

4. Intake and output is measured every shift for all residents with a urinary catheter and/or has been diagnosed with a UTI.

5. Licensed Nurse records intake and output every shift. **P.M. Shift LN totals the 24-hour intake and output.**

PURPOSE:

To provide an accurate record of fluid intake and output as is necessary for the individual.

PROCEDURE:

A. Refer to Laguna Honda Hospital Nutrition Services Department Standardized Fluid Measurements

<table>
<thead>
<tr>
<th>Item</th>
<th>Actual (Service Volume (in ml))</th>
<th>Total Volume of the Container (in ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water Pitcher (to marker)</td>
<td>800</td>
<td>800</td>
</tr>
<tr>
<td>Soup bowl</td>
<td>1860</td>
<td>180</td>
</tr>
<tr>
<td>Coffee Mug</td>
<td>180</td>
<td>240</td>
</tr>
<tr>
<td>Paper cup</td>
<td>180</td>
<td>240</td>
</tr>
<tr>
<td>Milk Carton</td>
<td>240</td>
<td>240</td>
</tr>
<tr>
<td>Prepackaged Juice</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Ind. Canned Juice</td>
<td>180</td>
<td>180</td>
</tr>
<tr>
<td>Non-Dairy Creamer</td>
<td>19915</td>
<td>42015</td>
</tr>
<tr>
<td>Liquid Supplements</td>
<td>240</td>
<td>240</td>
</tr>
<tr>
<td>Ice Cream Cup</td>
<td>12090</td>
<td>90120</td>
</tr>
<tr>
<td>Ice Cream sundae</td>
<td>159</td>
<td>159</td>
</tr>
<tr>
<td>Fruit Sorbet</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Gelatin Cup</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

B. Documentation

1. Intake
   a. If resident is on enteral nutrition, record intake in the Treatment Administration Record (TAR).
b. If resident is on fluid restrictions, receiving intravenous fluids for hydration or on parenteral nutrition, record intake in the **TAR Intake and Output section of the electronic health record (EHR)**.

   Note: For resident receiving I.V. fluids, Licensed Nurse will record the total amount infused and amount left in the bag in the I.V. Flow sheet (this is in addition to the documentation of intake in the TAR EHR).

   c. For residents whom intake may not always be able to be accurately measured and/or reported (e.g., residents on outings, consuming beverages outside neighborhood), individual needs will be documented in the RCP.

2. Output

   a. Record output in the **TAR Intake and Output section of the EHR**.

C. Notification

1. Notify physician for input and output monitoring initiated by nursing.

2. Notify physician for any clinical suspicion of inadequate I & O.

3. Notify dietitian when resident is placed or removed from fluid restriction.

REFERENCES:

- Nettina, S. The Lippincott Manual of Nursing Practice (9th Ed, 2010)

CROSS REFERENCES:

- NPP E 1.0 Oral Management of Nutritional Needs
- NPP E 5.0 Enteral Tube Feeding Management
- NPP E 6.0 Parenteral Nutrition
- NPP J 6.0 Intravenous (I.V.) Therapy Maintenance

Revised: 3/2008; 9/2009; 04/14/2011; 09/25/2012; 09/24/2013; 07/22/2014; 03/10/2015

Reviewed: 03/10/2015

Approved: 03/10/2015
MEASURING THE RESIDENT’S HEIGHT and WEIGHT

POLICYIES:

1. Any nursing staff except for Home Health Aide Licensed Nurses, Patient Care Assistants, and Certified Nursing Assistants may measure resident’s weight and height.

1.2. Residents’ height are is weighed measured on admission, annually, and monthly, as clinically indicated, and during the observation period of the (Minimum Data Set (MDS) unless otherwise as indicated by a physician order, by Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA).

2. Residents are weighed by the receiving neighborhood upon relocation.

3. The re-weigh is completed performed done anytime the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g. planned weight loss).

4. Any Resident Care Team (RCT) member may request more frequent weights.

5. Height is measured on admission and during the 7-day observational period of each annual MDS assessment and after an amputation of any part of a lower extremity.

6. A current height and weight measurement is obtained if a resident is to receive a medication (such as chemotherapy) that is dosed based on body surface area.

7. The Licensed Nurse, CNA, or PCA may measure the resident’s weight and height.

PURPOSE:

To obtain accurate height and weight measurements of the resident to facilitate effective care planning.

PROCEDURES:

A. Measuring and Recording the Height:

1. If resident is able to stand, resident is instructed to stand against the wall with feet flat on the floor and height is measured using tape measure.

2. To measure the height of a resident, who is unable to stand, assist the resident to lie flat on his/her back on a firm mattress or gurney. Determine the height in inches using a tape measure from the crown of the head to the soles of the feet.

3. To estimate the height of a resident who is contracted or bedridden, use any one of the formulas in Appendix 1, following two formulas (see G 4.0 Appendix 1 for application of formula):

   a. Forearm length: With a tape measure, measure the ulna length of the ulna between the point of the elbow and the midpoint of the prominent bone of the wrist. This method may be most practical for severely contracted residents.
b. Demi-span. With a tape measure, obtain measurement from the resident’s sternal notch to the tip of the middle finger in the coronal plane. May be most practical for residents with lower limb dysfunction.

4. The admission height is recorded on the Nursing Admission Assessment form, and in section K of the MDS, and eElectronic Health Record. Height measurements taken annually are recorded in the annual MDS in section K.

B. Measuring and Recording Weight:

1. The resident is weighed at the same time of the day, wearing approximately the same amount of clothing, without prosthesis and shoeless, and using the same type of scale.

Selection of scale

2.
   a. The frequency and type of scale (e.g. wheelchair or floor scale, EZ-Lift scale, or electronic bed scale) to be used is noted on the Front Card of the Resident Care Plan.
   b. If the resident’s condition changes, the nurse reassesses for the most appropriate scale.
   c. Use the scale’s manufacturer’s instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the central supply room (CSR).
   d. If the manufacturer’s instructions are not readily available, contact plant services.
   e. Improperly functioning scales are reported to plant Services.

C. Assessing Reporting and Documenting changes in the weight:

1. The CNA or PCA reports the weight to the primary licensed nurse charge nurse during the shift the weight is measured.

Unanticipated Significant Weight Change

2.
   If the variation is greater than or less than five pounds (2.27 kilograms) and is unanticipated weight change, the Licensed Nurse notifies the physician and dietitian. The nurse documents in the progress note his/her assessment and any action she may have taken.
   The Licensed Nurse notifies the physician and dietitian if the weight varies 5% or more in 30 days or 10% or more in 180 days.
   The Licensed Nurse asks the MDS Coordinator or Nurse Manager to add the resident’s name to the list of residents to be discussed at the next RCT meeting if there has been a significant weight change as described above.

2. The Licensed Nurse records the weight in pounds on the weight record (MR306) in kilograms in the LCR on the day it is taken. If the variation is greater than two pounds and is not expected or care planned, the Licensed Nurse notifies the physician and dietitian. The nurse documents in the progress note his/her assessment and any action she may have taken.

3. The Licensed Nurse notifies the physician and dietitian if the weight varies 5% or more in 30 days or 10% or more in 180 days.

4. The Licensed Nurse asks the MDS Coordinator or Nurse Manager to add the resident’s name to the list of residents to be discussed at the next RCT meeting if there has been a significant weight change as described above.
APPENDIX 1:

Height Measurement Guidelines for Bedridden Residents or Residents with Contractures

REFERENCES:

Nettina, S. The Lippincott Manual of Nursing Practice (9th Ed, 2010)

Revised Long-Term Care Resident Assessment User’s Manual, March 2009 Edition


Reviewed: 04/30/2012

Approved: 04/30/2012
BEHAVIORAL RISK ASSESSMENT AND CARE PLANNING

POLICY:

1. Residents have the right to be safe and free from harm.

2. The existence of aggressive behavior or the likelihood of being a target of aggressive behavior that places residents and staff at risk is regularly assessed in all residents.

3. The Registered Nurse (RN) is responsible for completing a behavioral risk assessment on each resident upon admission, quarterly, and whenever there is a change of condition, and upon transfer to another neighborhood, and whenever clinically indicated.

PURPOSE:

1. To maintain safe environment and enhance the therapeutic milieu.

2. To identify residents whose behaviors pose potential risks to themselves and/or others.

PROCEDURE:

A. Using the Nursing Assessment for Behavioral Risk Form

1. The Nursing Assessment for Behavioral Risk form (MR 340) is the assessment tool to be used as part of the comprehensive Minimum Data Set (MDS).
   a. Section 1 asks eight (8) questions that assess the resident to determine if he/she is at risk for aggressive behaviors directed at others.
      i. If any question is answered with a yes, the nurse is to access the online care plan template (located under LHH intranet/Forms/ Nursing Care Plans) to address the problem “At risk for aggressive behavior”. The care plan then is reviewed and further individualized by the Resident Care Team (RCT).
      ii. If a nurse determines that an aggressive behavior care plan is not indicated, an explanation is documented as to the reason. For example: “The resident’s increased psychomotor activity (pacing) is related to side effects of medication effects and not a related to aggression.”
   b. Section 2 asks six (6) questions that assess the resident’s risk for being a target of aggression.
      i. If any question is answered with a yes, the nurse is to access the online care plan template (located under LHH intranet/Forms/ Nursing Care Plans) to address the problem “At risk for being a target of aggression”. The care plan then is reviewed and further individualized by the RCT.
B. Assessment and Reassessment time parameters.

1. The Behavioral Risk Assessment is completed as part of a comprehensive Minimum Data Set (MDS) and therefore is completed:
   a. Within two (2) weeks of admission
   b. At the time of a significant change of condition
   c. Annually
   d. Quarterly

2. In addition, the assessment is completed
   a. Within two (2) weeks of relocation to another neighborhood
   b. When otherwise clinically indicated and at the request of any RCT member

C. Guidelines to Develop Behavioral Risk Care Plans

1. Refer to Attachment 1: Guidelines to Develop Behavioral Risk Care Plans residents health record

ATTACHMENTS:

Attachment 1: Guidelines to Develop Behavioral Risk Care Plans
Attachment 2: Nursing Assessment for Behavioral Risk (MR 340)
Attachment 3: Behavioral Monitoring Records: Code Sheet (MR 330A) and Log Sheet (MR 330B)

CROSS REFERENCES:

LHHPP 23-01 Resident Care Plan, Resident Care Team, & Resident Care Conference
LHHPP 24-01 Missing Resident Procedures
LHHPP 22-01 Abuse Protection Program: Prevention, Recognition, Reporting

Adopted: June 2005
Revised: 05/27/14; 09/08/2015
Reviewed: 09/08/2015
Approved: 09/08/2015
Obtaining, Recording and Evaluating Residents Weights

OBTAINING, RECORDING AND EVALUATING RESIDENTS WEIGHTS

POLICY:

1. Any nursing staff except for Home Health Aide may obtain residents' weights.

2. Resident weight is obtained on the day of admission/readmission, monthly, as clinically indicated, and during the observation period of the Minimum Data Set (MDS) unless otherwise indicated by a physician order.

3. Residents are weighed by the receiving neighborhood upon relocation.

4. Reweighs are performed each time the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g., planned weight loss).

5. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.

6. Monthly weights shall be obtained every first weekend of each month.

PURPOSE:

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

PROCEDURE:

A. Obtaining Weights

1. Check previous weight prior to weighing resident to immediately identify any potential discrepancy.

2. To obtain accurate weight, weigh resident in the day shift at a consistent time and have resident wear consistent clothing and/or devices.

3. Resident will be weighed using the same scale, clothing, and/or linen with each reweigh.

   a. Use the scale’s manufacturer’s instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the Central Supply Room (CSR).
   b. If the manufacturer’s instructions are not readily available, contact Facility Services.
   c. Improperly functioning scales are reported to Facility Services through a work order.

2.4. Immediately prior to weighing resident, staff shall zero the scale.

B. Reweighing

1. If there is a weight change greater than 5 pounds (+/-), immediately reweigh resident.

2. Continue to reweigh resident daily for the next 2 consecutive days.
C. Frequency of Weights

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

2. Residents shall be weighed weekly for 4 weeks after admission, then monthly, unless otherwise prescribed by physician.

3. Nursing will weigh resident for a significant change in condition, change in food intake, and other evidence of altered nutritional status or fluid and electrolyte imbalance.

D. Reporting

1. Weights must be reported to the licensed nurse during the shift it was obtained.

2. If the weight variation is greater than or less than five pounds (2.27 kilograms) and is unanticipated weight change, the licensed nurse notifies the physician and dietitian.

3. The nurse reports unintended weight loss or gain to the dietitian and physician:
   a. 5% or greater over 30 days
   b. 7.5% or greater over 90 days
   c. 10% or greater over 180 days

4. The licensed nurse will notify the MDS Coordinator or Nurse Manager to include resident with significant weight change on the list of resident’s for discussion at the next Resident Care Team meeting.

E. Documentation

1. The type of scale (e.g. wheelchair or floor scale, EZ-Lift scale, or electronic bed scale) to be used is noted on Baseline Care Plan.

2. Licensed staff documents all weights in kilograms on the resident’s electronic health record.

2.3 Licensed nurse will document on the electronic health record the assessment and actions taken for unintended weight changes.

REFERENCES

NONE

CROSS REFERENCES:

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

ATTACHMENT/APPENDIX:

NONE
Obtaining, Recording and Evaluating Residents Weights

Revised: 2018/1/9
Reviewed: 2018/1/9
Approved: 2018/1/9
COLLECTION OF URINE SPECIMEN

POLICY:

1. The licensed nurse may obtain urine specimen through midstream catch (clean-catch) technique, intermittent, or indwelling urinary catheter as ordered by the physician.

2. The Certified Nursing Assistant (CNA) or Patient Care Assistant (PCA) is allowed to collect urine specimen through midstream or clean-voided technique.

3. The licensed nurse will notify the physician if the specimen cannot be obtained.

PURPOSE:

To describe guidelines for the nurse collecting urine specimen.

PROCEDURE:

A. Equipment for Urine Collection

Obtain the following from Neighborhood Supply if not prepackaged kit:

- Sterile screw-cap specimen container
- Clean plastic bag
- Antiseptic Towelette
- 20 ml syringe with Luer-Lok tip (for catheter drain bag with needleless sampling port)
- (As needed) Urethral catheterization tray
- Requisition forms:
  - Urine/Fluids: Requisition for Urinalysis or other physician’s order urine tests
  - Microbiology: Requisition for Cultures
  - Label

B. Laboratory Requirements

1. All specimen containers must be labeled with stamped addressograph including neighborhood and bed number prior to collection of the specimen.

2. Licensed Nurse completes the laboratory requisitions with stamped addressograph and writes the method of specimen collection, date and time. Verify the physician's ID number, applicable pager number, ICD-10 codes, collector's name and indicate if STAT was ordered.

3. Licensed Nurse completes two different laboratory requisitions for urinalysis and for urine culture and sensitivity.

4. All specimen containers must be securely tightened to avoid leakage. Depending on the type of test, some urine specimens may require transport on ice.

C. Methods of Collecting Urine Specimen
Collection of Urine Specimen

1. Midstream (Clean-Voided) Technique – refer to Attachment 1.

2. Intermittent Urinary Catheter – refer to Attachment 2.

3. Indwelling Urinary Catheter
   a. Using aseptic technique, collect the specimen from the specimen collection port in the tubing of the urinary catheter (e.g., transurethral or suprapubic), not in the urine collection bag or from the catheter tubing directly.
   b. Clean the needleless sampling port with a facility-approved antiseptic solution and allow to air dry.
   c. Clamp or fold the urinary catheter tubing distal to the collection port.
   d. Insert a luer-lock tip syringe into the port at a 90 degree angle to the tubing and slowly aspirate the urine, withdraw about 10 ml of urine.
   e. Transfer the urine sample to the sterile specimen container and attach the lid securely.
   f. Wipe the sampling port with a facility-approved antiseptic swab; allows to air dry. Then unclamp or unfold the urinary catheter tubing to permit urine to drain into the collection bag.
   g. Secure and label the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

D. Disposition of Urine Specimens

1. For STAT order, on weekends, holidays, or after hours, the specimen is delivered to pavilion SNF and the Licensed Nurse will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation to pick-up specimen.

2. For regular working hours, send urine specimens directly to the Clinical Laboratory by any nursing staff for regular lab courier pick-up. For STAT-order, inform Lab Technician to include urine specimen in the earliest lab courier pick-up time.

3. For non-STAT order, on weekends, holidays, or after hours, urine specimens are delivered to and stored in the laboratory refrigerator.

4. Refer to Clinical Lab P&P for laboratory hours and courier pick-up hours.

E. Documentation

1. Treatment Assessment Record (TAR)
   Licensed Nurse or unit clerk will transcribe physician’s laboratory ordered test in the TAR. Licensed Nurse initials the TAR once specimen is obtained. Record the date, time, and method of collection in the reverse page of the TAR.

2. Laboratory Requisition Form - See Procedure Section B.
ATTACHMENTS:

Attachment 1 – Urine Collection using Midstream (Clean-Voided) Technique
Attachment 2 – Urine Collection using Intermittent Catheterization

CROSS REFERENCES:

A1 Clinical Laboratory Policies and Procedures
NPP F 5.0 Nursing Management of Urinary Catheter

REFERENCES:


Urine Specimen: Obtaining Midstream (Clean-Voided). Caple, C., Schub E, Pravikoff D, CINAHL Nursing Guide, April 28, 2017 – electronic access on October 25, 2018

Revised: 8/2001; 11/2008, 10/2010; 07/14/2015
Reviewed: 07/14/2015
Approved: 07/14/2015
ATTACHMENT 1 – Urine Collection Using Midstream (Clean-Catch) Technique

Description:
Midstream catch (clean-catch) technique is obtaining urine after the initial flow of urine.

1. Instructions for obtaining midstream catch:
   a. Wash hands thoroughly and apply non-sterile gloves.
   b. Sit the resident in the toilet seat.
   c. Clean the periurethral area with antiseptic towelette prior to voiding.
      
      Female: Spread the labia with the non-dominant hand. Using the towelette, clean the urinary opening by wiping one side of the labia from front of the labia towards the rectum (front to back). Repeat the same procedure on the other side of the labia using a new towelette. Then clean the urethral opening with a new towelette.
      
      Male: Retract the foreskin (if present). Clean the urinary meatus and the glans with a towelette, moving outward in a circular motion. Then repeat procedure using a new towelette.
   
   d. Instruct the resident to begin urinating. After a strong flow of urine, place the specimen container to collect the urine about 30 – 60 ml. Allow the resident to finish voiding.
   e. Avoid touching the interior surface of the specimen container or lid to avoid contamination. Close the container lid tightly and wipe the outside of the container with a new towelette.
   f. Wash hands thoroughly after the procedure.

2. Secure the specimen container and label with resident/patient identifiers and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

REFERENCES:

New: 07/14/2015
Reviewed: 07/14/2015
Approved: 07/14/2015
ATTACHMENT 2 – Urine Collection Using Intermittent Catheterization

1. Gather necessary supplies. Provide privacy and explain the procedure and its purpose to the resident or family.

2. Perform hand hygiene and apply on personal protective equipment (PPE) non-sterile gloves.

3. Provide good lighting.

3.4. Place pad or towel beneath resident to prevent soiling bed linen.

4-5. Position resident with full range of motion (ROM) as follows:

   Female: Dorsal recumbent position (on back with knees flexed), have resident relax the thighs. Alternate position: Sims’ position: side-lying with upper leg flexed at knee and hip.

