

**List of Hospital-wide/Department Policies and Procedures
Submitted to the Joint Conference Committee (JCC) for Approval on
November 12, 2019**

Hospital-wide Policies and Procedures

Revised Policies (page 3)

<u>Policies</u>	<u>Comments</u>
22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response	Revised to clarify the role of the mandated reporter and notification requirements; and updated Appendix A Investigation of Alleged Abuse Form.
22-07 Physical Restraints	Revised to add definition for chemical restraint.
24-06 Resident and Visitor Complaints/Grievances (re-titled)	Revised to include visitors in the policy; the Grievance Official was changed from Risk Management Nurses to the Assistant Hospital Administrator; contents from Suggestion boxes shall be picked up by a designee from Administration and routed to the Grievance Official; and complaints/grievances shall have a final resolution in 30 business days. Attachments C and D have been updated with new templates for Grievance Acknowledgement and Response.
24-08 Off Campus Appointments or Activities	Revised to add new procedure for patients eligible for Veterans Affairs transportation services.
25-05 Hazardous Drugs Management	Revised to be consistent with ZSFG practice and personal protective equipment recommendations that are built into the electronic health record (EHR) Medication Administration Record (MAR) – only one pair of chemotherapy gloves is required to handle solid tablet and capsule dosage forms.
60-04 Unusual Occurrences (UO)	Revised to align with procedures in LHHPP 22-01; and revised policy statement to state that any LHH employee may complete a UO report.
70-01 C9 Heat Emergency Plan	Revised to align with Public Health Emergency Preparedness and Response (PHEPR); and establish procedures for alerting the Nursing Office and monitoring high risk residents when the interior temperature in a care area reaches 80°F or higher.

Deleted Policies (page 69)

<u>Policies</u>	<u>Comments</u>
50-01 Accounting Financial Standards	Delete from hospital-wide policy and convert to Accounting department policy.
50-05 Signature Card for Expense Payments	Delete from hospital-wide policy and convert to Accounting department policy.

Department: Nursing Services

Revised Policies (page 73)

<u>Policies</u>	<u>Comments</u>
J 1.0 Medication Administration	Revised to reflect EHR workflow and clarify procedures for disposition of medications.

Department: Pharmacy Services

Revised Policies (page 89)

<u>Policies</u>	<u>Comments</u>
02.01.02 Disposition of Medications	Revised to specify that “Pharmaceutical Waste Containers shall be used to dispose of any medications that are opened but not administered, including partially used medications and any remaining crushed, dissolved or disguised medications that are not hazardous.”

*The following policies and procedures have been reviewed by LHH and ZSFG Committees.

San Francisco Department of Public Health (SFPDH)

Revised Policies

<u>Policies</u>	<u>Comments</u>
Order Entry	Revised to incorporate medication ordering verbiage to outline the process for pharmacists when refusing to verify a medication order that has already been given by a nurse; and removed Nutrition from the list of non-providers who may write orders.

Revised Hospital-wide Policies and Procedures

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

PHILOSOPHY:

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

POLICY:

1. LHH employees, contractors, and volunteers shall provide a safe environment and protect residents from abuse, neglect, misappropriation of property, exploitation, and use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition.
2. All LHH employees, contractors, and volunteers are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.
3. LHH employees, contractors, and volunteers shall immediately respond to and report observed or suspected incidents of abuse to the California Department of Public Health (CDPH), the Ombudsman, and Nursing Operations.
4. The LHH Department of Education and Training (DET) shall be responsible for developing curricula for and training all employees, [volunteers, and contractors](#) ~~and volunteers~~ on abuse prevention and timely reporting.
5. LHH Department Managers are responsible for monitoring staff compliance with this policy and LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.
6. LHH shall not employ or otherwise engage individuals who:
 - a. have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
 - b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and/or
 - c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

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

PURPOSE:

1. To protect the resident from abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.
2. To report incidents or alleged violations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms without fear of retaliation and in a timely manner.
3. To promptly investigate allegations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.
4. To provide clinical intervention to prevent and minimize abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.
5. To meet reporting requirements as mandated by federal and state laws and regulations.

DEFINITION:

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

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

- a. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm;

- saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
- b. "Sexual abuse" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."
 - c. Physical abuse, includes but is not limited to hitting, slapping, ~~pinching~~[punching](#) and kicking. It also includes controlling behavior through corporal punishment.
 - d. Financial abuse includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.
 - e. Mental abuse includes, but is not limited to humiliation, harassment, teasing, taunting, and threats of punishment or deprivation.
2. "Neglect" as defined at 42 CFR §483.5 means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."
 3. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion.
 4. Misappropriation of resident property means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."
 5. Mistreatment means inappropriate treatment or exploitation of a resident.
 6. Involuntary seclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/ his room (with or without roommates) against the resident's will, or the will of resident representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs.
 7. Injury of unknown source/origin is an injury when the source of the injury was not observed by any person, or the source of injury could not be explained by a resident, and when the extent of the injury, location of the injury or the number of injuries observed at one particular point in time or the incidents of injuries over time are suspicious in nature.
 8. Serious bodily injury [as defined in Section 6703 (b) (3) of the Affordable Care Act] is defined as an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

9. Criminal sexual abuse is defined in section 2011(19)(B) of the Act (as added by section 6703(a)(1)(C) of the Affordable Care Act), serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (related to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.
10. "Immediately" means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

PROCEDURE:

1. Screening of Potential Employees

a. Criminal Background Checks

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

b. Experience and References

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

2. Education

a. Employee and Volunteer Education

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

- ii. New employees/volunteers, including transfers or inter- facility reassignments to LHH, shall, as a condition of employment, participate in “The Abuse Prohibition/Prevention Program”, which includes the following:
 - Facility orientation program on residents’ rights, including confidentiality, preservation of dignity, identifying what constitutes abuse, and recognizing and reporting abuse without fear of retaliation;
 - Nonviolent safety management and prevention of challenging behaviors;
 - Review of the following policies and procedures that support the overall program:
 - LHHPP 22-03 Resident Rights
 - LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
 - LHHPP 22-07 Physical Restraints Including Bed Rails
 - LHHPP 22-08 Threats of Physical Violence to Residents
 - LHHPP 24-06 Resident Complaints/Grievances
 - LHHPP 22-10 Management of Resident Aggression
 - LHHPP 73-05 Workplace Violence Prevention Program
 - Annual in-service education provided by the Nurse Educators to all employees, which includes a review of residents’ rights, abuse and neglect prohibition/prevention, mandated reporting, and resident and employee freedom from retaliation when reporting abuse allegations.
 - Nurse Educators provide additional abuse and neglect prevention training to nursing and other staff annually, including recognition of psychological, behavioral, or psychosocial indicators of abuse, recognition of environmental factors that could potentially lead to abuse, and other pertinent abuse and neglect prevention and response educational topics.
- iii. Employees shall be notified of their reporting obligations to report any reasonable suspicion of a crime against a resident during the New Employee Orientation (NEO) and annually during residents' rights, abuse and neglect prevention in-services. Annual notification shall also include a description of the fines and Federal health care program sanctions associated with the

failure to report an abuse within the mandated time frames, as determined by the nature of the abuse.

- b. Employees shall be informed of their rights during NEO and through posted information in the Human Resources Department. This shall include the right to file a complaint with the State Survey Agency if anyone at LHH retaliates against an employee who files a report of a reasonable suspicion of a crime committed against a resident to a law enforcement agency (such as the San Francisco Sheriff's Department (SFSD) at 4-2319).
 - i. Information on employee rights related to reporting a crime or retaliation shall be posted in HR.
- c. Resident Education
 - i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.
 - ii. A listing of Residents' rights shall be posted on each unit.
 - iii. Resident education topics such as reporting abuse, neglect, exploitation and/or mistreatment shall be reviewed at the neighborhood/unit community meetings at least twice a year or more frequently as determined by the Resident Care Team (RCT).

3. Prevention

- a. Staff shall be trained in nonviolent safety management and prevention of challenging behaviors, which includes assessment, response techniques, and tools to prevent and identify potential crisis and/or de-escalate challenging behaviors. Training includes:
 - i. Nonverbal communication
 - ii. Para verbal communication
 - iii. Verbal communication
 - iv. Precipitating factors, rational detachment and the integrated experience
 - v. Staff fear and anxiety
 - vi. Decision making
 - vii. Physical interventions (disengagement skills) as a last resort

viii. Debriefing

- b. Staff and families shall be provided with information on how and whom they may report concerns, incidents and grievances, as well as feedback regarding their expressed concerns (see procedure 2.a. Employee and Volunteer Education).
- c. RCT members and clinical staff shall conduct ongoing resident assessments, revise care plans as needed, and monitor resident's needs and behaviors that may lead to conflict or neglect (see procedure 9 Resident Assessment and Care Planning).

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

- a. Abuse may result in psychological, behavioral, or psychosocial outcomes. The following signs may alert LHH staff to possible resident abuse and indicate the need for immediate reporting, response, and investigation:
 - i. Statements from a resident alleging abuse, neglect, misappropriation of resident property, or exploitation (including involuntary seclusion and unreasonable confinement) by staff, another resident, or visitor;
 - ii. Sounds and/or utterances that suggest physical or verbal abuse, neglect, misappropriation of resident property, or exploitation, chemical or physical restraints;
 - iii. Injuries, abrasions, falls, or bruises of unknown or suspicious origin and/or location;
 - iv. Illogical accounts given by resident or staff member of how an injury occurred;
 - v. Sudden or unexplained changes in resident's personality or behavior(s) such as aggressive or disruptive behavior, running away, fear of being around a certain person or being in a particular context, withdrawal, isolating oneself, expressions of guilt and/or shame, depression, crying, talk of suicide and/or attempts, disturbed sleep;
 - vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;
 - vii. Resident-to-resident altercations;
 - viii. Visitor-to-resident altercations;
 - ix. Discovery or observation of illicit photographs and/or recordings of residents being taken;

- x. Unexplained contraction of sexually transmitted diseases, vaginal or anal bleeding, or torn and/or bloodied underclothing.
- b. These signs may indicate that mental and/or verbal, sexual, or physical abuse, and/or the deprivation of goods and services has occurred; in the event that an indicator becomes apparent, LHH staff should immediately respond to and report the potential abuse.

5. Protection: Staff/Volunteer Intervention

- a. In the event that an employee/volunteer
 - i. Observes abuse,
 - ii. Suspects that abuse has occurred,
 - iii. Observes resident-to-resident or visitor-to-resident altercation,
 - iv. Identifies an injury of unknown source/ origin,
 - v. Learns about an allegation of abuse, neglect or exploitation of any LHH resident, and/or is the first person to learn of a resident-to-resident or visitor-to-resident altercation, that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.
- b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:
 - i. In the event of alleged employee to resident abuse, neglect or exploitation, the responsible manager shall reassign the employee who is being investigated to non-patient care duties or place the employee on administrative leave if non-patient care duties are not available at the point the manager was notified of the allegation. These measures shall be in place until the investigation is completed.
 - ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.
- c. The responsible manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.

- d. Upon receiving a report of alleged abuse, neglect or exploitation, the attending or on-call physician shall promptly perform a physical exam. The physician shall record in the progress notes of the resident's medical record the history of abuse as relayed, any findings of physical examination and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.
- e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.
- f. The employee and/or responsible managers, supervisors, physicians and others shall complete all required forms. See "Reporting Protocol".