   Male: Supine position with legs extended and thighs slightly abducted.

   For residents with limited ROM, position for comfort with sufficient staff as needed.

6. If perineal area is visibly soiled, cleanse with approved hygiene products perineal area.

5-7. Discard gloves and perform hand hygiene.

8. Established a sterile field nearby by the resident for easy access of the urinary catheter tray.

6.____

7-9. Apply on sterile gloves.

8-10. Remove the supplies from the catheter tray and organize them within the sterile field.

9-11. Maintaining a aseptic non-touch technique, clean the external orifice as follows:

   Female:

   a. Using the non-dominant hand, exposes the meatus by spreading the labial folds to expose the urinary meatus.

   b. Once the urethra is visualized, maintain hand position to prevent recontamination. If the labia closes after cleaning, the skin is considered contaminated and must be recalened.

   c. Keep the non-dominant hand in this position for the remainder of the procedure—this hand is now unsterile.

   d. Using the dominant hand, clean with antiseptic swab one side of the vulva and perineal area using one swipe technique beginning from the one side of the clitoris, cleaning along the labia majora, labia minora, and adipose tissue and ending before the perianal area. Discard the antiseptic swab.

   e. Clean the other side of the vulva and perianal area using the same technique as stated above.

   f. With a new antiseptic swab, clean the center of the vulva using the one swipe technique beginning above the clitoris, wiping directly over the urethral meatus and ending before the perianal area.
Male:

a. Using the non-dominant hand, hold the penis and gently retract the foreskin, if applicable. Once the urethra is exposed, keep the non-dominant hand in this position for the remainder of the procedure as this hand is non-sterile.

b. Using the dominant hand, apply antiseptic swab in a circular motion completely around the tip of the penis. Clean in a circular motion starting at the tip and working outward. Use separate sets of antiseptic swabs to complete separate cleansing cycles.

40.12. Generously lubricate the proximal tip of the catheter.

44.13. Using the dominant hand, grasp the catheter 3–4 inches from its insertion tip and secure the remainder of the catheter in the palm, if necessary, to keep the catheter sterile.

12.14. Insertion of intermittent catheter:

Female:

a. Slowly advances the catheter through the urethra toward the bladder
b. Once urine appears advance the catheter an additional 1–2 inches.

Male:

a. Hold the penis at a 90° angle to the patient's abdomen.

b. Slowly advances the catheter through the urethra until urine begins to flow.
c. Once urine appears, continues to advance the catheter an additional 1–2 inches.
d. Never force the catheter if meeting resistance.

13.15. Place the distal end of the urinary catheter within the sterile basin collection tray to obtain specimen.

44.16. Transfer the appropriate amount of urine to the sterile specimen container and attach the lid securely and label specimen with resident/patient identifiers. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

15.17. Withdraw the catheter and discard.

REFERENCES:

COLLECTION OF STOOL SPECIMENS

POLICY:

1. A physician's order is required to send specimens to the laboratory.

2. A Licensed Nurse who suspects some illness may collect or request a collection of stool and then confer with a physician to determine if the specimen should be sent to the laboratory.

3. The Licensed Nurse, Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA) may collect stool specimens.

4. Only the Licensed Nurse (or MD) may test and read the results for occult blood.

PURPOSE:

Stool specimens are collected appropriately to assist in the diagnosis of Gastro-Intestinal disease.

PROCEDURE:

A. Equipment needed for all stool collections

- Completed self-stick specimen identification label (date and time collected, stamped laboratory addressograph containing resident name, laboratory ID number, neighborhood, and bed number)
- Completed must be stamped with the laboratory addressograph and completed accurately, including the physician's ID number and ICD-9 codes.
- Sterile screw-top container or correct collection tube
- Specimen plastic bag
- Two tongue blades
- Bedpan, commode or specimen hat
- Paper towel

B. Procedure common to collection of all stool specimens

1. Fresh stool specimens are required for accurate laboratory results.

2. See procedure described in approved text Nursing Interventions and Clinical Skills by Elkin, Perry and Potter.

3. Once stool specimen is collected, clipped or placed the laboratory requisitions in the outside pocket of the specimen plastic bag.

4. Alert: The Licensed Nurse should check the resident's MAR and TAR for the use of barium, magnesium or oil of any kind within three days prior to stool collection as these may invalidate results.

C. Procedure for testing for occult blood by the licensed nurse

1. Additional equipment: Hemoccult Test Kit.

2. Follow the directions on the Hemoccult Test Kit.

D. Procedure for collection of stool specimen for laboratory testing for occult blood
1. Additional equipment: Stool specimen container for guaiac obtained from Clinical Laboratory Office.

2. See specimen disposition.

E. Procedure for collection of a stool specimen to be tested for ova and parasites (O&P)

1. Additional equipment: O&P collection kit obtained from the clinical lab.

2. It is important to collect this specimen prior to the start of medications.

3. Take the specimen to the lab while still warm and notify the lab technician. The specimen is not to be refrigerated.

4. Specimens are usually collected on three different days or as requested by the physician.

F. Procedure for collection of stool for other enteric pathogens:

1. Additional equipment: Specimen container containing non nutritive transport medium e. g. Para Pak C&S containers.

2. The licensed nurse must take the specimen immediately to the lab and contact the lab technician so that the specimen will reach the SFGH lab within two (2) hours.

3. Specimens to be tested for Clostridium difficile toxin assay or fecal leukocytes must be sent without transport medium or fixative. After collection these specimens must be taken immediately to the Clinical Laboratory at the Pavilion Mezzanine and placed in the refrigerator.

4. If collecting for C. Diff and another pathogen, use two different specific-containers, with separate laboratory requisitions and placed in the outside pocket for each specimen plastic bags.

G. Procedure for collection of stool for Pinworms

1. Additional equipment: Perianal SWUBE paddle in tube, found in the clinical lab. Follow the directions in the packet for obtaining specimen.

2. Collect specimen first thing in am before bathing or using toilet.

3. Usually collected on three consecutive mornings.

H. Disposition of Urine Specimens

1. For regular working hours, send stool specimens directly to the Clinical Laboratory by any Nursing Staff for regular lab courier pick-up. For STAT-order, inform Lab Technician to include stool specimen in the earliest lab courier pick-up time.

   Note: Please refer to type of lab test requested for stool specimen.

2. For non-STAT order, on weekends, holidays, or after hours, stool specimens are stored in the laboratory refrigerator (unless contraindicated) located in the North 1 and South 2 Residence Buildings. A designated A.M. shift nursing staff will bring all the stool specimens with requisition to the Clinical Laboratory for the first lab courier pick-up at 0830, Monday to Friday.

3. For STAT order, on weekends, holidays, or after hours, Licensed Nurse to call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation to pick-up specimen.
4. Refer to Clinical Lab P&P for laboratory hours and courier pick-up times.

I. Documentation of Collection Stool Specimen

1. **Treatment Assessment Record (TAR):** Licensed Nurse or unit clerk will transcribe physician's laboratory ordered test. Licensed Nurse to initial TAR once specimen is obtained. Will document the collection on the electronic health record date, time, and method of collection in the reverse page of the TAR.

2. **Nursing Assistant will document BM bowel movement on the DNCR form by CNA or PCA, on the electronic health record.**

REFERENCES:


Lippincott, Williams, and Wilkins, Best Practices: Evidence-Based Nursing Procedures, 2nd ed. (2007)


CROSS REFERENCES:

Nursing Policies and Procedures: H 6.0 STAT or Routine Clinical Laboratory Protocol

Departmental PP: Clinical Laboratory Policies and Procedures


Reviewed: 11/04/2010
SPUTUM SPECIMENS

POLICY:

1. A physician’s order is required to send specimens to the laboratory.

2. The Licensed Nurse, Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA) may collect sputum specimens collected by expectoration.

3. Only Licensed Nurses, Respiratory Therapists and physicians may obtain sputum specimens collected by suctioning.

PURPOSE:

To collect expectorated or suctioned bronchial secretion in order to assist with medical diagnosis.

PROCEDURE:

For additional information, see procedure in attached reference list.

A. Equipment for collecting all sputum specimens

1. Completed self stick specimen identification label (date and time collected,

2. Completed lab requisition, including the physician’s ID number and ICD -10 codes.

3. Sterile screw-top container (securely tightened after collection)

4. Specimen plastic bag(s)

5. Disposable gloves

B. Collection of specimens obtained by expectoration

1. First morning specimen is the most suitable, easier to obtain good quantity, quality of specimen.

2. Instruct resident to clear the nose and throat and rinse mouth with water.

3. If resident has pain due to a surgical incision or other factors, instruct to gently but firmly press a pillow over

4. Instruct resident to take several slow deep breaths, fully exhaling and performing a forceful cough; repeat as needed.

5. Instruct resident to cough deeply and expectorate sputum into the sterile specimen container.

6. Laboratory confirmations for acid-fast bacilli require 3 specimens collected on different days unless otherwise specified by physician.
C. Sputum collected by suctioning

**Additional Equipment**

Suction machine or wall suction if available
Suction catheter
Sputum trap (Mucous Specimen Trap)
Sterile lubricating gel
Sterile gloves

1. Administer supplemental oxygen prior to performing suctioning, if ordered.
2. Set-up suction equipment, setting suction to 100-150 mmHG for adults, and verify it is functional.
3. Visualize the nares to determine the most easily accessible passage.
4. Perform hand hygiene and use eye protection.
5. Attach in-line specimen trap to suction tubing.
6. Using sterile technique, open packages of sterile items. Use inner side of packaging for the sterile gloves as a “sterile drape” to place the catheter and container for sterile normal saline.
7. Put on sterile gloves; consider the dominant hand sterile and the non-dominant hand non-sterile.
8. Using non-sterile hand, pour sterile saline into the sterile container and squeeze a small amount of water-soluble lubricant onto the “sterile drape.”
9. With the sterile hand, attach the catheter to the in-line trap attached to the suction tubing. Use the non-sterile hand to hold the suction tubing and to control the suction valve during the procedure.
10. Using the sterile hand to manipulate catheter, dip the tip of the catheter into sterile saline to moisten the inside of the catheter.
11. Lightly coat end of the catheter with the lubricant.
12. Insert the suction catheter trip gently into the patient’s nasal passage. Twist the tip gently to help it advance through the turbinate.
13. Slowly advance the catheter tip into the patient’s trachea while instructing him/her to inhale without swallowing.
14. Instruct the resident to cough and, while the patient is coughing, use the nonsterile hand to apply suction 5-10 seconds by occluding the port on the suction tubing to collect 2-10 mL of sputum.
15. Rotate catheter gently while slowly withdrawing catheter.
16. Disconnect the in-line trap from the suction tubing and catheter and close tightly by connecting the rubber tubing to the trap male adaptor.
17. Clear the suction catheter with normal saline.
D. Disposition of specimens

1. Place the label on the container, place specimen(s) container in a clear plastic bag(s), and attach requisition(s).

2. Store sputum specimen in laboratory refrigerator until pick-up.

3. Laboratory Operation Hours and Regular Courier Pickup Hours (Refer to Clinical Laboratory P&P A1)

4. For STAT-order, inform Lab Technician to include sputum specimen in the earliest lab courier pick-up time.

E. Documentation

Licensed Nurse will document sputum collection onto the electronic health record Treatment Assessment Record (TAR): Licensed Nurse or unit clerk will transcribe physician’s laboratory ordered test. Licensed Nurse to initial TAR once specimen is obtained. Record the date, time, and method of collection in the reverse page of the TAR.

ATTACHMENTS/APPENDICES:

None

REFERENCES:


CROSS REFERENCES:

Clinical Laboratory Policies and Procedures
A1 Clinical Laboratory

Nursing Policies and Procedures
H 6.0 After Hours STAT Blood Draw


Reviewed: 12/27/10
GASTRIC SPECIMENS

POLICY:

1. Obtain a physician's order for desired test.
2. Licensed nurses collect gastric specimens.

PURPOSE:

To collect gastric contents for diagnostics.

PROCEDURE:

A. Equipment:

a. Basin for emesis (for gastric samples via emesis)
b. 35-60 ml syringe
c. Completed lab request
d. Sterile container with screw-top cover
e. Label for container
f. Clear plastic bag

B. Laboratory requisitions

1. Completed self-stick specimen identification label (date and time collected, stamped addressograph containing resident name, and neighborhood) and affix to the specimen container.
2. Completed requisition must be stamped with the addressograph and completed accurately, including the physician's ID number and ICD -10 codes.

C. Obtaining a gastric sample if resident has had emesis:

1. Provide resident with privacy.
2. Collect approximately 50ml, transfer to a sterile container with a screw top, and tightly close the container.
3. Affix the label on the specimen container. Place the specimen container inside the specimen plastic bag, then clip or place the laboratory requisitions in the outside pocket specimen plastic bag.
4. Assist resident to rinse his/her mouth.

D. Obtaining a gastric sample directly from the stomach:

1. Obtain and follow the specific instructions provided by the physician or clinical lab for the clinical test to be performed.
2. Position resident in High Fowlers position. Use a 35-60 ml syringe to withdraw 5-10 ml of gastric contents.
3. Affix the label on the specimen container. Place the specimen container inside the specimen plastic bag, then clipped or placed the laboratory requisitions in the outside pocket specimen plastic bag.

E. Disposition of Specimen

1. Place the label on the container, place specimen(s) container in a clear plastic bag(s), and attach requisition(s).

2. Store gastric specimen in laboratory refrigerator until pick-up.

3. Laboratory Operation Hours and Regular Courier Pickup Hours (Refer to Clinical Laboratory P&P A1)

4. For STAT-order, inform Lab Technician to include gastric specimen in the earliest lab courier pick-up time.

F. Documentation

1. Licensed Nurse will document specimen collection on the electronic health record.

   1. Licensed Nurse or Unit Clerk will transcribe physician’s laboratory ordered test.

   2. Licensed Nurse to initial TAR once specimen is obtained.

ATTACHMENTS/APPENDICES:

None

REFERENCES:


CROSS REFERENCES:

Clinical Laboratory Policies and Procedures
A1 Clinical Laboratory

Nursing Policies and Procedures
E 5.0 Enteral Tube Feeding Management
H 6.0 After Hours STAT Blood Draw


Reviewed: 12/27/10
AFTER HOURS STAT BLOOD DRAW

POLICY:

1. A Registered Nurse (RN) may perform venipuncture for STAT blood draw ordered by the physician.

2. The licensed nurse must notify the physician immediately if the specimen cannot be obtained.

PURPOSE:

To describe the guideline to nurses when obtaining after hours STAT blood draw.

PROCEDURE:

1. For STAT blood draw orders, when laboratory technician is unavailable or after hours, the licensed nurse will call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation arrangements to pick-up specimen.

2. For STAT-order, on regular working hours, inform Lab Technician to include lab specimen to the earliest lab courier pick-up time.

3. Refer to C 9.0 Transcription and Processing of Orders.

4. Licensed Nurse completes laboratory requisitions with stamped addressograph. Verify the physician's ID number, applicable pager number, ICD codes, pertinent medical diagnosis and medications. Indicate if STAT was ordered.

5. The RN must check and verify the identification of the resident.

6. Label specimens labeled with resident's name, with room number, date and time collected, stamped addressograph.

7. Place each specimen in a separate specimen plastic bag with its own lab requisition.

8. Secure the specimen container and place inside a specimen plastic bag. Place the laboratory requisitions in the outside pocket of the specimen plastic bag.

9. Licensed Nurse to initial TAR once specimen is obtained.

10. “Ward or Clinic Copy” to remain on requesting neighborhood.

11. STAT blood results are viewed on the electronic health records (EHR). Critical results are usually reported by phone to the unit licensed nurse or physician.

12. The Nurse documents the date, time, name of physician notified of the STAT tests results.

13. The charge nurse or team leader is responsible for communicating the status of all STAT orders to the oncoming shift to ensure follow up.
APPENDIX:

Appendix 1: Special Handling Instructions of Laboratory Specimen

CROSS REFERENCES:

A1 Clinical Laboratory Procedures
A2 Phlebotomy Procedure
A3 Identification of Resident and Collection of Blood Specimen
A4 Blood Culture Procedure

NPP J 7.0 Central Venous Access Device (CVAD) Management
NPP J 7.1 Peripherally Inserted Central Catheters (PICC) Management
NPP J 8.0 Blood Transfusion


Reviewed: 07/14/2015

Approved: 07/14/2015
ORAL AND NASOPHARYNGEAL SUCTIONING

POLICY:

1. Licensed Nurses may perform oral and nasopharyngeal suctioning when indicated, without a physician’s order.

2. For residents who are imminently dying, do not suction upper airway unless congestion causing resident/patient distress.

PURPOSE:

To maintain an open airway by removing oral and nasopharyngeal secretions which inhibit normal respiration.

PROCEDURE:

A. Equipment:

- Disposable suction kit (Frequently use French 10, 12, or 14)
- Suction machine
- Mask
- Water soluble lubricant
- Normal Saline
- Connecting tube
- Catheter plug

B. To suction nasopharynx via nose (if necessary) before suctioning mouth:

1. Position resident slightly on side in a high Fowler’s or semi-Fowler’s position when possible.

2. Attach the suction catheter to the suction machine.

3. Wash hands.

4. Apply sterile glove.

5. Open the sterile saline bottle. Open kit on a clean surface. Connect resident’s individual connecting tube and suction catheter.

6. Dip the tip of catheter into sterile saline to moisten the inside of the catheter, then lightly coat end of catheter with lubricant. Gently guide catheter into nostril, using a downward motion. Do not force. If one nostril is blocked, use the other.

7. Determine the appropriate depth of catheter insertion by measuring a distance equivalent to that between the tip of the nose and the earlobe.

8. Slowly advance the catheter tip into the resident’s pharynx while instructing him/her to inhale without swallowing.

9. Slowly withdraw catheter while gently rotating. Release suction intermittently every 1-2 seconds for approximately 10 seconds only.

10. Clear catheter by suctioning saline through it.
11. Repeat this procedure until the excess secretions are removed and resident is breathing comfortably.

12. Discard disposable catheter by wrapping catheter around your gloved hand and pulling the glove off around the catheter.

13. Plug the connecting tube with the sterile catheter plug.

14. Discard disposable suction canister, connecting tube, and catheter plug every 24 hours or PRN.

15. Each resident is to have his/her own suction kit, which is discarded after each suctioning episode.

C. To suction mouth and oral pharynx:

Guide catheter into throat and create suction intermittently for approximately 15 seconds only. Discard after each use.

D. Documentation:

1. Progress Notes: Document in the electronic health record (EHR) if any change from baseline, document assessment and evaluation of the intervention’s effectiveness. Describe the color, quality and approximate quantity of secretions removed and the condition of the resident.

2. Treatment Record: Document suctioning on front sheet in the EHR and describe effectiveness on the back side for prn.

ATTACHMENTS/APPENDICES:

None

REFERENCES

EBSCO – Nursing Reference Center - Nasopharyngeal Suctioning: Performing, September 18, 2015


Reviewed: 01/31/2014
TRACHEOBRONCHIAL SUCTIONING

POLICY:

1. Procedure is to be performed by a Licensed Nurse using sterile technique.

2. Suctioning should be done only when needed to reduce substantial secretions as indicated by increased respiratory difficulty, easily audible “gurgling” breathing sounds or post assessment of lung sounds.

3. For imminently terminal residents with audible airway congestion, do not suction unless congestion is causing resident/patient distress.

PURPOSE:

To clean air passages of accumulated secretions which prevent the resident from getting adequate ventilation by means of a suction catheter inserted through a tracheostomy.

PROCEDURE:

A. Equipment

Suction machine, if no wall suction, and unsterile emesis basin
Sterile suction kit (single-use) which contains: suction catheter, sterile gloves
Water soluble lubricant
Sterile connecting tubes
Sterile catheter plug
Mask and/or plastic apron; goggles, face mask, if needed
Sterile normal saline
Sterile gauze 4” x 4”
Resuscitation bag and oxygen tank or wall oxygen, if needed

B. Preparation of resident

1. Explain to resident (even if s/he is unresponsive) that suctioning may cause coughing and gagging which also helps to remove secretions. Continue to assure throughout the procedure to minimize anxiety and promote relaxation.

2. Provide for privacy.

3. Suggested positioning: Semi-Fowler’s position with chin up to promote lung expansion and productive coughing.

4. If the resident is able to cooperate, have him/her cough and breathe slowly and deeply.

5. If the resident has an artificial airway, or easily becomes hypoxic, hyperoxegenate his lungs, using the resuscitation bag for one or two breaths just before and after suctioning
C. Assessment

Auscultate lungs bilaterally and take vital signs, if resident's condition warrants.

D. Equipment preparation

1. Mask, plastic apron and/or goggles, face mask are to be worn by the nurse when the resident has copious secretions.

2. Wash hands thoroughly before and after performing this procedure. Put on mask.

3. Test the wall suction or plug in and test the suction machine and connect the tubing.

4. Label the sterile normal saline solution bottle with the date, time, and nurse's initial. Discard after 24 hours. Remove the cap from the normal saline bottle.

5. Open the suction kit on a clean surface. Place the sterile barrier under the resident's chin by handling only by the edges.

6. Put on the sterile gloves. Use one hand to do sterile suctioning. Use the other hand to handle non-sterile items.

7. Attach the sterile suction catheter to the connecting tubing by holding the catheter in your sterile gloved hand and the connecting tubing in your clean-gloved hand.

8. Remove resident oxygen mask if using.

9. Turn on the wall suction or suction machine.

10. Dip the catheter tip in the sterile saline solution to lubricate outside of the catheter.

11. With the catheter tip in the sterile saline solution, cover the control valve with the thumb of the sterile gloved hand and suction a small amount of the solution through the catheter to test the suction equipment and lubricate the inside of the catheter to facilitate passage of secretions through it.

E. Suctioning

1. With the catheter's control valve uncovered, gently insert the catheter deep into the trachea (and into a bronchus, if indicated), through the resident's tracheostomy tube. Do not apply suction during insertion to avoid tissue trauma and oxygen loss.

2. Apply suction for five to ten seconds during the withdrawal of the catheter by intermittently covering the control vent with the clean-gloved hand, while simultaneously rotating the catheter with the sterile-gloved hand.

3. If applicable, resume oxygen delivery after suctioning.

4. Observe the resident and allow him to rest before the next suctioning.

5. Repeat the suctioning until airway is cleared of excess secretions.
6. If secretions are thick, clear the catheter periodically by suctioning a small amount of sterile saline solution through it.

7. Clear the connecting tubing by suctioning saline solution to rinse it.

8. Turn off the suction and disconnect the catheter from the connecting tubing. Cover the connecting tube with the plastic bag.

9. To discard the catheter, coil it around your gloved hand and pull off the glove from the wrist over the coiled catheter. Put the catheter and the suction bowl into the infectious waste receptacle.

10. Auscultate lungs bilaterally and take vital signs, if the resident's condition warrants, to assess the procedure's effectiveness.

11. Perform tracheostomy care as needed.

F. Cuffed tracheostomy tube suctioning

Note: Cuff deflation /re-inflation to prevent necrosis, always done by Respiratory Therapist. (See Cross -Reference HWPP 27-05.)

G. Care of Equipment

1. Connecting tubing and catheter plug are to be changed every 24 hours or PRN.

2. Opened solutions are to be labeled with the date, time, nurse's initials, and discarded after 24 hours.

3. Disposable suction canister is to be changed every 24 hours or PRN.

H. Documentation

1. Pavilion Mezzanine Acute

   Interdisciplinary Progress Notes: RecordDocument the date, time of the procedure, and the reason for suctioning. Note the amount, color, consistency, and odor of the secretions and the frequency of suctioning. Record vital signs, including pain assessment; and auscultation findings before and after suctioning; hyper oxygenation measures if given; and pertinent data regarding the resident's subjective response to the procedure.

2. Skilled Nursing Neighborhood

   a. Interdisciplinary Progress Notes: When resident requires suctioning because of an unexpected change in his condition, document date, time, frequency of suctioning at least once each shift or more often as condition warrants, and include amount, color, consistency, and odor of secretions.

   b. Treatment Administration Record (TAR): When resident requires suctioning routinely to clear secretions, initial on the TAR document onto electronic health record. If resident requires as needed suctioning, describe the frequency of suctioning, character of the secretions, and outcome or effectiveness of procedure.
ATTACHMENTS/APPENDICES

None

REFERENCES:

EBSCO – Nursing Reference Center - Tracheostomy Care: Providing, February 20, 2015


CROSS REFERENCES:

Hospitalwide Policies and Procedures
27-05 Tracheostomy Management

Nursing Policies and Procedures
I 1.0 Oral and Nasopharangeal Suctioning
I 3.0 Tracheostomy Care


Reviewed: 10/25/2010
TRACHEOSTOMY CARE

POLICY:

1. Physician’s order is required for all tracheostomy care.

2. The first tracheostomy tube change will be performed by Ear, Nose, & Throat (ENT) Physician.

3. Cuffed tracheostomy tubes: Cuffed tracheostomies are only changed by ENT.

4. Upon admission, the attending physician may refer any resident with a tracheostomy to the ENT and/or other members of the Tracheostomy Team for review and evaluation. If the primary physician determines the referral is not indicated, the reason will be documented in the Physician Progress Note. Referral to the ENT shall be made via e-referral. Referral to the Tracheostomy Team shall be made on the “Tracheostomy Care Order Form” (MR 167).

5. Residents admitted with a speaking valve will also be referred to Speech pathology per HWPP 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir.

6. Airway suction, ambu bag, tracheostomy tube of appropriate size and oxygen are available at the bedside when any resident has a tracheostomy.

7. The disposable inner cannula (DIC) should never be cleaned and reused. It is intended for a one-time use only and is changed at least once daily by the day shift staff and as needed. Discard the used cannula and insert a new one, touching only the external portion. Lock it securely in place.

8. Subsequent replacements of the tracheostomy tube will be carried out by nursing at least once per month. If an urgent appointment is needed, phone the Surgical Clinic and mark “urgent” on the ENT e-referral. (Note: if an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy).

9. With the exception of those residents requiring specialized tracheostomy tubes, trained registered nurses or licensed vocational nurses will change the cuffless tracheostomy tube of residents who have had a tracheostomy for more than three weeks old and who have been seen by ENT for initial change. The type, tube size, and day of change are to be written ordered by the as a physician’s order, coded “T” so it will be processed to appear on the treatment sheet. (See Tracheostomy Order Form, MR #167).

10. Non-standard Tracheostomy Tubes for Special Needs (e.g., extra-long tracheostomy tubes): If a resident has a non-standard tracheostomy tube, the resident shall be referred to ENT for all tracheostomy tube changes. A spare non-standard tracheostomy tube will be kept at the bedside to be used only in an emergency (e.g., tracheostomy tube falls out).

PURPOSE:

To maintain a patent airway and to prevent infection.
PROCEDURE:

A. Emergency Care for Dislodged or Removed Tracheostomy Tube:

1. If the tracheostomy tube of a fresh tracheostomy becomes dislodged or pulled out, the licensed nurse is to have another staff person call code blue (Ext. 42999) and the ward physician while s/he stays with the resident and attempts to open the airway.

2. In a new tracheostomy (less than 7 days) do not attempt to reinsert another tracheostomy tube. Keep the wound open with a clamp (Mayo or Kelly) or use the stay sutures if they are present.

3. In a fresh tracheostomy (less than 21 days), a smaller size or a size below the existing tracheostomy tube should be at the bedside to keep the stoma open until the physician arrives.

4. In a more chronic, well-established tracheostomy, may keep tracheostomy open with a tracheostomy set, one size smaller, kept in treatment room.

5. During an emergency the physician may choose to immediately insert an endotracheal tube by mouth whether or not the tracheostomy is new or has an established tract.

6. The physician may transfer the resident with a fresh tracheostomy to an emergency room for acute surgical consultation.

B. Emergency Care Using the Resuscitation Bag:

1. Hyperextend the resident’s neck, UNLESS the resident has had a recent cervical injury, has a cervical brace, or is on cervical precautions.

2. If the tracheostomy tube has been accidentally removed and the resident does not have a complete upper airway obstruction, a gaping stoma, or a laryngectomy, a Bag Valve Mask (BVM) resuscitation device may be used to ventilate the resident by mouth while covering the stoma.

3. Squeeze the bag once every 5 seconds while it is connected to oxygen set at 15L/min until the physician arrives.

4. Nursing Alert:
   a. New tracheostomy
      i. Manipulation of neck ties and face plate should be minimized.
      ii. Residents who are likely to remove or manipulate the tracheostomy tube may have a physician’s order for mitten restraints if assessed as appropriate by Resident Care Team.
      iii. A suction machine is to be readily available.
      iv. A sterile clamp (Kelly or Mayo) and a sterile endotracheal tube and tracheostomy tube set matching the type of tube, but one size smaller that the tube the resident has in place, are to be kept in a plastic bag in the top drawer of the bedside stand.

   b. Tracheostomy emergency replacements sets should be kept in the bedside stand, sterile replacement tube sets and clamps may be kept in the treatment room. Keep one set for each size and type tracheostomy tube in use on the unit.

   c. Aspiration: If food or liquid is noted during suctioning, inform the resident’s physician immediately. Consider referral to speech therapy for urgent swallowing evaluation.
C. Resident Considerations:

1. Assess resident: there may be apprehension about choking, inability to communicate verbally, inability to remove secretions, and difficulty in breathing.

2. Explain the function of the equipment. Inform the resident and significant others that speaking with a tracheostomy is difficult.

3. Provide resident the best method of communication, for example: letter boards, paper and pencil, dry erase board.

4. The resident with a tracheostomy will be positioned at approximately 45 degrees or sitting upright when possible with position changes about every 2 hours to ensure ventilation to all lung segments and to prevent secretion accumulation around the tracheostomy tube.

5. The licensed nurse is to assess breath sounds as needed for evidence of crackles, rhonchi, or diminished breath sounds. Secretions are to be observed for amount, consistency, color, and odor.

6. The resident may be provided with shower bib during bathing to protect his/her airway. Shower bibs are obtained in LHH Central Supply Room.

D. Equipment:

- Disposable sterile tracheostomy care kit for suctioning, cleaning, additional sterile gloves.
- Suction equipment
- Sterile connecting tubing and catheter plug
- Mask, goggles and plastic apron
- Sterile clamps (Mayo, Kelly, or Magill)
- Water soluble lubricant
- Sterile saline solution
- Bedside waste bag
- 10 mL Luer syringe to inflate/deflate cuffed tubes
- Bag Valve Mask
- Oxygen source

E. Routine Tracheostomy Care: Changing Inner Cannula of Cuffed or Cuffless Tracheostomy:

1. Preparations:
   a. Perform suctioning of the trachea and pharynx as necessary before changing inner cannula. (Refer to NPP I 2.0 Tracheobronchial Suctioning)
   b. Wash hands thoroughly before and after performing this procedure.
   c. Put on a mask, goggles, and/or plastic apron if resident has copious secretions.
   d. Stand at the resident's side while suctioning or cleaning the tracheostomy tube.
   e. Label the sterile saline solution with the date opened, time, and nurse's initials. Discard after 24 hours.
   f. Remove the soiled dressing from around the stoma and discard.
   g. Observe the skin surrounding the tracheostomy for evidence of irritation or infection.
   h. Wash hands.
   i. Prepare the sterile field on the bedside table.
   j. Open the tracheostomy care set on sterile field and prepare the equipment
k. Put on the sterile gloves. Keep dominant hand sterile throughout the procedure. Use the other hand as clean hand to handle unsterile items.
l. Use your sterile-gloved hand to remove the remaining contents of the set onto the sterile field and separate the basins.
m. Use your clean gloved hand to pour the solution.

2. Tracheostomy site skin care:
   a. Tracheostomy site skin care should done every shift.
   b. Cleanse the skin around the stoma site. If crusts are present, soften them with sterile 4” x 4” gauze slightly moistened with sterile saline.
   c. Rinse with a sterile saline-soaked 4” x 4” gauze and pat dry. Avoid snagging loose threads on the tracheostomy tube because they could be inhaled.
   d. Cleanse external areas of tracheostomy tube with sterile cotton-tipped applicators moistened in the saline. Rinse areas with sterile saline-dipped applicators. Discard into bedside bag.
   e. Place a dry drain sponge under and around the tracheostomy tube. Reserve the extra tracheostomy dressings as needed for changes in between tracheostomy care.
   f. Replace the Velcro fastening tracheostomy tie if soiled.
   g. Discard used equipment. Remove and discard gloves and wash hands.

F. Changing Tracheostomy Tube of a Cuffless Tracheostomy - Done Monthly and PRN

1. Prepare equipment:
   a. Refer to Section E1 above to set up equipment for cleaning solutions and suctioning catheter.
   b. Open the packages containing the replacement tracheostomy tube and sterile 4” x 4” gauze.
   c. Squeeze a small amount of water soluble lubricant on the sterile 4” x 4” gauze
   d. Suction the resident if necessary.
   e. Insert obturator into the outer cannula of the new tracheostomy tube.
   f. Lubricate the tracheostomy tube well.

2. If difficulty occurs:
   If the resident goes into a laryngeal spasm, or the resident has difficulty breathing, or you cannot get the tracheostomy tube in place, as an emergency measure, quickly insert the mayo clamp into the stoma opening and spread the clamp. This is to be done only in case of emergency. Call the physician immediately

3. Changing the cuffless tracheostomy tube monthly and as needed:
   a. Use clean-gloved hand to cut the tracheostomy tape attached to the tracheostomy tube that you are going to change.
   b. Remove old tracheostomy tube.
   c. With sterile-gloved hand, insert the new tracheostomy tube into the stoma, using a downward motion.
   d. Quickly remove the obturator.
   e. Using sterile-gloved hand, insert the inner cannula and lock in place according to the type of tracheostomy tube in use. That is, a Shiley tube twists into place and a Portex tube snaps in place.
   f. Velcro/fasten the tracheostomy tie.
   g. Apply a sterile drain sponge around the tracheostomy tube.
G. Cuffed Tracheostomy Tubes: Only Changed by ENT physician

If an emergency occurs during the day shift, notify the physician. (MSPP #D06-01 Tracheostomy Management.) If an emergency occurs with a cuffed tracheostomy tube during am or pm shift, follow emergency procedures on page 1, part A.

1. The attending physician will document in the medical record if a resident is admitted with a cuffed tracheostomy tube and will write specific orders regarding cuff inflation/deflation.

2. If cuff inflation/deflation is ordered by the physician, Respiratory Therapy shall be consulted to review inflation/deflation procedure/precautions with Licensed Nurse.

H. Speech with a Tracheostomy Tube:

Consult with Speech Therapy for information on the care and use of speaking devices.

I. Documentation:

1. The licensed nurse is to document pertinent information, including the type and size of the tracheostomy in the care plan and treatment electronic health record.

2. Tracheostomy care during routine care or tube changes:

   For Acute care, residents with tracheostomies under 6 weeks in progress notes:
   a. Resident tolerance of tracheostomy care procedure such as cyanosis or respiratory distress.
   b. Appearance of the tracheostomy skin site
   c. Characteristics of secretions

   For chronic care residents with stable tracheostomies, initial treatment sheets and document above on weekly, monthly summaries.

3. Tracheal Cuff care:

   a. Tracheal cuff release time.
   b. Amount of air used for cuff inflation.
   c. Any changes in respiratory status during deflation/inflation.
   d. Amount, color and consistency of secretions

4. Inform physician and document if the resident develops a cough, chest pain, fever, rales, dullness of the chest on percussion, or stoma site develops signs of infection.

REFERENCES:


Lippincott, Williams, and Wilkins Staff; (2007) Best practices: evidence-based nursing procedures, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins

Mosby’s Clinical Skills, Tracheostomy Tube: Care and Suctioning

**CROSS REFERENCES:**

- LHHPP File: 27-05 Tracheostomy Management
- Nursing P&P I 2.0 Tracheobronchial Suctioning
- Nursing P&P I 5.0 Oxygen Administration

**ATTACHMENTS/APPENDICES**

None

Revised: 2000/09, 2008/08, 2016/09/13

Reviewed: 2016/09/13

Approved: 2016/09/13
OXYGEN ADMINISTRATION

POLICY:

1. A licensed nurse may administer oxygen during an urgent situation pending the physician's evaluation.
2. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.
3. Residents requiring continuous oxygen shall be placed in a room that has wall oxygen.
4. Oxygen tank shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.

PURPOSE:

To safely administer oxygen therapy.

BACKGROUND:

Disposable oxygen devices may include but are not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula, mask or tracheostomy mask

PROCEDURE:

A. Equipment:

1. Obtain oxygen delivery system supplies from neighborhood storage room or central supply.
2. Obtain from Central Supply, as needed:
   - "NO SMOKING" sign(s)
   - Small "E" tank oxygen cylinder with valve protection device attached. (Each Neighborhood will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)
   - Appropriate regulator
   - Compressed Air Connector if no humidification required
   - Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm.

B. Safety measures for oxygen are to be followed.

1. There is to be "OXYGEN IN USE" signs in the area of oxygen use or storage.
2. Residents and visitors are to be informed of the risks of smoking when oxygen in use, as needed.
3. "OXYGEN IN USE" signs are to be clearly visible:
   a. around the neck of the wall mounted oxygen flow regulators
   b. on oxygen or compressed air tanks in carriers or on wheelchairs use or stored outside of resident's room
   c. outside the door of resident's room when oxygen or compressed air is in use in the room
3. “OXYGEN STORAGE. NO SMOKING. NO OPEN FLAME” signs visible where oxygen is stored
   
4. No alcohol or tincture, oil, glycerin, Vaseline or petroleum product is to be used on or near residents receiving oxygen.

5. When oxygen tubing is not in use, make sure it is turned off and stored in bags.

6. Do not connect or disconnect electrical devices such as suction machines, electric razors and cell phones or any heat producing device during oxygen treatment,

7. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.

8. If fire breaks out on the neighborhood, turn off all oxygen sources. If a resident cannot survive without oxygen therapy, move resident/bed to a safe area before resuming oxygen.

9. If oxygen cylinders are required:
   a. Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
   b. Always look at the cylinder gauge to determine contents before administering any.
   c. Oxygen cylinders in storage shall be equipped with valve protection devices, and stored in oxygen cabinet.
   d. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.
   e. Cylinder valves shall be closed before moving cylinder on all tanks including empty cylinders.