6. Reporting Protocol

- a. All LHH employees, [volunteers, and contractors](#) are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.
 - i. ~~Employees~~ [The mandated reporter](#) shall immediately respond to and report observed or suspected incidents of abuse by contacting the following within 2-hours:
 - CDPH (415) 330-6353
 - Ombudsman (415) 751-9788
 - Nursing Operations (415) 327-1902
 - ii. [The mandated reporter](#) ~~Employees~~ may report anonymously to each internal and/or external agency.
- b. LHH mandates ~~staff to report~~ suspected abuse to [be reported to](#) the local Ombudsman office as required by State law.
- c. LHH also requires ~~the employee, manager/supervisor, agent or contractor of the facility to report to SFSD~~ any reasonable suspicion of a crime committed against a resident of LHH [be reported to SFSD](#).
 - i. Examples of crimes that are reportable include but are not limited to the following:
 - Murder;
 - Manslaughter;

- Rape;
- Assault and battery;
- Sexual abuse;
- Theft/Robbery
- Drug diversion for personal use or gain;
- Identity theft; and
- Fraud and forgery.

d. Notification requirements:

i. Within 2 hours: Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

ii. Within 24 hours: Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury. ~~If the criminal incident resulted in serious bodily injury to the resident~~

iii. The mandated reporter shall report the incident to CDPH, the Ombudsman and Nursing Operations.

iv. Nursing Operations shall notify the Chief Executive Officer (CEO), Administrator on Duty (AOD), SFSD, and QM.

~~ii. , SFSD, Chief Executive Officer (CEO) or designee, Ombudsman, Quality Management (QM) staff and the State Survey Agency (i.e. California Department of Public Health - CDPH) must be notified immediately, no later than 2 hours after the suspicion is formed.~~

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

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

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

- ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker. ~~Notify within 2 hours to the CEO or designee, CDPH, Ombudsman, SFSD, and QM staff of events involving alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.~~
- iii. ~~Notify within 24 hours to the CEO or designee, Medical Social Services Worker, Ombudsman, SFSD, QM staff and CDPH of events involving allegations of abuse that are not substantiated and do not result in serious bodily injury.~~
- f. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.
- g. If an abuse allegation involves a LHH staff person, the nursing supervisor shall notify HR and the staff person's immediate supervisor within 24 hours.
- h. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician.
- i. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of, resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to ~~the Sheriff's Department~~[SFSD](#). The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.
- j. In cases of alleged or factual rape the following steps must be taken:
 - i. ~~Facility LHH~~ staff must immediately notify ~~the San Francisco Sheriff's Department~~[SFSD](#) (Ext. 4-2319;~~4-2304~~).
 - ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

- iii. At the San Francisco Rape Treatment Center, the resident ~~will~~shall be interviewed, specimens ~~will~~shall be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.
- iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.
- v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.
- k. The results of the investigation shall be reported to CDPH within five working days of the incident by QM. If the alleged violation is verified, appropriate corrective actions shall be taken.
- l. The respective department head, in consultation with HR, shall report cases of substantiated abuse investigations to the appropriate employee's Licensing and Certification Boards.

Federal Regulation (F-Tags)	42 Code of Federal Regulation (CFR) 483.12(b)(5) and Section 1150B of the Social Security Act	
	F608 Reporting Crimes	42 CFR 483.12(c) F609 Reporting Allegations of Abuse, Neglect, Exploitation or Mistreatment
What to Report	Any reasonable suspicion of a crime against a resident.	All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property.
Who to Report Abuse Allegations or Crime Suspicion To	Every Employee (Mandated Reporter) shall report to: CDPH, the Ombudsman, and Nursing Operations. Employees shall report immediately.	
Who Will Report to CDPH and the Ombudsman	Employee (Mandated Reporter)	
Who Will Report to SFSD, QM, CEO/AOD	Nursing Operations	
When to Report to CDPH, Ombudsman and SFSD	Within two (2) hours of forming the suspicion of crime.	Within two (2) hours of knowledge of the allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property.

7. Investigation

- a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, neglect or exploitation shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).
- b. If an abuse, neglect or exploitation allegation involves a LHH employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or place the employee on administrative leave, pending completion of the investigation. The interim reassignment or administrative leave will be in place until the Nursing and HR Departments complete their investigations and confer on their findings. The employee shall be formally notified of the outcome of the investigation and future employee assignment.
- c. If an abuse allegation, neglect or exploitation involves a LHH employee and the conclusion to the investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by HR. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:
 - i. Severity of the allegation,
 - ii. Circumstances of the case per the investigation, and
 - iii. Prior disciplinary and employment history.
- d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to the LHH HR. The LHH HR shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse is substantiated.
- e. LHH HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.
- f. If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact [SFSD](#)~~the Sheriff's Department~~. The nursing supervisor or manager shall initiate action to protect the resident and the [Sheriff's Department](#)~~SFSD~~ and or San Francisco Police Department shall carry out the investigation.

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

8. Forms Completion and Submission

- a. The Charge Nurse or ~~reporting employee~~[designee](#) shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.
- b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the designation of Nursing Operations. The staff person may be the Nurse Manager, [Charge Nurse, Medical Social Worker or Nursing Operations Nurse Manager](#). ~~The completed SOC 341 shall be submitted to QM. /designee or Operations Nurse Manager or be designated to the Medical Social Worker to complete form SOC 341 during regular business hours and submitted to QM.~~ (Refer to LHH SharePoint Forms page for an electronic form).
- c. The investigating supervisor/manager conducting the investigation into resident abuse, neglect or exploitation shall verify that the Unusual Occurrence and ~~Report of Suspected Dependent Adult/Elder Abuse~~[the SOC 341](#) forms have been completed and submitted to QM.
- d. The SOC 341 shall be faxed to 415-751-9789 by Nursing Operations or designee and the fax verification submitted to QM.
- e. [The investigating supervisor/manager shall complete the Investigation of Alleged Abuse form and submitted to QM with attachments in cases of:](#)
 - i. [Resident-to-resident](#)
 - ii. [Visitor-to-resident](#)
 - iii. [Staff-to-resident](#)
 - iv. [Injury of unknow origin](#)
 - v. [Neglect](#)
 - vi. [Misappropriate of resident's property](#)
- ~~e. In cases of resident-to-resident or visitor-to-resident altercation, the investigating supervisor/manager shall complete the Investigation of Alleged Abuse form and submit the form, along with any attachments, to QM.~~
- f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the ~~investigating director/manager conducting the inquiry shall complete the Investigation of Alleged Abuse form and submit the form, along with any attachments to QM.~~ Final conclusion shall be determined by the Nursing Director, after conferring with the Chief Nursing Officer.

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

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

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

~~j.i. QM staff shall provide employee (mandated reporter), if not reported anonymously and staff information known, with a *Mandated Reporter Response Form* to acknowledge receipt of report and provide pertinent finding(s)/conclusion(s) as appropriate in accordance with HIPPA.~~

9. Resident Assessment and Care Planning

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

- i. Short-term and long-term measures to provide the resident with a safe and secure environment.
- ii. Measures to mitigate the psychological impact of the incident.
- iii. Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.
- iv. Physiologic factor(s) involved in this incident. (Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived? Was the resident in pain? Did the resident have signs of an infection or delirium?)
- v. Treatment that may have contributed to or induced the resident's behavior.
- vi. Need for psychiatric evaluation.
- vii. Environmental stimulus/factor(s) contributing to this incident (excessive noise, crowded room).
- viii. Staff action and/or inaction that may have contributed to the resident's behavior
- ix. Ability to modify environment.

- x. Likelihood of a repeat incident.
- xi. Interventions to minimize the risk of recurrence.
- xii. Need for frequent check-ins
- xiii. Need for relocation or transfer to another level of care.

ATTACHMENT:

Appendix A: Investigation of Alleged Abuse Form

REFERENCE:

LHHPP 22-03 Resident Rights

LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss

LHHPP 22-07 Physical Restraints Including Bed Rails

LHHPP 22-08 Threats of Violence to Residents by an External Party

LHHPP 22-10 Management of Resident Aggression

LHHPP 24-06 Resident Complaints/Grievances

LHHPP 73-05 Workplace Violence Prevention Program

[SOC 341 Form](#)

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05,
07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 17/09/12, 18/05/08, 18/09/11,
19/05/14, 19/07/09, 19/09/10, [19/11/12](#) (Year/Month/Day)

Original adoption: 05/20/92

Appendix A: Investigation of Alleged Abuse Form



San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

- Injury of Unknown Origin Misappropriation of Resident's Property Neglect Other to Resident
 Resident to Resident Staff to Resident Other

Occurrence of Incident

Date of Incident: _____ Time of Incident: _____ Location of Incident: _____

Brief Description of Incident

PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

No witnesses were identified.

Name: _____ Contact Number: _____ Interviewed Summary Attached

Name: _____ Contact Number: _____ Interviewed Summary Attached

PART II: REPORTER INFO

Date of Report: _____ Name of Reporter: _____ Job Class/Title: _____

Reporter is: LHH Staff Other (specify): _____ Contact Number: _____

Reported to: _____ Job Class/Title: _____

Page 1 of 6

Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

Own Decision Maker (ODM) Cognitively Impaired (CI) Surrogate Decision Maker _____

Resident B (Suspected Abuser) N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

Own Decision Maker (ODM) Cognitively Impaired (CI) Surrogate Decision Maker _____

Staff/Other N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident N/A

Reassignment of alleged staff to a non-patient area.

Staff sent home or on administrative leave.

Resident to Resident / Other to Resident N/A

Involved parties were separated and counseled. If not, please explain why:

One of more residents moved or relocated.

Other. Please explain:

Other Types of Alleged Abuse N/A

Please describe action taken:

Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

Notification Requirements to CDPH, CEO/AOD, Ombudsman, QM Staff and SFSD based on criteria below:

Within 2 hours: Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

Within 24 hours: Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.

Notification of Resident's Responsible Party N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist (Check appropriate boxes)

- Charge Nurse, Nurse Manager, and Nursing Director
- Physician
- Director of Social Work or Designee
- Urgent Psych for Evaluation (415-327-5130)
- Administrator/AOD
- Quality Management Department
- UO Documentation Complete
- Other _____

External Notification Checklist (Check appropriate boxes)

- Sheriff's Department (415-759-2319)
- SFSD Notification Form Faxed (415-759-3019)
- SOC-341 Completed and Faxed (415-751-9789)
- Rape Treatment Center (415-821-3222)
- Other _____
- CDPH Office (415-330-6353)
Name _____ Answering Machine
Date _____ Time _____
- Local Ombudsman Office (415-751-9788)
Name _____ Answering Machine
Date _____ Time _____

Sample call to CDPH:

This is ____ (your name and title) at Laguna Honda Hospital. This call is to notify you that on ____ (date and time), a report of alleged resident abuse involving ____ (name of resident) was received.

Please spell the resident's name(s) and give the resident's date of birth when reporting the incident. Specify if there was any resident injury that occurred. State that an investigation of the incident has been initiated.

If there are any questions, please contact Quality Management at ext. 4-3055, ext. 4-3057, ext. 4-3575, or ext. 4-3530.

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A N/A
 Name of Physician _____ Date _____ Time _____
 Brief Statement of Findings:

Medical Assessment of Resident B N/A
 Name of Physician _____ Date _____ Time _____
 Brief Statement of Findings:

Resident to Resident Incident Assessment(s) N/A
Please complete ONLY if incident is Resident to Resident.

	<u>Resident A</u>	<u>Resident B</u>
Behavior Risk Assessment current and complete.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Care plan discusses problem behavior or risk of being a target of aggression.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Order for any scheduled psychotropic medications.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Order for any PRN psychotropic medications.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Received PRN psychotropic medications within 6 hours prior to incident.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
History of problem behaviors within the last 3 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Prior psych consult completed within the last 12 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Additional psych consult necessary.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Resident Interview
Resident MUST be interviewed unless comatose, discharged, or expired.