C. Setting up and monitoring oxygen cylinders:
   1. Remove cap and plastic cover.
   2. Open and close valve quickly to remove dust from valve.
   3. Place proper diameter-indexed regulator, with adapter attached, on the tank and position so that regulator is perpendicular to tank for easy reading.
   4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
   5. No smoking sign will be pasted on front of tank. Also a no smoking tag, plastic bag with oxygen tubing, cannula, mask and compressed air connector will be hung on tank.
   6. Always check the amount of oxygen in cylinder before dispensing.
   7. Unless in use, the oxygen regulator is closed.
   8. Cylinders are to be stored on unit in appropriate cylinder holder.
   9. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply

D. Breaking down oxygen cylinders.
   1. Remove regulators from cylinders.
   2. Place valve covers on cylinders.
   3. Return empty cylinders to Central Supply.
E. Preparation of the Resident and Visitors:

1. Explain the procedure and reasons for it to the resident.
   a. Show resident the catheter or mask to be used.
   b. Reassure resident that you will be checking him/her.
   c. Elevate the head of the bed.
   d. Check that the call light is accessible. Give instruction on how to operate the call light, if needed. Reassure the resident that you want him/her to turn on the call light to inform you of any difficulties.
   e. If the resident is apprehensive, and if staffing permits, assign someone to stay with him/her until he adjusts.

2. Explain the "NO SMOKING" policy to the resident and visitors.

F. Preparation of Equipment:

1. Place "NO SMOKING" signs according to policy.
2. Wash hands.
3. Connect tubing to the flowmeter or humidifier and the administering device.
4. Assess equipment for proper functioning. Open oxygen flowmeter. There should be bubbles visible in the water of the humidifier, if used.

G. Administration:

1. Apply and adjust nasal cannula, mask or catheter to resident. Check placement frequently. If needed, use 4 x 4 gauze to cushion tubing that presses against the face or ears. Keep skin clean and dry. Observe these skin areas for skin breaks when oxygen is prolonged.

2. Turn on the oxygen and adjust flow rates as prescribed.

3. Increase frequency of oral hygiene as needed by resident's condition.

4. Nasal oxygen administered at 4 liters or less/minute does not need to be routinely humidified.

5. When humidifiers are used with oxygen, use pre-filled humidifier.

7. Check oxygen flow rate at frequent intervals.

8. Observe the resident frequently for signs of insufficient oxygen which may include:
   a. BP - increase above baseline or narrowed pulse pressure,
   b. Pulse - tachycardia,
   c. Respiration changes in rate, rhythm, depth, absence or presence of dyspnea,
   d. Decreased mental alertness - confusion, restlessness,
   e. Changes in skin and fingernail color, perspiration.

9. For Infection Control purposes, the opened nasal cannula, when not in use, will be stored in a clean bag.
H. Methods of Administration

Refer to Respiratory Services Departmental Policies and Procedures in the Cross Reference Section or The Lippincott Manual of Nursing Practice listed in the Reference Section of this NPP for Administering Oxygen by Nasal Cannula, Simple Face Mask With/Without Aerosol, Venturi Mask (High air flow oxygen entrapment [HAFOE] system, Partial Rebreathing or Nonrebreathing Mask, Continuous Positive Airway Pressure Mask, or by Manual Resuscitation Bag.

I. Documentation for Oxygen:

1. Order Sheet:
   When noting oxygen orders on the physician’s order sheet, code with the letter "T" in the Code column and transcribe to treatment sheet.

2.1. Tubing Label:
   All disposable used oxygen administration devices shall be labelled with the date and initials every 24 hours and as needed.

3. Treatment Administration Record (TAR) Electronic Health Record (EHR):
   a. Front side of treatment administration record
      For continuous use of oxygen each shift, the licensed nurse documents signs initials for the time and date administration opposite the order, then writes initials, signature and title in the signature section.
      b. For PRN use of oxygen, sign initials each time the oxygen is given. Licensed nurse documents when given and includes comment about how the oxygen was tolerated.
      c. When treatment is given by the respiratory therapist, the licensed nurse circles the correct time box and writes "RT" and her initials. Respiratory therapist does his own documentation.
      d. The replacement of all disposable used oxygen administration devices shall be noted on the resident’s TAR to serve as a reminder of the practice for all devices to be replaced documented on the ehr by AM shift nursing staff.
      b. Reverse side of treatment sheet – Progress Notes
         For PRN use of oxygen, each time oxygen is given, include a comment about how the oxygen was tolerated.

3. Electronic Health Record – Vital signs are recorded in the Electronic Health Record (EHR).
   4. Integrated Progress Notes – Monthly/weekly summary or more frequent PRN charting documentation based upon the resident’s condition and the judgment of the nurse.
   a. Resident’s response to treatment including adverse reactions and tolerance to the procedure, which may include the following items, as applicable.
      i. Date, time and performing the procedure
      ii. Oxygen liter flow rate
      iii. Method, frequency and duration of administration
iv. Specific assessments which may include vital signs, skin color, and level of consciousness.
Resident teaching done and the resident's level of understanding and compliance.
   h. 
   i. Date, time and person performing the procedure
   ii. Oxygen liter flow rate
   iii. Method, frequency and duration of administration
       Specific assessments which may include vital signs, skin color, and level of consciousness.
   b. Resident teaching done and the resident's level of understanding and compliance.
   i. Include oxygen administration and respiratory status on the Resident Care Plan.

ATTACHMENTS/APPENDICES:

I 5.0 Attachment 1: Oxygen Therapy Devices

REFERENCES:

Lippincott, Williams, and Wilkins Staff; (2007) Best practices: evidence-based nursing procedures, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

Respiratory Services Policies & Procedures:
A 2. Safety Regulations for Oxygen Therapy
A 6. Oxygen Administration: Nasal Cannula
A 7. Oxygen Administration: Simple- Oxygen Mask
A 8. Oxygen Administration: Non-Rebreather Mask
A 9. Oxygen Administration: Venturi Mask

Revised: 2006/03, 2006/04, 2009/08, 2017/01/10
Reviewed: 2017/01/10
CHEST TUBE CARE AND MAINTENANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) may care for residents with an existing chest tube(s) for non-acute/non-pneumothorax diagnoses, such as pleural effusion or for drainage of empyema.

2. Chest tubes will not be inserted at LHH. If the resident requires the replacement of an existing chest tube(s), or the insertion of a chest tube(s) for an acute diagnosis, the resident must be transferred to an outside acute facility.

3. The Registered Nurse (RN), once demonstrating competence in this procedure, is responsible for ongoing maintenance, including but not limited to: chest tube site assessment, new dressing changes, checking for air leaks, checking for presence of subcutaneous air (crepitus), and changing drainage units.

4. The Licensed Vocational Nurse’s (LVN) role in the management of chest tubes is to assist the RN with monitoring of chest tube output only, and reinforcement of an existing dressing (placing dressing over an existing dressing until a new dressing change can be performed by the RN).

5. Chest tubes may be clamped only as ordered by the physician and during the circumstances outlined in the procedure section.

6. For non-palliative care residents, vital signs will be assessed at a minimum of every 8 hours and as clinically indicated and chest tube output will be measured every 8 hours and as clinically indicated.

7. For palliative care residents, vital signs monitoring and chest tube output monitoring will be determined per individual basis and per physician order.

8. LHH will not perform chest tube irrigations, pleurodesis, or chest tube auto-transfusion.

9. Only a physician may remove a chest tube, and in the presence of a licensed nurse.

10. Two Curved Kelly clamps and two Xeroform gauze dressings must be kept at the resident’s bedside at all times in case of emergency, as well as one back-up collection container.

11. The Admission Coordinator (non-South 3 admissions) or the South 3 Team will alert the Clinical Nurse Specialist when a resident with a chest tube(s) is to be admitted so needed supplies can be ordered.

PURPOSE:

To outline procedures to manage residents requiring a chest tube or drain, and drainage system.

BACKGROUND

1. Residents with chest tubes/drainage systems are at risk for air leaks or accidental disconnection of the tube(s) to the closed system resulting in spontaneous pneumothorax, subcutaneous air, and acute respiratory distress.

2. A chest tube with underwater seal drainage is used to drain air, blood, or fluid from the pleural space (i.e., pneumothorax, Hemothorax, large pleural effusion, empyema) so that the compressed lung will re-expand. This water seal prevents inadvertent lung collapse by acting as a one way valve.
3. Indications for chest tubes include the following:
   a. To remove air, fluid, blood or purulent drainage from the pleural space and/or mediastinum.
   b. To allow re-expansion of lung tissue thereby improving pulmonary function.
   c. To resolve a mediastinal shift in the event of a tension pneumothorax.
   d. To prevent infection or enhance the resolution of the infection.

4. It is important to know the size of the chest tube in order to plan for the correct fit with the collection device. Refer to the operative report, procedural report, or other reference documentation. The chest tube sizes typically are:
   a. For air evacuation #12-32 French (Fr)
   b. For blood evacuation, standard chest tube size is 36Fr
   c. Flor fluid evacuation (e.g., pleural effusion) #9-12Fr pigtail catheter placed via interventional radiology.

DEFINITIONS:

Pneumothorax - Occurs when air leaks into the space between your lungs and chest wall. This air pushes on the outside of the lung and can cause it to collapse.

Hemothorax - Collection of blood in the pleural space

Pleural Effusion - Is an abnormal amount of fluid around the lung. Because pleural effusions are usually caused by underlying medical conditions, symptoms of these conditions are also often present (i.e., heart failure, cancer metastasis, etc.).

Empyema - pus in the pleural space

Heimlich Valve - is a type of one-way valve that connects to the chest tube. The valve lets extra air and fluid out of the chest, allowing the lung to fully expand. This is often used in the outpatient and long-term care settings.

Subcutaneous Air (Subcutaneous Emphysema) - Subcutaneous emphysema occurs when air gets into tissues under the skin. This usually occurs in the skin covering the chest wall or neck, but can also occur in other parts of the body. Subcutaneous emphysema can often be seen as a smooth bulging of the skin. When a health care provider feels (palpates) the skin, it produces an unusual crackling sensation as the gas is pushed through the tissue.

PROCEDURE:

1. Equipment
   a. The Admission Coordinator or the South 3 Team will alert the Clinical Nurse Specialist when a resident with a chest tube(s) is to be admitted so needed supplies can be ordered.
   b. Due to several different types of manufacturers of chest tubes and collection containers, refer to specific supplies as outlined in the manufacturer's instructions.
   c. The following items will be kept at the bedside:
i. Curved Kelly Clamps (2)

ii. Gauze 4x4 dressings (2)

iii. Xeroform gauze dressings (2)

iv. Sterile water if using water seal collection container

v. Items as outlined in manufacturer’s instructions unique to chest tube type (e.g., chest tube
caps, drainage containers, occlusive dressings)

vi. Suction head and tubing if required to enhance drainage for water seal collection container

vii. Personal protective equipment

2. Assessment of Resident

a. The RN will perform a respiratory assessment/monitoring each shift including the following (the
LVN may assist in data collection):

i. **Subjective Data:** pain assessment, activity tolerance, dyspnea, cough, or other subjective
data appropriate to the respiratory system.

   • Chest tube(s) can cause significant discomfort to the resident. A focus within the resident’s
     plan of care should be on pain management.

   • Assess for the need for premedication prior to mobility for resident’s with chest tube(s).

ii. **Objective Data:** lung sounds, respiratory effort, respiratory rate, sputum color and
    consistency, palpating for subcutaneous air (crackling feeling under the skin which could
    suggest air leak), non-verbal signs of pain/discomfort in the resident who is unable to
    communicate pain, skin color, condition of dressing (drainage, adherence of dressing).

iii. **Monitoring of the chest tube collection device:** color and amount of drainage each shift,
    bubbling in the water suction chamber (if utilizing a water seal collection device), kinking of
    tubing, and flow of pleural fluid in tubing.

b. **Assessment of the chest tube insertion site during dressing changes:** color of skin, warmth
   at and around insertion site, drainage from site, pain/tenderness, condition of skin surrounding site,
   drainage on old dressing, resident’s tolerance to the procedure.

c. Palliative care residents with a chest tube(s) will be assessed/evaluated per MD order.

   i. The licensed nurse should target assessment to symptom management and ensuring that the
      chest tube is patent and draining.

3. Care and Maintenance

a. Standard precautions will be utilized during the care of resident’s with chest tubes, or as determined
   by the physician and/or infection control nurse.

b. For non-palliative care patients, pleural fluid output will be monitored and documented every 8
   hours and PRN.

   i. For water seal collection containers, note the output by drawing a line on the container with the
      date/time for the corresponding output.
ii. For non-water seal collection containers, follow manufacturer’s instructions for direction on measuring of output specific to device.

c. Change chest drainage system(s) when accidentally broken, cracked, or full, and per physician order.
   i. Label the container when changing it with date and initials.

d. If a chest tube becomes disconnected from the collection container, clean the end with an alcohol wipe, reconnect to the collection container tubing, and secure the connection with tape.

4. Milking of Chest Tube(s) Procedure
   a. Routine milking of chest tubes is not recommended, and may be necessary in cases of active bleeding to prevent blood clotting or other thick drainage in the tubing that would interfere with patency.
   b. Perform milking of chest tube per physician order:
      i. Start proximally near the chest tube insertion site, squeezing in short segments until reaching the distal end (near the drainage container).
      ii. Stabilize the drainage tubing with one hand and slide the other hand from that point along the tubing away from the patient.

5. Clamping of Chest Tube(s)
   a. A chest tube may be clamped when changing a water seal drainage unit.
   b. Do not clamp for longer than one minute.
   c. If the resident exhibits signs of respiratory distress, unclamp the tube and immediately contact the physician.
   d. Clamp closest to the drainage unit, not closest to the resident, so the clamp can remain visible.
   e. Manual clamping is preferable to the use of a curved Kelly clamp.
   f. If a curved Kelly clamp must be used, place a thin piece of 4x4 gauze under the tips of the curved Kelly clamp to prevent cracking of the tube.

6. Special Consideration After Death
   a. For medical examiner and autopsy cases, do not remove the chest tube or drainage container.
   b. Otherwise, as part of post-mortem care, disconnect the chest tube and drainage container and dispose.

7. Documentation
   a. Document vital signs in the electronic health record (EHR) in the LCR, including pain assessment.
   b. Respiratory assessments and evaluation will be documented in the Interdisciplinary Progress Note. After dressing changes, document the condition of the chest tube site and tolerance to the procedure in the EHR Interdisciplinary Progress Note.
c. The RN will document chest tube dressing change, change in chest tube collection container in the EHR in the Treatment and Administration Record (TAR).

d. Initiate and update Resident Care Plan Activate and document on the Chest Tube Resident Care Plan (RCP) (see attached).

e. Document chest tube output on the each shift in the EHR TAR.

ATTACHMENT:

Appendix 1: Resident Careplan of Chest Tube Management

REFERENCE:

CROSS-REFERENCE:
None.

Original adoption: 01/12/2016

Approved: 01/12/2016
MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) are responsible and competent for administering, monitoring and documenting medications consistent with their scope of practice.
   a. Only RN may administer intravenous medications, whether by IV piggyback or IV push
   b. The LVN may administer medications per LVN scope of practice.
   c. The Nursing Assistant (CNA / PCA) may, under supervision of Licensed Nurses, administer: medicinal shampoos and baths, non-legend topical ointments, creams, lotions and solutions when applied to intact skin surfaces.

2. All medications, including over the counter drugs, require a physician’s order and indication for use.
   a. If indication for use is not on order, consult with physician.
   b. Topical creams/ointments available in the neighborhood (e.g., Dimethicone, Enzo) do not require a physician’s order.

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

4. Medications should not be left unattended.
   a. LN will remain with resident until resident has completely swallowed each medication.
   b. If concerned about ability or willingness to swallow, ask resident to open mouth and inspect for presence of medication.
   c. Refer to section H.2. for prescribed medications allowed at the bedside.

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

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

7. Powered medication administered via enteral tube should be diluted with 30-60 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

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

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

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

9. Medication administration times may by modified by licenses nurse to accommodate resident’s
clinical need or resident’s preference. Licensed nurse will send nursing order to pharmacy with medication administration time change and care plan resident preference rationale. See Appendix II: Specific Medication Administration Times for medications which require specific timing.

PURPOSE:

Medications will be competently and safely administered.

PROCEDURE:

A. Physician Order

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

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

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

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

B. Administration of Medication using 6 R’s

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

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

2. Right Drug, Dose, Route
   a. Checks for allergies to medications.
   b. Checks or verifies information about medication using one or more of the following references, when needed:
      i. Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
      ii. Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
iii. Checks medication and prescription label with Medication Administration Record (MAR) transcription. Checks physician order when there is a question.
iv. Special precaution needs to be applied when preparing and handling hazardous medication administration (Refer to LHHPP 25-05).
v. Review routes of administration
   a. Aerosol/Nebulizer: Refer to NPP J 1.3
   b. Enteral Tube Drug Administration: Refer to NPP E 5.0
   c. Eye/Ear/Nose Instillations: Refer to J 1.4
   d. IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

3. Right Time
i. Medications will be administered one hour before or one hour after the scheduled time on SNF units and 30 minutes before or after scheduled time on acute unit.
ii. All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
iii. See Appendix I for routine medication times and abbreviations.
iv. Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.
v. Medication administration times may be modified by licensed nurse to accommodate resident’s clinical need or resident’s preference. Licensed nurse will send nursing order to pharmacy with medication administration time change and care plan resident preference rationale. See Appendix II: Specific Medication Administration Times for medications which require specific timing. Pharmacist will verify for interactions. Modifications to routine times of administration at resident’s preference will be discussed with physician and pharmacist.

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

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

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

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

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

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

4. Pain
   Record pain scores per pain management policy. (Refer to HWPP 25-06)

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

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

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

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

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

E. Special Consideration
1. Fentanyl Transdermal (Patch) Application and Disposal (Refer to Pharmacy P&P 02.02.02 and 09.01.00)
   i. Application
      a. Select appropriate site for patch (as chest, back, flank or upper arm). Apply patch to non-irritated, non-irradiated skin.
b. Date and initial patch after application.

ii. Documentation on the MAR
   a. Document the following information:
      Fentanyl (Duragesic) __________ mcg/hr. _____ hrs Application date/time
   b. Document site of application on the MAR
   c. Verify placement every shift

iii. Verification of patch placement and monitoring
   a. Inspect site of application every shift to verify that the patch remains in place.
   b. If the patch has come off, attempt to locate the patch and dispose. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.

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

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

F. Administration of Medication(s) Through Enteral Tube

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

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

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

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

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

6. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).
7. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle pressure with the syringe.

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

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

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

G. Shaking Medications or Mixing a Suspension

1. Medications labeled “shake well” must be shaken vigorously to dilute the dose thoroughly immediately before administration.

2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”
   i. Any rolling motion used is acceptable as long as the suspension appears milky and the rolling action has not created bubbles.

H. Self-Administration and Bedside Medication

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

1. Self-Administration
   i. Licensed Nursing and other disciplines, as indicated, will collaborate to assess the resident’s ability to participate in medication self-administration using the Self- Administration of Medication Record (MR 341a).
   ii. Nursing, and/or other disciplines, will discuss the assessment of the resident’s ability to self-administer medication with the RCT.
   iii. The resident will prepare and take own medications, which are kept in medication cart, unless ordered for bedside by physician as indicated in the care plan (see also viii).
   iv. The nurse will observe medication preparation at each medication time and answer the resident’s questions, or reinforce the teaching as indicated. If the nurse notices the resident is about to make an error, he/she will intervene to stop the preparation. He/she will also discuss and clarify with the resident the accurate manner of self-administering medications. The RCT will be kept informed of any change in the resident’s ability to self-administer medications safely, or the need to re-evaluate the resident for self-administration of medications.

   v. Documentation will include the following;
      a. Topic/training skills taught and resident’s progress with learning on Medication Self-Administration Teaching Plan and Record (MR 341b).
      b. The Licensed Nurse who observes/teaches the resident on self-administration of medication will sign at the space provided on the Medication Self-Administration Teaching Plan and Record (MR341b).
      c. Resident’s agreement for participation in the self-administration of medications on the care plan.
      d. Documentation of the self-administration of the dose of medication is done on the MAR.
      e. Any follow-up plan identified by the RCT, necessary to reinforce safe and skilled medication self-administration will be documented using the Medication Self-Administration Evaluation Progress Note (MR 341b).

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

Appendix I and II - Routine Medication Times and Abbreviations; Specific Medication Administration Times
Appendix III – Anticoagulant Administration Protocol

REFERENCES:

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

CROSS REFERENCES:

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

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

Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds


Reviewed: 2018/07/10

Approved: 2018/07/10
APPENDIX I: ROUTINE MEDICATION TIMES AND ABBREVIATIONS

In an effort to be as home like and resident centered LH has adopted the universal medication schedule for medication administration when possible. Administration times are as follows:

- Q Morning 0900
- Q Noon 1300
- Q Evening 1700
- Bedtime 2100 or resident’s actual bedtime

If the medication order uses older nomenclature the following times apply:

- Daily “daily” 0900
- Twice daily b.i.d. 0900, 1700
- Three times a day t.i.d. 0900, 1300, 1700
- Four times a day q.i.d. 0900, 1300, 1700, 2100
- In the morning a.m. 0900
- Before meals a.c. 30 minutes before meals
- After meals p.c. 30 minutes after meals
- On an empty stomach 1 hour before or 2 hours after meal
- With food/meal with tray or may give with small snack such as crackers, sandwich, milk, pudding, nutritional supplement

<table>
<thead>
<tr>
<th>Dosage Interval</th>
<th>Abbreviation</th>
<th>Time(s)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every four hours</td>
<td>q 4 h</td>
<td></td>
<td>Nurse and MD will negotiate timing</td>
</tr>
<tr>
<td>Every six hours</td>
<td>q 6 h</td>
<td></td>
<td>taking into consideration the resident’s sleep and other clinical needs.</td>
</tr>
<tr>
<td>Every eight hours</td>
<td>q 8 h</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every twelve hours</td>
<td>q 12 h</td>
<td>0900, 2100 or *</td>
<td></td>
</tr>
<tr>
<td>Every other day</td>
<td>q week</td>
<td>0900 every other day or *</td>
<td></td>
</tr>
<tr>
<td>Once a week</td>
<td>q week</td>
<td>0900 Wednesday or *</td>
<td></td>
</tr>
<tr>
<td>Twice a week</td>
<td>2xw</td>
<td>0900 Monday and Thursday or *</td>
<td></td>
</tr>
<tr>
<td>Three times weekly</td>
<td>3xw</td>
<td>0900 Monday, Wednesday, Friday or *</td>
<td></td>
</tr>
</tbody>
</table>

Note: * Medication administration times may be modified by licenses nurse to accommodate resident’s clinical need or resident’s preference. Licensed nurse will send nursing order to pharmacy with medication administration time change and care plan resident preference rationale. Medication administration times may be modified to accommodate residents’ clinical need or with resident’s preferences in consultation with the physician and pharmacist.*
### APPENDIX II: SPECIFIC MEDICATION ADMINISTRATION TIMES

<table>
<thead>
<tr>
<th>Medication</th>
<th>Administration Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alendronate (Fosamax)</td>
<td>1st thing in the morning before anything except water; then keep resident in upright position for 30 minutes</td>
</tr>
<tr>
<td>Carbamazepine Suspension</td>
<td>Do not give or mix with other liquid medications. Causes drug-to-drug interaction if given the same time as other medications</td>
</tr>
<tr>
<td>(Tegretol)</td>
<td></td>
</tr>
<tr>
<td>Digoxin (Lanoxin)</td>
<td>Given q Noon</td>
</tr>
<tr>
<td>Insulin</td>
<td>Timed per meals and blood sugar monitoring; usually 30 minutes before meals unless otherwise specified. <strong>Exception:</strong> Insulin Lispro (Humalog) and Insulin Aspart (Novolog) should be given within 15 minutes before or immediately after a meal; Insulin Glargine (Lantus) or Insulin Detemir (Levemir) should be administered at the same time each day but does not need to be tied to the meal</td>
</tr>
<tr>
<td>Phenytoin Suspension (Dilantin)</td>
<td>Hold tube feedings for 1 hour before and after administration</td>
</tr>
<tr>
<td>Warfarin (Coumadin)</td>
<td>Given daily at HS</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Spaced evenly throughout 24 hours from the initial dose, unless otherwise ordered</td>
</tr>
<tr>
<td>Ciprofloxacin (oral Cipro)</td>
<td>Schedule with routine medications; hold calcium, iron and multiple vitamins with minerals supplements if scheduled at same time. Enteral feeds must be held 1 hour before and after administration of Ciprofloxacin. Administer with water.</td>
</tr>
<tr>
<td>Levofloxacin (Levaquin)</td>
<td>Schedule with routine medications; hold calcium, iron and multiple vitamins with minerals supplements if scheduled at same time. Administer with water.</td>
</tr>
</tbody>
</table>

**REFERENCE:** Applies to Appendix I & II


**CROSS-REFERENCES:** Applies to Appendix I & II

LHPP File: 25-02 Safe Medication Orders – Appendix A “Do Not Use Abbreviation List”
LHPP File: 25-01 High Risk – High Alert Medications

Adopted from NPP J 1.0 Medication Administration – Appendices (11/2006)


Reviewed: 07/22/2014

Approved: 07/22/2014
AEROSOL/NEBULIZER MEDICATIONS

POLICY:

1. Licensed Nurses are responsible for safely administering and monitoring aerosol and nebulizer treatments in the Skilled Nursing neighborhoods, but Respiratory Therapy may be consulted for complex needs.

2. Licensed Nurses or Respiratory Therapy are responsible for safely administering and monitoring aerosol and nebulizer treatments in Pavilion Acute.

PURPOSE:
To describe the process for the safe administration of aerosol/nebulizer treatments.

BACKGROUND:

1. Nebulizers are used for delivery of medication into the respiratory tract and/or moisturize airways and mobilize secretions.

2. Provision of relief for bronchospasm, wheezing, asthma and/or allergic reactions.

PROCEDURE:

A. Monitor resident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

2. Whenever resident's condition warrants and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or change in treatment.

3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Appendix 1, follow Manufacturer’s Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

3. When using multiple inhaled medications, wait 5 to 10 minutes between drugs to get maximum benefit. NOTE: If both bronchodilator and a steroid inhaler are prescribed, use the bronchodilator first.

4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.
5. **Compressor/ Nebulizer**
   
   a. Use with nebulizer face mask, which has medication cup and lid.
   b. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until nebulizer stops producing mist.
   c. Never place machine on soft surfaces, such as beds.

C. **Assessing Resident during treatment and for the effectiveness of treatment.**

   1. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed, and suction as clinically indicated.

   2. Assess the resident’s response to treatment.

D. **Documentation for Inhaled Medications**

   1. When treatment or inhalation medication is given by the respiratory therapist, s/he will document on the Electronic Health Record (EHR).

   2. Document any difficulties encountered during administration in the progress notes including interventions, outcomes and notifications.

   3. Resident self-administration should be discussed with resident care team and ordered by the MD.

   4. When treatment or inhalation medication is given by the respiratory therapist, s/he will initial on the MAR with initial and print name at the bottom of sheet.

   2. Document any difficulties encountered during administration in the progress notes including interventions, outcomes and notifications.

   3. Resident self-administration should be discussed in IDT and ordered by the MD.

**ATTACHMENTS/APPENDICES:**

Appendix 1: Various Inhaler Instructions

**REFERENCES:**

- [AeroChamber Plus® Flow-Vu® Cleaning Instructions](#)
- [EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler (Adults)](#)
CROSS REFERENCES:

Nursing Policies & Procedures
   I 5.0 Oxygen Administration

INTRAVENTOUS (I.V.) THERAPY MAINTENANCE

POLICY:

1. The Registered Nurse (RN) is responsible for the administration, monitoring, maintenance of intravenous (I.V.) therapy.

2. If the I.V. is designated as to maintain patency of an I.V. line, the order must specify the desired infusion rate. An I.V. designated only as “to keep vein open (TKO)” or “keep vein open (KVO)” should be infused at 30cc per hour not unless otherwise ordered. Use an I.V. pump for all I.V. infusions.

3. Peripheral I.V. site is to be changed or rotated every ninety-six (96) hours or earlier if necessary. An RN may restart peripheral I.V. site without a physician’s order if the I.V. site is infiltrated, inflamed or has dislodged as needed. All I.V. containers are changed every 24 hours and PRN according to physician’s orders.

4. Aseptic technique is used throughout the procedure. Body substance precautions must be observed. Gloves are worn to perform venipuncture and other vascular access procedures. Used I.V. equipment will be disposed of accordingly.

5. An I.V. certified by State of California Licensed Vocational Nurse (LVN) who demonstrated competency with I.V. therapy may perform these following procedures under the supervision of an RN:
   a. Perform venipuncture; may start, monitor, and discontinue I.V.
   b. Superimpose peripheral I.V. containers
   c. Change I.V. tubing of intravenous peripheral intravenous lines

* LVN cannot perform the following procedures:
   a. Administer I.V. medications
   b. Superimpose central line I.V. fluid containers
   c. Change central line I.V. tubing
   d. Discontinue central line or sutured I.V. lines
   e. Change central line I.V. dressings
   f. Administer fluids at an unspecified rate (i.e. “bolus wide open”)

6. Intake and output is monitored and documented every shift for a resident who is on continuous I.V. therapy.

PURPOSE:

To provide guidelines for licensed nurses with management of I.V. therapy.

RELEVANT DATA:

1. Peripheral venous catheter is usually inserted in veins of forearm or hand using a small flexible cannula. The end catheter of a peripheral I.V. line does not end in a great vessel.

2. Internal Jugular (I.J), External Jugular (E.J.), Peripherally Inserted Central Catheter (PICC) lines are to be managed as central lines; aseptic technique dressing changes are only done by RNs.
PROCEDURE:

A. Equipment:

Item
I.V. administration set
I.V. secondary set (piggy back)
Venipuncture catheter, appropriate sizes (22g, 20g, 18g)
Clear link luer lock intermittent injection site tubing
I.V. pressure hub
I.V. starter kit
I.V. solutions
I.V. minibag bag (NS or D5W) in 25, 50 or 100ml
Antiseptic pads
Gloves
Prescribed I.V. medications
I.V. and medication labels
I.V. Flow sheet

B. Preparation for peripheral I.V. insertion

1. Check physician’s orders prior to initiation of I.V. therapy. The physician’s order must include the type of I.V. solution, rate of administration and/or duration of administration and also must specify medication additives (i.e. name of drug, dosage and specific fluid amount).

2. Ensure that I.V. fluids and additives are compatible by referring to compatibility chart, Lexicomp (online formulary) or verifying with the Pharmacy.

3. Wash hands prior to palpation, inserting, replacing, or dressing any I.V. Wear clean gloves.

4. Prepare I.V. fluids and medications in designated medication room; cleanse preparation site with antiseptic pads prior to each preparation.

5. Label I.V. tubing and fluid bag with the date time, type of additives, and the initial of the RN preparing the admixture.

6. Select an appropriate site for insertion.

7. Peripheral I.V. insertion (Saline-lock without extension tubing)

   a. Wash hands. Put on gloves and perform venipuncture.
   b. Quickly connect the intermittent infusion site into the safety I.V. catheter port and release tourniquet.
   c. Secure I.V. needle in place with transparent dressing or tape.
   d. Clean injection port with antiseptic pads and instill pre-filled normal saline solution. Remove gloves. Wash hands.

8. Set and monitor the I.V. flow rate on the infusion pump.

9. If peripheral I.V. is an intermittent lock, flush with pre-filled normal saline every 8 hours, and before and after each administration of medication; unless otherwise indicated
C. Administering Medications
   1. Refer to NPP J 1.0 Medication Administration
   2. For I.V. fluids and additives are compatible by referring to compatibility chart, Lexicomp (online formulary) or verifying with the Pharmacy
   3. When administering chemotherapy I.V. medication refer to LHPP 70-02.

D. Maintenance of I.V. Site
   1. Peripheral I.V. site may be in place up to 96 hours. If the I.V. line is not changed in 96 hours, notify MD and document reason (i.e. poor vein access, resident refused I.V. site change), and notify the physician. If venous access is limited, request physician order to extend use of the current site.
   2. I.V. primary and secondary tubing is changed every 96 hours (unless there is contamination or drug incompatibility, may change as needed).
   3. I.V. solution is changed every 24 hours.
   4. I.V. transparent dressing is changed with each site change and as needed.
   5. For resident with fragile skin, consider use of the skin barrier prep prior to applying transparent dressing. May apply elastic net dressing to secure I.V. site when needed.
   6. Evaluation of Peripheral I.V. Site
      a. Inspect and gently palpate the area around the infusion site each shift and as needed.
      b. Assess for inflammation, blanching, discharge, hardness, swelling, pain, or temperature change (warmer or cooler). If complications are evident, change the infusion site.

E. Discontinuing Peripheral I.V. site:
   1. After hand washing and applying clean gloves, gently remove any tape or dressing after pressure with a 2 x 2 sterile dressing for 1-2 minutes or longer to prevent hematoma formation at the I.V. site.
   2. Place dry dressing or Band-aid over the insertion site.
   3. Any I.V. related products with visible blood are dispose in the sharps container.

F. Reporting and/or Documentation
   1. I.V. Flow Sheet - Electronic Health Record (EHR):
      a. Document procedure, date, time, new bags for continuous I.V. fluids; volume hung, type of solution, flow rate, type of line, site location and needle gauge and signature.
      b. Document I.V. site assessments, dressing or tubing changes, amount infused and amount left in bottle.
      c. Document
         i. Unusual findings on I.V. site
         ii. Difficulties encountered and how the resident tolerated the treatment
      d. Record intake and output every shift.
e. Document dosage and time of I.V. piggyback or I.V. push medications administered.
f. Saline flush maintenance instillations documented every shift, unless resident receives an intravenous medication at least every eight hours.
g. Complications immediately reported to physician.
h. Report type and amount of remaining solution, rate of flow and any special considerations to relief nurse.
   a. Document procedure, date, time, bag number for continuous I.V. fluids; volume hung, type of solution, flow rate, type of line, site location and needle gauge and signature.
   b. Each shift, document I.V. site assessments, dressing or tubing changes, amount infused, amount left in bottle and signature.
   c. Document on the back of PRN form:
      i. Unusual findings on I.V. site
      ii. Difficulties encountered and how the resident tolerated the treatment

2. Treatment Administration Record

   Record intake and output every shift. The 24-hour total is done on PM Shift.

4. Medication Administration Record

   Document dosage and time of I.V. piggyback or I.V. Push medications administered.
   a. Saline flush maintenance instillations must be recorded separately on medication sheet unless the resident receives an intravenous medication at least every eight hours.

5. Interdisciplinary Progress Notes

   b. Document complications immediately to the physician.
   c. Report type and amount of remaining solution, rate of flow and any special considerations to relief nurse.

REFERENCE:

CDC Guidelines for Prevention of Intravenous Therapy

CROSS REFERENCE:

Nursing P&P J 1.0 Administration of Medications

Nursing P&P J 7.0 Central Venous Access Device Management
LHPP 70-02 Antineoplastic/Cytotoxic Medications

Revised: 8/ 2000, 6/2010; 03/10/2015

Reviewed: 03/10/2015

Approved: __________
SUBCUTANEOUS ACCESS DEVICE

POLICY:

1. Subcutaneous access device may be inserted by a licensed nurse with a physician's order for medication administration by bolus or continuous infusion.

PURPOSE:

To describe a safe and alternate route for intermittent medication administration that avoids frequent punctures.

PROCEDURES:

A. Assess for any condition that may be contraindications to subcutaneous access device placement such as, generalized edema, poor peripheral circulation, minimal SQ tissue, bleeding disorders, severe pain with frequent boluses, irritant medications, or need for rapid boluses or dose escalations that may require large volumes of medication.

B. Assemble equipment for the procedure and educate resident/family about procedure:
   1. Smallest available gauge (e.g. 24 or smaller), short length (3/4" or smaller) IV catheter
   2. Short extension tubing with safety injection hub
   3. Alcohol swipes or antiseptic skin preparation
   4. Transparent site dressing

C. Select and prepare site using aseptic technique:
   1. Preferred subcutaneous sites include: anterior chest wall, upper abdomen, anterior or lateral aspects of thighs, above scapula on back or upper outer arm. Chest site is recommended for ambulatory residents abdomen site for residents with little SQ tissue.
   2. Prepare site with cleansing agent (alcohol or chlorhexidine) and allow to air dry.
   3. Prime extension set with sterile Normal Saline solution or medication.
   4. Use gloved hands to stabilize tissue over site, insert catheter/butterfly needle at 20-30°angle with bevel down. Note angle of insertion may vary depending on the amount of subcutaneous fat.
   5. Secure hub or wings with tape or securing device.
   6. Check for blood return. Remove if any blood return. Repeat insertion with new needle etc.
   7. Cover with transparent dressing and date.

D. Site maintenance
   1. Observe site every shift for irritation or leakage.
   2. Replace needle if any signs of irritation, absorption difficulties, or weekly unless other indicated.
   3. Transparent dressings may remain in place for up to 1 week
   4. Consult with physician if recurrent problems with site or concerns regarding medication absorption.

E. Administration of medication
   1. Medications (e.g., opioid analgesics, antiemetics, and benzodiazepines, etc., except irritant agents) ordered subcutaneously may be given through subcutaneous access device if volume of the medication is less than or equal to 2 ml.
   2. If giving medications by bolus (not continuous infusion) flush extension set with 0.5 ml NS to ensure medication was instilled (note flushing larger amount is often associated with discomfort).
3. Continuous infusions of medications at a rate of 3-5 ml/hour may provide more consistent medication blood level and will be regulated by an infusion pump.

F. Remove subcutaneous access device using aseptic technique, carefully dispose of sharps, and apply dressing if necessary.

G. Documentation

1. Document the insertion of subcutaneous access device and ongoing site monitoring in the Treatment Administration Record (TAR) and Electronic Health Record (EHR).


REFERENCES:

CROSS REFERENCE:
Nursing P&P J 1.0 Medication Administration

NEW: 02/10/2012
Approved: 03/27/2012
Reviewed: 11/10/2015; August 2017
ASSESSMENT, PREVENTION, AND MANAGEMENT OF PRESSURE ULCER/PRESSURE INJURY

POLICY:

1. The Registered Nurse (RN) is responsible for assessing each resident for presence and risk of pressure ulcer (PU)/pressure injury (PI) on admission and/or following any significant/clinical change in condition that may increase the resident’s risk of developing a pressure ulcer/pressure injury.