Resident A: Date _____ Time _____ Statement Attached Unable to Interview
 Resident B: Date _____ Time _____ Statement Attached Unable to Interview

Analysis
 Was this a deliberate act? Yes No If no, please explain: _____
 If yes, did the deliberate act result in:
 Physical Harm Yes No Pain Yes No Mental Anguish Yes No
 Describe any physical injury, pain, and/or mental anguish:

Investigation of Alleged Abuse

PART VII: CONCLUSION

Based on the interviews and other information available at this time, and in the exercise of my clinical judgment:

- | | |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> I conclude that the abuse is substantiated. | <input type="checkbox"/> I conclude that the theft occurred. |
| <input type="checkbox"/> I conclude that the abuse is <u>NOT</u> substantiated. | <input type="checkbox"/> I conclude that the theft did <u>NOT</u> occur. |

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

- | | |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Resident/responsible party has been notified of the outcome of this investigation. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Resident/responsible party was satisfied with the outcome of the investigation. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Employee(s) has been notified of the outcome of this investigation. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Reporter of alleged abuse has been notified of the outcome of this investigation. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Human Resources has been notified when staff to resident alleged abuse is substantiated. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |

Additional Required Documents

(Check appropriate boxes)

- | | |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| I have attached a copy of the staff reassignment/ send home letter. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| I have attached a copy of the resident's current and revised care plan. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| I have attached a copy of the staff assignments. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| I have attached a copy of the RCT special review and revised/reviewed the resident's care plan. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

Investigation of Alleged Abuse

ADDITIONAL SPACE

Please use space as needed. Indicate the section additional detail is being provided for.

Page 6 of 6

Delete outdated version



San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

- Injury of Unknown Origin Misappropriation of Resident's Property Neglect Other to Resident
 Resident to Resident Staff to Resident Other

Occurrence of Incident

Date of Incident: _____ Time of Incident: _____ Location of Incident: _____

Brief Description of Incident

PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

No witnesses were identified.

Name: _____ Contact Number: _____ Interviewed Summary Attached

Name: _____ Contact Number: _____ Interviewed Summary Attached

Name: _____ Contact Number: _____ Interviewed Summary Attached

Name: _____ Contact Number: _____ Interviewed Summary Attached

PART II: REPORTER INFO

Date of Report: _____ Name of Reporter: _____ Job Class/Title: _____

Reporter is: LHH Staff Other (specify): _____ Contact Number: _____

Reported to: _____ Job Class/Title: _____

Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

Own Decision Maker (ODM) Cognitively Impaired (CI) Surrogate Decision Maker _____

Resident B (Suspected Abuser) N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

Own Decision Maker (ODM) Cognitively Impaired (CI) Surrogate Decision Maker _____

Staff/Other N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident N/A

Reassignment of alleged staff to a non-patient area.

Staff sent home or on administrative leave.

Resident to Resident / Other to Resident N/A

Involved parties were separated and counseled. If not, please explain why:

One of more residents moved or relocated.

Other. Please explain:

Other Types of Alleged Abuse N/A

Please describe action taken:

Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

Notification Requirements to CDPH, CEO/AOD, Ombudsman, QM Staff and SFSD based on criteria below:

Within 2 hours: Events involving crimes or suspicion of crimes that result in bodily injuries; and alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.

Within 24 hours: Events involving crimes or suspicion of crimes that do not result in serious bodily injury; and allegations of abuse that are not substantiated and do not result in serious bodily injury.

Notification of Resident's Responsible Party N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist (Check appropriate boxes)

- Charge Nurse, Nurse Manager, and Nursing Director
- Physician
- Director of Social Work or Designee
- Urgent Psych for Evaluation (415-327-5130)
- Administrator/AOD
- Quality Management Department*
- UO Documentation Complete
- Other _____

External Notification Checklist (Check appropriate boxes)

- Sheriff's Department (415-759-2319)
- SFSD Notification Form Faxed (415-759-3019)
- Local Ombudsman Office (415-751-9788)
- SOC-341 Completed and Faxed (415-751-9789)
- Rape Treatment Center (415-821-3222)
- Other _____
- CDPH Office* (415-330-6353)
 - Name _____ Answering Machine
 - Date _____ Time _____

Quality Management Business Hours*

Monday to Friday (8:00 am - 5:00 pm) excluding holidays and weekends. If incident occurs after business hours, please contact CDPH directly (refer to Notification Requirements above).

Sample call to CDPH:

This is ____ (your name and title) at Laguna Honda Hospital. This call is to notify you that on ____ (date and time), a report of alleged resident abuse involving ____ (name of resident) was received.

Please spell the resident's name(s) and give the resident's date of birth when reporting the incident. Specify if there was any resident injury that occurred. State that an investigation of the incident has been initiated.

If there are any questions, please contact Quality Management at ext. 4-3055, ext. 4-3057, or ext. 4-3530.

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A N/A
 Name of Physician _____ Date _____ Time _____
 Brief Statement of Findings:

Medical Assessment of Resident B N/A
 Name of Physician _____ Date _____ Time _____
 Brief Statement of Findings:

Resident to Resident Incident Assessment(s) N/A

Please complete ONLY if incident is Resident to Resident.

	<u>Resident A</u>	<u>Resident B</u>
Behavior Risk Assessment current and complete.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Care plan discusses problem behavior or risk of being a target of aggression.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Order for any scheduled psychotropic medications.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Order for any PRN psychotropic medications.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Received PRN psychotropic medications within 6 hours prior to incident.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
History of problem behaviors within the last 3 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Prior psych consult completed within the last 12 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Additional psych consult necessary.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Resident Interview

Resident MUST be interviewed unless comatose, discharged, or expired.

Resident A: Date _____ Time _____ Statement Attached Unable to Interview

Resident B: Date _____ Time _____ Statement Attached Unable to Interview

Analysis

Was this a deliberate act? Yes No If no, please explain: _____

If yes, did the deliberate act result in:

Physical Harm Yes No Pain Yes No Mental Anguish Yes No

Describe any physical injury, pain, and/or mental anguish:

Investigation of Alleged Abuse

PART VII: CONCLUSION

Based on the interviews and other information available at this time, and in the exercise of my clinical judgment:

- I conclude that the abuse is substantiated. I conclude that the theft occurred.
 I conclude that the abuse is NOT substantiated. I conclude that the theft did NOT occur.

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

- Resident/responsible party has been notified of the outcome of this investigation. Yes No N/A
Resident/responsible party was satisfied with the outcome of the investigation. Yes No N/A
Employee(s) has been notified of the outcome of this investigation. Yes No N/A
Reporter of alleged abuse has been notified of the outcome of this investigation. Yes No N/A
Human Resources has been notified when staff to resident alleged abuse is substantiated. Yes No N/A

Additional Required Documents

(Check appropriate boxes)

- I have attached a copy of the staff reassignment/ send home letter. Yes No N/A
I have attached a copy of the resident's current and revised care plan. Yes No N/A
I have attached a copy of the staff assignments. Yes No N/A
I have attached a copy of the RCT special review and revised/reviewed the resident's care plan. Yes No N/A

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

Investigation of Alleged Abuse

ADDITIONAL SPACE

Please use space as needed. Indicate the section additional detail is being provided for.

Page 6 of 6

PHYSICAL RESTRAINTS

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. ~~A Rr~~ restraint order shall not be written as a standing or PRN order.
5. ~~The Rr~~ 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 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 rail restricts freedom of movement.
3. Chemical restraints are defined as any drug that is used for discipline or convenience and not required to treat medical symptoms
- ~~3.4.~~ 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.

4.5. Discipline: any action taken by the facility for the purpose of punishing or penalizing residents.

5.6. Manual Method: to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint

6.7. Medical symptom: is defined as an indication or characteristic of a physical or psychological condition.

7.8. 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. A physician order must be completed via EHR.
2. If the covering physician writes a restraint order, this shall be communicated to the attending physician during endorsement.
3. 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 completed via EHR.
 - ii. Complete Consent for Physical Restraint. Consents must include discussion with the resident or resident representative regarding:
 - Educate family/resident representative 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 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.

- 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.
 - 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.
 - Continuation of restraint use must be renewed 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.

DOCUMENTATION

1. The condition of the resident utilizing a restraint shall be monitored every 2 hours.
 - a. Assessments are to be documented by RNs via EHR and shall include, but are not limited to:
 - i. Circulation (including vascular checks such as capillary refill, temperature, edema and color of skin)
 - ii. Skin integrity of the restrained extremity(ies)

- iii. Signs of injury associated with a restraint
 - b. 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.
- 2. Certified nursing assistants or patient care assistants are to document via EHR on the following:
 - a. Proper placement of restraint as ordered
 - b. Release of restraint every 2 hours for:
 - i. ROM to the restrained extremity(ies) while awake
 - ii. Turning and repositioning
 - iii. 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.)

3. 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;
 - v. Safe application of physical restraints;
 - vi. Clinical identification of behavioral changes that indicate that restraint is no longer necessary; and
 - 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~~ Bed Rail 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, 19/11/12 (Year/Month/Day)

Original adoption: 96/07/15

RESIDENT AND VISITOR COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) strives to create an environment that is responsive to residents/visitors' ~~complaints/grievances~~ and addresses residents/visitors' 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~~ residents/visitors 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~~ residents/visitors 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) Administration Department ~~(Administration)~~ 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/visitors 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 experience and satisfaction of the residents/visitors ~~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/grievances 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/Visitor 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/Visitor 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/Visitor 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/visitor 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/visitor. 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~~Administration.
6. Residents/Visitors 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~~Administration. ~~Resident Complaint/Grievance forms and Suggestion forms shall be routed to Risk Management Nurses~~Assistant Hospital Administrator ~~and Suggestion forms shall be routed to Administration.~~
8. ~~Risk Management Nurses~~The Assistant Hospital Administrator shall triage the complaint/grievance, and create an Unusual Occurrence (UO) report, ~~and conduct follow up through the established UO process.~~
9. ~~Risk Management Nurses~~The Assistant Hospital Administrator shall act as the Grievance Officials and ~~are~~is 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.~~

~~8-10.~~ The appropriate department/unit manager shall acknowledge the complaint/grievance and or make contact the resident in ~~a timely manner (1 to 25 business-business days)~~. The resident's right to confidentiality and privacy will be respected at all times.

~~11.~~ 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 complaint if the matter can be confirmed to the Grievance Official. -

~~9-12.~~ The Grievance Official shall respond to the complaint/grievance with a final resolution in 30 business days.

~~10-13.~~ Appropriate corrective action(s) shall be implemented by the facility if an alleged violation of resident's rights is confirmed.

~~11-14.~~ 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.

~~12-15.~~ 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:

LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response

LHHPP 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, 19/11/12 (Year/Month/Day)

Original adoption: 92/03/01



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC

Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd
San Francisco, CA 94116

Phone: 415-759-2363
laguna.honda@sfdph.org

Click here to insert Month Day, Year

Patient/Resident/Family/Visitor (Full Name)
Street
City, State, Zip Code

Dear Patient/Resident/Family/Visitor,

This letter confirms that we are processing a concern you submitted on [DATE]. Thank you for taking the time to bring this matter to our attention.

We will investigate your concern(s), with the aim of understanding what occurred and how it can be avoided in the future. You may receive a call from a member of our staff to discuss this incident further. Upon completion of the investigation, we will provide you with a written response within 30 working days.

Thank you again for alerting us to your concerns. Together, we can continue to improve the care and services at Laguna Honda Hospital and Rehabilitation Center.

If you have any questions or concerns, please feel free to call us at (415) 759-2363 or email us at laguna.honda@sfdph.org.

Sincerely,

Laguna Honda Grievance Officer



San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC

Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd
San Francisco, CA 94116

Phone: 415-759-2363
laguna.honda@sfdph.org

Click here to insert date

Patient/Resident/Family/Visitor (Full Name)
Street
City, State, Zip Code

Dear Patient/Resident/Family/Visitor,

I am writing to thank you for documenting your concerns with the Laguna Honda Grievance Office on [click to insert grievance date of submission indicated on grievance form](#), and to provide you with an update on our investigation. As the person responsible for investigating your concerns about your time at our facility, I wish to apologize for your unpleasant experience. We realize that you come to Laguna Honda Hospital and Rehabilitation Center under difficult circumstances and we take complaints very seriously.