2. Upon resident’s intra-facility (within Laguna Honda) relocation, including Pavilion Acute, and/or vice-versa, the sending licensed nurse is responsible for conducting skin checks and complete skin section (see LHH Body Diagram form) for any presence of pressure injury/complex wound.

3. The sending RN from SNF and/or Pavilion Acute and the receiving RN from SNF and/or Pavilion Acute will perform skin assessment of the resident.

4. Upon resident’s discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and complete skin section of the Inter-facility transfer record (MR 113B).

5. Upon identification of PU(s), two RNs are required to verify and accurately stage the ulcer(s).

6. The RNs, Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA), and Home Health Aides (HHA) are responsible, within his/her scope of practice, for observing and reporting changes in residents’ skin status and implementing pressure injury prevention and/or treatment.

PURPOSE:

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

PROCEDURE:

1. Prevention of Pressure Ulcer/Pressure Injury for Resident at Risk (Refer also to Impaired Skin Integrity, Potential risk r/t Braden Score < 18 Care plan-Appendix)

   a. Skin care: nursing assistants should keep the resident clean and dry and minimize exposure to moisture and associated irritants from incontinence, perspiration or wound drainage as much as possible. Handle skin gently and minimize friction (refer to Appendix B for LHH Skin Care products).

   b. Skin check: nursing assistants are to thoroughly check the resident’s skin at least once daily, paying particular attention to bony prominences and are to report changes to the charge nurse or the designee. This may be incorporated into the resident’s daily hygiene care.

   c. Positioning: position using the 30-degree rule — no greater than 30 degrees on either side, or the head of the bed should not be elevated more than 30 degrees when possible. Avoid positioning directly on trochanter or existing ulcer.

   d. Repositioning: reposition residents who are immobile, at least every 2 hours or per care plan. Repositioning clock or written schedule (depending on the resident’s needs) may be utilized to monitor repositioning.
e. Caution when moving resident. Avoid shearing/friction by using lifting devices such as a trapeze or bed linen to move (rather than drag) residents who cannot assist during transfers and position changes.

f. Positioning devices: use wedge, pillows, and pads to keep bony prominences from direct contact with one another.

g. Support surfaces: nursing will apply a pressure-relieving support surface (bed/wheelchair) per protocol and/or specialized mattress when needed after evaluation by wound care CNS or designee. If re-evaluation is needed inform wound care CNS or designee. (Refer to LHPP 24-03 Specialized Bed And Support Surface Equipment).

h. Protective devices:
   i. Protectors for ankle and elbow to minimize friction.
   ii. Heel protectors/devices or pillows under the length of the lower legs to suspend the heels. Do not put the pillow directly under the knees.
   iii. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet.
   iv. Foam arm rest covers (available in central supply room) for wheelchair arms can be used.

i. Careful placement in chairs: position chair-bound resident in good postural alignment, distribution of weight, balance and pressure relief.
   i. Refer to occupational therapy for evaluation of appropriate seating device.
   ii. Avoid sitting directly on the pressure ulcer/pressure injury.
   iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.
   iv. Rest elbows, forearms and wrists on arm supports. Use foam armrest supports on wheelchair.
   v. Instruct or assist resident to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes, if they are able.
   vi. Document the use of positioning devices and repositioning schedule (as tolerated) in the resident care plan.

2. Assessment of Pressure Ulcer/Pressure Injury

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

   a. The charge nurse or the designee will inform the RCT of any resident identified at risk for pressure ulcers/pressure injuries, and develop an initial care plan. The RCT will review and contribute to the care plan as needed.

   b. The charge nurse or the designee will ensure that the plan of care is reviewed with nursing staff and ensure through direct supervision that the plan of care is being implemented.

   c. The RN will assess the ulcer(s) when present. The licensed vocational nurse (LVN) may assist in data collection under supervision of RN:
      i. location
      ii. size (length, width, depth in cm)
Assessment, Prevention and Management of Pressure Ulcer/Pressure Injury

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

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

d. The RN will reassess pressure ulcer(s)/pressure injury(ies), at least weekly, to determine whether the prescribed treatment is working and document on the facility approved wound assessment record (WAR) electronic health record (EHR) until healed. A clean pressure ulcer/pressure injury should show evidence of some healing within two weeks.

e. The RN will reevaluate the treatment plan weekly or as soon as there is any evidence of deterioration in the condition of the resident or the wound. If the ulcer fails to respond to treatment, refer the resident to the physician/wound care Clinical Nurse Specialist (CNS).

3. Management of Pressure Ulcer/Pressure Injury

a. Following detection of a pressure ulcer/pressure injury, the charge nurse or designee will promptly:
   i. notify the neighborhood physician (or if immediate treatment is needed, on-call physician) and a treatment plan shall be implemented within eight (8) hours;
   ii. notify wound care Clinical Nurse Specialist
   iii. notify the dietitian within 24 hours (call Dietary office)
   iv. notify the resident and/or Surrogate Decision Maker (SDM) within forty-eight hours
   v. complete facility approved WAR
   vi. develop a plan of care for prevention and treatment of the ulcer(s)
   vii. complete an Unusual Occurrence form
   viii. schedule Resident Care Conference

b. Develop/revise plan of care for prevention and treatment of the ulcer(s).

c. The RN will assess pressure ulcer(s)/pressure injury(ies) weekly. The LVN may assist in gathering data under supervision of the RN.

d. The RN will reevaluate the treatment plan if the ulcer(s) fails to show evidence of healing within two weeks, or when the ulcer shows signs of deterioration.

e. The Attending Physician in conjunction with the RN will evaluate non-healing and worsening ulcers and refer to the Plastic Clinic/Wound Care CNS.

4. Documentation of Pressure Ulcer/Pressure Injury
a. Admission: Complete Braden Scale Form (MR# 367) and body diagram skin assessment on the Nursing Admission Assessment form (MR #321) and Admission Nursing Assessment on the electronic health record (EHR).

b. Intra-facility relocation: Document condition of skin and complete the facility approved LHH Body Diagram form.

c. Annually: Document condition of skin as part of Minimum Data Set (MDS). Complete the facility approved pressure ulcer/pressure injury risk assessment tool.

d. Discharge to outside facility or intra-facility acute unit: Document condition of skin and pressure ulcer(s)/pressure injury(ies) on the EHR and complete the body diagram with the approved inter-facility transfer/LHH body diagram form.

e. Document the required Pressure Ulcer/Pressure Injury Risk assessment tool on admission, followed by weekly x3, quarterly, annually, and/or following a decline/significant change of condition.

f. Resident Assessment Instrument (RAI): When a pressure ulcer/pressure injury is triggered as a Care Area Assessments (CAA) Problem Area, the MDS Coordinator will:

   i. Utilize the CAA guidelines to identify additional areas needing assessment.
   ii. Document the assessment in the CAA notes, including the decision to care plan or not.
   iii. Review the RAI policy and consult with the physician and RCT to determine if a significant change in condition MDS assessment must be completed when a resident develops a stage 2 or higher pressure ulcer/pressure injury.

g. Resident Care Plan: If the resident is identified as being at risk for pressure ulcers/pressure injuries as determined using the facility approved pressure ulcer/pressure injury risk assessment tool, or has a pressure ulcer/pressure injury, a comprehensive, interdisciplinary care plan is developed that:

   i. Identifies problems (i.e., PU risk factors and/or presence of ulcer),
   ii. Develops individualized goal(s),
   iii. Develops interventions to address prevention or treatment.

h. SNF and Acute care units: Wound assessments are done weekly and/or when there is a decline in the condition of the wound. These assessments are documented on the facility approved WAR the EHR.

i. DNCR notes: Nursing Assistants are to document any changes in skin condition they observed on the DNCR record on the EHR, including the name of the licensed nurse notified.

j. Weekly or monthly nursing summaries: Summaries include assessment of any new resident’s risk factors for developing pressure ulcer(s)/pressure injury(ies) as well as evaluation of the effectiveness of implemented treatment/interventions and revision of care plan as needed.

k. Notification: Document all notification to the physician, wound care CNS, dietitian and family or SDM when a pressure ulcer/pressure injury is detected and when the ulcer shows no evidence of healing.
I. Resident education / counseling: Resident teaching or counseling related to prevention/management of pressure ulcers/pressure injuries is to be documented in the progress notes/WAR, and/or resident care plan.

APPENDICES:

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

REFERENCES:

Evidence-Based Pressure Ulcer Prevention: A Study Guide for Nurses, HC Pro, 2008 Sizewise

CROSS-REFERENCES:

LHHPP File: 24-15 Prevention and Management of Pressure Ulcer
Nursing P&P C 1.0 Admission and Readmission Procedures
Nursing P&P C 1.2 Nursing Guidelines for Relocation between Laguna Honda SNF Neighborhoods
Nursing P&P C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
Nursing P&P C 4.0 Notification and Documentation of Change in Resident's Status

Document originated: 2001/11
Revised: 2005/02; 2008/03; 2015/12/04; 2017/11/04; 2018/03/06
Reviewed: 2018/03/06
Approved: 2018/03/06
WOUND ASSESSMENT AND MANAGEMENT

POLICY:

1. The Registered Nurse (RN) is responsible for performing wound assessment, dressing application, and notifying the physician for presence of wound infection, wound deterioration, and non-healing wound.

2. The Licensed Vocational Nurse (LVN) under the supervision of the RN may collect wound assessment data and perform dressing application as ordered by the physician.

PURPOSE:

1. To provide a guideline in wound assessment and appropriate wound management.

BACKGROUND:

A. Definitions:

1. Arterial - wounds caused by ischemia, which is related to the presence of arterial occlusive disease.

2. Diabetic or Neuropathic - Neuropathy is often associated with diabetes. Wounds results from damage to the autonomic, sensory, or motor nerves and have an arterial perfusion deficit.

3. Pressure – wounds due to the damage to the skin or underlying structures as a result of tissue compression and inadequate perfusion.

4. Venous – wounds caused by failure of the venous valve function to return blood from the lower extremities to the heart. This causes venous congestion and leads to venous hypertension.

<table>
<thead>
<tr>
<th>Types of Wound</th>
<th>Arterial</th>
<th>Diabetic/Neuropathic</th>
<th>Pressure</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>The distal aspect of arterial circulation can be anywhere on the leg, including the toes and feet</td>
<td>Can be anywhere on the lower extremity, usually located on the foot</td>
<td>Usually over a bony prominence</td>
<td>Located in the gaiter area (ankle to mid-calf), it is often medial malleolus and maybe circumferential</td>
</tr>
<tr>
<td>Wound Margin</td>
<td>“Punched out,” well-defined borders</td>
<td>Usually with a calloused edge</td>
<td>Usually circular</td>
<td>Irregular shaped</td>
</tr>
<tr>
<td>Wound Size</td>
<td>Can be small, but often increases due to lack of arterial perfusion</td>
<td>Often small</td>
<td>Can be very large or very small</td>
<td>Usually large</td>
</tr>
<tr>
<td>Wound Bed</td>
<td>Pale wound bed, little or no granulation, necrotic tissue is common</td>
<td>Similar to arterial wounds, usually with a calloused edge</td>
<td>Can have viable or necrotic tissue</td>
<td>Usually shallow, can have viable or necrotic tissue</td>
</tr>
<tr>
<td>Exudate</td>
<td>Minimal to no exudate</td>
<td>Minimal to no exudate</td>
<td>Can vary from none to heavy</td>
<td>Can vary from none to heavy to generalized weeping</td>
</tr>
</tbody>
</table>
# Wound Assessment and Management

## Types of Wound

<table>
<thead>
<tr>
<th>Edema</th>
<th>Arterial</th>
<th>Diabetic/Neuropathic</th>
<th>Pressure</th>
<th>Venous</th>
</tr>
</thead>
<tbody>
<tr>
<td>If present, localized</td>
<td>If present, localized</td>
<td>Can be localized, usually not seen</td>
<td>Generalized edema to lower extremity</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>Occurs at rest, at night, or when the extremity is elevated</td>
<td>Due to neuropathy, the pain maybe absent or severe</td>
<td>Usually present, but often undertreated</td>
<td>Often occurs in a dependent position along with edema</td>
</tr>
</tbody>
</table>
| Best Practice | 1. If perfusion is not adequate, consider vascular consult  
2. If perfusion is adequate, follow protocol based on wound assessment and characteristics  
3. If dry and stable, leave eschar intact | 1. Maintain optimal moisture  
2. Control diabetes, if appropriate  
3. Repetitive removal of callous  
4. Bioburden control and prevention of systemic infection  
5. Remove pressure with appropriate off-loading shoe or other appliance | 1. Remove necrotic tissue  
2. Maintain optimal moisture  
3. Protect periwound skin  
4. Control bioburden  
5. Remove pressure | 1. Compression  
2. Remove necrotic tissue  
3. Maintain optimal moisture  
4. Protect periwound skin  
5. Control bioburden  
6. Ensure lower extremity moisturization |

## PROCEDURE:

A. Management of Pressure Ulcer – refer to LHHPP 24-15 Management of Pressure Ulcers.

B. For management of arterial, diabetic/neuropathic, or venous wounds, refer to table under Background section.

Note: For wounds that would require compression dressing, refer to Attachment 1: Two Layer Compression Bandage System

C. Use of Advanced Wound Products Specific to Skin Substitutes and Extracellular Matrix (ECM)

1. Special dressing specifically the skin substitutes and ECM are only applied in the Outpatient clinic. Refer to Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM.

2. To prevent damage of the newly applied product, the primary dressing is left in place up to 7 days.

3. Secondary dressing is changed when soiled or dislodged.

D. Documentation and Reporting on the Electronic Health Record (EHR)

   a. Treatment Administration Record (TAR)  
      — Document  
      a. Initial application of treatment ordered.  
      —  
      1. Wound Assessment Record (W.A.R.)  
      —  
      1.  
   a. Document a complete wound assessment (e.g. location, description of wound, including size, quantity and quality of drainage if present, progress towards healing and when deterioration of the wound is observed or suspected) weekly.
2. Integrated Progress Notes

b. Report any undue bleeding, untoward reactions to the physician; and document.

c. Document progress towards healing, resident's reaction to dressing change and response to pain, if necessary.

3.1 Resident Care Team (RCT)

a. RCT will conduct a meeting for new onset or worsening of wound.

ATTACHMENTS:

Attachment 1: Two Layer Compression Bandage System
Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM
Attachment 3: Wound Assessment Record

REFERENCES:

The Wound Care Handbook from Medline Industries (2007)

CROSS-REFERENCES:

LHHPP 24-15 Management of Pressure Ulcers
NPP K 1.0 Pressure Ulcer Prevention and Treatment
NPP C 4.0 Physician Notification of Change in Resident Status

Revised: 8/2000, 3/2008; 05/12/2015
Reviewed: 05/12/2015
Approved: 05/12/2015
MANAGEMENT OF RESIDENTS ON HEMODIALYSIS

POLICY:

1. A physician’s order by a LHH physician or a nephrologist is required for hemodialysis and related lab work, diet orders, and medications.

2. All residents on hemodialysis are weighed daily at the same time each day, on the same scale with the same amount of clothing.

3. Coordination of nursing care for the resident undergoing hemodialysis is the joint responsibility of the LHH licensed nurse (LN) and the hemodialysis nurse.

4. Nursing interventions for pre and post hemodialysis care are care planned. The dialysis center phone numbers for routine and emergency consultation are listed in the care plan.

5. The licensed nurse will communicate to the dialysis nurse any clinically relevant change in the resident’s condition via dialysis communication form.

6. Dialysis catheters are NEVER used for blood draws or IV hydration, unless ordered by MD during life threatening situations.

7. The licensed nurse will monitor the AV shunt and fistula for audible bruit and palpable thrill every shift and report absence of bruit and/or thrill to the LHH physician.

8. Dialysis schedule may be adjusted based on clinic visits or planned surgical procedures. Consult with physician and team.

PURPOSE:

To coordinate care of residents receiving hemodialysis treatment at an outside agency location through collaboration with the dialysis agency, its nephrologists, the Laguna Honda Hospital ward physician and nursing staff.

PROCEDURE:

A. Care Before Dialysis

1. LHH staff prepare resident for transport to dialysis treatment.
   a. Notify physician and dialysis nurse prior to transporting if resident has symptoms of acute illness.
   b. The team may decide that transporting to the clinic is still necessary, but precaution such as a patient mask, may be indicated. For cases of contagious illness – such as the flu, notification/consultation with the infection control nurse is also appropriate to contain the spread of infection.
   c. Vital signs prior to sending resident to dialysis.
2. Consult with the pharmacist and/or physician regarding timing of anti-diabetic medications and water soluble medications.

3. Report any change in the resident’s physical and emotional status or any new physician’s orders to the dialysis nurse or technician. Send the primary physician’s phone number and pager.

4. If the resident is unable to eat during dialysis, arrange for a tray to be served later. Send a bag meal with the resident when indicated.

5. Securely fax the Dialysis Communication Form to the dialysis center for any pertinent information that the dialysis center needs regarding current condition of the resident.

B. Care Immediately After Dialysis

1. The LN reviews the Dialysis Communication Form from dialysis center for any changes in condition of the resident post-dialysis.

2. The LN documents in the Integrated Progress Note any clinically relevant communication that is sent/faxed between LHH and the dialysis center.

3. The LN notifies the LHH physician immediately of changes in dialysis venous access device patency and laboratory values outside acceptable ranges for the resident. Consultation with the dialysis clinic nurse or physician is done as needed.

4. The LN receives a resident status report from the dialysis nurse to include:
   a. dry weight from dialysis
   b. fluid status/balance
   c. vital signs/tolerance of procedure
   d. lab tests and results
   e. medications given or with held
   f. blood transfusion if given
   g. unusual events
   h. type of temporary hemodialysis access

5. The LN observes for any bleeding at the access site upon return from dialysis.

6. The LN observes fistula for thrill and bruit. If thrill or bruit is absent, notify the physician immediately.

7. Perform vital signs upon return from dialysis and prn unless ordered otherwise. Report any significant changes to the physician.

8. Fluid Monitoring (refer to NPP G 3.0 Intake & Output).

C. Vascular Access Precautions

1. Constrictive clothing or jewelry cannot be worn on the extremity with dialysis access.

2. Venipuncture for laboratory tests, I.V. fluids, or taking blood pressure may not be performed on the extremity with dialysis access.
   a. A sign should be posted at the head of the bed to alert health team members not to use extremity with shunt or fistula.
D. Tunneled Dialysis Catheter Care

1. The dialysis nurse performs the dressing change of the shunt or dialysis catheter during each treatment at the dialysis center.

2. Neighborhood RN may perform dressing reinforcement if dressing is soiled or loosened.

E. Resident Education

1. Explain precautions for the extremity with the vascular access.

2. Educate resident to report any changes or problems to vascular access.

3. Educate importance of following fluid intake limitations and appropriate diet.

F. Documentation

1. Resident Care Plan – see appendix “Hemodialysis Care Plan”

2. Electronic Health Record (EHR)
   a. Type of Access
   b. Document presence or absence of AV shunt/fistula audible bruit and palpable thrill
   c. Condition of dialysis access site.
   d. Vital signs and weight
   e. No blood draw or b/p on (site)
   f. Height and Weight

2. Treatment Assessment Record (TAR)
   a. Type of Access
   b. Document presence or absence of AV shunt/fistula audible bruit and palpable thrill
   c. Condition of dialysis access site.
   d. Vital signs and weight
   e. No blood draw or b/p on (site)

3. LCR: Height and Weight

3. Interdisciplinary Progress Notes
   a. Resident response to dialysis treatments in weekly/monthly summary.
   b. Assessment of ability to comprehend and follow precautions needed for venous access, dietary and fluid requirements.
   c. Documentation health education or teachings given to resident.

4. Dialysis Communication Form: Communication via secured fax between dialysis nurse and unit nurse resident’s information or changes in condition such as lab, weights, vital signs or any unusual drainage, bleeding from the dialysis site. Describe any need to reinforce site dressing. (See Appendices)
   a. Resident response to dialysis treatments in weekly/monthly summary.
   b. Assessment of ability to comprehend and follow precautions needed for venous access, dietary and fluid requirements.
c. Documentation health education or teachings given to resident.

5. Neighborhood Census Report: Outpatient hemodialysis is considered a clinic visit and therefore, is to be documented on the unit census report.

6. Dialysis Communication Form: Communication via secured fax between dialysis nurse and unit nurse resident’s information or changes in condition such as lab, weights, vital signs or any unusual drainage, bleeding from the dialysis site. Describe any need to reinforce site dressing. (See Appendices)
REFERENCES:


CROSS REFERENCE:

Nursing P&P D3 1.0 Oral Hygiene
Nursing P&P G 3.0 Intake and Output
Nursing P&P J 7.0 Central Venous Access Device (CVAD) Management

APPENDICES:

Attachment 1: Coordination of Care for LHH Residents Requiring Outpatient Hemodialysis
Attachment 2: Dialysis Communication Form
Attachment 3: Resident Care Plan Hemodialysis
Attachment 4: Dialysis TAR Template

Adopted: 2000/08


Reviewed: 2017/01/10

Approved: 2017/01/10
EMERGENCY INTERVENTION FOR CHOKING

POLICY:

1. Nursing staff must follow facility's procedures (e.g., urgent speech referrals) to safely manage residents who are identified to be at risk of aspiration.

2. Residents, regardless of code status, who are observed to manifest signs of choking must promptly be attended to with rescue interventions and activate code blue.

3. All nursing staff will be trained in conscious emergency identification and intervention for choking during orientation, annually, and as needed.

4. All licensed nurses must be proficient in emergency intervention for all individuals who are choking as evidenced by current CPR certification.

PURPOSE:

To ensure that residents who are choking receive prompt, effective interventions.

DEFINITION:

Choking is obstruction or constriction of the airway passage due to a foreign body such as inadequately chewed food which can result into respiratory blockage or even death. The universal sign of choking is clutching of the neck with hands; other choking signs include ineffective cough or no cough at all, inability to speak, possible cyanosis, high-pitched noise while inhaling or no noise at all, or poor or weak air exchange. Choking is considered a medical emergency and prompt intervention is needed.

Heimlich maneuver is a technique intended to remove foreign body from the airway passage to relieve resident from choking. This maneuver consists of repeated abdominal thrusts by wrapping your arms around the resident's waist from behind and making a fist with one hand and placing it against the resident's abdomen.

PROCEDURE:

A. Responding to resident who manifests signs of possible choking

1. If resident remains alert and responsive but exhibits signs of choking such as inability to breathe, cough, or speak, assess resident’s mouth for any foreign bodies, perform Heimlich maneuver, and have a fellow employee activate Code Blue.

2. If resident is able to expel or nursing staff is able to retrieve the object that caused the blockage, the licensed nurse will retain the object until further instructions from the physician and nursing supervisor.

3. After a choking incident, the registered nurse will perform a thorough assessment, inform the physician of assessment data and request for additional interventions (e.g., urgent speech referral, update in advanced directive, or downgrading diet). (Refer to HWPP 26-02: Management of Dysphagia and Aspiration Risk)
B. Refer to Attachment for Choking Interventions for a Conscious and Unconscious Resident

C. Documentation

1. Licensed Nurse is to document the procedures and the condition of the resident, pre and post choking incident, in the Interdisciplinary Progress Notes电子健康记录 (EHR) and update resident care plan.

2. CNAs/PCAs document the incident in the DNCR supplementary note page.

REFERENCES:


American Heart Association, BLS for Healthcare Providers 2011

CROSS REFERENCES:

LHHPP File 24-16 Code Blue
LHHPP File 26-02 Management of Dysphagia and Aspiration Risk


Reviewed: 03/25/2014

Approved: 03/25/2014
ATTACHMENT:

A. Choking Intervention for a Conscious Resident

1. Stand or kneel behind the resident and wrap your arms around the resident's waist.

2. Make a fist with one hand.

3. Place the thumb side of your fist against the resident's abdomen, in the midline, slightly above the navel and well below the breastbone.

4. Grasp your fist with your other hand and press your fist into the victim's abdomen with a quick, forceful upward thrust.

5. Repeat thrusts until the object is expelled from the airway.

6. Give each new thrust with a separate, distinct movement to relieve the obstruction.

B. Choking Intervention for an Unconscious Resident

1. Resident who manifest signs of choking may be initially responsive; however if airway passage continues to be obstructed, resident may become unresponsive.

2. If resident became unresponsive or if found responsive, activate Code Blue.

3. Lower the resident to the ground and begin CPR, starting with compressions.

4. Every time you give a breath, open mouth and check for objects blocking the airway passage. Remove objects from mouth if visible.

5. If unable to see objects, continue to perform CPR. Do not do a blind sweep.
Revised Pharmacy Policies and Procedures
POLICY AND PROCEDURE FOR AUTOMATIC STOP ORDERS

Policy:
Pharmacy and Therapeutics Committee will establish stop-orders on various classes of scheduled and as needed (PRN) medications.

Purpose:
- To limit the duration of medication therapy in the event the physician has not done so by specifying a number of days or number of doses.
- To minimize over-treatment, polypharmacy and associated adverse effects.

A. The Stop Order Policy is applicable to all medication as specified below.

B. The attending physician will be notified of stop orders before the medication order expires so that the medications are renewed if necessary to assure continuity of treatment.

C. Such notification will be documented by the licensed nurse in compliance with the medical records policy.

D. The Stop Order Policy will be available electronically on the Pharmacy Policy and Procedure Page.

Procedures:

1. The Stop Order Policy is applicable to the following medication classes as specified below.
2. The Attending Physician will be notified of all stop orders, and may choose to renew or re-prescribe based on clinical assessment.
3. Such notification will be documented by the Licensed Nurse in compliance with the medical records policy.
4. The Stop Order Policy will be available electronically on the Pharmacy Policy and Procedure Page.

Medication Categories with a Specific Stop Order include the following:

A. Schedule II Medications:
- Stop order in seven (7) days unless the prescription is written for 30 days or specified maintenance in the order. The prescription specifies a number of days and refills. The medication is considered maintenance if it is written for 30 days with 11 refills. Examples include:
  - Codeine
  - Fentanyl patches (Duragesic)
  - Hydrocodone and acetaminophen (NorCo, Vicodin)
  - Hydromorphone (Dilaudid)
  - Methadone
  - Methylphenidate (Ritalin)
  - Morphine (Oramorph SR, MS Contin, Roxanol)
  - Oxycodone
  - Oxycodone & acetaminophen (Percocet)
  - Oxycodone & aspirin (Percodan)
B. Anticoagulants:

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

NOTE: If the Prescriber does not renew a warfarin or low molecular weight heparin order, he/she will be contacted to renew or discontinue it. If the Prescriber is not readily available, warfarin/low molecular weight heparin may continue for up to 14 days or until contacted (it shall not be discontinued without a specific "D/C" order from the Prescriber).

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

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

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

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

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

G. As Needed (PRN) medications not used in greater than 60 days;

All PRN medications that have not been administered for at least 60 days may be considered for automatic discontinuation. Exceptions to this will include the following indications: pain, bowel hygiene, anxiety/behavior, chest pain and other specific clinical indications as determined by the reviewing Pharmacist. Providers will be notified of any discontinuation and may re-order the medication. Documentation of rationale for maintaining the unused as needed medication by the provider will exclude the medication from subsequent automatic discontinuation and future requests will be made via Medication Regimen Review.

H. Genito-urinary antispasmodics (flavoxate (Urispas), hyoscyamine (Levsin), oxybutynin (Ditropan), propantheline (Pro-Banthine), tolterodine tartrate (Detrol)) will have an automatic stop of 14 days unless the Prescriber has specified a definite discontinuation order date, for 30 days with refills or specified maintenance in the order.
All other medication classifications will be in effect for 45 days.

New: 4/93
Revised: 1/94; 4/98, 6/98, 11/99, 6/00, 11/00, 04/03, 04/04, 08/05, 05/06, 01/08, 4/11, 2/15, 6/15, 4/17, 1/18
Reviewed: 04/09, 02/10, 4/12, 8/13, 4/14, 6/16, 8/17
Policie:

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 48 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)

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.
POLICY AND PROCEDURE FOR OMNICELL MEDICATION TRANSACTION AUDIT

Policy: The Clinical Pharmacist shall audit Omnicell transaction for medication accountability.

Purpose: To ensure that medications are administered as ordered and in accordance with applicable LHH Pharmaceutical Services procedures and California Pharmacy law.

Procedure:

1. The clinical Pharmacy staff will audit at least one nursing unit (2 Omnicell cabinets) per month. The goal is to audit each nursing unit at least once during each calendar year.

2. **Four** residents from each nursing unit (One **Two** residents from each neighborhood, total **2** residents from each Omnicell cabinets) will be randomly selected. Five days worth of Omnicell transaction data for each resident will be collected from Omnicell data system. The name of the resident, medication name & strength, medication transaction time, quantity issued, quantity wasted and user name will be collected.

3. Clinical pharmacy staff will compare and review the Omnicell transaction data with resident's medication profile and Medication Administration Record for accuracy.

4. Any discrepancies will be clarified and reported to the Nurse Manager and Nursing Director for follow up.

5. The Pharmacy Department will report results of the Omnicell Medication Transaction Audit to the MERC (Medication Error Reduction Committee) and the P&T committee.

New: 7/96 DL /BT
Revised: 2/06, 01/08, 04/09, 10/09, 6/11, 10/18
Reviewed: 2/10, 5/12, 8/13, 7/15, 10/18
Revised Rehabilitation Services Policies and Procedures
REHABILITATION SERVICES FOR GENERAL SNF UNIT PATIENTS

POLICY:

In addition to rehabilitation services provided to patients on the Rehabilitation Unit, rehabilitation services are provided to meet the rehabilitation needs of patients 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/electronic 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 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 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, 19/01/07
Revised: 18/08/24, 06/09/22, 07/08/24
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. Physicians must refer patients to Rehabilitation Services via the electronic medical record.
   
   ba. Physiatrists for LHH inpatients: Physicians must complete an electronic referral for LHH Physiatry.
   
   eb. Acute Rehabilitation (IRF)- or SNF Rehabilitation, or LHH inpatients: 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 forwarded to Admissions and Eligibility. Physicians must refer patients to Rehabilitation Services via the electronic medical record. Physicians must refer patients to Rehabilitation Services via the electronic medical record.

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, 19/01/07
Revised: 18/08/24, 06/09/22, 13/08/22
Original Adoption: 99/08/23
OUTPATIENT REHABILITATION SERVICES

POLICY:

The Rehabilitation Services at LHH will maintain an outpatient program providing physical therapy, occupational therapy, speech/language pathology, audiology, physiatry, and neuropsychological services. [Title 22 § 70597(e)]

The outpatient program has a two-fold purpose:

1. To provide continuity of care to patients who have completed inpatient rehabilitation care, and

2. To provide comprehensive, integrated care for outpatients not requiring prior hospitalization.

PROCEDURE:

1. A coordinated system of outpatient scheduling and appointments is maintained [Title 22 § 70597(e)(1)].

2. An Outpatient Treatment Chart will be maintained for each outpatient receiving rehabilitation services in the Medical Records department. The Outpatient Treatment Chart will include information required under the provisions of Title 22, §70597(e)(2).

22. The outpatient evaluation and treatment information will be maintained in the medical record. Medical records are maintained as required under the provisions of Title 22, §70597(e)(2).

ATTACHMENT:

None

REFERENCE:

Barclays California Code of Regulations, Title 22 § 70597(e)(1–2)

Most Recent Review: 16/08/05, 18/08/14, 19/01/07
Revised: 06/09/22, 13/08/22, 17/08/14
Original Adoption: 99/08/23
ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION: SPEECH-LANGUAGE PATHOLOGY

POLICY:

Patients are seen by a Speech Pathologist for a speech-language evaluation upon referral by a Laguna Honda Hospital physician. Outpatients may be referred by a licensed physician in the community.

PROCEDURE:

1. Upon receipt of a physician’s order, the speech pathologist reviews the medical history and schedules the patient for an evaluation.

2. The initial evaluation includes, but need not be limited to, the following assessment of:
   a. Oral motor function
   b. Speech production
   c. Voice production
   d. Auditory comprehension
   e. Oral expression

3. When indicated, evaluation also includes assessment of reading comprehension, written expression, and language-related cognitive skills.

4. When indicated, patients are evaluated for and provided with, augmentative communication devices (e.g., picture/word boards, electronic communication aids).

5. Once the patient has been evaluated, an initial evaluation and treatment plan is written entered in the medical record and electronically signed by the speech pathologist and the physician. The treatment plan includes goals and the frequency/duration of treatment. If treatment is not indicated, the reason is documented.

6. The treatment plan is reviewed with the patient, caregivers and family (if available).

7. The speech pathologist and the physician electronically sign the treatment plan.

8. The Speech Therapy Initial Evaluation/Treatment Plan is entered in the medical record.
The treatment plan is documented in the Patient Care Plan. All Rehabilitation Services PCT meetings are attended by the patient’s primary therapist or a representative. PCT meetings on other Units are attended on an as-needed basis on the request of any PCT member.

The speech pathologist works with Unit staff and other caregivers to ensure carryover of skills, as needed.

The Speech Pathologist may develop a formal Restorative Care Program –Level I or II to be carried out by trained staff, when indicated.

Following each treatment session, a signed note is entered into the medical record for documenting the treatment and the patient’s performance is documented in the medical record and electronically signed.

Signed progress notes are written documented at least once weekly for in-patients, and at least once monthly for outpatients. These notes summarize the patient’s performance/improvement over the period covered. In the Rehabilitation Services (Pavilion Building, Mezzanine Floor) the Rehabilitation Interdisciplinary Case Conference (MR 504) form containing the FIM progress values and conference comments may substitute for a weekly progress note. Treatment goals are updated, as needed.

A signed discharge summary is written and filed documented in the medical record upon completion of the treatment program. In the Rehabilitation Services (Pavilion Building, Mezzanine Floor) the Rehabilitation Interdisciplinary Case Conference (MR504) form containing FIM progress values and conference comments may substitute for a discharge summary.

ATTACHMENT:
None

REFERENCE:
Barclays California Code of Regulations, Title 22 § 70597(a)(4)
Most recent review: 16/08/05, 17/08/01
Revised: 04/08/18, 10/12/07, 14/08/22, 19/02/7
Original Adoption: 99/08/2
ESTABLISHMENT OF TREATMENT PROGRAMS AND DOCUMENTATION: DYSPHAGIA

POLICY:

Patients are seen by a speech pathologist for a dysphagia evaluation upon referral by a physician. Following the evaluation, the speech pathologist develops a treatment plan, as indicated. The treatment plan may include swallowing therapy, to be carried out by the speech pathologist, and/or recommendations regarding food texture and strategies to facilitate improved swallowing and reduce the risk of aspiration.

PROCEDURE:

1. Evaluation
   a. Upon physician referral, the speech pathologist reviews the medical history and schedules the patient for a dysphagia evaluation.
   b. Dysphagia evaluation includes, but need not be limited to, the following:
      i. Thorough review of the patient’s swallowing history, as possible, including review of any episodes of choking or pneumonia, current diet and dietary restrictions, and consultation with Nursing and/or a physician regarding observations/reason for referral.
      ii. Assessment of oral motor function
      iii. Observation of dentition.
      iv. Assessment of voice quality.
      v. Assessment of speech production.
      vi. Observation of level of alertness, responsiveness and general cognitive status, including ability to follow directions.
      vii. Assessment of oral preparatory and oral phase of swallowing with different food/liquid consistencies, as indicated, depending on readiness and safety.
      viii. Observation for signs of pharyngeal phase impairment and aspiration.
   c. When a dysphagia evaluation involves upgraded food or liquid consistencies not currently included in the patient’s diet order, tray precautions will be followed per LHPP 2602:
d. The speech pathologist recommends further assessment via modified barium swallow study (MBSS), when indicated. This recommendation is discussed with the physician, who makes an e-Referral-electronic referral for the MBSS. The speech pathologist confirms the scheduled appointment with Nursing in writing regarding the date, time, and place for the MBSS. Nursing arranges transportation and completes necessary paperwork.

e. Upon completion of the evaluation, the speech pathologist documents results and recommendations in the medical record and reviews them with caregivers.

2. Aspiration Precautions/Specialized Feeding Plans (SFP’s)

3.2. Refer to LHPP 2602.

4.3. Treatment

a. When swallowing therapy is recommended, the speech pathologist will write document a treatment plan to be signed by both the speech pathologist and the physician to be entered in the medical record.

b. When treatment involves upgraded food/liquid consistencies/textures not currently included in the patient’s diet order, refer to tray precautions in LHPP 2602.

c. The speech pathologist reviews the treatment plan with the patient, caregivers and family (when available).

d. The treatment plan includes goals, frequency, and duration of treatment.

e. The speech pathologist incorporates the treatment plan into the Patient Care Plan.

f. The speech pathologist works with staff and family, as indicated, to ensure carryover of skills.

g. Following each treatment session, the speech pathologist writes a documented the patient’s performance in the medical record, documenting the patient’s performance.

h. The speech pathologist writes enters a progress note once weekly for patients and at least once monthly for outpatients. These notes summarize the patient’s performance/improvement over the period covered and update treatment plan/goals, as needed. In the Rehabilitation Services, Pavilion Bldg. Mezzanine Floor, the Rehabilitation Interdisciplinary Case Conference report (MR 504) may substitute for a weekly progress note.

i. Upon completion of treatment, the speech pathologist enters a discharge summary the medical record. In the Rehabilitation Services, Pavilion Bldg. Mezzanine Floor, the Rehabilitation
Interdisciplinary Case Conference report (MR-504) may substitute for a discharge summary.

5.4. Treatment Modifications

See Rehabilitation Services P&P #50-04, Summary of Responsibilities, PT, OT, ST, Audiology, and Physiatry, paragraph 4, Treatment Modification regarding changes to treatment plans.

6.5. Follow-Up

a. The Speech Pathology Department is available to monitor any patient during a meal who has been seen for a dysphagia evaluation. The request may be made by any member of the PCT. No physician’s order is required for monitoring of a patient on his/her current diet. The Department should be contacted directly by phone.

b. Request for re-evaluation may be made if indicated (physician’s order required); refer to guidelines for referral for dysphagia evaluation as outlined in LHPP 2602, Management of Dysphagia and Aspiration Risk.
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 care physician will provide the Audiologist with a medical clearance. If a pathology is suspected 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 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 primary 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.

8. Following each session, the treatment and patient’s performance is documented in the medical record and electronically signed.

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, 19/02/08

Original Adoption: 99/08/2
DISCHARGE PLANNING AND DURABLE MEDICAL EQUIPMENT

POLICY:

Patients’ discharges are discussed and planned during patient care conferences. Appropriate durable medical equipment is ordered and provided for patients on discharge.