Your statement indicates that [click here to insert a short reflective summary of concern\(s\)](#). I have completed a detailed review, which involved an evaluation of the documentation provided and speaking with care team members and staff involved. I have found [click here to insert simplified language at a 6th grade reading level summarizing the findings as indicated in the chart](#). We have determined that [click here to provide your final assessment](#).

We have discussed how this situation can be avoided in the future and have resolved to [click here to insert corrective actions taken](#). I want to thank you for bringing your concern to my attention, as it has allowed me to investigate and determine how to prevent this from occurring to you and others and in the future.

I do hope this letter provides you with an assurance that all issues you brought forward have been thoroughly evaluated and appropriate follow-up action has been taken. We regret this experience and extend a sincere apology to you. Feedback is important to us as we strive to provide quality healthcare and rehabilitation services with compassion and respect. If I can be of assistance to you in the future, I do hope that you will feel free to contact me at [click here to insert primary contact number](#).

Sincerely,

Name, Credentials
Working Title

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 Form 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 shall be completed by a Licensed Nurse or Unit Clerk.
- b. The Unit Clerk or designee shall:
 - i. fax the Transportation Prescription Form to A&E to arrange transportation services with a contracted transportation service.
 - ii. write the appointment on 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.
- d.e. For patients who are eligible for Veterans Affairs (VA) transportation services, all the arrangements are made by the VA. The unit clerk or designee notifies the transportation coordinator at the VA about the resident's dialysis and other medical appointment times and locations. The transportation coordinator at the VA schedules the rides with the VA's contracted vendor. The Unit Clerk or designee and the transportation coordinator at the VA will shall communicate changes in the appointment schedule or VA transportation vendor.

e.f. 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 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
- provide 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 designee.
- 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.~~

~~e.b.~~ Whenever possible, the staff at the appointment destination shall access the needed information through an electronic health record.

~~d.c.~~ When needed information is not in an electronic health record 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 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.

6. Escorts for discharging resident out of the City and County of San Francisco (CCSF).

- a. Generally, transportation for discharging patients within the Bay Area involving a City vehicle will be handled by the Social Services Department. A Nursing staff member may accompany the Social Worker, but it is the responsibility of the Social Worker to reserve and drive a City vehicle to the discharge location.
- b. If travel outside of the Bay Area is required, the Nursing office is contacted to solicit a Patient Care Assistant (PCA) to voluntarily escort the resident out of CCSF. Such an escort arrangement would involve transportation via airline or bus. If no PCA staff is willing to escort the resident, plans for the trip as arranged by Laguna Honda will be abandoned.
- c. The need for escort shall be based on supervision only. No treatments or other medical intervention shall be administered by the PCA during escort.

- d. Travel airline or bus tickets for the resident and the staff person shall be made in advance through City-approved travel agencies.
- e. If accommodation is required during the trip, The Accounting Department shall attempt to book lodging for the staff and resident using a P-Card. If attempts to book the lodging are unsuccessful, the staff person shall be asked to pay for the lodging and be reimbursed through the Business Travel Reimbursement process.
- i. Separate accommodations shall be provided for the resident and the staff member.
 - ii. Social Services and/or Accounting shall assist the employee in completing forms and other requirements for travel reimbursement. The applicable form is Travel/Training Authorization Form.
- f. Staff members shall be paid the applicable premium rates during the duration of the trip. Preapproval is required by the Chief Nursing Officer.
- g. Expenses related to employee travel will be charged to the Nursing operating fund. Expenses related to resident travel will be charged to the Gift Fund.

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 24-10 Coach Use for Close Observation
MR908 Transportation Prescription

Revised: 99/01/12, 12/07/31, 13/05/28, 13/09/24, 15/09/08, 19/03/12, 19/07/09, 19/11/12 (Year/Month/Day)
Original adoption: 96/07/15

HAZARDOUS DRUGS MANAGEMENT

POLICY:

1. Hazardous Drugs (HDs) shall be managed according to established safe procedures to mitigate the risk to resident, employee and environmental safety.
2. Intravenous cytotoxic/chemotherapy drugs shall not be initiated or administered at Laguna Honda Hospital and Rehabilitation Center (LHH).
3. The management of intravenous cytotoxic/chemotherapy drugs initiated elsewhere via an ambulatory computerized drug delivery (CADD) pump shall be restricted to the Pavilion Mezzanine Acute (PMA).
4. Staff who are trying to conceive (male or female), or are pregnant or breast-feeding, shall not administer cytotoxic or Hazardous Drugs or handle excreta of residents on chemo precautions. Staff who fit into these categories should inform their immediate supervisor for work reassignment.
5. Nurses preparing medications shall never crush or cut tablets, or open capsules labeled as "hazardous" by the Pharmacy.
6. Clinical staff responsible for the ordering, dispensing, administering and monitoring of hazardous drugs shall be provided with training on hazardous drugs.

PURPOSE:

To safely handle, administer, and dispose of Hazardous Drugs (HDs). This policy has procedures relating to three areas of care:

1. Prescribing Cytotoxic Drugs
2. Preparing, Administering and Disposing of Hazardous Drugs
3. Exposure and Spill Management of Hazardous Drugs

DEFINITION:

1. Hazardous Drug (HD): Any drug which poses significant risk to a healthcare worker by virtue of its teratogenic, mutagenic, carcinogenic, reproductive toxicity potential, or which can cause serious organ or other toxic manifestation at low doses. Drug classes listed as HD include: cytotoxic/chemotherapy agents, hormonal agents, immunosuppressants, some antiviral agents, some antibiotics and some biological response modifiers.

2. **Cytotoxic Drug:** A type of hazardous drug that destroys cells or inhibits or prevents their function. Cytotoxic drugs include drugs used for cancer (chemotherapy) and in some cases those drugs are used to treat other conditions (e.g., psoriasis, arthritis, transplant rejection). Not all drugs used to treat cancer are cytotoxic.
3. **Chemo Precautions for cytotoxic medications:** Precautions required when handling and disposing of excreta from residents who are currently receiving or have recently received cytotoxic drugs or cytotoxic chemotherapy. The duration of chemo precautions after the administration of any cytotoxic drug is 7 days unless otherwise identified and documented on the medication administration record by pharmacist that verified the original order.

PROCEDURE:

1. Procedure for Prescribing Cytotoxic Drugs

- a. Consulting medical specialists (oncologist, rheumatologist, and dermatologist) may prescribe cytotoxic drugs, in consultation with a LHH physician responsible for the resident's care.
 - i. A LHH physician may order cytotoxic drugs in consultation with a clinical pharmacist.
 - ii. Cytotoxic/Chemotherapy IV infusions initiated at another healthcare facility and continued at LHH (for example, CADD pump continuous infusion of fluorouracil) shall be ordered by a LHH physician. The ordering healthcare facility that originally ordered the continuous cytotoxic/chemotherapy infusion shall furnish and dispense these medications.
 - iii. "Off-label" prescribing of cytotoxic drugs is prohibited, unless the provider documents the rationale for use and supporting evidence

2. Preparing and Administering Hazardous Drugs (HDs)

- a. General Principles for HD Medication Administration
 - i. Hazardous Drugs shall be identified by a label on the medication from the pharmacy and will also be identified as hazardous on the medication administration record in the electronic health record. A list of common hazardous drugs prescribed at the hospital is located on the nursing and pharmacy intranet.
 - ii. Procedures for oral, enteral, subcutaneous and topical routes of administration shall comply with Nursing policies and procedures.

iii. Appropriate personal protective equipment (PPE) shall be used according to the likelihood of particular exposure:

- Wear two pairs of chemotherapy gloves when handling HDs and medication administration equipment or supplies. The standard hospital supply of exam gloves are rated for chemotherapy. Wear one or two pairs of chemotherapy gloves depending on the dosage form being handled:
 - Solid intact tablet/capsule – 1 pair of gloves
 - Parenteral – 2 pairs of gloves
 - Liquid oral solution – 2 pairs of gloves
 - Transdermal patch – 2 pairs of gloves
 - Suppository – 2 pairs of gloves
 - Topical – 2 pairs of gloves
- When wearing 2 pairs of gloves the outer gloves shall be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated
- Wear a splash-resistant chemo gown and eye protection if risk of spillage or splashing is possible. Yellow gowns used for contact precautions do not provide adequate protection.
- Before leaving the immediate area where a cytotoxic drug was administered or prepared, remove PPE and dispose in a yellow cytotoxic waste container.

b. Oral/Enteral Hazardous Drugs (HDs): Handling and Administration

- i. Never crush or cut tablets, or open capsules labeled as “hazardous” by the Pharmacy.
- ii. If a resident is unable to swallow intact tablets or capsules, contact Pharmacy to provide an alternative dosage form. Contact Pharmacy for liquid dosage form immediately if tablets/capsules are dispensed for an enteral feeding resident.
- iii. If a HD is to be administered enterally via GT/JT, a liquid preparation must be obtained from pharmacy.
- iv. After a hazardous drug has been administered, discard administration equipment such as medication cups, PPE, and enteral feeding syringes, into the yellow cytotoxic waste container.

c. Intravenous Administration of Hazardous Drugs (HDs)

- i. Intravenous cytotoxic drugs shall not be administered except via CADD pump as stated in policy statements 2 and 3.

- Prior to administration of intravenous HDs nursing shall obtain a yellow cytotoxic waste container from EVS. In addition, an intravenous medication infusion pump shall be obtained.
 - Wear a splash resistant chemotherapy gown and two pairs of gloves when starting or discontinuing intravenous HDs or changing I.V. tubing.
 - Face shields or goggles shall be used when there is a splash hazard.
 - Place an absorbent pad with impermeable plastic backing underneath the infusion site to contain any leakage of solution which may occur during handling of I.V.
 - All PPE and equipment used for administration of intravenous HDs shall be disposed of in a yellow cytotoxic waste container.
- d. Subcutaneous or intramuscular hazardous drugs including cytotoxic chemotherapy may be administered at LHH and shall be administered using the same processes described in Nursing Medication Administration Policy. The Pharmacy shall dispense the medication in a pre-filled syringe for administration.
- e. Topical HDs including cytotoxic chemotherapy may be administered at LHH according to Nursing Medication Administration Policy using two pairs of gloves and a chemo gown. Chemo precautions for handling patient excreta are not required for residents receiving only topical HDs.
- f. Disposal of Hazardous Drug Waste from Medication Administration
- i. Unused, unopened or expired drugs shall be returned to the pharmacy for disposal.
 - ii. Any contaminated containers or materials used in the preparation or administration of HDs including cytotoxic/chemotherapy, shall be disposed of in a yellow, cytotoxic waste container.
 - iii. Do not pour hazardous drugs/solutions down drains or into toilets.
- g. Chemo Precautions for cytotoxic drugs
- i. Residents may excrete active drug and/or hazardous metabolites for a limited time after administration of a cytotoxic drug. The duration of chemo precautions after the administration of any cytotoxic drug is 7 days unless otherwise identified and documented on the medication administration record by the pharmacist that verified the original order.

- Note: Follow standard infection control precautions whenever contact with body fluids is possible (regardless of medication regimen).
- ii. A chemo precautions cart shall be ordered from Central Processing Department and a yellow, cytotoxic waste bin shall be ordered from EVS. The chemo precautions cart contains appropriate PPE, a spill kit, and a yellow sign for the door.
 - iii. Place yellow sign on resident room door to inform all staff that all waste generated in the room must be disposed of in the yellow, cytotoxic waste bin.
 - iv. Use double gloves and splash-resistant chemo gown available on the cart when handling blood or excreta. A face shield shall be worn if splashing is possible.
 - v. Linen that is contaminated with cytotoxic drugs or excreta from patients who are on chemo precautions shall be separated from regular dirty linen and placed in a yellow laundry bag from the cytotoxic medication cart.
 - vi. Linens used by patients who have received cytotoxic drugs, which are not contaminated with body fluids shall be handled as other linen.
 - vii. Staff Laundering Practices for residents on Chemo precautions:
 - Staff laundering residents' personal clothing soiled with urine or feces shall wear double gloves and a splash-resistant chemo gown. If splashing is possible, face shield shall be used.
 - Personal clothing soiled with urine or feces for a patient on chemo precautions shall be:
 - Washed separately from other residents' clothing if resident is incontinent.
 - Placed in a yellow laundry bag for transport to washing machine.
 - Sent through two cycles of washing (first a pre-wash, followed by a second wash) with regular detergent.
 - Personal clothing that is not soiled with urine or feces shall be handled according to standard laundry procedure.

3. Hazardous Drug Exposure Response

- a. If an exposure to hazardous drugs occurs, immediately remove the contaminated PPE and dispose in the yellow cytotoxic waste container.

- b. Provide first aid as outlined below:
 - i. If there is skin or mucous membrane contact: wash contact area thoroughly with soap and water. Avoid iodine preparations or chlorhexidine.
 - ii. If there is eye exposure, immediately flood affected eye with a gentle stream of water for at least 15 minutes using the emergency eye wash. Make sure the eye is open and the individual blinks and rotates eye in all directions.
 - iii. If there is a needle stick injury or sharp exposure, immediately rinse any sharps injury with soap and water. Report the exposure to the Needle stick hotline for expert assessment and advice regarding immediate treatment.
- c. Report the exposure to your supervisor, who shall complete an injury report according to the LHH 73-01 IIPP.
- d. Complete an Unusual Occurrence report for residents or other exposed individuals.
- e. If exposure involves a resident, provide immediate first aid as outlined above and immediately notify the physician and nursing supervisor.

4. Hazardous Drug Spill Management

- a. Spills of hazardous drugs or body fluids contaminated with cytotoxic/chemotherapy drugs shall be contained by the person who caused the spill with help from another staff person on the scene using a Chemo Spill Kit.
- b. Chemo Spill Kits are available on PMA, and on Chemo carts that are provided to resident rooms where there are chemo precautions in effect.
- c. Procedures for cleanup are provided in the Spill Kit and in Appendix B.

ATTACHMENT:

Appendix A: Procedures for Cleanup of Chemotherapy and Hazardous Drug Spills

REFERENCE:

LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 73-10 Medical Waste Management Program
LHHPP 73-14 Personal Protective Equipment
NPP J 1.0 Medication Administration
NPP J 6.0 Intravenous Therapy Maintenance
PPP 07.02.00 Preparation, Handling, and Disposal of Hazardous Drugs
Medical Waste Management Act, California Health and Safety Code (Section 117690).
January 2007.

<http://www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/MedicalWasteManagementAct.pdf>

CDC NIOSH (National Institute for Occupational Safety and Health). 2004- 165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings

U.S. Department of Labor Occupational Safety & Health Administration. 2008. Controlling Occupational Exposure to Hazardous Drugs; Section VI: Chapter 2; www.osha.gov

American Society of Health System Pharmacists. 1/12/2006. ASHP Guidelines on Handling Hazardous Drugs.

Revised: 13/11/21, 17/07/11, 17/09/12, 19/07/09, 19/11/12 (Year/Month/Day)

Original Adoption: 08/09/30

Replaces LHHPP 70-02 Cytotoxic Agents (Chemotherapy) (rev. 03/05/08)

Replaces NPP J10.0 Antineoplastic/Cytotoxic Medications (rev. 00/08/03)

Appendix A: Procedures for Cleanup of Chemotherapy and Hazardous Drug Spills**Procedure for Cleanup of Chemotherapy and Hazardous Drug Spills**
Laguna Honda Hospital and Rehabilitation Center
July 29, 2016

This procedure is designed to for the cleanup of hazardous drug spills, and spills of body fluids containing cytotoxic drugs, including collection and disposal of spilled materials, cleaning of surfaces, and decontamination to remove any residual contamination.

Cleanup Requires 2 Persons

- Respondent 1 (R1) – Performs Hands-on cleanup (generally the person involved in or closest to the spill).
- Respondent 2 (R2) – Controls access to the area. Provides “Situational Awareness” for R1. Prepares and passes supplies and equipment so R1 never needs to leave the area.

Note: Persons who have had skin, body or clothing contamination should not be assigned to cleanup unless they have thoroughly decontaminated and changed into clean clothing.

Personal Protection Needed

- Safety Glasses
- Shoe covers
- Inner gloves (long cuff)
- Outer gloves (shorter cuff)
- Chemo Gown
- Face shield
- Fitted N95 respirator

Procedures

1. Block off spill area using “Do Not Enter” signs in the spill kit (Use the tape provided in the box). Notify area supervisor of the spill.
R2 shall read off and use the checklist on the back of the “OK to Enter” sign to keep track of the cleanup progress, initialing steps as they are completed.
2. R1 dons all PPE in the following sequence
 - Safety Glasses
 - Chemo Gown
 - Shoe covers
 - Fitted N95 Respirator
 - Face shield

- Long cuff inner gloves
- Short cuff outer gloves

R2 dons short cuff gloves (or any available) and readies supplies. R2 prevents people from entering the spill area and watches R1, warning them about dragging clothing or possible contact with contaminated surfaces, and passing materials and supplies to R1 so they never need to step away from the spill.

3. R1 uses scoop/scrapper to collect broken glass and gently place them in a yellow chemo waste bag. DO NOT use your gloved hands. Place the waste bag in a rigid yellow chemotherapy contaminated waste container immediately.

For liquid spills:

Taking care not to step or come in contact with spilled materials, R1 uses sorbent supplies in the spill kit to soak up the spilled materials. Use:

- Spill pads if there are puddles
- “Green Z” sorbent powder if there is spattered liquid or lots of droplets

Use scoop/scrappers to collect used green-Z. Place used Green Z, scoops/scrappers, and/or spill pads into yellow chemo waste bags.

For dry material spills:

Avoiding contact with dry material, R1 uses the dampened sponge to push spilled material into the scoop.

- Avoid using scraper from orange scoop/scrapper; use the sponge
- Do NOT over wet the sponge
- Do NOT use sponge to clean surfaces.

4. After all the spilled materials are collected, R1 removes outer pair of gloves and dons a fresh set.
5. R1 uses detergent solution in a wash bottle to gently wet down the area (try to go 1 foot beyond known spill area). Gently agitate/wipe detergent on surfaces with paper towels. Use spill pads or clean sponge if lots of detergent solution is left over. Repeat detergent wipe down a second time.

R2 adds water to detergent wash bottle (labelled Alconox 5 gm) up to the fill line and gently agitates it. Place the detergent back into the plastic bag before handing it to R1.

6. R1 removes outer pair of gloves and dons a fresh set.

7. When area has dried, R1 uses step 1 - (Blue Label) of Surface Safe Wipes to wipe the spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag. Wait for two minutes.
 8. R1 removes outer pair of gloves and dons a fresh set.
 9. R1 uses step 2 - (Red Label) of surface safe wipes to re-wipe the entire spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag.
 10. R1 removes all PPE in following sequence:
 - Shoe Covers
 - Outer Gloves
 - Chemo gown
 - Face shields
 - Inner Gloves
 - Safety glasses
- Place the used PPE in a chemotherapy waste bag for disposal.
11. R2 places the chemotherapy waste bags in a chemotherapy waste bin, and removes and disposes off their gloves as conventional trash.
 12. R1 and R2 immediately wash their hands and arms with soap and water.
 13. Post green "OK TO Enter" sign showing cleanup has been completed.
 14. Contact EVS and request a "disinfection" (i.e. wet-cleaning) of the area. Ask EVS to check the floor and spot wax as necessary.

Complete and submit the Unusual Occurrence (UO) report.

UNUSUAL OCCURRENCES

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that ~~Hospital personnel~~staff primarily utilize the electronic Hospital-wide Unusual Occurrence (UO) reporting system to report ~~document follow-up~~ investigations, communicate with relevant personnel and document corrective actions related to unusual occurrence events.
2. An Unusual Occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student.
3. ~~Unusual Occurrence reports (UOs)~~UO reports shall be completed and ~~timely~~ submitted timely by ~~the charge nurse, department/unit manager or designee, or any LHH~~ employee who witnesses or becomes aware of an unusual occurrence. The initial report shall be completed by the first staff member responding to the event and those who are most knowledgeable about the occurrence.
4. UOs are confidential under Evidence Code 1156/1157. No copies are to be made except by Quality Management (QM) staff.
5. The QM Department shall maintain the UOs as part of Performance Improvement Patient Safety (PIPS) Committee records.
6. Access to the ~~Performance Improvement~~PIPS Committee records and reports shall be strictly limited to QM staff, Departmental and Hospital Performance Improvement Committees, Medical Executive Committee (MEC), and Joint Conference Committee.

PURPOSE:

The purpose of the Unusual Occurrence system is to identify those events or conditions and institute corrective action that will address immediate needs and prevent similar future incidences. The process shall consider and evaluate potential legal exposure and, if necessary, initiate preparations for an appropriate legal response by the Deputy City Attorney's Office.

PROCEDURE:

1. General Provisions

- a. Filing a UO in no way replaces the ongoing responsibility of individuals to take action as necessary, investigate the occurrence, follow up appropriately, including referral to Human Resources, and report problems as they occur through the normal supervisory channels.

- b. Malicious reports or reports with punitive intent are not appropriate. Interdepartmental conflict are to be discussed by the departments involved and reported on a UO only when not resolved in a timely manner.
- c. ~~The Performance Improvement and Patient Safety~~PIPS Committee ~~(PIPS)~~, a Committee of the Medical Staff, is responsible for reviewing and evaluating ~~Unusual Occurrence~~UO Reports as part of the Hospital Quality Assurance and Performance Improvement (QAPI) Program.

2. Reporting, Investigation and Follow-up

- a. Before the end of the work shift, the Charge Nurse, reporting employee, or designee shall:
 - i. Completes the on-line UO which is directly transmitted to the Quality Management Department.
 - Necessary information for completing the UO:
 - Include the name of patient/resident (if applicable), unit, date of occurrence, time of occurrence, description of incident and person(s) notified.
 - Include the name(s) of staff, visitors, volunteers, students and other residents who were involved in the incident or witnesses to the incident.
 - Specifically identify who said what and/or who witnessed what part of the incident.
 - List what led up to the incident, other pertinent events occurring at the time, and any contributing acts of friends, relatives, or residents that may have led to the event.
 - Describe any equipment involved.
 - Note any injuries and state what medical care has been provided or is planned.
 - ii. Informs the supervisor on the shift of the occurrence. ~~If staff suspects resident abuse, the supervisor must be notified immediately and the Report of Suspected Dependent Adult/Elder Abuse form (SOC341 4/90) must be completed and submitted with the Unusual Occurrence report (refer to Hospital-wide Policies and Procedure LHHPP 22-01). On the evening, night and/or weekend/holiday hours, notify the Operations Nurse Manager on duty~~Follow

- [the reporting protocol as described in LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response.](#)
- iii. ~~Notifies~~[Notify](#) the attending physician if the incident involves the clinical care of a resident.
 - iv. ~~Notifies~~[Notify](#) the resident's family or surrogate decision-maker of the incident as appropriate.
 - v. ~~Submits~~ other necessary documents to QM Department.
- b. The supervisor or Operations Nurse Manager on duty shall determine whether immediate additional follow-up or action is required and whether notification of the ~~Medical Director~~[Chief Medical Officer](#), Division Head, and Administrator on Duty is warranted.
- c. If the incident involves a resident, documentation of the event, clinical response, and monitoring activities must be noted in the medical record according to the Hospital-wide Policies and Procedures. Do not document in the medical record the fact that a UO has been completed.
- d. A unique log number shall be assigned to each submitted UO. Risk Management ~~Nurses~~ shall triage [the](#) UOs within 24 hours or the next business day and request for follow-up information as- necessary using the on-line UO system:
- i. Follow-up and investigation of UO reports:
 - UO notification shall be sent to managers, supervisors and other relevant staff. UO follow-up and or investigation report(s) are requested from managers as necessary to determine contributing factors, corrective actions taken and/or referrals for follow-up actions.
 - The manager and or other relevant staff assigned shall log in to the on-line UO system [daily](#), review their respective worklist and read the UO report and or messages no later than the next business day.
 - Completed follow-up and/or on-line investigation reports are to be submitted to the QM Department within four business days of the UO report.
 - Risk Management ~~Nurses are~~[shall be](#) responsible for tracking the return of follow-up and or investigation reports.
 - Staff ~~are required to~~[shall](#) use the on-line UO system and not use the email system to address case specific UO issues.

- ii. Follow-up of reportable UOs (refer ~~to Hospital Wide Policies and Procedures File 60-03 for a list of reportable events~~ to LHHPP 60-03 Incidents Reportable to the State of California):
- ~~The Risk Management Nurse shall notify the designated Division Head(s) and managers of reportable occurrences and~~ may direct further staff actions on reportable occurrences.
 - ~~Completed follow-up and/or on-line investigation reports are to be submitted to the QM Department no later than the 4th calendar day following the incident.~~
 - Telephone notification of reportable Unusual Occurrences to California Department of Public Health (CDPH) shall be made by ~~Risk Management Nurses during regular work hours.~~ the mandated reporter.
 - ~~Weekend/Holiday reporting of Unusual Occurrences shall be carried out by the Nursing Operations Manager on duty with notification to the Risk Management Nurse on the next business day.~~
 - ~~The Risk Management Nurse shall assure that the required follow-up letter is sent to CDPH and a copy placed in the CDPH appropriate file.~~
- e. ~~QM staff~~Risk Management shall aggregate ~~Unusual Occurrence~~UO data to identify patterns/trends. UO summary reports shall be brought to the PIPS committee for further review, evaluation, and recommendations (e.g., if patterns/trends are identified, the PIPS Committee may work with the involved departments to institute further studies and develop a plan of correction, which may include a mechanism for ongoing monitoring).
- f. The UO report may be classified as closed by ~~the~~Risk Management ~~Nurse~~ or designee after sufficient essential information is gathered and corrective action(s) implemented to minimize risk of occurrence.
- g. UO summary reports shall be submitted to the ~~Medical Executive Committee (MEC)~~ through the PIPS committee and to the Joint Conference Committee. Recommendations from these Committees shall be forwarded to the MEC.

3. Downtime procedure for reporting an Unusual Occurrence

- a. Before the end of the work shift, the charge nurse, reporting employee, or designee shall:
- i. Complete the UO form F-821A “Confidential Report of Unusual Occurrence” (~~also refer to LHHPP 96-06 Unusual Occurrence Confidential Report~~), ~~Revised 06/00, “Confidential Report of Unusual Occurrence”~~:

- Complete Part 2 by using the resident's plastic ID plate to imprint the forms. If more than one resident is involved, write additional names in Part 2. If the occurrence does not involve a resident, information must be written in regarding any staff or visitors involved.
- Complete Part 3 by stating the facts as outlined in Section 2 above.

ATTACHMENT:

None.

REFERENCE:

LHHPP 22-01 [Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response](#)~~Abuse Protection Program: Prevention, Recognition, Reporting~~

LHHPP 24-06 Resident Suggestions and Complaints

LHHPP 60-03 Incidents Reportable to the State of California

LHHPP 60-08 Risk Management Program

LHHPP 60-12 [Review of Sentinel Events \(Applicable to Acute Care Units Only\)](#)

LHHPP 96-06 Unusual Occurrence Confidential Report

LHHPP 96-07 Unusual Occurrence Follow-up Report

Laguna Honda Form SOC_341 ~~(4/90)~~

Laguna Honda On-line UO Pocket Guide

Revised: 96/07/15, 98/08/10, 00/03/09, 08/01/08, 11/09/27, 15/09/08, 18/11/13, 19/11/12 (Year/Month/Day)

Original adoption: 94/08/15

HEAT EMERGENCY PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to responding to heat emergencies by providing a safe and healthy environment for its residents, patients, and staff and assisting in a regional response to impacts on the local healthcare system.

PURPOSE:

1. To implement procedures for responding to excessively warm climate conditions that may impact operations and pose a threat to the health and well-being of residents and staff.
2. To participate in a coordinated effort to manage any city-wide medical surge resulting from a heat emergency.

PROCEDURE:

1. Recognizing a Heat Emergency

~~a. When temperatures are predicted to reach 85 degrees F or higher in San Francisco, Facility Services shall begin to monitor both exterior and interior temperatures.~~

~~When the interior temperature in any resident care area reaches~~

a. When the temperature outdoors at LHH reaches 85 degrees F, the Facility Services Director, Chief Engineer, or Watch Engineer shall notify the Nursing Office.

b. ~~80~~When the interior temperature in any care area reaches 80 degrees F or higher, the Facility Services Director, Chief Engineer, or Watch Engineer shall notify the Chief Executive (CEO), designee, or Administrator on Duty (AOD) and Nursing Office.

i. The CEO or AOD shall activate HICS in order to manage the heat emergency. For HICS activation process, refer to LHHPP 70-01 B1 Emergency Response Plan.

i.ii. The Workplace Safety Officer, CEO or AOD shall notify Public Health Emergency Preparedness and Response (PHEPR) of high temperatures in patient care areas.

2. Recognizing Heat-related Illnesses

C9 Heat Emergency Plan

~~When temperatures start to rise inside the facility, all staff shall be on the lookout for symptoms of heat-related illnesses in both residents and their co-workers (see Table 1).~~

~~When the temperature outdoors at Laguna Honda HH reaches 80 degrees F, the Facility Services Director, Chief Engineer, or Watch Engineer shall notify the Nursing Office.~~

a. ~~When the Nursing Office receives notification that the temperature outside is 80 degrees F of high temperatures, the Nursing Department shall begin monitoring high risk residents' vital signs hourly and follow procedure 4.~~

b. ~~If there is a suspicion of heat-related illness in a resident, the physician will evaluate the resident to determine the need for transfer to an acute care setting or movement to a cooler location.~~

b-c. ~~All cases of confirmed or suspected heat-related illness in any building occupant shall be reported to the command center at 415-759-4636 (4-4636).~~

c-d. ~~In the event of an immediate medical emergency, staff at the location of the emergency shall call 911 and then notify the command center at 415-759-4636 (4-4636).~~

Table 1: Symptoms and First Aid for Heat-Related Illness

Illness	Symptoms	First Aid
Heat stroke	<ul style="list-style-type: none"> ▪ Confusion ▪ Fainting ▪ Seizures ▪ Excessive sweating or red, hot, dry skin with lack of sweating ▪ Very high body temperature 	<ul style="list-style-type: none"> ▪ Call 911 ▪ Place affected person in shady, cool area ▪ Loosen clothing, remove outer clothing ▪ Fan air on affected person; cold packs in armpits ▪ Wet affected person with cool water; apply ice packs, cool compresses, or ice if available ▪ Provide fluids (preferably water) as soon as possible ▪ Stay with affected person until help arrives
Heat exhaustion	<ul style="list-style-type: none"> ▪ Cool, moist skin ▪ Heavy sweating ▪ Headache ▪ Nausea or vomiting ▪ Dizziness ▪ Light headedness ▪ Weakness ▪ Thirst ▪ Irritability ▪ Fast heart beat 	<ul style="list-style-type: none"> ▪ Have affected person sit or lie down in a cool, shady area ▪ Give affected person plenty of water or other cool beverages to drink ▪ Cool affected person with cold compresses/ice packs ▪ Affected residents shall be evaluated by the medical staff ▪ Affected employees should seek medical treatment if signs or symptoms

C9 Heat Emergency Plan

		worsen or do not improve within 60 minutes <ul style="list-style-type: none"> ▪ Do not return to work that day
Heat cramps	<ul style="list-style-type: none"> ▪ Muscle spasms ▪ Pain ▪ Usually in abdomen, arms, or legs 	<ul style="list-style-type: none"> ▪ Have affected person rest in shady, cool area ▪ Affected person should drink water or other cool beverages ▪ Wait a few hours before allowing affected person to return to strenuous work ▪ Have affected person seek medical attention if cramps don't go away
Heat rash	<ul style="list-style-type: none"> ▪ Clusters of red bumps on skin ▪ Often appears on neck, upper chest, folds of skin 	<ul style="list-style-type: none"> ▪ Try to work in a cooler, less humid environment when possible ▪ Keep the affected area dry

Adapted from: www.osha.gov/SLTC/heatstress/heat_illnesses.html

3. Status Reports and Communication

- a. Department Operating Status Reports (DOSRs) shall be used to determine whether there has been any potential impact on services or the health of residents or staff. ~~DOSRs shall be completed upon activation of HICS and periodically as requested by the Incident Commander.~~
- b. Any change in the DOSR status shall be reported to the command center at 415-759-4636.
- c. Any neighborhood or department needing resources to manage the heat emergency shall request assistance from the command center.
- ~~b-d.~~ The HICS Command Center shall establish and maintain regular communication with the Department of Public Health according to Appendix A.

4. Maintaining Comfortable Temperatures for Residents and Staff

- a. Provide plenty of water to both residents and staff for adequate hydration.
- b. Close all windows in the new hospital buildings to ensure the ventilation system can provide the coolest environment possible. ~~The ventilation system in these buildings is capable of cooling our interior spaces to about 25 degrees cooler than the outdoor air, but opening windows allows hot air to enter and reverse any effect of the air conditioning.~~
- c. Distribution of available fans shall be coordinated through the HICS Command Center and distributed to ventilate the hallways in the neighborhoods. ~~Fans shall be available and used to ventilate the hallways in the neighborhoods.~~

- ~~d. Digesting high-calorie food (such as ice cream) increases body temperature, and is therefore not recommended.~~

5. Cooling Centers

- a. Cooling centers with air conditioning, ice, and water dispensers shall be set up in various locations throughout the campus to provide relief for anyone experiencing early symptoms of heat stress.
- b. Conference rooms B-102, B-104, and A-100 shall be available as cooling centers for staff in the administration building.
- ~~c. One dining room in each neighborhood in the towers and the Oceanside Room in Pavilion Mezzanine shall be available as cooling centers for residents and staff in the neighborhoods.~~

6. Regional Medical Surge

- a. During a heat emergency, San Francisco's health care system may be impacted with an increase in emergency calls.
- b. LHH shall be prepared to receive admissions from ZSFG or other acute care hospitals in accordance with the LHH Medical Surge Plan.

ATTACHMENT:

~~None.~~

~~Appendix A: TO BE DEVELOPED BY, OR IN CONJUNCTION WITH, PHEPR~~

REFERENCE:

70-01 B1 Emergency Response Plan
70-01 C4 Medical Surge Plan

Revised: ~~19/09/10~~ 19/11/12 (Year/Month/Day)

Original adoption: 17/11/14 (Year/Month/Day)

Hospital-wide Policies and Procedures For Deletion

FOR DELETION**ACCOUNTING FINANCIAL STANDARDS****POLICY:**

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) will operate in accordance with "generally accepted accounting principles," and standards of the American Institute of Certified Public Accountants; the United State General Accounting Office; and Structures and Guidelines, rules and regulations of the City and County of San Francisco Controller's Office.
2. All division and department heads shall assure that accounting and auditing standards are in place and appropriate controls are met for all programs operating under their auspices.

PURPOSE:

To ensure that the City and County of San Francisco Controller's standards are met throughout all Hospital financial operations.

PROCEDURE:

1. Laguna Honda's Finance Division will implement and maintain the Structures and Guidelines of the City and County of San Francisco Controller's Office.
2. Laguna Honda's Finance Division will assure that financial transactions are completed in accordance with Federal, State and City regulatory standards and are maintained for audit review for an appropriate duration following the close of fiscal year.
3. Division and department heads shall request the assistance of the Finance Manager for Finance in matters requiring application of generally accepted accounting principles and existing financial guidelines.

ATTACHMENT:

None

REFERENCE:

None

Revised: 03/01/09, 07/12/18, 12/09/25 (Year/Month/Day)

Original adoption: 92/05/20

FOR DELETION

SIGNATURE CARD FOR EXPENSE PAYMENTS

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) to require management staff approving expense documents and reimbursements to have a signature specimen on file with the Accounting Department.

PURPOSE:

The purpose of this policy is to allow Accounting staff to validate if the approver signature appearing on the expense and reimbursement documents is valid by matching it with the Signature Card on file.

PROCEDURE:

1. All Executive Staff and a designate must complete the attached signature card and submit it to the hospital Accounting Office.
2. Accounting Office will not process payments until the applicable Signature Card is on file.

**LAGUNA HONDA HOSPITAL & REHABILITATION CENTER
REIMBURSEMENT/PAYMENT AUTHORIZATION SIGNATURE CARD**

Division Head Name: Print -Last, First

Division Name

Division Head Signature

Division Head Title

Designate Name: Print-Last, First

Designate Title

Designate Signature

Date

Revised: n/a

Original adoption: 10/01/12 (Year/Month/Day)

Revised Nursing Policies and Procedures

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible 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-prescription topical ointments, creams, lotions and solutions when applied to intact skin surfaces.
 - Moisture barrier cream to macerated areas is acceptable for CNA/PCA to apply.
2. All medications, including over the counter drugs, require a physician's order which includes:
 - a. Medication name/agent
 - b. Dose
 - c. Frequency
 - d. Route of administration
 - e. Indication for use.
 - If indication for use is not on order, consult with ordering physician.
3. Licensed nurses will follow the "6 Rights" of medication administration:
 - a. Right resident
 - b. Right drug
 - c. Right dose
 - d. Right time
 - e. Right route
 - f. Right documentation
4. Bar Code Medication Administration is not a substitute for the Licensed Nurse performing an independent check of 6 Rights.
5. Arm bands should only be scanned if arm band is secured on resident. Arm bands should be replaced if worn, torn or not scanning.
6. Medication preparation should be performed at the resident's side (i.e. If resident is in bed, preparation will be at bedside).
7. Medication should only be prepared at the time just prior to administration. Do not prepare medications prior to administration or store out of package.
8. Medication separated from original package and stored for administration at later time is considered pre-pouring and is not acceptable.
9. IV medications must be labeled with resident name, date and time of preparation, medication name, strength, amount and name of person preparing.
10. Medication times are standardized in the EHR. Medication administration times may be modified to

Medication Administration

[For JCC Approval 11/12/19](#)

accommodate residents' clinical need or with resident's preferences. Licensed nurse will notify pharmacy via Electronic Health Record (EHR) with medication administration time ~~change request, change and will care plan the rationale.~~

11. 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.

12. 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.

13. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Non-hazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

13.14. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

14.15. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

15.16. Oral medications that are safe to be crushed can be crushed at discretion of LN. Each crushed medication must be given individually unless ordered by physician to crush and combine medications, pharmacy reviews for compatibility and ~~is care planned~~ documents in the EHR.

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

18. Topical creams and ointments that are ordered "until healed" can be discontinued by LN via an order in EHR and ordered "per protocol, co-sign required".

16.19. Topical creams/ointments available in the neighborhood (e.g., Dimethicone, Enzo) do not require a physician's order.

17.20. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.

RELEVANT DATA & DEFINITIONS:

BCMA: Bar Code Medication Administration

eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record

EHR: Electronic Health Record

WOW: Workstation on Wheels

CRITICAL POINTS:

A. SIX RIGHTS OF MEDICATION ADMINISTRATION

1. RIGHT RESIDENT

- Two forms of identification are mandatory.
 - Verify identity of resident using any two methods:

- Successful scan of identification band. Only if arm band is on resident.
 - Resident is able to state his/her first and last name (Ask for first and last name without prompting)
 - Resident Medication Profile Photograph matches resident. Bring image next to the resident for comparison.
 - Resident is able to state date of birth (Ask without prompting)
 - In situations where the licensed nurse can positively identify the resident, visual identification is acceptable as a second form of identification.
 - Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).
2. RIGHT DRUG
- Review eMAR for drug/medication ordered.
 - Review resident allergies to medications or any other contraindication.
 - Check medication label and verify with eMAR for accuracy. Check with physician when there is a question.
 - Checks or verifies information about medication using one or more of the following references, when needed:
 - Online Lexi-comp reference
<http://www.crlonline.com/crlsql/servlet/crlonline>
 - Black Box Warnings via Online Lexi-comp reference
<http://www.crlonline.com/crlsql/servlet/crlonline>
3. RIGHT DOSE
- Review eMAR for dose of drug/medication ordered.
 - Check medication label and confirm accuracy of dose with eMAR.
4. RIGHT TIME
- Review eMAR for medication administration time
 - Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin and any medication ordered more often than q4 hours will be administered within 30 minutes before or after schedule time.
 - All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
 - See Appendix I for routine medication times and abbreviations.
 - Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.
5. RIGHT ROUTE
- Review routes of administration
 - Aerosol/Nebulizer: Refer to NPP J 1.3
 - Enteral Tube Drug Administration: Refer to NPP E 5.0
 - Eye/Ear/Nose Instillations: Refer to J1.4
 - IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: <http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf>
6. RIGHT DOCUMENTATION

For JCC Approval 11/12/19

- Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.
- If resident is not wearing armband or refuses to allow scanning of arm band, document reason in override section.
- If product/medication is not scanned, document reason in override section.

B. OVERRIDE OF MEDICATION ADMINISTRATION

1. If a resident requires urgent attention, use clinical judgment when deciding to override BCMA in order to provide care.
2. Document override reason.

C. TWO LICENSED NURSE INDEPENDENT CHECK OF MEDICATIONS:

- The process which 2 Licensed Nurses perform an independent review of the medication to be administered without prompting or cueing for other LN prior to medication being administered: Each LN reviews the Right resident, Right medication, Right dose, Right route and Right time. Each LN will complete their own documentation in EHR.

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

1. Crushing medications is based on nursing judgement and resident care plan.
2. Hazardous, enteric, sustained release medications may not be crushed.
3. Medications labeled "do not crush" may not be crushed.
4. Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.
5. Staff may choose to wear mask when crushing or cutting pills.
6. 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).
7. 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~~

E. HAZARDOUS MEDICATIONS:

1. Special precautions need to be applied when preparing and handling and disposing of hazardous medication. (Refer to Hazardous Drugs Management LHHPP 25-05).

F. PHYSICIAN ORDER

1. Licensed nurses may accept 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. Verbal orders should only be taken during emergent situations when provider is unable to enter order due to care being provided to resident.

For JCC Approval 11/12/19

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.

PURPOSE:

Medications will be competently and safely administered.

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.
2. Retrieve any due medications that are stored in OmniCell and retrieve medication cassette from medication cart for the resident you will be administering medications and bring to resident's bedside/chair side with WOW. Carry only one resident's medications at a time.
3. Log into EHR. Scan arm band of resident to correctly identify resident and open their eMAR.
 - a. If wearing arm band, this is one form of identification, then use second form of identification to confirm Right Resident.
 - b. If not wearing arm band, navigate to eMAR of resident who will receive medications.
 - c. Use two forms of identification to confirm Right Resident. Document an override and select the reason why bar code scanning of resident is not used.
4. Confirm with resident they are ready to receive their medications.
5. Scan medication(s) barcode(s) at bedside/chairside.
6. Compare each medication package to medication prescribed in eMAR according to first 5 Rights.
7. Immediately prepare if appropriate. (i.e., crush) and administer medication(s).
 - a. If this is first dose being given, document 1st dose resident education has been performed, as appropriate.
8. Remain with resident until all medications have been taken.
 - a. Never leave medications at bedside/chairside.
9. Document in real time in EHR medication(s) given, not given, etc.
10. Log out of EHR and return cassette to medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

Medication Administration

[For JCC Approval 11/12/19](#)

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).
2. Do not add medication directly to an enteral feeding formula.
3. **Prior to administering medication, stop the feeding and flush the tube with at least 15 mL water.**
4. Dissolve tablets or dilute medication in at least 30 mL of water to sufficiently allow for medication to pass through the tube.
5. **Each medication should be administered separately. After each medication flush the tube with 15 mL of water.**
6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.
7. 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 stopped 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.
8. 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.
9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).
10. 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 flush with the syringe.
11. After all medication is administered, instill approximately 15 mL of water to flush medication.
12. 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.
13. Document amount of flush used for medication administration in flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

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 4, 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 (brand name Misty-Fast)
 - a. Use with nebulizer face mask, which has medication cup and lid.
 - b. Pour medication into the cup. Connect blue end of the tubing to the cup and the green end of the tubing to the air source.
 - c. Air source
 - i. Nebulizer machine: Do not place machine on soft surfaces. Turn on machine until mist is no longer produced.
 - ii. Compressed wall air: Turn on flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.
 - iii. For residents with a physician's order for oxygen AND is not a known carbon dioxide (CO₂) retainer: Oxygen may be used as a delivery method. If using oxygen, set liter flow at 8 liters per minute for 3-4 minutes or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.
 - d. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until nebulizer stops producing mist.

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.

SPECIAL CONSIDERATIONS:

1. If resident does not wish to take medication at prescribed time, you may attempt to return and administer at a later time, if medication is still in original packaging.

2. If not given within the time schedule, review "Appendix II: Specific Medication Administration Times and Abbreviations" to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.
3. Other medications should be reviewed for modification of times (see Policy Statement #9.)
4. If non time sensitive medications are given outside the time schedule, document the rationale in override section of eMAR.
5. If medications have been prepared/removed from packaging, and resident does not take, medication must be wasted and documented in eMAR.
6. Request from pharmacy any missing doses and/or need for replacement.

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

1. IV medication prepared by pharmacy and IV fluid bags will have medication label which includes bar code for administration.
2. In urgent situations, if RN needs to prepare IV drip, it must be labeled with resident name, date and time of preparation, medication name, strength and amount, name of person preparing.
3. Prepare parenteral medication and fluids in a clean work space away from distractions.
4. Prepare IV as close as possible to administration time and administer no more than 1 hour after reconstitution preparation. Such as spiking IV fluid bag, spiking prepared IV antibiotic bag, reconstituting antibiotic.
5. *Exception:* Insulin and IM injections should be drawn into syringe at time of administration.

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."
3. Any rolling motion used is acceptable as long as the suspension appears milky and the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Every cardiovascular drug requires vital sign monitoring as outlined below:
 - a. Frequency of monitoring:
 - i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.
 - ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.
 - b. Default parameters:
 - i. Hold medication for SBP < 105 and/or hold for HR < 55.
 - ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify

- physician.
- c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.
 - d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.
 - e. If a resident is on weekly cardiovascular monitoring schedule and a medication is held the licensed nurse will monitor and 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 physician has been notified of outcome of monitoring and the resident's vital signs has been outside of the hold parameters for 3 consecutive days.
2. PRN Cardiovascular Medication Orders
- a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics
 - a. Document VS once every shift for duration of therapy, and response to therapy.
2. Pain
 - a. Document pain scores per pain management policy. (Refer to HWPP 25-06)
3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)
4. High Alert Drugs (Refer to HWPP 25-01)
5. Hazardous Medications (Refer to HWPP 25-05)
6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT TO SHIFT LN REPORTING

1. During change of shift, hand-off and reporting to team lead or charge nurse, report:
 - a. Any new medications started, indication and monitoring required.
 - b. Any suspected Adverse Drug Reactions (ADRs).
 - c. If receiving medication that require monitoring, report clinically relevant data including abnormal VS or laboratory results.
 - d. Time or food sensitive medications to be given on incoming shift.
 - e. PRNs given at end of shift requiring evaluation of effect.
 - f. Refusal of medication.

FENTANYL TRANSDERMAL (PATCH) APPLICATION AND DISPOSAL (Refer to Pharmacy P&P 02.02.02)

1. Application
 - a. Don gloves during any time you will be touching patch.

- b. If resident currently has a patch on, remove the old patch before applying a new patch.
 - c. Select appropriate site for patch, on flat area, such as chest, back, flank or upper arm. Apply patch to non-irritated, non-irradiated skin.
 - d. Clip hair if needed (Do Not shave) prior to applying patch. Avoid use of oils, alcohol, or soaps to surface area as they may affect patch adhesion or drug absorption. Allow skin to dry completely before applying patch.
 - e. Peel liner from the back of the patch and press patch firmly to skin using palm of hand for at least 30 seconds to obtain seal.
 - f. Date and initial patch after application.
2. Document application and location of patch in the eMAR.
 3. Verification of patch placement and monitoring
 - a. Inspect site of application every shift to verify that the patch remains in place every shift.
 - b. Document verification in the eMAR.
 - c. If the patch has come off, attempt to locate the patch and dispose. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.
 - d. Do not apply heat source to patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.
 - e. If resident is diaphoretic, patch may come off. In some instances transparent dressing covering patch may keep it in place.
 - f. The resident may shower, wash and bathe with the patch in place as long as not scrubbing over the patch area which will disturb the adhesive.
 4. Disposal
 - a. Fold the old patch in half so that the adhesive sides are in contact and discard in medication disposal container.
 - b. Document disposal on the eMAR. A waste/witness co-signature is not required for a used patch.

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**
 - a. Licensed Nursing and other disciplines, as indicated, will collaborate to assess the resident's ability to participate in medication self-administration.
 - b. Nursing, and/or other disciplines, will discuss the assessment of the resident's ability to self-administer medication with the RCT.
 - c. The nurse will follow the 6 Rights of medication administration including scanning of resident and medications resident will be taking.
 - d. The resident will prepare and take own medications, which are kept in medication cart, under the supervision of the LN. (Unless ordered for bedside by physician as indicated in the care plan.)
 - e. The nurse will observe self-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.

- f. The LN observing the resident taking the appropriate medications, LN will document in eMAR as given and will note "self administered".
 - g. Documentation will also include the following;
 - i. Topic/training skills taught and resident's progress with learning in the EHR education section.
 - ii. Resident's agreement for participation in the self-administration of medications on the care plan.
 - iii. Any follow-up plan identified by the RCT necessary to reinforce safe and skilled medication self-administration will be documented in the education section of EHR.
2. **Bedside Medication (Refer to Pharmacy Policy 02.01.03: Bedside Storage of Medications)**
1. Prior to placing medications at the bedside, the interdisciplinary team shall determine that the resident can safely self-administer medications and an appropriate plan of care shall be written.
 2. Only medications prescribed by physicians for bedside storage may be kept at bedside. In general, the
 - a. following may be prescribed for bedside use.
 - i. Sublingual or inhalation medications for immediate use.
 - ii. Ophthalmic medications (eyedrops or ointments)
 - iii. Over-the-counter (nonprescription) medications.
 - iv. Other prescription items approved by the Interdisciplinary Team.
 - v. Medication intended for a trial of resident self-administration prior to discharge and approved by the Interdisciplinary Team.
 1. Discharge medications will be dispensed and labeled by Pharmacy in accordance with State and Federal laws.
 2. For oral dosage forms, no greater than a 7-day supply of medication will be stored at bedside. (Greater than 7-day supply is permitted for topical agents, inhalers and ophthalmics).
 3. Prescription drugs other than sublingual or inhalation forms of emergency drugs shall be stored on the resident's person or in a locked cabinet or drawer.
 4. No controlled drugs shall be kept at bedside.
 5. The Pharmacy will label all bedside medications in appropriate lay-language.
 6. The registered nurse or LVN assigned to medication duty will supervise the use of self medications and chart the medications used on the medication and treatment record.
 - a. The medications used will be recorded in the resident's health record, based on observation of self-administration by nursing personnel and/or information supplied by the resident.
 - b. The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time the medication is supplied.

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See [LHHPP 73-11](#) Medical Waste Management Program [73-11](#) & [LHHPP 25-05](#)

Hazardous Drugs management).

- a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Non hazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

~~4.2.~~ The LN must secure narcotics/controlled substances from time of receipt/removal from OmniCell to administration by having in physical possession or constant surveillance.

~~2.3.~~ Narcotics/controlled substances that are removed and not administered and/or are only partially administered, shall be immediately wasted in pharmaceutical waste container with witness of a 2nd LN.

- a. The need for partial wasting shall be identified prior to leaving the medication room.
- b. A 2nd LN shall be present to initiate controlled substance waste.
- c. The 2nd LN shall witness both when the medication is still in the sealed packaging and the wasting of the partial does.
- d. Both LNs shall document the waste in Omnicell ~~and eMAR.~~

~~3.4.~~ If resident refuses medication, LN shall ~~medication~~ return medication to original package.

- a. LN shall get a 2nd LN to initiate controlled substance waste.
- b. 2nd LN shall validate and ID medication since packaging has been opened.
 - (i) This may be done via looking up the IC medication tag through Lexicomp.
- c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.
- d. Both LNs shall document waste in Omnicell and eMAR.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

1. Emergency Box and Crash Cart stores medications that are used for emergency situations and during CODE BLUE. Locks are checked and documented in the Emergency Equipment / Refrigeration Monitoring Sheet.

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the EHR for each out-on-pass medication, including controlled substance medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.
 - a. The nurse will have the order filled at the hospital Pharmacy.
 - b. The pharmacist will dispense the medications in properly labeled child-proof containers.
 - c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.
 - d. controlled substance prescriptions
2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.

For JCC Approval 11/12/19

- a. Controlled substances **may not** be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.
 - b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.
 - c. The physician will counsel the resident on proper use of his/her medications.
3. When Resident is on therapeutic leave/out on pass, the MAR will be on hold status.

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:
 - a. Will be given to family or guardian to take home.
 - b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.
 - c. Pharmacy manages the medications and may dispose of as necessary.
 - d. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.
 - e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by LHH Pharmacy.
2. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside unless approved for self-administration.
3. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

1. After confirming a medication that is due is missing, notify pharmacy for replacement.

EXCESS MEDICATIONS

1. If resident is refusing medications and there are an excess of medications, notify pharmacy.

ATTACHMENTS:

Appendix I ~~and II – Routine Medication Times and Abbreviations;~~ Specific Medication Administration Times

Appendix III – LN Wasting Controlled Substance (Partial Dose)

Appendix IV – LN Wasting Controlled Substance (Resident Refuse Meds)

REFERENCES:

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

[For JCC Approval 11/12/19](#)

Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. *Institute for Safe Medication Practices*. Retrieved from <http://www.ismp.org/tools/donotcrush.pdf> or <https://onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053>

[AeroChamber Plus® Flow-Vu® Cleaning Instructions](#)

DeWit, Susan, Fundamental Concepts and Skills for Nursing, 3rd edition, 2009

[EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler \(Adults\)](#)

Lippincott, Williams, & Wilkins, Best Practices: Evidence-Based Nursing Procedures, 2nd ed, 2007

Nettina, Sandra, Lippincott Manual of Nursing Practice, 8th edition, 2005

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: 25-08 Management of Parental Nutrition
LHHPP File: 25-11 Medication Errors and Incompatibilities
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines: Infection Control Manual
LHHPP File: 73-11 Medical Waste Management Program

LHH Pharmacy P&P 01.02.02 Stop Orders

[LHH Pharmacy P&P 02.01.02 Disposition of Medications](#)

LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches

LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets

LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications

LHH Pharmacy P&P 02.02.00 Controlled Substances

LHH Pharmacy P&P 02.02.00b Distribution of Medications and Medication Order Processing

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

Nursing P&P J 1.3 Aerosol/Nebulizer Medications.

Nursing P&P I 5.0 Oxygen Administration

Nursing P&P J 7.0 Central Venous Access Device Management

ATTACHMENTS:

[Appendix I and II – Routine Medication Times and Abbreviations; Specific Medication Administration Times](#)

[Appendix III – Anticoagulant Administration Protocol](#)

Appendix 4: Various Inhaler Instructions

REFERENCES:

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

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

CROSS REFERENCES:

LHHPP File: 25-01 High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal Telephone Medication Orders
LHHPP File: 25-04 Adverse Drug Reaction Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines: Infection Control Manual
LHHPP File: 73-11 Medical Waste Management Program
LHHPP File: 25-11 Medication Errors and Incompatibilities

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
LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P 02.02.00 Controlled Substances

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
Nursing P&P J 1.3 Aerosol/Nebulizer Medications.

LHH Respiratory Services P&P A.11 Hand Held Nebulizer
LHH Respiratory Services P&P A.12 Continuous Aerosol Therapy

Revised Pharmacy Policies and Procedures

POLICY AND PROCEDURE FOR DISPOSITION OF MEDICATIONS

Policy:

All discontinued medications will be returned to the pharmacy for disposal, return to stock, or hold. Medications will be returned to the pharmacy when resident is deceased, discharged, or the medication is discontinued.

Purpose:

To ensure residents' medications are appropriately disposed or destroyed.

Procedures:

- I. Returned medications from Automated Dispensing Cabinets (ADCs). *See Automated Dispensing Cabinet Dispensing Procedures (PHAR 09.00)*
- II. Returned medications from units
 - A. Controlled Substances: Schedule II, III, IV, and V not in ADC
 1. Sign-out sheets with unused medications are returned to pharmacy.
 2. Sheet must be properly signed.
 3. Amount of medication returned must correspond with sign-out sheet inventory.
 4. Returned medications, if in unit dosages, properly labeled and identified, will be reissued to other units.
 - B. Nonscheduled Medications
 1. Pharmacy staff will check all medications returned to the pharmacy.
 2. Unopened, properly labeled medications may be returned to stock and credit applied when appropriate.
 3. Contaminated medications will be disposed.
 4. Unidentifiable medications will be disposed.
 5. Outdated medications will be returned to manufacturer for credit.

III. Medications on Hold

A. Medications may be temporarily held (e.g. resident discharged to acute hospital outside LHH but is expected to return, or medication temporarily stopped) in the Pharmacy until resident returns to LHH or until a temporarily discontinued medication order is renewed. The Nurse will bag the medications and label them with resident's name, date, and write the word "HOLD", and forward to Pharmacy.

IV. Pharmaceutical Waste Disposal

A. Pharmaceutical Waste Containers (Blue & White) shall be used to dispose of any medications that are opened but not administered, including partially full or used medications (e.g. pills, capsules, ointments, paste, and patches) and any remaining crushed, dissolved or disguised medications that are not hazardous. Environmental Services will dispose through a certified medical waste disposal vendor.

B. Controlled substances returned from units that are not suitable for use due to damaged packaging or part of patient personal medications upon admission stored in the pharmacy for greater than 30 days will be disposed via the Cactus Sink which makes them irretrievable. The waste will be documented by two staff who witness the destruction.

C. DISPOSAL of Hazardous Drug Waste: See Hospitalwide policy on Hazardous Drugs Management

Reviewed: 04/03dw, 06/04dw, 02/06, 01/08, 04/09, 2/10, 5/11, 4/12, 8/13, 5/14

Revised: 06/08dw, 10/09, 4/10, 2/15, 3/19, 10/19