PROCEDURE:

Community Skills Evaluations and Home Evaluations for Equipment:

1. Community skills evaluation and/or home evaluations for appropriate durable medical equipment may include members of the interdisciplinary staff. The attending physician should order the referral by checking the appropriate box on form MR 505, Rehabilitation Services Physician Order Form/Consultation Request and submit it to the Rehabilitation Services Department. The attending physician shall refer to the appropriate discipline via the electronic medical record.

2. The home assessment for durable medical equipment will determine specific equipment needs for the patient. Appropriate ordering forms will be completed by an Occupational Therapist or Physical Therapist, signed by the referring physician, and submitted to the supplier, who will process the forms to the funding source. Equipment will be delivered to the patient’s home or to the hospital, as indicated.

3. Funding sources include Medicare, Medi-Cal FFS or Managed Care, private insurance, private pay, San Francisco Health Plan, Community Living Fund, or other sources.

ATTACHMENT:

None

REFERENCE:

None

Most Recent Review: 16/08/05, 17/08/05, 18/08/14, 19/01/07
Revised: 06/09/22
Original Adoption: 99/08/23
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 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 assessment 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

      a. Job match considerations
      b. Overviews
      c. Training locations
      d. Career-specific information

iv. VR assists with career exploration

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 SFGetcareLCR, 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—the electronic health record, 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 General Store. 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.

bh. Gift Shop: Vocational Rehabilitation is responsible for the operation of the Gift Shop. 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
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 notes for assessments and progress notes in the electronic medical record.

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. Vocational Rehabilitation staff informs the person making the referral of the outcome of the interview with the resident.

5. LCR Progress notes 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. A new assessment form, indicating “re-assessment” is added to medical electronic medical records when a resident is re-admitted after discharge.

ATTACHMENT:

None.

REFERENCE:

None. Vocational Rehabilitation Departmental policy VR 2.0.

Revised: 19/3/5, 18/8/23, 17/09/12 (Year/Month/Day)
Original adoption: 12/07/13
Hospital-wide
Policies and Procedures
For Deletion
POLICY FOR DELETION

LEAD PAINT CONTROL PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) is committed to a policy of safe and effective management of lead-containing paints in its buildings. No employees are to perform lead paint abatement or cleanup of lead-containing materials. Only licensed contractors will perform this work.

PURPOSE:

The Lead Paint Control Plan is established to ensure that all employees are aware that Laguna Honda contains lead paint and that they will not disturb or remove such materials.

PROCEDURE:

1. Project Review
   a. The Facilities Director or designee will review renovation and demolition projects involving the removal of paint and will coordinate for an independent industrial hygienist to perform material bulk sampling to determine lead content.

2. Definition of Lead Containing Material
   a. Materials found to contain 0.5 percent or more lead by weight or one milligram per square centimeter (mg/cm²) or more lead content will be considered lead containing.

3. Lead Abatement
   a. If lead abatement work is needed, the work will be performed by a licensed lead abatement contractor. An independent industrial hygienist will be hired to provide oversight to the abatement work and provide verification that the lead abatement 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 lead waste. The generator identification number for Laguna Honda is CAD-982482218.
4. Posting

   a. A hazards communication sign shall be posted at the entrance of abatement work.

ATTACHMENT:
None

REFERENCE:
None

Revised: 13/05/28 (Year/Month/Day)
Department
Policies and Procedures
For Deletion
POLICY FOR DELETION

CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)

POLICY:

1. LHH has designated skilled nursing units to provide services. CAPD will not be given in non-designated units.
2. A Dialysis Treatment Center or LHH physician’s order is required for dialysis solution type, amount, frequency of instillation and dwell time, and medication.
3. Only licensed nurses who have received training and have met skills competency may perform this procedure.
4. An ongoing Quality Improvement Program will be in place to review resident’s outcome and staff competency.

*University of California Renal Center – SFGH (415) 476-4639–daytime phone # from 8a-4:30pm
(800) 235-3568- 24 hour services

DEFINITION:

Peritoneal dialysis is a procedure by which hypertonic fluid is introduced into the peritoneal cavity, equilibrated and drained out at alternating intervals, thereby removing metabolic wastes, removing or adding fluids and electrolytes, and adjusting acid-base balance. It utilizes the principles of osmosis and diffusion, with the peritoneum functioning as a semi-permeable membrane for residents with partially or totally non-functioning kidneys. A higher dextrose concentration will thus remove more fluid from the resident.

PURPOSE:

1. To drain dialysate effluent and instill fresh dialysate aseptically.
2. To promote metabolic stability in residents with renal failure.

EQUIPMENT:

From CSR or unit supply:
- Mask
- Povidone-iodine prep pads
- Small gauge syringes (22-27) with at least a 1-inch needle (1 for each medication to be added)
- PDI Sani-Clot Plus

From Dialysis Center or Materials Management:
- Stay-safe organizer
- Stay-safe cap
- Prescribed Dialysis solution(s) (1.5%, 2.5% or 4.25% dextrose) with attached tubing (Fresenius is the common supplier)

From Pharmacy: prescribed medication additive (such as Heparin, Epogen, or antibiotics)

PROCEDURE:

A. Evaluate and Prepare the resident:

1. Assess for peritonitis, tunnel infection, and fluid balance before each exchange.
a. **Peritonitis**: (e.g., abdominal pain, fever, nausea, vomiting, or diarrhea). If symptoms are present, notify the physician immediately and consult as needed with the dialysis center. Hold the exchange unless advised to proceed by the physician.

b. **Tunnel Infection**: (e.g., irregularity along subcutaneous tunnel, catheter loose in tunnel, abscess over tunnel, purulent drainage from exit, simultaneous peritonitis). Gently palpate and inspect the tunnel area. Document positive findings and notify the physician.

c. **Fluid balance assessment**:
   - **Too wet/ fluid overload**: (e.g., headache, coughing, short of breath, weight gain, high blood pressure, discomfort lying flat, difficulty sleeping, fatigue, tight clothes, edema). Evaluate intake for excessive salt or fluids, check labs for declining residual renal function, and check catheter function. Notify physician/nephrologist for new orders.
   - **Too Dry/ dehydrated**: (e.g., headache, dizziness, blurred vision, weight loss, low BP, syncope, fatigued and weak, sweating, nausea, cramps, dry mouth). Evaluate for causes such as vomiting, diarrhea, NPO or excessive fluid restriction, use of a hypertonic solution, or inaccurate dry weight. Notify physician/nephrologist for new orders.

2. **Monitor vital signs** (in relation to above symptoms and baseline):
   a. **Weigh** daily or more often if ordered and PRN. Compare weight to “dry weight” (weight after you drain the exchange in the morning). Weight should be taken at the same time of day with the same amount of clothing.
   b. **Blood pressure**, temperature, pulse, respiration/ lung sounds: if symptomatic and as ordered.

3. **Monitor lab values** according to the physician’s orders and resident care plan.
   a. Labs commonly ordered at least monthly include BUN, serum creatinine, sodium, potassium, calcium, magnesium, phosphate levels, and hemoglobin and hematocrit.
   b. Albumin, total protein, hematocrit, cholesterol panel, parathyroid hormone (PTH) levels, and other laboratory values may also be ordered periodically.

4. **Prepare the resident**:
   a. Offer toileting and position for comfort and optimum exchange (usually semi-fowlers or seated in a chair) and explain the procedure.
   b. Close windows and doors and restrict pets from the area during the exchange to reduce exposure to pathogens.
   c. Promote resident independence by including in decisions and by resident teaching at the appropriate level for the resident.

**B. Prepare the bag**:

1. Warm the prescribed dialysis solution using a portable dialysate warmer provided for this only. The dialysate warmer are set at 37 degrees centigrade and the green light goes off when the solution reaches this temperature. The temperature can be checked by folding the bag over an oral digital thermometer. To avoid contamination by microorganisms, **do not** warm in a basin of water or in a microwave.

2. **Clean the surface on which you will prepare the bag** with a standard disinfectant (such as PDI Sani-clot Plus).

3. **Mask**, then wash your hands for 30 seconds and dry well.

**C. Add prescribed medication**:

1. Add the medication just before the exchange.
2. Clean the bag port and medication vial with a povidone-iodine pad, allowing the pad to stay in contact for 5 minutes.

3. Use at least a 1-inch needle, preferably 22 gauge. Do not draw air into the syringe and expel air from the medication vial back into the vial prior to withdrawing. Inject promptly into cleansed CAPD solution bag medication port. Repeat steps for additional medications.

4. Invert the bag to distribute the medication and attach a completed “medication-added” sticker.

D. Procedure for the stay•safe™ CAPD Exchange Procedure (Also refer to manufacturer’s direction on the stay•safe organizer)

1. Position the organizer at the edge of the work place or an IV pole.
2. Remove the extension set from the patient’s clothing. Close the stay•safe extension set clamp.
3. Mask, then wash hands.
4. Open solution bag by tearing from a notched edge of the package overwrap. Wipe off any moisture on the bag surface.
5. Place the solution set on the work surface. Separate the fill from the drain bag.
6. Verify the integrity of the solution bag by squeezing the bag to check that there are no leaks and the solution looks clear. Color variation from clear to slightly yellow will not affect the product efficacy and may still be used. Check the expiration date. Check for the correct dextrose concentration. Check for the correct volume. DO NOT USE IF THERE IS ANY DOUBT ABOUT THE INTEGRITY OF THE SOLUTION AND PACKAGING.
7. Locate the colored plastic cover on the stay•safe disc. Turn the blue dial on the disc counter-clockwise until it fits into the cut-out portion of the plastic cover. Remove the plastic cover after the dial is in Position 1.
8. Place the disc into the organizer (fill will be on the right, drain line on the left).
9. Hang the solution bag on an IV pole and place the drain bag at the floor level. Break the frangible in the solution bag outlet port.
10. Remove the stay•safe cap from its packaging. Place the cap into the left-hand notch of the organizer. (For the left-handed user, reverse this placing the cap into the right-hand notch of the organizer).
11. Place the end of the extension set in the other organizer notch. Remove the protective cap from the stay•safe disc and discard the cap.
12. Remove the cap from the extension set by twisting the connection counter-clockwise. (The used cap will stay in the organizer with the used pin). Connect the extension set (from the patient) immediately to the stay•safe disc by twisting clockwise to secure the connection.
13. Facemask maybe removed at this time, the system will not be opened again during the exchanged.
14. Open the extension clamp. Patient outflow (DRAIN) will start immediately.
15. When the patient drain is complete, turn the blue dial to Position 2. This will begin to flush.
16. After approximately 5 seconds, turn the blue dial to position 3. This will begin to fill.
17. When the fill is complete, turn the dial to the last dot on position 4 and you will feel a “click”. This will insert the closure pin of the disc into the extension set connector and seal the system.
18. Close the clamp on the stay•safe extension set.
19. Remove the white protective cover from the new stay•safe cap. Do not discard the cover, it will be used later.
20. Remove the extension set from the stay•safe disc and immediately attach to the new stay•safe cap. Twist clockwise to secure the connection.
Continuous Ambulatory Peritoneal Dialysis (CAPD)

21. Removed the capped extension set from the organizer. Secure the extension set to the abdomen.
22. Place the protective cover from the new stay-safe cap on the used cap.
23. Remove the cap from the organizer and connect the other end of the protective cover to the disc to prevent drips.
24. Observe the drained dialysate (effluent) for cloudiness. If cloudy, save the fluid and set and immediately call the dialysis clinic. If clear, discard the fluid and used set as instructed by the training facility.

E. Catheter and Skin Care:

1. Catheter and skin care are performed on a daily basis and best done prior to one of the exchanges using sterile water and a sterile dressing, unless otherwise ordered. A nursing treatment order for the above is appropriate. A physician’s order is needed if antibiotic ointments or other medications are to be used.
2. Mask; wash hands for 30 seconds and dry well.
3. Use clean gloves to remove the old dressing and tape, taking care not to touch the skin or catheter. Dispose of old dressings and gloves in the biohazard container.
4. Change gloves and cleanse with sterile water soaked 4 x 4, from insertion site out in a circular pattern. Pat dry with 4X4.
5. Per policy, avoid tub bath in water that covers the catheter and insertion site. Water may be showered over the abdomen by the 14th day post catheter insertion.
6. If a resident takes a shower or a bath, liquid soap is recommended to clean the site. Pat dry with 4X4.
7. Inspect the site for redness, swelling, tenderness, exudate while cleansing and report adverse symptoms promptly to the physician. Do not remove purulent exudate until a culture has been taken. (A small amount of crusting or scab is common and can be left intact.)
8. Inspect catheter for cracks or leaks. Report to physician promptly if catheter is damaged.
9. Apply a dry sterile 4x4 using aseptic technique, unless an alternate dressing is ordered.
10. Teach resident to participate in the dressing change to their level of ability.

F. Documentation:

1. Document on the CAPD flow sheet (includes date, time, effluent amount, appearance, solution infused, balance, dextrose %, additives, BP, dry weight, and signature)
2. Document in the progress notes if resident teaching, adverse reactions or other significant assessment findings, physician notification, or renal center consultation occurred.
3. Individualize and update the Residents Care Plan to reflect appropriate nursing interventions.
5. Document the infusion and medication additive administration on the medication administration record (MAR).
REFERENCES:
Peritoneal Dialysis Patient Guide – Fresenius Medical Care

CONSULTANTS:
Jennifer Gunn, RN, University of California Renal Center—SFCH
Shirley Bird, RN, Fresenius CAPD educator 1(800)662-1237 ext. 2849

LHH CLINICAL RESOURCES
Elisa Ramirez, RN, MSN, CNS, Nursing Education Coordinator
Bea Gunn, APRN-BC, CNS, Clinical Resource Nurse
John Butts, RN, Clinical Resource Nurse

CROSS REFERENCES:
NPP J1.0 Medication Administration
NPP C9.0 Transcription and Processing of Orders

Reviewed: __________
Reviewed: __________
Reviewed by Elisa and no revision recommended at this time.
Approved: __________

For Ghe use only:
Date sent to Policy Reviewer __________
Date received from Policy Reviewer __________
Date reviewed by NEC __________
Date approved by NEC __________
Date routed to MEC __________
Date emailed to Karina __________
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Effluent (Amount out, cc's)</th>
<th>Appearance</th>
<th>Balance (cc's)</th>
<th>Solution</th>
<th>% Dextrose</th>
<th>Additives</th>
<th>BP</th>
<th>Dry Weight</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laguna Honda Hospital
375 Laguna Honda Boulevard
San Francisco, CA 94116
MR-322(8/96)
# CONTINUOUS AMBULATORY PERCUTANEOUS DIALYSIS (CAPD) LICENSED NURSES SKILLS CHECK LIST

**EMPLOYEE NAME:** 
**Shift (circle):** Days / Evenings / Nights

<table>
<thead>
<tr>
<th>ASSIGNMENT</th>
<th>REGULAR STAFF (list unit _____)</th>
</tr>
</thead>
</table>

**Directions:** Licensed Nurse must be able to demonstrate steps in CAPD exchange  
S = Satisfactory  
U = Unsatisfactory

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>S</th>
<th>U</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Correctly verbalizes correct % of Dextrose solution used to do CAPD exchange</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>according to physician order (depending on the dry weight of the resident).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Correctly defines term dry weight means and how is it calculated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Washes hands before the procedure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gathers supplies (gloves, mask, dialysate and a new cap—should verbalized how to correctly warm the dialysate)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Explains procedure to the resident.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Verbalizes that dialysis exchange can be done—when the resident is in bed (preferably) or in chair.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Procedure for the **stay•safe™ **CAPD Exchange Procedure**

1. Demonstrates how to position the organizer at the edge of the work place or an IV pole.
2. Removes the extension set from the patient’s clothing. Close the stay•safe extension set clamp. Places mask on the patient
3. Masks, then washes hands. Wears non-sterile gloves
4. Opens solution bag by tearing from a notched edge of the package overwrap. Wipes off any moisture on the bag surface.
5. Places the solution set on the work surface. Separate the fill from the drain bag.
6. Verifies the integrity of the solution bag by squeezing the bag to check that there are no leaks and the solution looks clear. Color variation from clear to slightly yellow will not affect the product efficacy and may still be used. Check the expiration date. Check for the correct dextrose concentration. Check for the correct volume.
7. Locates the colored plastic cover on the stay•safe disc. Turn the blue dial on the disc counter-clockwise until it fits into the cut-out portion of the plastic cover. Remove the plastic cover after the dial is in the cut-out. The dial will now be in Position 1(*)
8. Places the disc into the organizer (fill the will be on the right, drain line on the left).
9. Hangs the solution bag on an IV pole and place the drain bag at the floor level. Breaks the frangible in the solution bag outlet port.
10. Removes the stay•safe cap from its packaging. Place the cap into the left-hand notch of the organizer. (For the left-handed user, reverse this placing the cap into the right-hand notch of the organizer).
11. Removes the stay•safe cap from its packaging. Place the cap into the left-hand notch of the organizer. (For the left-handed user, reverse this placing the cap into the right-hand notch of the organizer).
12. Places the end of the extension set in the other organizer notch. Remove the protective cap from the stay•safe disc and discard the cap.
13. Removes the cap from the extension set by twisting the connection counter-clockwise (The used cap will stay in the organizer with the used pin). Connect the extension set (from the patient) immediately to the stay•safe disc by twisting clockwise to secure the connection.
14. Removes facemask at this time, the system will not be opened again during the exchange.

15. Opens the extension clamp. Patient outflow (DRAIN) will start immediately.

16. When the patient drain is complete, turn the blue dial to --- Position 2(●●). This will begin the flush.

17. After approximately 5 seconds, turns the blue dial to position 3 (○ ◀ ●). This will begin the fill.

18. When the fill is complete, turns the dial to the last dot on position 4(●●●●) and you will feel a “click”. This will insert the closure pin of the disc into the extension set connector and seal the system.

19. Closes the clamp on the stay•safe extension set.

20. Removes the white protective cover from the new stay•safe cap. Do not discard the cover, it will be used later.

21. Removes the extension set from the stay•safe disc and immediately attach to the new stay•safe cap. Twist clockwise to secure the connection.

22. Removes the capped extension set from the organizer. Secure the extension set to the abdomen.

23. Places the protective cover from the new stay•safe cap on the used cap.

24. Removes the cap from the organizer and connect the other end of the protective cover to the disc to prevent drips.

25. Observes the drained dialysate (effluent) for cloudiness. If cloudy, save the fluid and follow protocol.

Discards: Discard effluent and tubings in the hazardous waste bin.

Documents: On the CAPD Flow sheet and Progress Notes as indicated.

DESCRIPT ALL INDICATORS WHEN UNSATISFACTORY IS CHECKED:

Meets LIHH standards for CAPD skills competence
Does not meet LIHH standards for CAPD skills competence

NAME/TITLE OF OBSERVER ________________________________ DATE _____________

REFERRAL FOR Licensed Nurse: WHO DOES NOT MEET LIHH CAPD SKILLS COMPETENCY:

REFERRED TO: ____________________, NURSE MANAGER/NURSING SUPERVISOR ON (DATE) ____________ FOR FOLLOW UP.

Signed: __________________________

NURSE MANAGER/NURSING SUPERVISOR FOLLOW UP ACTIONS:

Date: ______ Reassess competency
Date: ______ Consult with DET regarding education plan
Date: ______ Consult with Human Resources regarding performance standards

OTHER: