

**Annual Departmental and Hospital-wide Policies and Procedures Review
Submitted to the Joint Conference Committee (JCC) for Approval on
September 10, 2019**

The annual Laguna Honda Hospital (LHH) policy and procedure review meeting was held on August 26, 2019 to review hospital-wide and departmental policies and procedures that were newly developed, revised or deleted over the past year. This includes policies and procedures that were previously submitted and approved by the JCC on 11/13/2018, 03/12/2019, 05/14/2019, and 07/09/2019.

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

Hospital-wide Policies and Procedures

New Policies (page 9)

<u>Policies</u>	<u>Comments</u>
LHHPP 20-13 Notification of Proposed Transfer/Discharge Due to Nonpayment for the Stay at the Facility	Created to identify residents who do not submit necessary paperwork for third party payment or refuses to pay after third party denies the claim; and to inform residents that ongoing failure to respond to notices of nonpayment may result in transfer/discharge.
LHHPP 21-19 Timely Documentation of Medical Encounters in the Electronic Health Record	Created to adopt the SFDPH policy on timely documentation of medical encounters in the electronic health record (EHR).
LHHPP 21-20 Timely Reviewing of Results in the Electronic Health Record	Created to adopt the SFDPH policy on timely review of diagnostic results that are posted in the EHR.
LHHPP 21-21 Electronic Health Record Downtime	Created to adopt the SFDPH policy for planned and unplanned downtime of the EHR.

Revised Policies (page 39)

<u>Policies</u>	<u>Comments</u>
LHHPP 20-06 Leave of Absence (LOA) (re-titled)	Revised to include out-on-pass check-in process and protocol; and reflect EHR processes.
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response	Revised to include steps for mandated reporter.
LHHPP 22-10 Management of Resident Aggression	Revised to update staff education from SMART to nonviolent safety management and prevention of challenging behaviors; replaced Behavioral Assessment Team with behavioral screener; clarified that behavioral health assessments are to be conducted upon referral by the primary physician; included notification of LHH Psychiatry clinicians already working with residents to be included in RCT review for residents who display aggressive/hostile behavior.

LHHPP 22-12 Clinical Search Protocol	Revised to include out-on-pass check-in process and when to initiate clinical search protocol.
LHHPP 24-10 Coach Use for Close Observation	Added policy statement to clarify that Nurse Director/Supervisor shall make the final determination, in collaboration with the RCT, for coach assignments.
LHHPP 55-03 Pre-Admission Screening and Resident Review (PASRR)	Revised to replace terminology for mental retardation to Intellectual or Developmental Disability (ID/DD).
LHHPP 70-01 A2 Emergency Preparedness	Revised to add procedure on resident preparedness.
LHHPP 70-01 A3 Emergency Resources and Maps	Updated list of staff trained and eligible to be assigned HICS roles; and updated list of assigned vehicles.
LHHPP 70-01 B1 Emergency Response Plan	Updated Appendix B for Emergency Contacts.
LHHPP 70-01 B3 Resident Evacuation Plan	Revised to clarify procedure on decision to evacuate; and revised Appendix A for Alternate Care Sites.
LHHPP 70-01 C1 Fire Response Plan	Revised to clarify fire evacuation plan for non-resident areas of the hospital and clarify procedures for when residents are present in Simon Auditorium or the Chapel during fire alarm.
LHHPP 75-07 Theft and Lost Property	Revised to combine LHHPP 75-08 Handling Lost and Found Items and add procedure for claims and liability.

Deleted Policies (page 149)

<u>Policies</u>	<u>Comments</u>
LHHPP 75-08 Handling Lost and Found Items	Combined with LHHPP 75-07 Theft and Lost Property.

Department: Admissions & Eligibility*No changes were made.***Department: Central Processing Department***No changes were made.***Department: Clinical Laboratory Services**Deleted Policies (page 153)

<u>Policies</u>	<u>Comments</u>
D – Patient, Visitor and Staff Relation	Material is outdated.
E – Specimen Processing Test Guide	Material is outdated.

Department: Clinical Nutrition Services & Diet Manual*No changes were made.*

Department: Environmental Services*No changes were made.***Department: Facility Services***No changes were made.***Department: Food Services***No changes were made.***Department: Health Information Services***No changes were made.***Department: Medical Staff***No changes were made.***Department: Nursing Services**Revised Policies (page 159)

<u>Policies</u>	<u>Comments</u>
D 1.0 Restorative Nursing Care (re-titled)	Revised to reflect current procedures.
D6 1.1 Battery Operated Lift Transfer	Added policy statement to require two nursing staff members for operation of the EZ Lift.
G 7.0 Obtaining, Recording and Evaluating Residents Weights	Revised policy statement to clarify that all residents shall be weighed on admission, then monthly, with proper documentation for weights not taken.
J 1.0 Medication Administration	Revised procedures for wasting medication and added new appendices for standard work of wasting controlled substance.

Department: Outpatient Clinics*No changes were made.***Department: Pharmacy Services**Revised Policies (page 195)

<u>Policies</u>	<u>Comments</u>
01.02.01 Orders for Medications and Standing Orders	Monthly med regimen review attestation serves as the monthly medication renewal; removed statement on faxing all orders to pharmacy.
02.01.00a Acute Care Hospital Order Processing and Medication Distribution	Updated to reflect the change to electronic prescribing; and clarified the labeling section.

02.01.00b Skilled Nursing Distribution of Medications and Medication Order Processing	Updated to reflect the change to electronic prescribing; clarified the labeling section; and updated distribution to reflect 48-hour supply model.
02.01.02 Disposition of Medications	Any pharmacy staff may check medication returned unused from the floor
02.01.03 Bedside Storage of Medications	Revised to reflect EHR documentation; and changed multidisciplinary to interdisciplinary.
02.02.00 Controlled Substances	E-prescribing vs faxing.
02.05.00 Investigational Drugs	Updated to reflect e-prescribing.
03.01.02 Medication Pass Observation	Minor revisions regarding assignment of staff to conduct medication pass observation.
03.03.00 Infection Control	Minor edits to refer to specific policies for expiration dating.
05.03.00 Therapeutic Interchange	Deleted "written order."
06.04.00 Drug-Food interaction counseling	Revised in conjunction with Clinical Nutrition Services. Notification process will be via report from the EHR; referenced the Clinical Nutrition policy and removed attachments.
07.01.00 Sterile Product Preparation, Handling, and Disposal	LHH does not compound sterile hazardous products. Details related to non-sterile hazardous compounding, equipment, precautions, and cleaning of the hazardous drug room were removed and are addressed in the completely rewritten policy 07.02.00.
07.02.00 Preparation, Handling and Disposal of Hazardous Drugs	Policy rewritten to incorporate regulatory changes and to be consistent with recently updated hospital-wide policy 25-05 Hazardous Drugs Management. New policy details all aspects of handling hazardous drugs receipt, storage, transport, compounding, labeling, training, hazardous drug identification.

Department: Radiology*No changes were made.***Department: Rehabilitation Services***No changes were made.***Department: Respiratory Services***No changes were made.***Department: Social Services**Revised Policies (page 285)

<u>Policies</u>	<u>Comments</u>
7.2 Services	Replaced "Initial Assessment" with "Resident Social History Initial Assessment."
7.4 Recording	Revised procedure 3 to clarify that the Discharge Planning and Expected Discharge sections under the Social Work tab in the EHR must be completed within 48 hours of admission or re-admission.

7.5 Discharges to the Acute Care Unit (PMA)	<p>Policy: Replaced “receiving ADT notice” with “Admission Report”.</p> <p>Procedure A. 1: Replaced: “Daily Admission, Discharge and Transfer notice” with “face sheet in their mailbox”.</p> <p>Procedure A. 2: Added “a consult note under the Notes section in the EHR”.</p> <p>Procedure 4: Replaced “documenting anticipated discharge destination and any psychosocial changes that have occurred due to the acute episode” with “and any psychosocial changes that have occurred due to the acute episode under the Expected Discharge section under the Social Work tab in the EHR”.</p> <p>Procedure 5: Replaced “stamped copy of the Psychosocial” with “Resident Social History”; deleted (MR 703); replaced “uploaded into” with “completed in”; added “acute medical record”.</p>
7.7 Discharge Planning and Implementation	<p>Procedure 1: Deleted “within five working days (two working days for short stay residents)”; deleted “psychosocial” and “(MR 703)”; added “If there is discharge potential, 1) a care plan will be completed under the Care Plan tab in the EHR, 2) the Discharge Planning and Expected Discharge sections under the Social Work tab must be completed within 48 hours of admission.”</p> <p>Procedure 6: Added “A Discharge Checklist will be reviewed by all team members to review to ensure resident is ready to go.”</p> <p>Procedure 8 was deleted.</p> <p>Procedure 9 became Procedure 8: Replaced “A medical social services Post-Discharge Plan of Care (MR 705)” with “An After Visit Summary (AVS)”; deleted “the inception of the discharge planning process and a finalized version at”; deleted “A copy of the written discharge instructions (MR 313A Post-Discharge Plan of Care/Home Instructions) will be given to resident and/or resident representative and box will be checked off on the MR 705.”</p>
7.8 Resident Care Conferences	<p>Procedure 2: Replaced “Resident Care Conference form” with “EHR Team Conference tab”; added “by adding themselves as a participant and completing their note section.”</p> <p>Procedure 3: Replaced “the resident care plan” with “a follow up consult note.”</p> <p>Procedure 4: Replaced “Progress Note” with “consult note”. Replaced “progress” with “consult.”</p>
7.9 Readmission Assessments	<p>Procedure I. 2: Replaced “progress” with “consult”.</p> <p>Procedure II. 1: Deleted “occurs six months and under from the date of discharge,”; added “Resident Social History”; replaced “and uploaded into the EHR and a” with “in the EHR under Notes section by coping a previous note and”.</p> <p>Procedure II. 2 was deleted.</p> <p>Procedure II. 3 became Procedure II 2.</p>
7.10 Confidentiality of Resident Information	Replaced “Medical Record Department” with “Health Information Systems” under Purpose, Procedures 1 and 2.
7.11 In-service Training	Minor revisions.

7.14 Resident Self-Determination Act (PSDA)	Added "(2 days for those coded as short stay)"; procedure 2: replaced "Psychosocial Problems" with "Affect/Mood (Include Conservator Issues)" and added "Resident Social History".
7.15 Addressing Resident's Spiritual Needs	Procedure 1: Added "Resident Social History" and deleted "Psychosocial."
7.16 SNF Neighborhood Transfers	Replaced "write" with "complete a consult"; added "transfer/move"; replaced "transfer" with "consult"; added "consult" to procedure 5.
7.17 Notifications to San Francisco Sheriff's Department (SFSD)	Replaced "A psychosocial" with "a Resident Social History."
7.18 Discharge Database Information	Replaced "Progress" with "Consults"; replaced "discharge database" with "EHR".
7.19 Burial and End of Life Care Arrangements	Added "Resident Social History"; deleted "Psychosocial"; deleted "A copy of the Initial Psychosocial Assessment is sent to the Admissions and Eligibility worker who is assigned to the resident."

Department: Spiritual Care ServicesNew Policies (page 305)

<u>Policies</u>	<u>Comments</u>
C4.0 Fire Alarm During Chapel Service	Created to protect residents, employees and visitors from fire while they attend Chapel services.

Department: Vocational Rehabilitation*No changes were made.***Department: Volunteer Services**Revised Policies (page 307)

<u>Policies</u>	<u>Comments</u>
A1.0 Volunteer Recruitment Process Life Cycle	Rephrased wording of policy for clarification.
A2.0 Volunteer Fingerprinting	Rephrased sections to provide a more generalized description of procedures. Rephrased wording of policy for clarification.
A3.0 Volunteer Orientation	Rephrased wording of policy for clarification. Updated policy to reflect current information.
A4.0 Volunteer Infection Prevention	Rephrased wording of policy for clarification. Updated policy to reflect current information and operating procedures.
A5.0 Volunteer Injury	Rephrased wording of policy for clarification.
A6.0 Record Keeping	Rephrased wording of policy for clarification. Updated policy to reflect current information and operating procedures.
A7.0 Non-Designated In-Kind Donations (re-titled)	Rephrased wording of policy for clarification. Updated policy to reflect current information and operating procedures.
A8.0 Clothing Room	Rephrased wording of policy for clarification. Updated policy to reflect current information and operating procedures.

A9.0 Resident Library	Rephrased wording of policy for clarification. Updated policy to reflect current information and operating procedures.
A10.0 Holiday Gifts	Rephrased wording of policy for clarification.
A11.0 Volunteer ID Badge Procedure	Rephrased wording of policy for clarification. Updated policy to reflect current information and operating procedures.

Department: Wellness & Activity TherapyRevised Policies (page 341)

<u>Policies</u>	<u>Comments</u>
A9 Call-In Procedures	Revised to include updated procedures and guidelines.

New Hospital-wide Policies and Procedures

NOTIFICATION OF PROPOSED TRANSFER/DISCHARGE DUE TO NONPAYMENT FOR THE STAY AT THE FACILITY

POLICY:

The resident who has failed, after reasonable and appropriate notice, to respond to notices of nonpayment for the stay at the facility will be issued a Notice of Proposed Transfer/Discharge

Nonpayment applies if the resident does not submit the necessary paperwork for third party payment (e.g. Medicare or Medicaid) or after the third party denies the claim and the resident refuses to pay for his or her stay.

Nonpayment applies if the resident's account has been sent to Bureau of Delinquent Revenue (BDR).

PURPOSE:

1. To identify residents who do not submit the necessary paperwork for third party payment or, after the third party denies the claim, refuses to pay for the stay at the facility.
2. To identify residents whose accounts have been sent to BDR.
3. To inform residents that, after reasonable and appropriate notice, ongoing failure to respond to notices of nonpayment may result in transfer/discharge from the facility.

PROCEDURE:

1. Unresolved account balances and Referrals to the BDR.

The Laguna Honda Patient Accounting Department and A & E will follow A&E's Policy on Residents with Unresolved Account Balances and Referrals to the BDR. Documentation related to the accounts will be kept with resident's records.

2. Follow-up on Delinquent Accounts.

- a. The A&E Manager or designee shall notify the resident's medical social worker (MSW) regarding the resident's delinquent accounts.
- b. The MSW shall inform the RCT of the resident's financial status. The MSW and/or RCT will inform the ombudsman and the resident of his/her nonpayment status as it relates to potential discharge. If possible, the RCT shall work to facilitate resolution of nonpayment status. If no resolution is forthcoming, the resident will

be subject to Notice of Proposed Transfer/Discharge based on nonpayment and a plan for discharge will be pursued.

- c. The A&E Manager or designee, Patient Accounting Manager or designee, MSW Director or designee, UM Nurse Manager or designee will meet monthly to identify residents who would be subject to Notice of Proposed of Transfer/Discharge due to nonpayment of accounts. The resident list will be brought for discussion at the monthly UM Committee for appropriate action.

ATTACHMENT:

None.

REFERENCE:

A & E Department P&P on Residents with Unresolved Account Balances and Referrals to the Bureau of Delinquent Revenue (BDR)

Original adoption: 19/09/10 (Year/Month/Day)

TIMELY DOCUMENTATION OF MEDICAL ENCOUNTERS IN THE ELECTRONIC HEALTH RECORD (EHR)

PURPOSE:

The purpose of this policy is to ensure continuity, efficiency, and appropriateness of patient care and billing compliance by: 1) requiring timely documentation of a resident encounter including history, examination, impression and recommendations; 2) ensuring that resident encounters are easily and readily accessible to other healthcare team members; and 3) documenting the proper billing codes and levels of service.

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall adopt the San Francisco Department of Public Health policies and procedures on timely documentation of medical encounters in the Electronic Health Record (EHR) as applicable.
2. Clinical care team members who document in the medical record shall complete documentation for all resident encounters in a timely manner, in accordance with California Department of Public Health regulations.
3. Clinical encounters shall be documented electronically in the EHR so that they are accessible to clinical team members within the San Francisco Department of Public Health (SFDPH).
4. Clinical team members have a legal and professional responsibility to document promptly all clinical services performed for residents for whom they provide care. Such resident encounters shall be documented, clearly and comprehensively, thereby facilitating the resident's care and subsequent care by others.
5. LHH staff shall respect the privacy expectations that residents have regarding their protected health information (PHI) and shall maintain, secure, and use PHI only in a manner permitted by and consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other relevant statutes.

DEFINITIONS:

1. **EHR**: Electronic health record used throughout the SFDPH.
2. **Closing encounters**: Closing a patient encounter in the EHR serves as an electronic signature that identifies the author or responsible party who takes ownership of and attests to the information contained in the medical encounter.
3. **Co-sign**: In some instances, there may be more than one provider involved in the care of a patient, often involving supervision of a trainee. In this situation, a supervising provider shall review and jointly attest to the information contained in the medical

encounter. For an encounter which requires a co-signature, it is considered closed when it has been co-signed.

4. **Provider**: Anyone who is a member of the Medical Staff or an Affiliated Professional.
5. **Supervisor**: A clinician who supervises and is ultimately responsible for the care rendered by a student or trainee.
6. **Trainee**: Intern, student, resident or fellow who requires supervision by a clinical supervisor.
7. **Staff**: All care team members who are NOT members of the medical staff or affiliated professionals.
8. **Clinical care team member**: Anyone who provides clinical care to patients, including Providers, Supervisors, Trainees, and Staff.
9. **Appointment provider of record**: care team member listed in the EHR as the person whom the patient or client is scheduled to see.

PROCEDURE:

1. The procedure and timeline for clinical documentation are described as follows.

Type of encounter	Function	Timeframe to complete documentation
Clinical care team member is the only team member documenting within the encounter, with no Supervisor involved in care (e.g., a primary or specialty care, laboratory, nursing, or immunization visit)	Appointment provider of record closes the encounter	Within 72 hours of the start of the encounter, which is considered to be the moment after check-in when clinical information is first entered into the note by the rendering provider.
Trainee is the appointment provider of record, with a Supervisor overseeing care	Supervisor closes the encounter. Supervisor may or may not provide additional clinical information.	Within 72 hours of the start of the encounter, which is considered to be the moment after check-in when clinical information is first entered into the note by the trainee.

2. Compliance

The supervising managers of each clinical service are responsible for responding to generated reports showing clinical care team members who are not compliant with the above policy. Supervisors and managers are responsible for developing and implementing remediation plans for those clinical care team members. Timely documentation is a requirement for continued privileges to see patients in the SFDPH, and medical staff members and Affiliated Professionals who are not compliant with this policy shall be subject to revocation of their clinical privileges, in keeping with the LHH bylaws. Non-provider clinical care team members are not members of the medical staff, and those who are not compliant with the above policy may be subject to progressive discipline as dictated by their respective Collective Bargaining Agreements or their clinical training programs.

Teaching services are responsible for ensuring that Trainees sign all precepted notes in time for Supervisors to review and lock the encounter within 72 hours of the appointment.

ATTACHMENT:

None.

REFERENCE:

SFDPH P&P Timely Documentation of Medical Encounters in the Electronic Health Record

Original adoption: 19/07/09 (Year/Month/Day)

Effective date: 19/08/03 Epic launch

TIMELY REVIEWING OF DIAGNOSTIC RESULTS IN THE ELECTRONIC HEALTH RECORD (EHR)

PURPOSE:

The purpose of this policy is to ensure continuity, efficiency, and appropriateness of patient care by: bringing diagnostic test results and messages to the attention of the appropriate clinical provider in a timely manner; ensuring that diagnostic test results and messages are evaluated and remedial action(s) initiated as appropriate and ensuring the earliest possible diagnosis and treatment of critical conditions.

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall adopt the San Francisco Department of Public Health policies and procedures on the timely review of diagnostic results that are posted in the Electronic Health Record (EHR) when applicable and consistent with the California Department of Public Health regulations.
2. Diagnostic test results shall be evaluated in a timely manner and action(s) initiated as appropriate.
3. LHH staff shall respect the privacy expectations that residents have regarding their protected health information (PHI) and shall maintain, secure, and use PHI only in a manner permitted by and consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other relevant statutes.

DEFINITIONS:

1. **EHR**: Electronic health record used throughout the SFDPH.
2. **Result**: This includes, but is not limited to, all diagnostic test results such as laboratory tests, microbiology, imaging, and pathology as well as patient messages, messages from clinical support staff or other care providers (e.g., medication prescription refills, appointment requests).
3. **Reviewed**: Within the EHR, “reviewed” indicates that all actions and documentation taken in response to a result has been completed. No further documentation or routing of that individual result can be completed within the test itself, although further documentation can be completed. The action of “reviewing” a result/message removes it from any provider’s inbox.
4. **Assigned**: Results can be routed to any user in the EHR. This can also be done after results are received, for the purposes of clinical action / documentation or non-clinical action.

5. **Critical Test Results**: extreme and possibly life-threatening values, also known as "Panic Values"
6. **Abnormal Test Results**: test results outside of the reference range.
7. **Unsatisfactory Specimens**: improper specimens and/or technical issues.
8. **Within Normal Limits Test Results**: test results within the reference range.
9. **Provider**: Anyone who is a member of the Medical Staff or an Affiliated Professional.
10. **Supervisor**: A clinician who supervises and is ultimately responsible for the care rendered by a student or trainee.
11. **Trainee**: Intern, student, resident or fellow who requires supervision by a clinical supervisor.
12. **Staff**: All care team members who are NOT members of the medical staff.
13. **Clinical care team member**: Anyone who provides clinical care to patients, including Providers, Supervisors, Trainees, and Staff.
14. **Appointment provider of record**: care team member listed in the EHR as the person whom the patient or client is scheduled to see.

PROCEDURE:

1. Viewing of results can be initially performed by a designated RN or clinician provider to allow them to communicate to the responsible clinical provider the need to view, act upon, and document action regarding abnormal or critical test results.
2. The following timelines indicate the required timeline for actions by a clinical provider.

Type of result	Timeframe to review result
All Results	
Normal results	Within 7 calendar days
Abnormal results	Within 72 hours
Results communicated to ordering clinic/provider as critical	Within 24 hours

3. Labs/tests shall be assigned upon ordering or reassigned for clinical action to the clinical provider who ordered the test (either directly or by standing order protocol).

4. Compliance

- a. The supervising managers of each clinical service are responsible for responding to generated reports showing clinical care team members who are not compliant with the above policy. Supervisors and managers are responsible for developing and implementing remediation plans for those clinical care team members. Timely reviewing of results is a requirement for continued privileges to see patients in the SFDPH, and medical staff members and Affiliated Professionals who are not compliant with this policy shall be subject to revocation of their clinical privileges, in keeping with the LHH bylaws.

ATTACHMENT:

None.

REFERENCE:

SFDPH P&P Timely Reviewing of Results in the Electronic Health Record

Original adoption: 19/07/09 (Year/Month/Day)

Effective date: 19/08/03 Epic launch

ELECTRONIC HEALTH RECORD (EHR) DOWNTIME

PURPOSE:

The purpose of this policy is to describe the policies and procedures for planned and unplanned downtime of the Epic electronic health record (EHR). It outlines the methods, tools, forms, reports, and roles and responsibilities for continuing access to and documentation of resident care data before, during, and after a downtime scenario. Documentation includes, but is not limited to, physician orders, appointment scheduling, admissions, discharges, transfers, resident care plans and medications.

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall adopt the San Francisco Department of Public Health downtime procedures to maintain uniform practice to ensure continuity, efficiency and appropriateness of resident care and billing compliance.

DEFINITIONS (Definitions of acronyms or specialized terminology):

EHR	An electronic health record (EHR) is defined as a systematic collection of electronic health information about individual residents or populations.
EHR Downtime	The time period in which the EHR is unavailable to the end users until the time that the EHR is restored to the end users for use (including downtime required for all IT work and for all back-loading activities).
AOD	Administrator on Duty
BCA	Business Continuity Access
BMDI	Biomedical Device Integration
CPOE	Computerized Physician Order Entry
ERO	Epic Read Only
HICS	Hospital Incident Command System
HIM	Health Information Management (i.e. Medical Records)
IT	Information Technology
MAR	Medication Administration Record
MEA	Medical Evaluations Assistant
PAS	Patient Access Services (i.e. Admissions and Eligibility)
POC	Point of Care
WDE	Web Data Entry

BACKGROUND:

1. Types of Downtime

- a. **Epic Hyperspace Not Available.** Hyperspace is the normal Epic environment caregivers use to view and enter data. Planned hyperspace downtime may be related to a scheduled version upgrade or other code updates or fixes. Unplanned hyperspace downtime may be necessary if Epic is not functioning correctly, and the system is taken down to preserve data and diagnose issues. In this scenario, caregivers can access Epic Read-Only for the latest results, medication and procedures up to the time the downtime started.
- b. **Citrix Not Functioning.** Citrix is an application product that supports access to Epic across the organization. If Citrix is not functioning correctly, caregivers will be unable to log into Epic Hyperspace or Epic Read-Only. Both scheduled and unscheduled downtimes can occur with Citrix outages. In this scenario, caregivers can access BCA Web for formatted reports of patient data.
- c. **Network Outage.** If network connectivity is lost across the health system or at a single location, caregivers will be unable to access Epic. In addition, network outages may affect printing, phone and email use, and access to Hyperspace. In this scenario, caregivers can access BCA PC (Downtime Computer) for formatted reports of resident data.
- d. **Planned Downtime.** An event in which the EHR system is unavailable. Caregivers will be forewarned and notified which EHR tool to use. The communication should also refer to this policy by title and number.
- e. **Unplanned Downtime.** A sudden interruption or lapse of the EHR. This downtime shall be communicated in accordance with IT downtime policies and may be escalated to involve the disaster policy and procedures. Caregivers will be notified which EHR tool to use and the communication should refer to this policy by title and number.

2. Business Continuity Access (BCA) Tools

- a. **Epic Read-Only:** Provides read-only access to Hyperspace. This is the environment that is typically used for planned downtimes.
- b. **BCA Web:** This environment provides site-based formatted reports of key resident information and can be accessed from any computer. This would be used during a Citrix outage in which Epic Read-Only is not available.
- c. **BCA PC (Downtime Computer):** These computers can be identified by the **visible markings on the PC and keyboard** in each department. They will provide unit specific reports of key resident

information. The BCA PC (Downtime Computer) must always be kept turned on and can be used in daily operations to allow reports to download properly. These computers will provide the only access during an internet outage.

d. **Instructions** for accessing data during downtime see [Appendix G](#).

3. BCA Table and Classification

Business Continuity Access (BCA)	Epic Read Only (ERO)	BCA Web	BCA PC (Downtime Computer)
Similar view to live environment	X		
Includes latest results, orders and medications (up to time downtime started)	X		
Use when Hyperspace (Epic Read Only) is <u>not</u> available		X	X
Reports – snapshot of the time census with minimal but adequate information may be more than 1-hour since the report was updated		X	
Available on all workstations	X	X	
No documentation or input can be entered	X	X (ADT only)	X
Each unit should use approved paper charting	X	X	X
Should be used when internet is available	X	X	
Should be used when internet is down			X
Reports – department specific reports		X	X
Print downtime reports		X	X
Available on designated downtime computers (BCA PC)			X
Use only when Hyperspace (ERO) and BCA Web are not available			X
Planned Downtime			
Level P1: <30 min	X	X	
Level P2: >30 min to 4 hours	X	X	
Switch from Planned to Unplanned Downtime			

Level U2: >4 hours or , network is not available			X
Unplanned Downtime			
Level U1: <30 min (network is available)	X	X	
Level U2: >30 minutes or unknown (network is not avail.)			X
Additional instructions will be provided by HICS.			

PROCEDURE:

1. Census Management

The census management process will be used when a downtime requires the BCA PC (Downtime computer). Census management for inpatient units will physically occur in the HICS Command Center on each hospital campus only. The Ambulatory/Outpatient Clinics will maintain their own census changes.

House Supervisors or AODs will print “back up census” on the BCA PC. A census tracking sheet may be used in the event of an unplanned downtime. It will be the responsibility of the receiving, admitting, and discharging departments to track and report this information to the census management phone line in real time.

- a. Each campus/department will identify a resource to complete the Census Management Worksheet in real time, for any ADT transaction defined on the form.
- b. HICS (or delegate) will keep a “master” record of the census. This data will then be entered, for each hospital campus only, into the census management spreadsheet located on CHN Intranet under Downtime Resources.

HICS will facilitate a unit by unit verification of the physical census with each department’s designated leader (i.e. Clinical Supervisor) prior to Patient Access beginning their back-loading.

2. Registration Back-Loading

All departments and areas that regularly perform registration and scheduling will be responsible for back-loading of inpatient and outpatient information.

- a. Once IT has completed their portion of the EHR system downtime, the system will be released to the registration teams for backload.

- b. The HICS Management Team will do a unit by unit verification of the physical census at the time back-loading begins. This will be done over the phone with each department's designated leader (i.e. Clinical Supervisor).
- c. Patient Access and other registration departments will back load all Admission, Discharge, and Transfer (ADT) transactions for residents that are currently in the facility.
- d. Once Patient Access and other registration departments have completed back-loading inpatient information, they will notify IT.
- e. IT will return use of the EHR to Patient Access and other registration departments for "live" use.
- f. IT will send out system wide notification when the downtime is complete and the EHR is available for use.

3. Key Point (Proxy Charting)

- a. Proxy charting of downtime data is acceptable once the EHR is available. Proxy documentation is defined as entering data into the EHR that was collected by another caregiver.
 - i. A progress note in the EHR must be written by the nurse who is entering data as proxy indicating the following:
 - Purpose for entering data – Downtime
 - Date & time range of downtime data for which she/he is entering
 - Name and title of the caregiver(s) for whom she/he is entering
 - Example progress note: *EHR downtime occurred between 0500 and 0730 on 10/23/16. Between 0800 and 0820, this nurse entered MAR, I&O, and vital sign documentation into the EHR as proxy for A. Nurse, RN, for the care provided by A. Nurse, RN between 0500 and 0730.*
 - ii. For each data entry, the proxy will also use the "Document for Another User" and comment to document the name and title of the caregiver(s) for whom the proxy is entering data i.e. medication administration, vital signs etc. (See [Appendix E](#))
- b. Departments may require additional data entry during downtime recovery to reflect procedural activity, or resident status. Refer to department specific data entry procedures.

- c. Departments shall be responsible for developing staffing plans that support documentation in the pre, during and post downtime phases.
- d. In the event of an extended downtime, HICS may provide additional instructions.

4. Hospital Downtime Instructions

a. Pre-Downtime (Hospital)

Procedure	Department Leadership and Caregiver Responsibility
Paper Documentation	<ol style="list-style-type: none"> 1. Ensure the medical record integrity is maintained during downtime. Refer to LHHPP 21-05 Medical Record Documentation. 2. Each unit will have a downtime box/folder with downtime forms. 3. Each unit is responsible for maintaining their downtime box/folder and ensuring sufficient forms are available for staff to document. 4. All forms used during the downtime must be the current version and include document management barcodes. 5. Staff will prepare the appropriate downtime forms for use. 6. Print resident identification stickers. 7. Label all downtime forms with resident identification sticker. 8. Providers are responsible for maintaining paper prescriptions available for their use in the event of discharge during downtime.
Printing Pre-Downtime	<ol style="list-style-type: none"> 1. Ensure sufficient supplies, including paper and printer cartridges, are available. 2. Printing downtime reports to be completed one (1) hour prior to a planned downtime. 3. Individual units will be responsible for printing and distributing the downtime reports and Medication Administration Records (MARs).
Printing As Needed Documents (per resident acuity and/or nursing preference)	<ol style="list-style-type: none"> 1. MAR report should be printed for each resident on the unit. Departments are responsible for printing their resident MARs <ol style="list-style-type: none"> a. To print, open the resident record and then the MAR activity b. Click on the "Report" button in the menu bar at the top of the MAR c. When the report opens, click print (prints to dept. printer) 2. Clinical Summary Report
Printing As Needed Documents	<ol style="list-style-type: none"> 1. Clinical Summary Report 2. Unit Census Report 3. Discharge Education (if discharge anticipated)

(With BCA PC (Downtime Computers)	4. After Visit Summary (AVS) Discharge Instructions (if discharge anticipated) Note: In the Emergency Department, documents will be printed only as needed.
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b. During Downtime (Hospital)

Procedure	Inpatient Units, SNF and Acute
General	<ol style="list-style-type: none"> 1. All resident care provided during the downtime should be documented, including but not limited to, interventions, education, procedures, updates to the care plan, vital signs, medication administration, admission history and discharge notes. 2. Charges for care rendered during the downtime should be documented on a downtime charge form.
Orders	<ol style="list-style-type: none"> 1. Orders will be written on paper. Each order sheet must be dated, timed and signed with legible first and last name. 2. Telephone or verbal orders must be noted with read back, the name of the provider that gave the order, and caregiver name and title (See Appendix A). 3. Original order sheets should be kept in the resident's hard chart. 4. For nurse collect lab specimens – the first and last name of the caregiver who 5. collects the specimen must be legibly written on the paper downtime order (See Appendix B)
Stat Orders	Call and send a paper copy to the appropriate department.
Non-Stat Orders	Send a paper copy of the order sheet to the performing department with a note indicating the date and time it was sent on the orders sheet.
Non-Medication Orders	Document the order (supplies) on downtime form and enter into the EHR once the system is back up. (Note: Will be completed after the system is back up)
Medication Orders	Send (Fax or Tube) a paper copy of medication orders to pharmacy during the downtime. Pharmacy will enter medication orders when the system is back up.
Food Orders	<ol style="list-style-type: none"> 1. Send (Fax or Tube) a paper copy of the order to Food Services. 2. Call Food Services with any new diet orders or changes to diet orders or food allergies.

Medication Administration Record	<ol style="list-style-type: none"> 1. Additional medication orders will be written on the printed MAR until full, then the blank paper MAR will be used. 2. For new admits during the downtime, the blank MAR will be used. (See Appendix C) 3. For medications discontinued during downtime, the entire line on the paper MAR will be crossed out with a single line and annotated by user's initial, date and time. Any remaining administration boxes will be marked with a black X and a note will indicate the medication was discontinued with the date and time. (See Appendix D) 4. If a medication is held during the downtime, circle the scheduled time in the appropriate column on the paper MAR. Caregiver will write their initials and title with the reason code from the key at the bottom of the MAR. (See Appendix D)
Discharging Residents - Resident Education - Paper Prescriptions	<ol style="list-style-type: none"> 1. Whenever possible, use DPH-approved resident education printed from KRAMES. 2. Print two copies and label with resident stickers. One copy will be given to resident and one copy will be placed in the resident chart to enter into EHR after downtime 3. Make a copy of any paper prescriptions given to the resident and keep copy in the chart. When the EHR is back up RN will add these to the home medication list.
Transferring Residents	For non-critical resident transfers: careful consideration will be taken prior to transferring non-critical residents and the House Supervisor / AOD or, HICS Management Team may be consulted if needed.

c. Post-Downtime Back-Loading (Hospital)

Procedure	Inpatient Units	SNF and Acute
General Instructions	When downtime is complete, document in EHR (see below).	<ol style="list-style-type: none"> 1. Back-loading of orders and documentation will not occur for residents in short stay areas. 2. For all new/incoming residents, documentation will be entered in the EHR. 3. For add-on cases in the OR, the RN, Charge RN or Manager will complete the following: <ol style="list-style-type: none"> i. Case Entry

		<ul style="list-style-type: none"> ii. Schedule the Case iii. Events for charging <ul style="list-style-type: none"> a. In Room b. Out of Room c. Sedation Start d. Sedation Stop e. PACU events 4. For Trauma events, RN scribe will document the following: <ul style="list-style-type: none"> i. Trauma Activation ii. Trauma Start iii. Trauma End iv. Trauma Staff <p>Trauma Outcome</p>
<p>Entering Non-Medication Orders</p>	<ul style="list-style-type: none"> 1. Non-medication orders: Radiology, Respiratory Therapy, and Lab enter their specific orders into the EHR. All other non-medication orders will be entered into the EHR using the other mode “Transcribed by nursing during downtime”, 2. New admission/transfer orders (non-medication) will be entered by nursing in the receiving department. Review all paper orders to ensure orders not completed during the downtime are entered into the EHR. Orders will be entered into the EHR using the order mode “Transcribed by nursing during downtime”. 3. Discharged residents will not require order back-loading and will remain on paper documentation. 	<ul style="list-style-type: none"> 1. Any new orders will be entered into the EHR once the system is back up. 2. New admission/transfer orders (non- medication) will be entered by receiving department. 3. Discharged residents and/or residents who will be discharged from the short stay area will not require order back-loading and will remain on paper documentation.

Entering Medication Orders	Pharmacy enters medication orders. Written medication orders will be delivered to pharmacy during downtime.	For admitted residents, any medication orders will be entered into the EHR once the system is back up.
Verifying Orders	After the downtime, the nurse is responsible for verifying that written orders (medication and non-medication) entered into the EHR were entered correctly.	
	(See Appendix A).	
Charges	Charges will be entered into the EHR once system is available.	<p>Medication Charges: If the administration of medications is not back loaded in the EHR, a paper copy of the MAR must be sent to pharmacy for back-loading of medication charges. Department leaders (managers, supervisors or charge nurses) are responsible for collecting the downtime MARs and faxing to the central pharmacy within 2 hours of the end of the downtime. LHH: 415-759-6017</p> <p>All Other Charges: Any other charges will be documented once system is available by support staff.</p>
Progress Note	Nursing will enter a progress note stating, "EHR unavailable from <start date/time> to <end date/time>. See paper documentation in resident's chart."	
Paper Documents	After the downtime, paper documents will remain in the hard chart on the unit until scanned into the EHR.	

5. Hospital Back-Loading

a. Downtime less than 4 hours – Back-loading

Documentation Requirements	<ol style="list-style-type: none"> 1. All care documented on paper should be entered into the EHR by the caregiver who performed the care. 2. In the case of a shift change during downtime, the oncoming nurse will enter the documentation from the prior shift. Refer to the Key Point on proxy charting. 3. Device data from BMDI will file to the timestamp in the queued-up message and will appear in the EHR to be validated as normal process only if a resident remains in the same room during downtime. If a resident is moved during downtime, once transfer is complete in the EHR the device will pull in at the ADT transfer time and caregivers will back document the start time of the fixed device data to be appropriate.
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b. Downtime greater than 4 and less than 6 hours – Back-loading

Documentation Requirements	<p>The following documentation from paper records MUST be entered into the EHR:</p> <ol style="list-style-type: none"> 1. For residents admitted during downtime: an admission assessment, allergies, height, weight, and home medications. 2. All medications administered during downtime will be entered into the MAR by the nurse, LIP or proxy. 3. Minimally, the last set of vital signs and any vital signs not within normal limits for the resident. 4. I & O for the downtime 5. New lines, drains, and airways placed during the downtime. New wounds identified during the downtime 6. POC tests results if the results are not interfaced directly from the POC device/ laboratory information system. 7. Respiratory treatments received during downtime 8. Discharge or transfer documentation 9. For residents who have been discharged and received paper prescriptions, a paper copy will be made and entered into the home medication list. 10. Caregivers will chart on paper flowsheet and manually enter data from the BMDI into the EHR.
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c. Downtime greater than 4 hours or, extended downtime

Documentation Requirements	<p>In the event of an extended downtime, HICS will provide additional instructions. Example: Paper documentation will be scanned into EHR.</p>
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6. Provider Documentation

Providers will use note templates to document during downtimes. Using the templates below, providers can print and handwrite, type or use voice recognition (dragon). In some areas (ED) scribes may be used for documentation during downtime.

The following documents will be stored on the Intranet and SharePoint with links.

- Provider Progress Note
- ED Provider Note
- History and Physical

Downtime order sets templates will be available in the document library (**Sample list**):

- LHH Admission Orders for Skilled Nursing Facility [541]
- LHH IP Adult Admission Orders [880]
- LHH Discharge Orderset

7. Outpatient Downtime Instructions

a. Pre-Downtime (Outpatient)

Procedure	Department Leader and Caregiver Responsibility
<p>Paper Documentation</p>	<ol style="list-style-type: none"> 1. Ensure the medical record integrity is maintained during downtime. Refer to LHHPP 21-05 Medical Record Documentation. 2. Each department will have a downtime box/folder with downtime forms. 3. Each department is responsible for maintaining their downtime box/folder and ensuring sufficient forms are available for staff to document. 4. All forms used during the downtime must be the current version and include document management barcodes. 5. Staff will prepare the appropriate downtime forms for use. 6. Print resident identification stickers. 7. Label all downtime forms with resident identification sticker and/or resident identifier information. 8. Providers are responsible for maintaining paper prescriptions available for their use in the event of discharge during downtime.

Printing Pre-Downtime	<ol style="list-style-type: none"> 1. Ensure sufficient supplies, including paper and printer cartridges, are available. 2. For walk-in/drop-in patients, the clinic will identify the patient’s name, DOB and will update the patient information once system is back up. 3. Printing downtime reports to be completed one (1) day prior to a planned downtime. 4. Individual departments will be responsible for printing and distributing the downtime reports.
Printing Required Documents	<ol style="list-style-type: none"> 1. Department Appointment reports. 2. Clinical Summary Reports.
Printing As Needed Documents (With BCA PC (Downtime Computers))	<ol style="list-style-type: none"> 1. Print the following as needed for each resident: <ol style="list-style-type: none"> a. Last visit notes b. Problems, Allergies and Medication lists c. Progress notes d. Labs and diagnostics e. Current and/or overdue orders 2. Organize and prepare packets for each appointment with all printed documents.
Order Entry – 30 minutes Prior to Downtime	<p>Electronic order entry will stop 30 minutes prior to the planned downtime. Paper order entry will begin 30 minutes prior to downtime.</p>

b. During Downtime (Outpatient)

Procedure	Department Leader and Caregiver Responsibility
General	<ol style="list-style-type: none"> 1. All resident care provided during the downtime should be documented, including but not limited to, interventions, education, procedures, updates to the care plan, vital signs, treatments, allergies and medication changes. 2. MEA/Support staff will complete a flow sheet of all triage, orders, prescriptions refills, etc. on a paper progress note. 3. Charges for care rendered during the downtime should be documented on a downtime encounter form (Clinic forms)
Orders	<ol style="list-style-type: none"> 1. Orders will be written on paper. Each order sheet must be dated, timed and signed with legible first and last name. 2. Telephone or verbal orders must be noted with read back, the name of the provider that gave the order, and caregiver name and title (See Appendix A). 3. For staff collecting lab specimens – the first and last name of the caregiver who collects the specimen must be legibly written on the paper downtime order.
Stat Orders	<p>Call and send a paper copy to the appropriate department.</p>

Non-Stat Orders, including non-medication	<ol style="list-style-type: none"> 1. Send (fax) a paper copy of the order sheet to the performing department with a note indicating the date and time it was sent on the orders sheet. 2. Laboratory tests will be ordered on paper requisition forms during the downtime <u>and</u> the diagnosis to cover each test must be clearly written on the requisition form. <p>(Note: Will be completed after the system is back up)</p>
Medication Orders	Send (fax) a paper copy of medication orders to pharmacy during the downtime.

c. Post Downtime Back-loading (Outpatient)

Procedure	Department Leader and Caregiver Responsibility
General Instructions	When downtime is complete, document in the EHR (see below).
Entering New Encounters	Patient Access staff will schedule any walk-in appointments for patients seen during downtime who were not previously scheduled. They will use SSN, Name and DOB as identifiers to match an existing record or create a new MRN.
Entering Non-Medication Orders	Non-medication orders will be entered in the EHR by the Support staff using the order mode "Ordered during downtime." Non-medication orders include those orders that were not completed during the downtime (i.e. nursing orders, lab, radiology, etc.).
Entering Medication Orders	<p>Nurse/MEA/Support staff will update the medication list in the EHR using the copy of the paper order before it is sent to HIM to be scanned to the chart.</p> <p>Note: Each department will determine who will perform entering or transcribing the medication orders.</p>
Verifying Orders	After the downtime, the Support staff is responsible for verifying that written orders (medication and non-medication) entered into the EHR were entered correctly (see Appendix A).
Charges	Charges will be entered into the EHR once the system is available by support staff, e.g. Front Desk
Progress Note	Provider will document their note electronically within the EHR post downtime. Written progress notes will be scanned into the chart and attached to the encounter at a later date for reference.
Paper Documents	After the downtime, and once the chart is updated, paper documents will be routed to HIM to be scanned into the EHR.

Documentation Requirements	<p>The following documentation from paper records MUST be entered into the EHR:</p> <ol style="list-style-type: none"> 1. All care documented on paper should be entered into the EHR by the caregiver who performed the care. 2. In the case of a shift change during downtime, the oncoming MEA/nurse will enter the documentation from the prior shift. Refer to the Key Point on proxy charting. 3. Vital signs and Allergies 4. New medications and Medication discontinuations 5. Vaccines administered 6. Updates to the care plan 7. Assessments 8. POC tests results if the results are not interfaced directly from the POC device/ laboratory information system 9. Patient charts can be accessed from any department in the EHR system. If the change of shift is weekly for specialties, documentation must be completed as close as possible before the end of shift otherwise the next shift should continue to complete documentation.
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8. Outpatient Provider Documentation

Providers shall use note templates to document during downtimes. Using the templates, providers can print and handwrite, type or use voice recognition.

ATTACHMENT:

Appendix A: Written Orders – Noting Orders, Verifying Orders After Downtime

Appendix B: Lab Specimens

Appendix C: Writing Order on MAR with Administration Times

Appendix D: Discontinuing an Order on the MAR and Holding a Dose

Appendix E: Documenting a Note by Proxy

Appendix F: Downtime Charge Form

Appendix G: Instructions for Accessing Data During Downtime

REFERENCE:


LHHPP 21-05 Medical Record Documentation

SFDPH P&P Electronic Health Record (EPIC EHR) Downtime

Original adoption: 19/07/09 (Year/Month/Day)

Effective date: 19/08/03 Epic launch

Appendix A – Written Orders: Noting Orders, Verifying Orders After Downtime



Community Health Network
San Francisco General Hospital
Medical Center

NAME _____

DOB _____

MRN _____

PCP _____

PHYSICIAN ORDERS

INSTRUCTIONS:

1. Use ball point pen.
2. Doctors write in black ink.
3. Nurses write in red ink.
4. Nurses time and date order when transcribed.
5. Provider is to sign all orders and include CHN ID #.
6. Students and house staff are to indicate their year in training.

PATIENT ID / ADDRESSOGRAPH _____

DRUG ALLERGIES:
(include reactions) _____ NKDA

DATE & TIME	PHYSICIAN ORDERS	SIGNATURE TITLE & CHN ID#

Appendix B – Lab Specimens

DATE, TIME RECEIVED	ACC #	PHYSICIAN NAME (Print) I.D. NUMBER PAGER/EXTENSION	PATIENT NAME: MEDICAL RECORD NUMBER:
LAB USE ONLY		COLLECTED BY DATE TIME (24 hour time)	BILLING: BIRTHDATE: SEX: M F
<p>MICROBIOLOGY REQUISITION</p> <p>SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER CLINICAL LABORATORY</p> <p>STAT TEST: INDICATE BY WRITING "STAT" AFTER TEST</p>		WARD OR CLINIC LOCATION	ICD CODE: DIAGNOSIS / ANTIMICROBIAL THERAPY
<p>USE ONE REQUISITION FOR EACH SPECIMEN. This requisition may be used for more than one test per specimen. Refer to the on-line Clinical Laboratory Manual for specimen and collection information.</p>			
<p>SOURCE OF SPECIMEN</p> <p><input type="checkbox"/> BLOOD (site of draw _____)</p> <p><input type="checkbox"/> CSF</p> <p><input type="checkbox"/> FLUID (specify source) _____</p> <p><input type="checkbox"/> THROAT (use Double Swab kit for Rapid group A Strep Test)</p> <p><input type="checkbox"/> TRACHEAL ASPIRATE</p> <p><input type="checkbox"/> SPUTUM, expectorated</p> <p><input type="checkbox"/> SPUTUM, induced</p> <p><input type="checkbox"/> BRONCHOALVEOLAR LAVAGE (BAL)</p> <p><input type="checkbox"/> NASOPHARYNX</p> <p><input type="checkbox"/> NASAL</p>	<p>BACTERIAL TEST(S) REQUESTED</p> <p><input type="checkbox"/> Routine culture. If source of specimen & type of collection are appropriate, work-up will include Gram stain, anaerobic culture, and susceptibility testing. Throats are tested for Group A strep only unless other specific organisms are requested. Nasals are tested for Staph aureus only. Stool culture includes E. coli O157 culture and shiga toxin test. Rectal/Vaginal are tested for group B strep only.</p> <p>Add to routine culture:</p> <p><input type="checkbox"/> Vibrio <input type="checkbox"/> Yersinia</p> <p><input type="checkbox"/> Legionella <input type="checkbox"/> H. ducreyi (chancroid)</p> <p><input type="checkbox"/> Other (specify) _____</p> <p><input type="checkbox"/> Gram stain only (no culture)</p>	<p>VIRAL TEST(S) REQUESTED</p> <p><input type="checkbox"/> Herpes simplex only culture</p> <p><input type="checkbox"/> Routine viral culture (NOT including CMV) (Specify virus) _____</p> <p><input type="checkbox"/> Routine viral culture including CMV (Specify virus) _____</p> <p><input type="checkbox"/> Direct FA for Varicella-zoster virus (from lesions only) Submit specimen in viral transport medium. Slides are NOT acceptable.</p> <p><input type="checkbox"/> Rapid test for respiratory syncytial virus (RSV)</p> <p><input type="checkbox"/> Rapid test for Influenza A and B viruses</p> <p><input type="checkbox"/> Other (specify) _____</p>	

Appendix C – Writing Order on MAR with Administration Times

Medication Administration Record

DOB: / / NAME: MRN: Allergies: Page: +

FROM:		TO:	Scheduled Admin Times	Initial Administration Times on the lines beside the Medications (Use letters below to chart omit reasons)		
START	STOP	MED DOSE, ROUTE & FREQUENCY		0001-0700	0700-1500	1500-2400

Appendix D – Discontinuing an Order on the MAR and Holding a Dose

INSULIN REGULAR HUMAN 4 UNIT/0.04 ML - 20 UNIT/0.2 ML SOLN [HUMULIN R] Item #13407 SUBCUT THREE TIMES DAILY BEFORE MEALS AND AT BEDTIME. SS ALGORITHM: *BG <70mg/dL: Begin Hypoglyc Protocol. Call MD, *BG 70-130: 0 UNIT, *BG 131-180: 4 UNIT, *BG 181-240: 8 UNIT, *BG 241-300: 10 UNIT, *BG 301-350: 12 UNIT, *BG 351-400: 16 UNIT, *BG >400: 20 UNIT and Call MD.		07/15 08:00	08:00 12:00 <i>discontinued 7/18/11 @ 1830 NN</i>	17:00 21:00	
LACTULOSE UD SOLN [ENULOSE] Item #11140 PER_TUBE TWICE A DAY. 30 G/45 ML		07/05 21:00	09:00	21:00	

RESPONSE D. Relief in 30 Minutes R. Relief in 30 Minutes S. No Relief	MEDS NOT GIVEN A. NPO Diag B. NPO Surgery C. NPO Studies D. Pt Refused E. Nausea F. Hold Dose G. Off Unit H. Drug Not Avail J. Patient Asleep K. See Nursing Notes	INJECTION SITES I. Right Deltoid Area III. Right Gluteal Area V. Right Abdomen VII. Right Thigh II. Left Deltoid Area IV. Left Gluteal Area VI. Left Abdomen VIII. Left Thigh	INITIALS NN _____ _____	PRINT NAME N. NURSE _____ _____	SIGNATURE D. NURSE RNC _____ _____
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Appendix E – Documenting a Note by Proxy

Documented By: INPATIENT, NURSE Schedule Date/Time: 11/14/17 1000

Medication

× acetaminophen (TYLENOL) chewable tablet 80 mg : Dose 80 mg : oral : Every 6 hours PRN : mild pain

Action: Given During Downtime

Date: 11/14/2017 Time: 1000

Comment: Enter Comment

Route: oral

Dose: 80 mg

Product Instructions:
 Adult maximum acetaminophen dose per 24 hours = 4 g
 Pediatric maximum acetaminophen 650 mg/dose, 5 doses or 75 mg/kg
 Ordered Admin Amount: 1 tablet (1 × 80 mg tablet)
 Last Admin: 10/31/17 at 1006
 Frequency: Every 6 hours PRN
 Route: oral
 Order Dose: 80 mg
 Priority: Routine
 Order ID: 1134429
 Order Start Time: 10/25/17 at 1352
 PRN Reasons: mild pain
 References: Micromedex
 acetaminophen: 0 mg administered out of the max 4,000 mg in the last 24 hours as of Tue Nov 14, 2017 1142

Administration Warning

Product was not scanned

Scan the barcode for acetaminophen (TYLENOL) chewable tablet 80 mg
 or
 Select the MAR action and an override reason if required.

Action: Given During Downtime

Override reason: System downtime

Accept Cancel

Documented By: INPATIENT, NURSE Schedule Date/Time: 11/14/17 1000

Medication

× acetaminophen (TYLENOL) chewable tablet 80 mg : Dose 80 mg : oral : Every 6 hours PRN : mild pain

Action: Given During Downtime

Date: 11/14/2017 Time: 1000

Comment: Downtime

Route: oral

Dose: 80 mg

Document for Another User:
 BURN, NURSE
 A cosign request will be filed for: BURN, NURSE

Product Instructions:
 Adult maximum acetaminophen dose per 24 hours = 4 g
 Pediatric maximum acetaminophen 650 mg/dose, 5 doses or 75 mg/kg
 Ordered Admin Amount: 1 tablet (1 × 80 mg tablet)
 Last Admin: 10/31/17 at 1006
 Frequency: Every 6 hours PRN
 Route: oral
 Order Dose: 80 mg
 Priority: Routine
 Order ID: 1134429
 Order Start Time: 10/25/17 at 1352
 PRN Reasons: mild pain
 References: Micromedex
 acetaminophen: 0 mg administered out of the max 4,000 mg in the last 24 hours as of Tue Nov 14, 2017 1138

Recent Actions
 10/30 10/31
 1054 1006
 MAR Hold Given

Appendix F – Downtime Charge Form

Downtime Charge Ticket

Patient Name: _____
 CSN/Acct #: _____
 Service Date: _____
 Department: _____

Patient Label: _____

Qty	Procedure Master #	Procedure Record Name	Revenue Code	CPT Code	Billing Category
	1100001	HC R&B MED/SURG PRIVATE	0110		Room & Board
	1200001	HC R&B MED/SURG SEMIPRIV	0120		Room & Board
	1250001	HC R&B HOSPICE PRIVATE	0125		Room & Board
	2000001	HC R&B INTENSIVE CARE UNIT	0200		Room & Board
	2060002	HC R&B INTERMEDIATE CARE PVT	0206		Room & Board

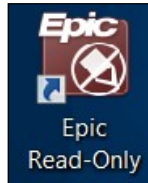
Downtime Charge Ticket

Appendix G – Instructions for Accessing Data During Downtime

To Access Epic Read-Only

Epic Read-Only allows users to view all clinical information in a Read-only version of Epic Hyperspace.

1. Click on Epic Read-Only icon.



To Access BCA Web

BCA Web allows access to reports from any computer. BCA Web will not be available if the internet is down. BCA Web is used for registration, census management and to print reports during downtime.

1. To access BCA web - click on the BCA Web icon.



2. Login with your Epic credentials.

The image shows a login form for Epic Business Continuity Web Access. At the top, the word "Epic" is written in red, and "Business Continuity Web Access" is written in black. Below this, there are two input fields: "User ID:" followed by a field with four black dots, and "Password:" followed by a field with three black dots. At the bottom right of the form is a "Log In" button.

3. Search options from BCA Web include:
 - **Resident Search** by name/MRN to see all reports for a specific resident (below)
 - **Census Search** by Unit to see a list of all residents in a specific unit (below)
 - **Folder list** of all available BCA workstations to see all reports available on that BCA PC

The screenshot shows a web application interface with a top navigation bar containing 'Census', 'Patient Search', 'Folder List', and 'Logout'. The 'Census' tab is highlighted. Below the navigation bar, there is a 'Census' section with the text 'Choose the census unit'. A dropdown menu is open, showing '(none)' as the selected option. A red arrow points to the dropdown menu. Below the dropdown menu is a 'Show Census' button.

Reports available to print are:

- Department appointment report for ambulatory/procedural areas
- Clinical summary
- MAR
- Dietary reports
- Status boards
- Census reports

To Access BCA PC (Downtime Computer) Reports

BCA PC (Downtime Computer) is available when the internet is down. Access using the downtime computer with the red keyboard.

1. Click on the BCA Printing Icon located on the downtime computer.



2. Login with your Epic credentials. (You won't be able to login if you have never used the computer.)

The screenshot shows a login window titled 'Business Continuity Access PC'. Below the title, the Epic ID 'Epic29928W10' is displayed. There are two input fields: 'User ID' and 'Password'. Below these fields is a 'Sign In' button.

The left pane is used to filter reports and the right pane displays the reports.

To sort reports, click on the column headers.

To review a report, double click on the report or highlight and select view.

To print a report, highlight the desired report and select print.

(Multiple reports can be printed by holding Ctrl or Shift and click on more than one report.)

Business Continuity Access PC - BOINT1WKADBC01 - Generic User

Reports Administration Help Log Out

Search All Reports

Filter by Tags: All None

SBH PSYCH EMERGE...
SBH SAGE VIEW

Report Type

ADT Downtime Census...
Ambulatory Clinical Su...
Department Appointmen...
Dietary Report
Inpatient MAR
 Patient Summary
Single Patient List
Top Order Sets

Report Title	Date Created	Patient	MRN	Department	Room	Bed
Clinical Summary - CSN 100101893	November 16 2:56 PM	Ccv, Ekramer	40002014	SBH ICU	101	101 A
Clinical Summary - CSN 100103201	November 16 2:37 PM	Trauma, Timothy	40002838	SBH ICU	118	118 A
Clinical Summary - CSN 100104801	November 16 2:37 PM	Doe, Jane L	40003129	SBH ICU	113	113 A
Clinical Summary - CSN 100102771	November 16 2:37 PM	Integratedoneb, Thirtytwo	40002443	SBH ICU	112	112 A
Clinical Summary - CSN 100102156	November 16 2:37 PM	Iscool, Spencer	40002555	SBH ICU	109	109 A
Clinical Summary - CSN 100067998	November 16 2:37 PM	Cupidoneb, Thirtyfour	40001321	SBH ICU	108	108 A
Clinical Summary - CSN 100102867	November 16 2:37 PM	Hepa, Rin	40002777	SBH ICU	107	107 A
Clinical Summary - CSN 100102124	November 16 2:37 PM	Trauma, Tony	40002670	SBH ICU	105	105 A
Clinical Summary - CSN 100101897	November 16 2:37 PM	Ccv, Larcher	40002011	SBH ICU	104	104 A
Clinical Summary - CSN 100102694	November 16 2:37 PM	Trauma, Tanya	40002748	SBH ICU	103	103 A
Clinical Summary - CSN 100101896	November 16 2:37 PM	Ccv, Ezumwait	40002022	SBH ICU	102	102 A

Select All Refresh View (0) Print (0)

Revised Hospital-wide Policies and Procedures

For JCC Approval on September 10, 2019

Reviewed by HEC on August 13, 2019

LEAVE OF ABSENCE (LOA)~~(OUT ON PASS)~~

POLICY:

1. Residents who wish to leave the grounds of Laguna Honda Hospital and Rehabilitation Center (LHH) shall have written orders from their attending physician and appropriate pass medications.

2. The following patient movements shall be considered LOA:

a. Scheduled appointments (Clinic/Dialysis, OR/IR/Cath Lab)

b. Out on Pass (day/overnight/weekend)

~~1.~~c. Another facility (Emergency department/Psychiatric emergency services/Acute care)

d. Off campus with staff (for example, home evaluation, bus trip)

~~2.3.~~ Out on Leave of Absence (LOA) Pass (OOP) is the responsibility of the unit Resident Care Team (RCT) and may be granted for, but is not limited to, the following in accordance with the resident's plan of care:

a. A visit with relatives or friends.

b. A therapeutic LOA - Absences for purposes other than required hospitalization which shall be appropriate to the physical and mental well-being of the resident.

c. Participation by developmentally disabled residents in an organized summer camp for developmentally disabled persons.

~~3.4.~~ A resident shall not be admitted, granted LOA, ~~pass, bed hold~~ or discharged on the basis of race, color, religion, ancestry or national origin.

5. For LOA due to acute hospitalization

a. The Laguna Honda Hospital Patient Flow Coordinator shall coordinate both LOA and bed reservation procedures in conjunction with Admissions and Eligibility (A&E) department and the neighborhood physician representing the neighborhood RCT. A bed reservation is a bed designated for a resident's anticipated admission, transfer, or for a missing resident for whom LHH receives no remuneration. A bed reservation may be cancelled if, due to a bed shortage, that bed is needed for a new admission to LHH.

b. Medi-Cal and some insurances pay for up to seven days of LOA due to acute hospitalization. Further clarification regarding insurance coverage shall be routed to Utilization Management.

For JCC Approval on September 10, 2019

Reviewed by HEC on August 13, 2019

- c. A resident whose hospitalization exceeds the LOA period under the State plan is re-admitted to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility and is eligible for Medi-Cal nursing facility services or Medicare skilled nursing facility services.
- d. The facility shall submit claims for resident LOA days based on allowable reimbursement.

PURPOSE:

1. To protect the health and safety of LHH residents and to assure continuity of care.
2. To accurately track and monitor residents who are on LOA.
3. To maintain bed availability for a specific resident.
4. To provide for return of the resident to his/her prior neighborhood wherever possible.
5. To comply with state and federal regulations.

BACKGROUND:

1. A resident who is receiving Medicare Part A SNF benefits is permitted to go OOP on a therapeutic leave as necessary; however, Medicare will not provide reimbursement to the facility for that day of leave if the resident does not return to the facility by midnight.
2. If the LOA is an overnight visit (or longer) to the home of relatives or friends, LOA reimbursement by Medi-Cal is restricted as follows: Maximum time period of 18 days per calendar year for non-developmentally disabled recipients; Up to 12 additional days of leave per year may be approved in increments of no more than two (2) consecutive days when the following conditions are met:
 - a. The request for additional days of leave shall be in accordance with the individual resident care plan and appropriate to the physical and mental well-being of the patient.
 - b. At least five days of SNF inpatient care must be provided between each approved overnight LOA/OOP/Pass.
 - c. Maximum of 73 days per calendar year of developmentally disabled recipients.

For JCC Approval on September 10, 2019

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- d. At the time of admission, if resident has not been an inpatient of any SNF facility for the previous 2 months or longer, the resident is eligible for full complement of leave days.
- e. A resident's return from overnight OOP-LOA/pass may not be followed by a discharge within 24 hours.

PROCEDURE:

1. Notification of LOAPass Policy

- a. Upon admission, A&E provides the resident, or family member, or legal representative with the California Standard Admission Agreement which includes written information regarding LOA-acute hospitalization. The MSW provides bed hold information at the time of transfer, or within 24 hours of transfer in cases of emergency transfer. Should the written information change, LHH shall reissue the new information to the resident, their family member, or legal representative.
- 2. An order from the Physician for a LOA for OOP (day/overnight/weekend) and for sending out to Another facility (ED/PES/Acute Care) shall be written in the EHR. The Physician and the Licensed Nurse shall follow the process as specified in the EHR.
- 3. LOA-admitted to Acute Hospital from ED/PES
 - a. The Physician shall write a discharge summary note and enter a discharge order with the appropriate disposition code.
 - b. The Licensed Nurse or Unit Coordinator shall update the LOA to discharge.
 - c. The day of departure from SNF is counted as day 1 of LOA; the day of return is not counted.
 - d. LHH shall hold the bed up to seven (7) days during acute hospitalization.
 - e. Bed hold must terminate on the resident's date of death.
 - f. LHH claims must identify the inclusive date of the LOA.
 - g. LHH residents discharged to an acute care at another hospital (other than ZSFG, PM Acute Medical):

The Licensed Nurse on the neighborhood shall call the acute care hospital after the seventh day of LOA to ensure that resident was not discharged from acute care hospital before the seventh day to reflect accurate bed hold days.

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~~h. The resident who is returning from LOA due to an acute hospitalization within the 7 days or after 7 days of holding the bed shall be readmitted.~~

~~a. LHH Admissions & Eligibility and Social Services shall provide each newly admitted resident/surrogate decision maker (SDM) with information regarding the pass policy.~~

~~2.4. Request for OOPa Pass and the Pass Order Form~~

~~a. A resident/surrogate decision maker (SDM) may request a pass from the physician. Such residents will be assessed by their Resident Care Team (the RCT) in arranging for pass privilege.~~

~~b. An OOP order from the physician shall be written in the EHR with medications if appropriate. A pass instruction order from the physician, using the Pass Order Form, must shall be written in the resident's medical record for a pass.~~

~~i. The order must specify:~~

~~• The need for a responsible person to accompany the resident if the resident is unable to go out unattended.~~

~~ii. Pass orders must shall also be completed for PRN passes and must shall be renewed on a monthly basis and reviewed quarterly by the RCT.~~

~~c. The Pass Order Form is to shall contain the following information in addition to elements listed in procedure 4.~~

~~i. Resident name~~

~~ii. Medical Record Number~~

~~iii. Pass beginning date/time~~

~~iv. Pass ending date/time~~

~~v. Destination/Address~~

~~vi. Telephone Number~~

~~vii.b. Responsible Person~~

~~viii. Resident/Responsible person's signature~~

~~ix. Special instruction (if any)~~

~~x. Pass Medications (if any)~~

~~For JCC Approval on September 10, 2019
Reviewed by HEC on August 13, 2019~~

~~xi. Duration of Bed Hold (if appropriate)~~

~~xii. Physician's name, signature, physician's phone, & date/time~~

~~xiii. Notice concerning failure to return by midnight of scheduled return date may result in discharge from LHH if a pass extension is not obtained from the physician.~~

~~xiv. Care unit & Care unit telephone extension~~

~~xv. Nurse's name who notes the order, Signature & date/time~~

~~One copy of the form shall be provided to the resident/legal decision maker SDM and one copy of the form shall remain in the medical record.~~

~~d. For residents requiring pass medications, the physician order must specify the following:~~

~~i. Medication by name~~

~~ii. Strength~~

~~iii. Frequency~~

~~iv. Directions for use~~

~~v. Quantity to be dispensed~~

~~e.c. Refer to Pharmacy ~~policy~~ Services policy and procedure 02.01.04 Pass Medications when the pharmacy is open or closed.~~

~~d. Nursing staff shall check the number and appearance of the pass medication(s) and review directions and specific pass instructions with the resident or SDM.~~

~~f.e. The RCT shall advise the resident concerning failure to return by midnight of scheduled return date may result in discharge from LHH if a pass extension is not obtained from the Physician.~~

~~f. The nurse shall note in EHR in the medical record that the resident is OOP ~~out on pass~~, time of departure, instructions given, expected time of return, and actual time of return.~~

~~g. LHH will not be reimbursed from bed hold in the event a resident discharged within 24 hours of return from an overnight OOP.~~

~~g.~~

For JCC Approval on September 10, 2019

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3.5. Census Management

- a. ~~The Licensed Nurse/Unit Coordinator shall complete the OOP information in Unit Manager in EHR. When the patient returns from LOA, the Licensed Nurse/Unit Coordinator shall mark the resident back in bed in Unit Manager in EHR. Nursing Department is responsible for census management which is done electronically through the electronic health record (EHR) system. Refer to EHR Instruction sheets that are posted in the Intranet.~~
- b. ~~In the event the resident does not return from LOA, the Licensed Nurse/Unit Coordinator shall update the LOA to discharge. Refer to Appendix A for census management by Medicine, Nursing, Medical Records, Admissions and Patient Accounting Services for case scenario of resident who go on pass.~~

4.6. Compliance/Adherence with Pass Privilege

- a. Resident's/~~surrogate decision maker's~~SDM's obligation to participate in and comply with the procedure.
 - i. When leaving on pass and on returning from pass, residents shall check in and out with the nursing staff on the care unit.
 - The License Nurse (LN) shall check-in with the resident within an hour of returning to LHH. The LN shall complete the *Check-In Form – Resident Returning from an Out On Pass* (see attachment [AB](#)).
 - When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors (LHHPP 22-12 Clinical Search Protocol).
 - i. ~~When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors (LHHPP 22-12 Clinical Search Protocol).~~
 - ii. Non-adherence or non-compliance with the pass privilege shall result in a counseling meeting ~~of with~~ the resident ~~with the Resident Care Team and the (RCT)~~ and, if appropriate, development of an interdisciplinary care plan addressing the problem.
 - iii. Residents who remain OOP out on pass longer than the duration specified by the physician or residents who can understand the risks of leaving hospital grounds and who leave the hospital grounds without a pass order shall be considered an elopement and may be subject to discharge.

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- b. Extension/Re-order ~~of of Therapeutic LOA (OOP)~~ may be granted provided the following conditions are all met:
 - i. The resident's whereabouts is known.
 - ii. There was a verbal contact between the resident/responsible party and the Nursing Unit Staff or Physician.
 - iii. Therapeutic LOA.
 - iv. The reason for extension of OOP is appropriate/valid.
- c. The Physician documents the reason for the extension of OOP in the medical record.

~~ATTACHMENT:~~

~~Appendix A: Case Scenarios for Census Management by Medicine, Nursing, Medical Record, Admissions and Patient Accounting Services for Residents who: 1. Go for an ER visit, 2. Go to PES, 3. Elopement MCI, 4. Elopement, and 5. Go on Pass~~

~~ATTACHMENT:~~

~~Attachment A: Check-In Form – Resident Returning from an Out on Pass~~

REFERENCE:

~~LHHPP 20-02 Bed Hold~~

~~LHHPP 22-12 Clinical Search Protocol~~

~~Laguna Honda Pharmaceutical Services Pharmacy Services P&P 02.01.04~~

Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold

~~Pass Order Form~~

Revised: 09/10/27, 14/01/28, 14/03/25, 17/11/14, 19/05/14, 19/09/10 (Year/Month/Day)

Original adoption: 99/04/2

APPENDIX A: FOR DELETION

Case Scenarios for Census Management by Medicine, Nursing, Medical Record, Admissions and Patient Accounting Services For Residents Who 1. Go for an ER Visit, 2. Go to PES, 3. Elopement-MCI, 4. Elopement-AWOL, and 5. Go on Pass (applying Medi-Cal & Medicare Rules about SNF stays)

1. ER Visit - A resident from the SNF goes to the ER on Day X (July 17) and is under observation (23 hr observation rule in the acute hospital)					
Scenarios	MD	Nursing Census	Medical Record (Open/Close)	ADT by Admissions	Billing Status (LOA/Bed Hold/LTC Day)
a) Stays past midnight but is not admitted to the acute hospital on July 17	Make sure there was an MD order of "Transfer to ER"	No EHR activity; Post on WebADT.	Open	No EHR activity	LTC for Medi-Cal <i>Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours</i>
b) Returns before midnight on July 17	Make sure there was an MD order of "Transfer to ER". Covering MD shall address if there are recommendations from ER.	No EHR activity	Open	No EHR activity	LTC day
c) Returns after midnight from ER observation (less than 23 hours) on July 18	Make sure there was an MD order of "Transfer to ER". Covering MD shall address if there are recommendations from ER.	No EHR activity; Post on WebADT.	Open	No EHR activity	LTC day for Medi-Cal <i>Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours</i>
d) Is admitted to hospital from ER past midnight on July 18	Write "Discharged to Acute Hospital". DC date/time are based from when resident left LHH, ex 7/17	- ZSFG: ZSFG ED A&E will do DC to LBH. -Other Hospitals: Unit Nurses will do DC to LBH in EHR based on date/time resident left LHH, ex 7/17.	Close – discharge date is based on date and time patient left LHH	"LHH Discharge to Bed Hold" will be done based on date and time resident left LHH.	Bed Hold

2. PES – A resident from the SNF is 5150'ed and goes to PES on Day X (July 17)					
Scenarios	MD	Nursing Census	Medical Record (Open/Close)	ADT by Admissions	Billing Status (LOA/Bed Hold/LTC Day)
a) Stays past midnight at PES but is not admitted to acute psych hospital on July 17	Make sure there was an MD order of "Transfer to PES".	No EHR activity; Post on WebADT.	Open	No EHR activity	LTC for Medi-Cal <i>Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours</i>
b) Returns before midnight on July 17	Make sure there was an MD order of "Transfer to PES". Covering MD shall address if there are recommendations from PES.	Nothing done on EHR Post on WebADT.	Open	No EHR activity	LTC Day
c) Returns after midnight from PES on July 18, less than 23 hours in PES	Make sure there was an MD order of "Transfer to PES". Covering MD shall address if there are recommendations from PES.	No EHR activity; Post on WebADT.	Open as long as patient returns before 23 hours	No EHR activity	LTC for Medi-Cal <i>Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours</i>
d) Stays past midnight at PES but is not admitted to acute psych hospital on July 18 after 23 hours	Write "Discharged to Acute Psych Hospital". DC date/time are based from when resident left LHH, ex 7/17.	Nursing will discharge resident to Bed Hold Status. Bed hold date and time when resident left LHH July 17.	Close	Discharge with bed hold	Bed hold
Note: Final Decision of a return of the patient is dependent upon LHH Clinical Team/Behavioral Assessment Team					

3. Elopement-MCI – A resident from the SNF is missing and cognitively impaired on Day X (July 17)					
Scenarios	MD	Nursing Census	Medical Record (Open/Close)	ADT by Admissions	Billing Status (LOA/Bed Hold/No Bill)
a) Remains MCI past midnight on July 17 going into 7/18	Write order "Resident Discharged". DC date is date resident was last seen, ex. 7/17.	Nurses will do Final DC in EHR on 7/17, before 2359. DC time is time resident last seen.	Close – discharge date based on date and time patient noted missing – documentation in chart and census needs to be clear. Need to consider that there is post-discharge documentation	Discharge date is the date patient left LHH. There is reserve bed; no bed hold	No Bill
b) Is found and returns before midnight on July 17	MD to address that resident was found.	No EHR activity	Open	No EHR activity	LTC Day
c) If located in ER, go to ER scenario					
Note: A new medical record must be initiated when the resident who was declared MCI is re-admitted.					

4. Elopement-AWOL – A resident from the SNF goes AWOL on Day X (July 17)						
Scenarios	Status: Re-admitted or Not re-admitted or Discharged or Not Discharged	MD	Nursing Census	Medical Record (Open/Close)	ADT by Admissions	Billing Status (LOA/Bed Hold/No Bill)
a) Is elopement past midnight on July 17 and does not return	Not re-admitted	On Call MD writes Discharge Order (AWOL)	Nurses will do Final DC in EHR on 7/17 before 2359. DC time is time resident was last seen.	Close – discharge date is based on date and time patient was noted missing	Final Discharge function will be done.	No Bill on July 17
b) Is elopement past midnight on July 17 and presented himself/herself to an ED	Not Re-admitted	On Call MD writes Discharge Order (AWOL). If LHH was notified that resident is returning after seen at ED, on call MD in collaboration with RCT assesses and determines that all of the following are met: a) resident has no skilled nursing needs, b) is safe to be discharged to the community, c) has post-discharge plan in place based on (RCT) discussion, post elopement and 30-day notice delivered; and d) there is MD documentation that resident was notified of the AMA and Pass policies.	Nurses will do Final DC in EHR on 7/17 before 2359. DC time is time resident was last seen	Nurses will do Final DC in EHR on 7/17 before 2359. DC time is time resident was last seen	Final Discharge function will be done.	No Bill on July 17
c) Returns before midnight on July 17	Not discharged	On Call MD receives report from the unit staff nurse of resident's return	No EHR activity	Open	No EHR activity	LTC Day

<p>d) Returns from elopement after midnight on July 18 or successive days and is not re-admitted</p>	<p>Not re-admitted</p>	<p>On call MD in collaboration with RCT assesses and determines that all of the following are met: a) resident has no skilled nursing needs, b) is safe to be discharged to the community, c) has post-discharge plan in place based on RCT discussion, post elopement and 30-day notice delivered; and d) there is MD documentation that resident was notified of the AMA and Pass policies.</p>	<p>Nurses will do Final DC in EHR on 7/17 before 2359. DC time is time resident was last seen.</p>	<p>Chart remains closed</p>	<p>No EHR activity</p>	<p>N/A Account closed on July 17</p>
<p>e) Returns from elopement after midnight on July 18 or successive days and is re-admitted</p>	<p>Re-admitted</p>	<p>On Call MD in collaboration with RCT if at least one of the following conditions is present: a) resident has skilled nursing needs, b) not safe to be discharged to the community, c) has no post-discharge plan in place based on RCT discussion, post elopement and 30-day notice not delivered d) there is no MD documentation that resident was notified of the AMA and Pass policies.</p>	<p>If nurses receive instructions from MD to re-admit resident, only A & E can re-admit in EHR.</p>	<p>New chart if re-admitted</p>	<p>Re-admit the resident on EHR system if resident is re-admitted</p>	<p>LTC Day if re-admitted</p>

5. Pass - A resident from the SNF who goes on Pass (physician approved with orders) on Day X (July 17)					
Scenarios	MD	Nursing Census	Medical Record (Open/Close)	ADT by Admissions	Billing Status (LOA/Bed Hold/No Bill)
a) Returns before midnight on July 17 (by expected return date/time)	MD to make sure there is a pass order	No EHR activity	Open	No EHR activity	LTC Day
b) For an overnight pass and returns July 18 (after expected return date/time) <i>Note: No overnight passes shall be ordered for residents covered by Medicare SNF PPS</i>	MD to make sure there is an order extending the resident pass	“Transfer Screen” function done to change Service Code to “LOA” on July 17. Code changed back to unit service code upon return 7/18. Post on WebADT.	Open – Note: there must be documentation in chart extending the resident pass by physician	Resident is on LOA	LOA
c) For 2 nights and returns on July 19 <i>Note: No overnight passes shall be ordered for residents covered by Medicare SNF PPS</i>	MD to make sure there is a pass order	“Transfer Screen” function done to change Service Code to “LOA” on July 17 and 18. Code changed back to unit service code upon return 7/19. Post on WebADT.	Open	Resident is on LOA	LOA
d) Went to ER while on LOA status and returns by expected return date/time	MD receives report from unit staff nurse that resident went to ER	LOA code is maintained and code changed back to unit service code upon return. Post on WebADT.	Open	LOA	LOA
e) Went to ER while on LOA status and did not return by expected return date/time	MD to write an order to extend the resident’s pass	LOA code is maintained.	Open	LOA	LOA
f) Admitted to acute while LOA	MD to write discharge order to acute	DC to LBH based on date/time resident is admitted as acute inpatient. Post on WebADT.	Close	“Laguna Honda Discharge to Bed Hold” will be done based on date/time resident was admitted to acute.	Bed Hold

Attachment **BA**: Check-In Form – Resident Returning from an Out On Pass



San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

ADDRESSOGRAPH

**CHECK IN FORM
RESIDENT RETURNING
FROM AN OUT ON PASS**

Form to be completed by the Licensed Nurse assigned or designee, within one hour of return to LHH from out on pass.

These questions are designed to ensure individual residents’ welfare and safety and the safety of the other residents and staff the neighborhood.

<u>Question</u>	<u>YES</u>	<u>NO</u>	<u>Comments</u>
<u>Was everything okay while you were out on pass?</u>			
<u>Did anything unusual happen while you were out? (fall, accident, not feeling well, etc.)</u>			<u>If yes, please follow protocol in reporting</u>
<u>Did you bring back anything with you that we need to add to your personal belonging list?</u>			
<u>*Do you have any medications either prescribed or non-prescribed, or street drugs in your possession that you brought back to LHH?</u>			<u>If yes, follow protocol for illicit substance and clinical search</u>
<u>*Do you have any lighters, igniters or smoking products (e-cigarette, vapes, etc.) in your possession that you brought back to LHH?</u>			<u>If yes, follow protocol for clinical search.</u>
<u>Staff Observation of Resident</u>	<u>YES</u>	<u>NO</u>	<u>Comments</u>
<u>*Does the resident appear to be under the influence of alcohol or drugs?</u>			<u>If yes, follow protocol for clinical search.</u>
<u>Does the resident have any visible unexplained bruises, cuts or abrasions (or any signs potential signs of abuse)?</u>			<u>If yes, follow protocol for abuse or injury.</u>

Any item mark with * asterisk is a trigger to initiate clinical search

NAME OF LICENSE STAFF

DATE

[For JCC Approval on September 10, 2019](#)

[Reviewed by HEC on August 13, 2019](#)

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.

2.3. 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. to their direct supervisor, nurse manager or supervisor.

3.4. The LHH Department of Education and Training (DET) shall be responsible for developing curricula for and training all employees and volunteers on abuse prevention and timely reporting.

4.5. 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.

5.6. The facility 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.

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6.7. 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

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- within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.
- b. "Sexual abuse" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."
 - c. Physical abuse, includes but is not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
 - d. Financial abuse includes, but is not limited to, wrongful, temporary or permanent use of a resident's money without the resident's consent.
 - e. Mental abuse includes, but is not limited to humiliation, harassment, 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;

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

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 is 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

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- 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](#) ~~and Hostility~~
 - LHHPP 73-05 Workplace Violence Prevention Program
 - Annual in-service education provided by the Nurse Educators to all employees, which includes a review of residents’ rights, abuse and neglect prohibition/prevention, [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

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

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,

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- 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-

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- 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 are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.
 - i. Employees 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. Employees may report anonymously to each internal and/or external agency.
- b. ~~The facility~~ LHH mandates staff to report suspected abuse to the local Ombudsman office as required by State law.

[For JCC Approval on September 10, 2019](#)

[Reviewed by HEC on August 13, 2019](#)

- c. ~~The facility~~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.
- i. Examples of crimes that are reportable include but are not limited to the following:
- Murder;
 - Manslaughter;
 - Rape;
 - Assault and battery;
 - Sexual abuse;
 - Theft/Robbery
 - Drug diversion for personal use or gain;
 - Identity theft; and
 - Fraud and forgery.
- ii. If the criminal incident resulted in serious bodily injury to the resident, SFSD, Chief Executive Officer (CEO) or designee, Ombudsman, Quality Management (QM) staff and the State Survey Agency (i.e. California Department of Public Health - CDPH) must be notified immediately, no later than 2 hours after the suspicion is formed.
- iii. Criminal incidents not resulting in serious bodily injury to the resident be reported to the CEO or designee, Ombudsman, SFSD, QM staff and CDPH within 24 hours of the time the suspicion is formed.
- d. 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

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker. Notify within 2 hours to the CEO or designee, CDPH, Ombudsman, SFSD, and QM staff of events involving alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.
- iii. Notify within 24 hours to the CEO or designee, Medical Social Services Worker, Ombudsman, SFSD, QM staff and CDPH of events involving allegations of abuse that are not substantiated and do not result in serious bodily injury.
- ~~iv. During regular business hours, Monday to Friday from 8:00 am to 5:00 pm excluding holidays and weekends, the reporting function to CDPH is performed by Quality/Risk Management Nurses.~~
- ~~v. After regular business hours, weekends and on holidays, the reporting function is performed by the Nursing Operations Manager.~~
- e. 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.
- f. 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.
- g. 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.
- h. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of, resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to the Sheriff's Department. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.
- i. In cases of alleged or factual rape the following steps must be taken:
- i. Facility staff must immediately notify the San Francisco Sheriff's Department (Ext. 4-2319; 4-2301)
 - ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- 3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.
- iii. At the San Francisco Rape Treatment Center, the resident will be interviewed, specimens will be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.
 - iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.
 - v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.
 - j. This policy designates the Director of QM as the primary mandated reporter for LHH. The Director of QM or designee ensures that allegations of resident abuse are reported to the Ombudsman, Sheriff's Department, and CDPH.
 - k. The results of the investigation shall be reported to CDPH within five working days of the incident. If the alleged violation is verified, appropriate corrective actions shall be taken.
 - 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 . can report to Quality Management during business hours via phone and by completing a UO. Employees can also report to the Nursing Office via Nursing Operations Manager or Supervisor after business hours (including weekends and holidays); Employees can also report directly to CDPH and/or SFSD. Please report immediately.	
Who Will Report to CDPH and the	Quality Management Nurse during business hours Nursing Operations Manager or Supervisor during non-business hours (including weekends and holidays)	

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

<u>Ombudsman</u>	<u>Employee (Mandated Reporter)</u>	
Who Will Report to Ombudsman and SFSD/SFSD, QM, CEO/AOD	<u>Nurse Manager, Nursing Director or Employee Nursing Operations</u>	
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.

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to the LHH HR. The LHH HR shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse is substantiated.
- e. LHH HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.
- f. If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact the Sheriff's Department. The nursing supervisor or manager shall initiate action to protect the resident and the Sheriff's Department and or San Francisco Police Department shall carry out the investigation.
- g. The nurse manager or nursing supervisor shall inform the resident and responsible party of the findings of the investigation and provide a feedback to the employee who reported the criminal incident or abuse allegation.

8. Forms Completion and Submission

- a. The Charge Nurse or reporting employee shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.
- b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the [designation of Nursing Operations. The staff person may be the](#) Nurse Manager/designee or Operations Nurse Manager or be designated to the Medical Social Worker to complete form SOC 341 during regular business hours and submitted to QM. (Refer to [LHH designated site for copies of electronic forms related to the allegation of abuse investigation](#)[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 forms have been completed and submitted to QM.
- d. The SOC 341 shall be faxed to 415-751-9789 by [Nursing Operations or designee](#) ~~the reporting employee~~ and the fax verification submitted to QM.
- 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.

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- 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. QM staff shall submit form SOC 341 to the Ombudsman Office via fax (415-751-9789) when fax verification by the reporting employee is not received by the QM staff.
- i. QM staff shall provide a copy of the form SOC 341 to the Sheriff's Department.
- i.j. 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 members 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.

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- 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](#)

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19/07/09, [19/09/10](#) (Year/Month/Day)

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[For JCC Approval on September 10, 2019](#)

[Reviewed by HEC on August 13, 2019](#)

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

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:

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

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: _____

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

Investigation of Alleged Abuse

ADDITIONAL SPACE

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

MANAGEMENT OF RESIDENT AGGRESSION

POLICY:

1. It is the policy of the San Francisco Department of Public Health to provide services in an environment that is safe and secure for all residents, employees and visitors. In order to achieve this ~~environment~~, violence or threats of violence will not be tolerated from employees, residents, and visitors.
2. Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) employees, volunteers and residents shall ~~work~~ make every effort to minimize the risk of aggressive/hostile events.
3. ~~Laguna Honda~~LHH shall establish a consistent and uniform response to ~~such any~~ aggressive ~~veon/-or~~ hostile ~~city~~ situations should ~~they~~it occur.
4. Management of potential or actual aggressive or hostile situations occurring in a neighborhood shall be the responsibility of the Resident Care Team (RCT) with the assistance of the San Francisco Sheriff's Department (SFSD) and the ~~Department of~~LHH Psychiatry staff as needed.
5. Management of potential or actual aggressive/hostile situations occurring in public spaces shall be the responsibility of the SFSD with assistance from the RCT.

PURPOSE:

To ~~maximize~~ ensure the safety and security of residents, visitors, volunteers and employees regarding aggressive/hostile situations.

PROCEDURE:

1. Staff Education

- a. New employees ~~will~~ shall be provided with ~~Safety Management and Response Techniques Training (SMART)~~ training on nonviolent safety management and prevention of challenging behaviors -during their orientation.
- b. Clinical staff ~~will~~ shall be provided with annual ~~SMART~~ updates on nonviolent safety management and prevention of challenging behaviors.
- c. Annual ~~SMART~~ updates on nonviolent safety management and prevention of challenging behaviors are also available for non-clinical staff members.
- d. All staff ~~will~~ shall receive annual in-service on Prevention of Violence in the Workplace.

2. Assessment and Reports

a. Pre-Admission Assessment

- i. The ~~b~~Behavioral screeener (designated LHH Psychiatry clinician) Assessment Team (BAT) will screen individuals with history of significant psychiatric and/or behavioral problems upon request from the LHH Admission Committee. (HWPP-LHHPP 20-01 Admission to Laguna Honda & Relocation between SNF Units Appendix B)

b. Nursing Assessments

- i. See NPP G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning.

c. Resident Care Team (RCT) Assessments

- i. The RCT assesses and monitors the resident's behaviors through:
 - Daily observations
 - Review of the Behavioral Monitoring Record (BMR) to identify, track and review the potential risk behaviors
 - Regular review and revision of the resident's plan of care
 - Physician's Quarterly Psychotropic Review, which summarizes effects on behavioral symptoms targeted by psychotropic ~~drugs~~medications
 - Discussions during Resident Care Conference
 - Unusual Occurrence (UO)
 - Feedback from ~~Department of LHH~~ Psychiatry ~~staff clinicians~~ as a part of their consultations to the RCT and/or ongoing behavioral health treatment for the resident.

d. Behavioral Health Assessments

- i. Upon referral by the primary physician, LHH Department of Psychiatry staff clinicians provide behavioral health assessment and treatment for the resident. These may include mental health treatment, substance use treatment, and neuropsychological assessments and testing, as well as assisting the RCT in developing and implementing the resident's behavioral management plan.

3. Intervention

- a. On ~~Laguna Honda~~ LHH Neighborhoods/Units
 - i. In case of escalating aggressive behavior by a resident:
 - The RCT is responsible for using ~~SMART~~ nonviolent safety management and prevention of challenging behaviors principles to attempt to safely ~~to~~ defuse actual or potential ~~or~~ aggressive/hostile situations that occur on the unit.
 - If needed, the RCT may request the assistance of the SFSD by dialing 4-2999, and giving their name, location, and the nature of the aggressive/hostile behavior event.
 - b. Outside of ~~Laguna Honda~~ LHH Neighborhoods/Units
 - i. In case of actual or potential ~~or~~ aggressive/hostile situations by a resident occurring in public areas:
 - Employees, volunteers, or visitors in the area shall call 4-2999 and report the event.
 - If any employees is/are present, ~~he or she is~~ they are responsible for using ~~SMART~~ nonviolent safety management and prevention of challenging behaviors principles if able to safely attempt to defuse the situation, while waiting for assistance from SFSD.
 - The SFSD may request assistance from the RCT where the resident resides to further manage the disposition of the resident.

4. Management of Resident Aggressive/Hostile Behaviors ~~Behavioral Crisis~~

- a. In case of an aggressive/hostile resident behaviors event involving weapons, or situations that pose risk of violence or injury, staff can call 4-2999 using the Dr. Grey” code.
- b. If the aggressive behavior is displayed by a resident, ~~t~~The unit physician ~~will~~ shall assess the likely cause of ~~the such aggressive~~ behavior and intervene accordingly, including consulting RCT members, and possible call to LHH Ppsychiatry urgent pager or after hour on call psychiatrist as needed.
- c. The RCT ~~will~~ shall assess for environmental and/or psychosocial factors.
- d. The RCT shall ~~i~~nitiate or revise the plan of care to ensure safety ~~ly~~ for all care for the resident and protect the staff.

- e. Any plan must be communicated to all shifts to ensure consistency.
- f. ~~If In the event~~ staff requires assistance and wish to summon assistance from the SFSD without being detected, staff may use duress buttons ~~are~~ located under the desk in each nurse's station and in the living rooms at the end of the hallway of each household.

5. Follow-up of Resident Aggressive/Hostile Incidents

- a. If it is determined that the resident who displayed aggressive/hostile behavior can continue to be safely cared for at ~~Laguna Honda~~ LHH:
 - i. The RCT shall meet by the next business day to develop and/or update the Plan, of Care. Any LHH Psychiatry clinician(s) already working with the resident shall be notified and included in the review.
 - ii. The RCT shall refer the resident for behavioral health consultation as clinically indicated, if LHH Psychiatry clinician ~~behavioral health consultants~~ are not already involved.
 - iii. A copy of the plan is provided to the resident, if appropriate.
 - iv. The plan must be communicated to all shifts to ensure consistency.
- b. If the resident is medically stable and can be safely discharged to the community:
 - i. The physician may discharge the resident.
 - ii. The Medical Social Worker, or designee, shall complete the Notice of Transfer/Discharge, explain the Notice and issue the Notice to the resident.
 - iii. If a discharged resident refuses to leave the facility, the SFSD will be contacted.

6. Resident Victims of Aggression

- a. The resident ~~will~~ shall be examined by a physician and appropriate treatment shall be initiated.
- b. Support and counseling will be provided by delegated members of the RCT.
- c. If indicated, a referral to LHH psychiatric-Psychiatry for consultation and follow-up will be ~~ordered-made by the primary physician and provided to the resident.~~
- d. The resident will be observed until baseline behavior and mood indicate stability and goals are met as indicated in the plan of care.

7. Staff Witnesses or Victims of Aggression

- a. The nurse manager or nursing director shall meet with involved staff to determine need for debriefing or defusing post-incident.
- b. ~~If a Staff Incident Response Team (SIRT) meeting is deemed indicated, DPH Employee Assistance Program (EAP) may be contacted by the nurse manager or nursing director if further emotional support for unit staff is needed (LHHPP 73-05 Workplace Violence Prevention Program). will follow up with SIRT facilitators (members of Department of Psychiatry staff and Social Work Department).~~

8. Documentation

- a. A Focused Progress note is entered into the resident's ~~medical~~ electronic health record (EHR), including an objective description of the behavior, interventions attempted, outcomes, and follow-up measures taken.
- b. Unusual Occurrence (UO)
 - i. Following an aggressive incident, the staff witness of the event is expected to file a UO
 - ii. ~~The incident shall be Log an entered~~ ry in the Resident's Behavioral Monitoring Record.
 - iii. Review and revise the Resident's care plan as described under Section 6 above.

ATTACHMENT:

Appendix 1: Behavioral ~~Health~~ Management Process Flow Chart

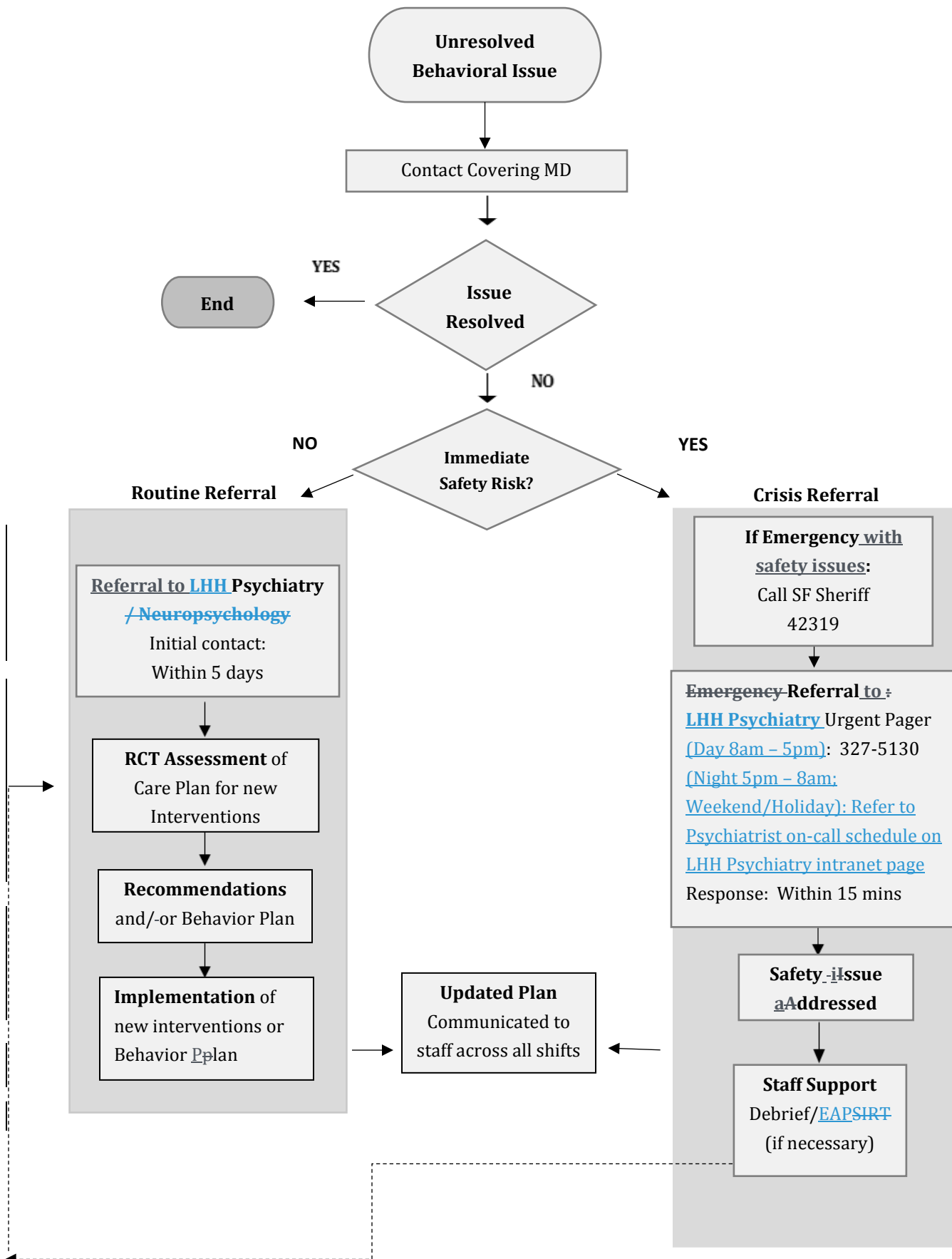
REFERENCE:

LHHPP 20-01 Admission to Laguna Honda & Relocation ~~B~~etween SNF Units
 LHHPP 20-04 Discharge Planning
 LHHPP 23-01 Resident Care Plan, Resident Care Team and Resident Care Conference
 LHHPP 60-04 Unusual Occurrences
 LHHPP 75-04 ~~STAT~~ Calls For Sheriff's Assistance
 LHHPP 75-06 Dr. Grey Code
 LHHPP 76-04 Violence in the Workplace: Zero tolerance
 Nursing Behavioral G6.O Risk Assessment & Guidelines for Care Planning P& P
 Nursing P&PJ2.5 Monitoring Behavior & Effects of Psychoactive Medications
 Physician P&P DO8-01 Acute Psychiatric Emergencies

Revised: 10/06/08, 16/01/12, 19/09/10 (Year/Month/Day)

Original adoption:

Appendix 1: Behavioral Health Management Process Flow Chart



[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

CLINICAL SEARCH PROTOCOL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall act to ensure the safety of residents and staff, and to provide necessary care for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being.
2. Active substance use, drug dealing, unsafe smoking and use of dangerous objects endangers the safety of residents and staff and does not promote a resident's well-being.
3. For the safety of residents and staff, and the well-being of residents, dangerous objects, illegal drugs, non-prescribed medications, cigarettes, lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame, alcohol and/or drug paraphernalia are prohibited at LHH.
4. When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, ~~or when returning from a Leave of Absence/Pass,~~ staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors as described below.
- 4.5. After completion of the *Check-In Form – Resident Returning from an Out On Pass when a resident returns from a Leave of Absence/Out On Pass (LHHPP 20-06 Leave of Absence (Out on Pass)) and there is a potential risk and/or reasonable suspicion that a resident possesses contraband.*

PURPOSE:

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

DEFINITION:

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

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

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

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

[For JCC Approval on September 10, 2019](#)

[Reviewed by HEC on August 13, 2019](#)

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

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

PROCEDURE:

1. Indications for Searches

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

2. Search Procedures

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- a. Neighborhood staff may initiate searches to ensure the health and safety of residents and staff.
- b. Searches shall be conducted in a reasonable manner that respects the individual's dignity and privacy. A search should be conducted only to the extent required to assure contraband is not present. The method and purpose of the search shall be explained to the resident.
- c. To the extent possible, residents shall be present while their property (including intended packages) and rooms are being searched.
- d. The permission of the resident should be requested prior to any search (except in cases of danger to self or others). It is recommended that a SFSD deputy be present for searches that involve a resident who may display behavioral escalation during the search.
- e. Repeated searches of resident's rooms and property are permitted when there is a potential risk and/or reasonable suspicion that they are in possession of contraband. Examples include but are not limited to:
 - i. Resident appearing to be under the influence of drugs or alcohol;
 - ii. Reasonable suspicion that contraband is in a resident's possession (Risk factors may include the resident having history of bringing and/or selling alcohol, street drugs and/or other contraband in LHH);
 - iii. Resident having current suicidal or homicidal ideation or expressed feelings of inflicting serious harm to themselves or others;
 - iv. Reasonable suspicion of theft (Risk factors may include resident history of theft while on the unit, credible witness report, etc.); and/or
 - v. Resident deemed an unsafe smoker and/or smoking while on, or near an oxygen delivery device.
- f. Staff shall take Universal Precautions such as wearing double gloves when handling resident belongings or suspected contraband. Staff shall avoid reaching into any pockets. Instead, staff shall pour out the contents of bags, boxes, packages, or other personal belongings, ask the resident to empty their pockets, and/or gentle patting.
- g. A minimum of two staff shall be present during a search.
- h. Whenever a search is conducted the following information shall be documented in the resident's medical record:
 - i. The facts constituting a reasonable suspicion to conduct the search.

- ii. The scope of the search:
 - Who conducted the search;
 - Manner the search was conducted; and
 - Who was present during the search.
- iii. The results of the search:
 - Items found and seized; and
 - Disposition of items found and seized.
- iv. Resident's response and any pertinent clinical information.
- v. If a resident is not present during the search, staff shall advise the resident regarding the basis for the search and the outcome of the search process.
- i. New Admissions:
 - i. All newly admitted residents shall be informed that admission procedures require a routine inventory of his/her property by LHH staff.
 - The resident shall be asked to empty his/her pockets, purse, suitcase and other belongings.
 - Any contraband shall be removed from the resident's possession.
 - Any weapons or dangerous objects shall be turned over to the SFSD.
 - Illicit or illegal drugs shall be turned over to the SFSD.
 - A notation shall be made in the progress note (refer to procedure 2.h.) and the resident shall be given a property receipt for items that are being held by staff.
 - j. When a resident is assessed as suicidal or homicidal, or has a history of drug use or violent behavior, or is suspected of having contraband, a search may be initiated. Staff shall notify the SFSD's Office of the search and request stand-by for support, if needed. Types of searches which may be conducted by staff include:

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

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

3. Unit Searches of the Resident Rooms and Common Areas

a. Preparation

- i. Staff shall notify SFSD of the search and request stand-by support if the resident has a history of aggressive behavior or has exhibited aggressive behavior previously during a clinical search. On such instances, at least one LHH SFSD deputy shall be stationed outside the entrance/exit of the resident’s room to provide support in the event:
 - the resident threatens or becomes verbally or physically aggressive toward staff, or other residents;
 - or staff observe that the resident has a dangerous object in their possession; and/or
 - staff observe that the resident has illicit or illegal drugs in their possession.
- ii. Staff shall review basic safety search procedures before proceeding, including nonviolent safety management and prevention of challenging behavior principles as needed.
- iii. Search teams shall be identified (2 staff per household) by the nurse manager.
- iv. One staff shall be assigned to monitor the unit entrance/exit.

For JCC Approval on September 10, 2019
Reviewed by HEC on August 13, 2019

- v. Staff may request canine search assistance as needed from the SFSD's Office (refer to procedure 4).
 - vi. A mandatory community meeting shall be called to announce the safety search and instruct the residents to wait in the Great Room until called to their bedside for the search.
- b. During the Search
- i. Two staff shall provide support for each neighborhood being searched. The duties shall include escorting residents from the Great Room to the residents' rooms, working with agitated residents, collecting confiscated substances and paraphernalia, communicating with staff at entrance/exit, etc.
 - ii. At least one staff shall observe the residents in the Great Room. If available, Activity Therapy may run an activity group during the wait.
 - iii. Residents who have been searched may leave the unit, however shall not be able to return until the search is concluded, or may be asked to wait in a separate dining room.
 - iv. All confiscated substances and paraphernalia shall be bagged, labeled and secured in the medication room until the search is completed.
 - v. Staff shall help with de-escalation and provide support as needed.
 - vi. SFSD shall provide support:
 - When a resident becomes verbally or physically aggressive toward staff or other residents;
 - exhibits behavior that threatens the safety or well-being of other residents or staff;
 - staff observes that the resident has a dangerous object in their possession; and/or
 - staff observes that the resident has illicit or illegal drugs in their possession.
- c. After the Search

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- i. All confiscated contraband shall be catalogued by the staff member that conducts the clinical search, disposed of in the manner described below, and documented in the resident's medical record:
 - Confiscated cannabis from a resident with or without a valid cannabis card shall be disposed of by 2 staff members (including one supervising nurse) using the smart sink in the supplemental drug room.
 - Confiscated alcohol shall be poured down the sink while witnessed by another staff, and the container shall be discarded in the recycle bin.
 - Cigarettes confiscated from unsafe smokers shall be held or disposed of based upon the resident's care plan for smoking.
 - E-cigarettes, lighters, matches, and other devices that ignite, light, or fuel a flame shall be bagged, labeled by nursing staff and secured by Social Services for safekeeping.
 - Dangerous objects (including, but not limited to, guns or objects with a blade four inches or more in length) or illicit or illegal drugs shall be confiscated by SFSD at the direction of LHH staff, catalogued by LHH staff, and transported by SFSD for proper destruction.
 - Should the resident or a surrogate decision-maker indicate that the dangerous object(s) are of sentimental value, then said item(s) shall be bagged and labeled by nursing staff, and secured by SFSD for safekeeping.
 - Said items shall be stored in a secured and locked location on LHH property for safekeeping.
 - Dangerous object(s) shall be transported to and from the secured and locked location by SFSD only.
 - The dangerous object may be released to the resident by SFSD upon discharge or to a person identified by the resident or the resident's surrogate decision-maker or personal representative.
 - Only the SFSD shall retrieve the dangerous object from the storage location on the LHH campus.
 - Dangerous objects shall not be released to the resident, person identified by the resident, resident's surrogate decision-maker, or personal representative if the attending physician or the SFSD reasonably determines that the person would be a safety threat to

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

themselves or to others if the dangerous object was released to them.

- LHH shall keep any such confiscated dangerous objects for a maximum period of ninety (90) days after discharge.
- All other confiscated contraband shall be disposed of in the following manner:
 - Any confiscated substances in pill or capsule form that cannot be identified, shall be transferred to the pharmacy for identification and proper disposal.
 - Any other confiscated substances that cannot be identified shall be given to SFSD.
 - Any confiscated dangerous objects that contain a blade shorter than four inches in length, shall be disposed of by the DPH Security Director, or transported by SFSD for safekeeping in the manner described in Section 3(c)(i).
 - Confiscated sharps shall be disposed in the sharps container by nursing staff, and witnessed by at least one other staff member.
- ii. UO's and Focused Progress Notes shall be completed by the unit staff.
- iii. The Resident Care Team (RCT) shall be informed when searches were conducted. The RCT shall review the incident and assess if the resident's care plan shall be modified.

4. Canine Searches

- a. LHH has access to canine assistance for drug searches when needed.
 - i. A request by LHH administrative staff can be made to the SFSD for unit-wide or hospital-wide searches.
 - ii. The search dog shall be handled by a professional handler only.
 - iii. Staff shall be sensitive to those residents who may have negative reactions when they are around dogs.
 - iv. Staff and residents shall be instructed about proper ways to interact with the dog, such as no petting or feeding.

5. Visitors

[For JCC Approval on September 10, 2019](#)
[Reviewed by HEC on August 13, 2019](#)

- a. All visitors shall be informed that LHH strives to be a safe, drug-free healing environment, and that all contraband, and illegal activities are prohibited. If a visitor is suspected of bringing in contraband, LHH staff may implement interventions, including but not limited to: inspection of packages the visitor brings to the unit, restricting visits, and/or calling SFSD for support.

[For JCC Approval on September 10, 2019](#)

[Reviewed by HEC on August 13, 2019](#)

ATTACHMENT:

None.

REFERENCE:

[LHHPP 20-06 Leave of Absence \(Out on Pass\)](#)

LHHPP 22-03 Resident Rights

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

LHHPP 22-10 Management of Resident Aggression

LHHPP 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use ~~By~~[by](#)
Residents or Visitors

LHHPP 75-10 Security Services Standard Operating Procedures

LHHPP 76-02 Smoke and Tobacco Free Environment

Check-In Form – Resident Returning from an Out ~~On~~[on](#) Pass

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

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

COACH USE FOR CLOSE OBSERVATION

POLICY:

1. Nursing Services at Laguna Honda Hospital and Rehabilitation Center (LHH) is responsible for providing close observation of residents when needed. The nurse manager/charge nurse in collaboration with Nursing Operations staff are responsible for allocating staff for coach assignment to provide the appropriate level of supervision.
2. Resident behaviors that may require close observation include but are not limited to the following:
 - a. High risk for falls
 - b. Impulsive behavior
 - c. Risk for aggression
 - d. Elopement risk
 - e. Intrusive behavior
 - f. Harm to self or others (See Policy #3)
 - g. Other extenuating needs as determined by Resident Care Team (RCT) and with the approval of Nursing Director/Nursing Operations
3. Close observation measures are not intended for residents who are actively suicidal (defined as someone who is verbalizing an intent to harm self and has a plan and means to do so) or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting.
4. The use of a coach is intended as a short-term intervention while developing a long term plan for resident safety.
5. The RCT is responsible for the initial assessment and ongoing evaluation/need for close observation measures.
6. Nurse Director/Supervisor shall make the final determination, in collaboration with the RCT, for coach assignments.
- 6.7. Coaches shall provide continuous close observation of the resident and avoid any distractions, such as speaking in a non-business language or a language the resident does not understand, personal cell phone use, reading, or sleeping, in order to maintain resident safety.

~~7.8.~~ LHH PCA/CNA/HHA are expected to complete electronic health record (EHR) documentation for a resident who is provided with a coach.

~~8.9.~~ The charge nurse is responsible for checking the resident's condition frequently and as needed.

~~9.10.~~ The Licensed Nurse (LN) shall review EHR coach documentation for their shift and determine if the coach status is initiated, continued or discontinued.

PURPOSE:

To provide a therapeutic and physically safe environment with appropriate level of supervision for residents who have been determined to have safety needs that exceed routine care and intervention measures.

PROCEDURE:

1. Role of the RCT

- a. If the RCT determines that a resident's behaviors and condition require close observation, the RCT shall do the following

Assess the need

- The RCT (at a minimum, the MD and RN) shall review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety.
- i. Develop an observation and intervention plan as follows:
 - Possible close observation measures may include, but are not limited to:
 - increasing the frequency of observation time periods
 - assignment of staff to provide close observation
 - ii. Develop measurable goal/s related to the use of close observation.
 - iii. Implement the plan
 - The nurse manager/charge nurse shall assign staff, preferably unit staff who have received coach training and know the resident, to promote resident safety while providing direct care needs. The charge nurse shall round frequently to check on the resident's condition and for updates.

- Any request for additional staff used as coach shall be made through the Nursing Office.
 - When a resident's family member or significant other assists with the resident's care and observation, the care plan shall reflect their participation and education. Nursing staff shall maintain overall responsibility for the care provided to the resident, including appropriate education on safety measures to be given to the resident, family and/or staff providing close observation of the resident.
- v. Evaluate the plan (Focused Review)
- While close observation is implemented, the RCT shall meet weekly to:
 - Review any changes in resident's condition.
 - Assess effectiveness of current interventions.
 - Evaluate resident goals and the need for ongoing close observation.
 - The RCT shall summarize each meeting via EHR.
 - The RCT and other consultants which may include Nursing Directors, Quality Management, Rehab, Psych and Pharmacy staff shall conduct a Focused Review if a resident has required a coach to provide close observation greater than 30 days.
 - If no progress is made after 60 days of close observation, resident case shall be referred to clinical leadership for long term placement.
 - If after 60 days the resident continues to require close observation the RCT may decrease focused reviews to monthly while continuing efforts in seeking long term placement.
- vi. Documentation (See Attachment A for table reference)
- The coach providing the close observation shall document their observations of the resident's behavior and any interventions each shift via EHR.
 - LHH PCA/CNA are expected to complete EHR documentation.
 - Observations documented via EHR shall be incorporated in the Weekly or Monthly Summary by the licensed nurse.

- The behavior monitoring flowsheet shall be completed every shift by nursing and other clinical staff as appropriate. Weekly behavior summary shall be completed by the LN via EHR.
- The care plan shall be updated on an ongoing basis and include interventions for addressing the safety needs of the resident, including the need for close observation.
- Each RCT meeting shall be documented via EHR and include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.
- Education provided to the resident, resident's family or significant other as related to safety measures shall be documented.

2. Role/Expectations of the Coach Providing Close Observation

- a. The coach provides close observation for one or more residents. All coach staff that are LHH employees, are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:
 - i. Reporting to the charge nurse at the start/end of their shift for endorsements and obtaining shift endorsement from outgoing coach.
 - ii. Close monitoring of assigned resident(s) to prevent resident(s) from injury to self or injury to others.
 - iii. Engaging the resident with goal-focused resident-centered interventions and ongoing activities.
 - iv. Observation, reporting and documentation of resident behavior, including observation of factors that contribute to improving resident's behavior and/or contributes to agitating the resident.
 - v. Provision of nursing care as normally expected of a coach, including feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, skin care and 1 person pivot transfer.
 - vi. May contribute to the weekly focused reviews and plan of care.
 - vii. Transport/escort residents to internal/external scheduled appointments.
 - viii. Other duties as assigned, including specific responses to certain needs of the resident.

- ix. Ensure environment is clean and free of clutter, which includes but is not limited to bed making, replenishing of pitcher, and bedside cleaning.
- x. Coaches shall not leave residents unattended under any circumstances, coaches are to use call light to summon for help.
- xi. Registry coaches shall perform all the duties as outlined in procedure 2. Registry coaches may assist the LHH nursing assistant or licensed nurse with the following, but may not perform independently:
 - Feeding residents on a Specialized Feeding Plan
 - Showering/bathing
 - Use of any equipment or assistive devices for which they have not been trained.

ATTACHMENT:

Attachment A: Coach Use for Close Observation Roles and Responsibilities

REFERENCE:

None.

Revised: 00/03/28, 00/11/22, 01/05/10, 01/05/18, 09/06/09, 13/01/29, 16/11/08, 17/11/14, 19/07/09, 19/09/10 (Year/Month/Day)

Original adoption: 98/11/16

Attachment A: Coach Use for Close Observation Roles and Responsibilities

Role	Responsibility
LHH PCA/CNA	<ul style="list-style-type: none"> • Responsible for all duties within their scope of practice for assigned resident. • Documents via EHR and communicates resident behaviors to regular CNA and or team.
Registry Coach	<ul style="list-style-type: none"> • Responsible for all CNA Duties except showering and using equipment without assistance. • Documents via EHR and communicates resident behaviors to regular CNA and or team. • May assist LHH nursing assistant or licensed nurse but not perform independently: <ul style="list-style-type: none"> ○ feeding residents on a specialized feeding plan ○ showering/bathing ○ use any equipment or assistive devices for which they have not been trained
Regular CNA	<ul style="list-style-type: none"> • Completes EHR documentation with input from Coach • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet
Charge Nurse/LNs	<ul style="list-style-type: none"> • Gives report to oncoming coach • Completes rounds frequently for updates • LN will review EHR coach documentation for their shift and determine was the coach status initiated, continued or discontinued.
Resident Care Team	<ul style="list-style-type: none"> • Assesses need for Close Observation • Weekly: Focused review to evaluate continued coach need • 30 days: Provides Special Review with consultants • 60 days: May refer to Clinical Leadership for placement
LHH Home Health Aide	<ul style="list-style-type: none"> • Completes EHR documentation as applicable • Communicates resident behaviors to regular CNA and or team.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

POLICY:

Residents who are newly admitted from any healthcare facility, or admitted and re-admitted from the community to Laguna Honda Hospital and Rehabilitation Center (LHH) shall have a Pre-Admission Screening and Resident Review (PASRR) assessment completed on the day of admission or prior to admission.

PURPOSE:

1. To screen and identify residents who may have a diagnosis of mental illness (MI) and/or ~~mental retardation (MR)~~ Intellectual or Developmental Disability (ID/DD), and to refer these residents to the Department of Mental Health (DMH), and/or Department of Developmental Services (DDS).
2. To partner and coordinate the assessment review process with State programs and ensure that individuals with mental illness and ~~mental retardation~~ ID/DD receive the care and services they need in the most appropriate setting.

BACKGROUND:

Federal laws governing Nursing Facilities (NFs) require completion of PASRR for all residents initially entering NFs to determine if they are Mentally Ill or Mentally Retarded have an ID/DD. If a resident is found to have MI or MR ID/DD, the PASRR helps determine whether NF care is appropriate or whether resident needs specialized services.

PROCEDURE:

1. Completion of PASRR

- a. Upon resident admission, the Utilization Management (UM) Nurse completes the revised PASRR Level I DHCS Form 6170 via DHCS' PASRR web-based system.
- b. The web-based system generates a "No Need Letter" if the resident does not need referral to DMH or DDS. The system generates a "Need Letter" if the resident does need referral to DMH or DDS.

Note: If a PASRR Level I was recently submitted and is pending evaluation/determination or still an active case, the system is not going to allow another entry/submission of an Initial PASRR Level I (refer to Attachment A – Duplicate Entry Message).

The UM Nurse uploads the PASRR Level I and the No Need Letter or Need Letter in the electronic health record (EHR) and files a copy to the electronic Treatment

Authorization Request (eTAR) folder. Social Services shall give the No Need Letter or Need Letter to the resident/responsible party.

- c. The Medical Social Worker (MSW) includes information from PASRR for Minimum Data Set (MDS) coding, and MR705.
- d. The UM Nurse notifies the Director of Social Services via EHR if a Resident Review/Status Change PASRR was submitted and for the MSW to give the No Need Letter or Need Letter to the resident/responsible party.
- e. The UM Nurse sends notification via EHR to the Physician, Nurse Manager, Clinical Nurse Specialist, and MSW if a PASRR Level II will be conducted and most likely a PASRR Level II Determination Letter will be received.

2. Completion of Level II referral to DMH

- a. The PASRR web-based system determines if DMH referral is required and automatically sends the referral to DMH.
- b. UM Designee logs the PASRR referral and files a copy after receiving a hard copy from UM Nurse.
- c. DMH Contractor shall contact the UM Nurse/designee to confirm that the resident is still in-house prior to assigning a psychologist or psychiatrist to conduct the DMH Level II Evaluation.
- d. For an evaluation scheduled on Monday-Thursday, the assigned psychologist or psychiatrist shall inform the neighborhood nurse before the psychologist/psychiatrist comes on-site to conduct the evaluation. For an evaluation scheduled on Friday-Sunday or holidays, the UM Nurse/designee shall inform the neighborhood Nurse Manager, Charge Nurse, MSW and physician via EHR of the planned evaluation. The Evaluator is to call the Nursing Office on the day of evaluation to inform the Neighborhood and to check if resident still in-house.

3. Completion of Level II referral to DDS

- a. The PASRR web-based system determines if DDS referral is required and automatically sends the referral to DDS.
- b. The UM Designee logs the PASRR referral and files a copy after receiving a hard copy from the UM Nurse.
- c. The Golden Gate Regional Center (GGRC) representative obtains resident information from UM Nurse Manager or designee prior to conducting Level II evaluation.

- d. The GGRC representative conducts Level II evaluation and sends report to UM Department.

4. Review by the Resident Care Team (RCT)

- a. If there is a significant change of condition, the MDS coordinator notifies UM via the EHR.
- b. The UM Nurse completes status change PASRR Level I via DHCS' PASRR web based system. Go to procedure 1 for completion of PASRR. Go to procedure 2 for completion of Level II referral to DMH. Go to procedure 3 for completion of Level II referral to DDS.

5. DMH Report

- a. Upon availability of Level II Report from the web-based system, the UM Nurse shall print the report and the UM designee shall:
 - i. Log the report.
 - ii. File one copy in the PASRR binder.
- b. The UM Nurse shall upload the report in EHR.
 - i. The UM Nurse sends notification via EHR to the Physician, Nurse Manager, Clinical Nurse Specialist, and MSW of the availability of the PASRR Level II Determination Letter in EHR. The UM Nurse files a copy to the eTAR folder. The MSW shall give the report to the resident/responsible party.

Note: In April 2016, the DMH started completing a 1-page categorical letter.

- c. If the Level II Determination Letter is not available in the web based system in 14 working days following evaluation, the UM Nurse or designee shall follow-up and contact DMH.
- d. The Physician shall review the PASRR Report with the Resident Care Team (RCT) during RCT meetings.
- e. MSW shall also initiate Level II discussion with RCT, revises the plan of care and discharge plan as needed or otherwise addresses recommendations that are not implemented in the medical record.
- f. The RCT shall incorporate Level II recommendations into the resident's care plan

6. DDS Report

- a. Upon receiving the GGRC report, the UM Nurse shall:
 - i. Log GGRC report
 - ii. File one copy in the UM DDS binder
 - iii. File a copy in the eTAR folder.
 - iv. Upload scanned DDS report in EHR.
 - v. Sends notification via EHR to the Physician, Nurse Manager, Clinical Nurse Specialist, and MSW of the availability of the report in EHR.
- b. The Physician shall review the Report with the Resident Care Team (RCT) during RCT meetings.
- c. The MSW shall also initiate Level II discussion with RCT, revises the care plan and discharge plan as needed.
- d. The RCT shall incorporate Level II recommendations into the resident's care plan.
- e. If the Level II Report is not received in 90 days following evaluation, the UM Nurse Manager or designee shall follow-up and contact GGRC.

ATTACHMENT:

Attachment A: Duplicate Entry Message

REFERENCE:

Medi-Cal Provider Manual Part 2: Preadmission Screening Resident Review
State Operations Manual (SOM) Appendix PP F285

Revised: 15/07/14, 16/08/18, 16/11/08, 17/09/12, 19/07/09, [19/09/10](#) (Year/Month/Day);
Original adoption: 11/11/29

Attachment A: Duplicate Entry Message

The screenshot displays the PASRR Level I Wizard interface. At the top, there is a navigation bar with 'Dashboard' and 'Level I' dropdown menus, and a 'Welcome, [User]' notification. Below this, the breadcrumb trail shows 'PASRR I > PASRR I Wizard'. A progress bar at the top of the main content area indicates six steps: 1. Resident Identification (completed), 2. Resident Information (current step), 3. Facility Completing Level I, 4. 30-Day Exempted Hospital Discharge, 5. Categorical Determination, and 6. MI Screen. The 'Resident Information' section contains several fields: 7. Gender (dropdown menu), 8. Marital Status (dropdown menu), 9. Primary Language Spoken (dropdown menu), and 11. Hearing Impaired? (radio buttons for Yes and No). An 'Error Message' dialog box is overlaid on the form, stating: 'This is a duplicate entry with the caseid : and which is an active case and a Level I is not required.' with an 'OK' button. At the bottom right of the wizard, there are 'Prev' and 'Next' navigation buttons. The footer of the application shows 'Copyright © 2016 State of California, All Rights Reserved.' and 'PASRR Version 3.14.0.0'.

EMERGENCY PREPAREDNESS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to Emergency Preparedness through a continuous cycle of planning, organizing, conducting training exercises, evaluating processes, and implementing corrective actions.
2. LHH staff is responsible for participating in training, exercises, and achievement of departmental and hospital-wide goals for emergency preparedness.
3. All City and County of San Francisco employees are mandated disaster service workers (DSWs) and are required to return to work during a disaster if called upon to do so. DSWs may be needed for their regular duties, but may also be asked to perform other duties they are trained to perform and they may be asked to report to another location, including alternate care locations set up under an 1135 waiver. Employees are provided with a disaster service worker identification badge that provides access to alternate locations.
4. Staff are responsible for providing their current emergency contact information to the Department Manager and the Human Resources department. Department Managers are responsible for maintaining an accurate call back list.
5. The facility shall utilize the Hospital Incident Command System (HICS) for internal and external communication during emergency incidents and planned events.
6. Communication and coordination with public health and other hospitals city wide is achieved through regular meetings, joint exercises, and coordinated planning.

PURPOSE:

To have staff trained and prepared to respond to emergency situations.

PROCEDURE:

1. Training and Exercises

- a. New employees are introduced to Emergency Preparedness concepts during their orientation.
- b. Emergency Preparedness in-service is provided at least annually.
- c. Additional training is provided through exercises that include defining and practicing departmental and individual roles with the Incident Command Structure (ICS) and development of next steps based upon exercise evaluation.

- d. Training and department specific goals emphasize continuous home preparedness development and maintenance, including keeping an emergency wallet card with an out of area contact in the event that local telephone service is limited during an actual event.

2. Communication and Coordination

- a. Each department shall assign a representative to the Emergency Preparedness Committee who is responsible for continuously enhancing and sustaining emergency preparedness.
- b. Coordination of meetings and related activities is achieved through the Emergency Preparedness Coordinator under the direction of the Department of Workplace Safety and Emergency Management.
- c. Residents are apprised of emergency preparedness and response procedures in the resident handbook, which is reviewed with the resident on admission by a social worker.
- d. The department manager shall facilitate continuous updates for the emergency call back lists. The confidential call back lists are kept securely in the HICS Command Center.
- e. Emergency preparedness updates are communicated to the leadership forum, executive committee, neighborhood and departmental meetings, community meetings, and residents' council as necessary.
- f. LHH participates in a city-wide emergency preparedness healthcare coalition to support the goal of interoperability and coordination of planning, mitigation, response, and recovery activities.
- g. Multiple communication systems are available and practiced to achieve redundancy in the event of technology downtime and to achieve coordination city-wide. 800 MHz radios and METS phone (Mayors Emergency Telephone System) are tested monthly.

3. Re-Assessment and Planning

- a. A Hazards and Vulnerability Assessment (HVA) is completed annually to identify emergency incident risks to drive training and exercise development.
- b. Opportunities to participate in state wide, city wide, DPH wide and other multi-jurisdictional exercises are incorporated into exercise plans each year for a minimum of 2 exercises annually, no more than 6 months apart. Real incidents requiring HICS activation can substitute for exercises.

- c. Response plans for the following list of hazards have been developed by the facility and are reviewed annually for performance improvement opportunities:
 - i. Earthquake
 - ii. Mass Prophylaxis
 - iii. Fire
 - iv. Spill
 - v. Medical Surge
 - vi. Water Disruption
 - vii. Power Outage
 - viii. Heat Emergency
 - ix. Active Shooter
- d. Emergency Supplies
 - i. Emergency equipment and supplies are stored in a central location near Materials Management Warehouse and in the HICS command center.
 - ii. The kitchen maintains a 7-day food supply for 2000 people and water to augment the 600,000 gallons of water in towers behind the 5th floor parking lot.
 - iii. A par level of linen maintained by the Environmental Services Department.
 - iv. A cache of antibiotics for LHH Pharmacy is available for delivery from DPH storage sites. (Refer to Appendix H: Hazard Specific Plans –Emergency Responder Dispensing Plan.)
 - v. Par levels of medical and personal patient care supplies are available through most vendors.

4. Emergency Preparedness Manual

- a. Provides the policy, purpose and procedures for emergency response with appendices for pertinent details.
- b. The manual also provides lists of resources and serves as an informational tool for responding to emergencies.

5. Personal Staff Preparedness

- a. Staff are encouraged to continuously enhance their personal preparedness.
- b. Key activities recommended are having a household plan, including a communication and meeting plan, as well as assembling preparedness supplies in a kit at home and as a "Go bag," for work or the car, and completing a Red Cross Emergency Wallet Card (See Attachment A).
- c. Information and links are provided on the WSEM web site on the LHH intranet.

6. Resident Preparedness

Each resident admitted to LHH shall be provided with an individual emergency plan, which shall include:

- a. A list of equipment and supplies that must be available to the resident in the event of emergency
- b. A plan for placement in the event of facility evacuation
- c. A list of items that must be included in the resident's go kit if evacuated

ATTACHMENT:

Attachment A: American Red Cross Emergency Contact Card

REFERENCE:

LHHPP 70-01 B1 Emergency Response Plan

Revised: 15/07/17, 15/09/08, 18/07/10, 19/03/12, 19/09/10 (Year/Month/Day)

Original adoption: 13/05/28

EMERGENCY RESOURCES AND MAPS

Staff Trained and Eligible to be Assigned HIMT Roles	2
Emergency 800 MHz Radios	3
Vehicle List	4
Site Map	5

A3 Emergency Resources and Maps

Staff Trained and Eligible to be Assigned HICS Roles*

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

Arnaldo	Ritchele
Banaria	Nora
Banchero-Hasson	Monica
Blanco	Irin
Brunswick	Arnold
Cantor	Mark
Carton-Wade	Jennifer
Ceconni	Loretta
Chan	Sherry
Cozzi	Gary
Dayrit	Elizabeth
Duong	Susan
Durand	Kate
Ferrer	Valerie
Fishman	Amie
Fouts	Michelle
Frazier	William
Garcia	Emeterio
Garrick	Rodney
Grimes	John
Guina	Edward
Hirose	Mivic
Jackson	Chauncey
Kenyon	Diana
Lee	Sheri
Lee	Vincent
Ma	Chia Yu
McShane	Michael
Ng	Sandy
Nguyen	Quoc
Radoc	Ronald
Rosen	Susan
Schindler	Elizabeth
Spencer-Davies	Jacky
Talai	Nawzaneen
Thanh	Olivia
Thompson	Kathy
Valencia	Madonna

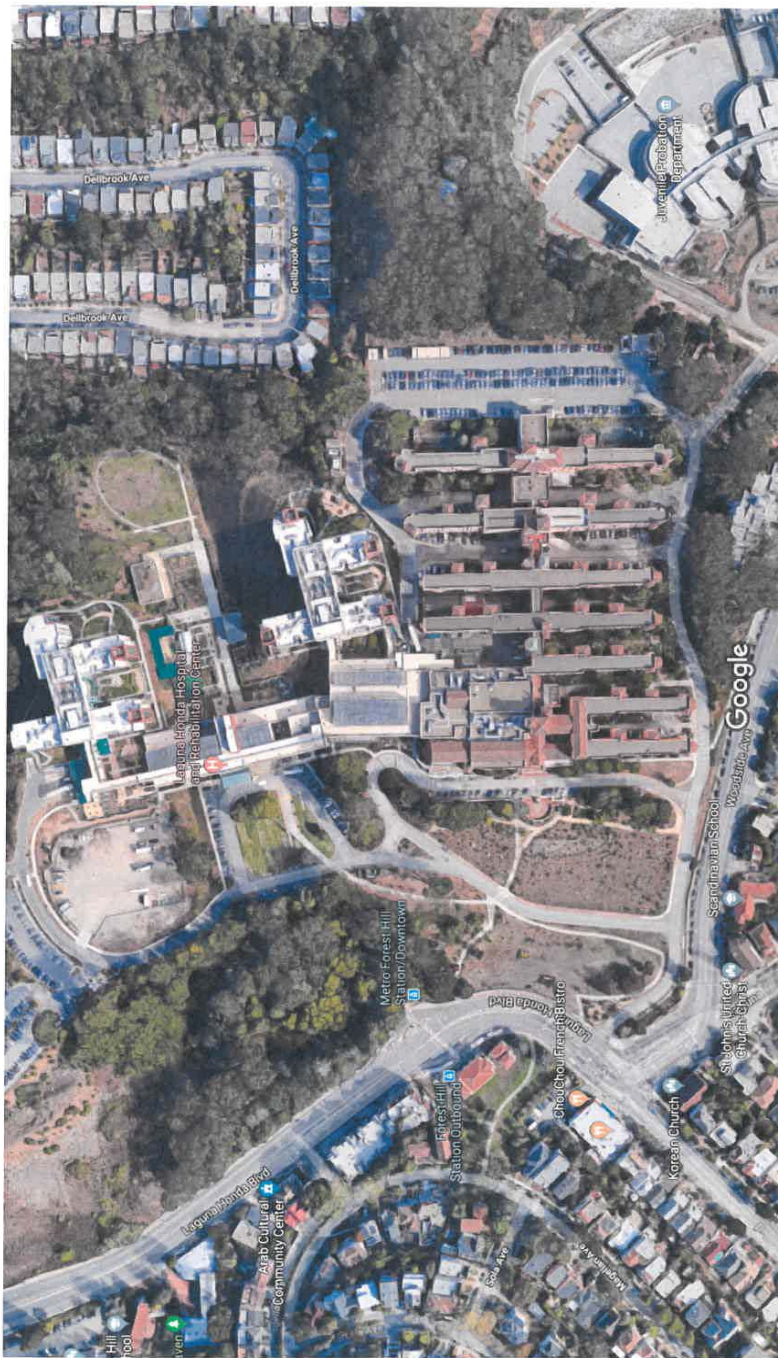
Emergency 800 MHz Radios		
Radio #	Location	Staff Assigned
119-3	1 st Floor Administration Building Executive Administration Suite	CEO
137	4 th Floor Administration Building A401 Command Center	CMO
269	1 st Floor Pavilion Building Nursing Office	CNO
173	5 th Floor Administration Building Health At Home (on site at LHH – F5)	Nurse Manager, HAH
190	4 th Floor Administration Building LHH IH Office	Industrial Hygienist WSEM
191	1 st Floor Administration Building Executive Administration Suite	COO
255	4 th Floor Administration Building LHH WSEM Director's Office	WSEM Director
271	4 th Floor Administration Building A401 Command Center	HICS Team
270	2 nd Floor Administration Building LHH Facility Services	Diana Kenyon <u>Facility Services Director</u>
272	2 nd Floor Administration Building LHH Facility Services	<u>Facility Services Director</u> Diana Kenyon

Vehicle List

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

	555-00011		Ford	F550	2015	Gasoline	1474007	Bus	<u>Activity Therapy Dept</u> <u>Activity Dpt.</u>	23 + WC
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Site Map



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

Revised: 13/05/28, 18/09/11, 19/05/14, [19/09/10](#) (Year/Month/Day)

EMERGENCY RESPONSE PLAN

POLICY:

1. The immediate priorities of Laguna Honda Hospital and Rehabilitation Center (LHH) during a disaster are:
 - a. Protection of lives
 - b. Stabilization of the incident, and
 - c. Protection of property and the environment.
2. LHH shall coordinate emergency response with the Department of Public Health (DPH) and, communicate status and resource needs or requests throughout any major event to the Department Operations Center (DOC).

PURPOSE:

1. The purpose of this plan is to serve as a guide for a rapid, effective, and coordinated response to any event resulting in a disruption of normal operations at LHH.
2. The purpose of an effective response will be to provide continued, quality service to residents, maintain essential internal and external communications, manage the use of resources; facilitate recovery efforts; and reduce the impact of the event.

PROCEDURE:

1. Activating the Hospital Incident Command System (HICS)

- a. If an emergency situation affects the normal operation of the facility, the employee who discovers the situation shall immediately report it to his or her supervisor. The supervisor shall notify the Chief Executive Officer (CEO) or Administrator on Duty (AOD) of the major event that adversely affects the facility's ability to deliver care in the usual and customary manner, or to an accepted standard.
- b. The CEO or AOD shall activate HICS and either assume or designate the role of Incident Commander.
- c. If the CEO or AOD cannot be reached, the Operations Nurse Manager shall assume the role of Acting Incident Commander and assign someone to notify the following in the order listed:
 - i. Chief Operations Officer (COO)
 - ii. Chief Medical Officer (CMO)

- iii. Chief Nursing Officer (CNO)
- iv. Quality Management Director
- d. The first person to be reached on the above list shall assume or delegate the position of Incident Commander. Staff qualified to serve as the Incident Commander are those who have completed minimum training, which includes ICS 100, 200, 700 as well as additional HICS training, and whom are deemed by the CEO or AOD to be qualified to manage the specific incident. A list of staff with this level of training can be found in Section A3 Emergency Resources and Maps and shall be updated quarterly by the Emergency Management Coordinator.
- e. If the designated Incident Commander is not on site when HICS is initiated, the Operations Nurse Manager shall serve as Acting Incident Commander who shall serve until the designated Incident Commander arrives to relieve them.
- f. HICS roles are activated at the discretion of the Incident Commander for emergency incidents or planned events with the number of positions activated scalable to the situation. The Incident Commander is the only position ALWAYS activated and shall assume responsibilities of any role(s) not activated.
- g. An incident may be initiated from LHH or the hospital may be informed of a city-wide incident through external notification by EMS Duty Officer or DPH Departmental Operation Center.
- h. Whenever HICS is activated, all department and neighborhood managers or designees shall assess the status of their area using the Department Operating Status Report (DOSR), (see Appendix A), which shall be faxed to the Command Center at 415-504-8313, or delivered to the nearest DOSR collection bin within 15 minutes of HICS activation. The DOSR collection bins are in the following locations:
 - i. B102
 - ii. Clinic Registration Area
 - iii. Cadet's desk at the Pavilion main entrance
 - iv. Nursing Office

2. Notifications

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

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

- b. Additional notifications may be sent from the command center to all employees or subgroups of employees using the DPH Alert system.
- c. Whenever an incident is anticipated to impact, or require assistance from, other agencies or facilities, the CEO, AOD, or Incident Commander shall notify the Director of Health and the DEM Duty Officer that Laguna Honda has activated HICS.

3. Communications Plan

- a. Communication shall be maintained with DPH throughout large scale incidents in order to verify status, prioritize, share resources, and coordinate city-wide.
- b. The Liaison Officer or Incident Commander shall establish communications with the EOC and/or the DPH DOC if activated.
- c. If the DOC is not activated, communications shall be established with DPH PHEPR during normal business hours.
- d. An emergency contact list, including key Laguna Honda contacts and external agencies is available in the command center and as Appendix B.

- e. The ReddiNet system shall be used to receive information from EMS, DPH, and other health facilities during multiple casualty incidents (MCIs) affecting the San Francisco health care system.
- f. The Public Information Officer or Incident Commander shall maintain communications and provide regular updates to the Laguna Honda community, including employees, residents, and resident families.
- g. Any requests for information coming from the media shall be forwarded to the DPH Public Information Officer. No Laguna Honda employee shall make a statement to the media.
- h. In the event that regular communications systems are unavailable, a variety of back-up communication methods are available at the discretion of the Incident Commander:
 - i. Radios are available in the command center, Nursing Office, and offices for the CEO, COO, Sheriff, Emergency Management Coordinator, and Health at Home.
 - ii. A Mayor's Emergency Telephone System (METS) phone is available in the command center for direct contact with city emergency services officials. The METS system is also connected to the State of California's satellite telephone system for direct communication with the Governor's Office of Emergency Services in Sacramento, as well as the emergency operations centers of surrounding counties.
 - iii. Messengers shall be used if all communication devices have failed, or as needed to augment communication devices.

4. Off-Duty Staff Response

- a. All staff are mandated disaster service workers.
- b. Off duty staff are expected to:
 - i. First assure their own safety and that of their family
 - ii. Wait to be called back to work or report for the next scheduled shift unless required to report immediately per the departmental emergency plan.
 - iii. Listen to the radio in case the phone lines are down (Radio stations KNBR 680, KGO 810, or KCBS 740)

- c. Staff are advised to check road conditions and radio announcements before traveling. The city may also assist staff to and from their assigned locations in the event that roads and bridges are compromised, as announced on radio and other means available.
- d. The Incident Commander shall activate staff to HICS positions according to the needs of the response.
- e. Additional staff may be called to either their regular duties or to the labor pool. Each department manager/designee leads the call back process and response according to their Departmental Procedure. If the department manager or designee is not available, the Incident Commander or Logistics Section Chief may initiate call back of any staff deemed necessary for the response.

5. Use of Volunteers

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

6. Equipment and Supplies

Equipment and supplies to support a safe and effective staff response are maintained by the Department of Workplace Safety and Environmental Management (WSEM), Materials Management, Nutrition Services, and the Pharmacy. Table 2 lists critical equipment and supplies along with their storage locations.

Table 2: Emergency Equipment and Supply Locations	
EMERGENCY EQUIPMENT/SUPPLY	STORAGE LOCATION
Seven days' worth of food for 2000 people	Kitchen
600,000 gallons potable water	Water tanks east of facility
266 gallons of bottled water	Kitchen
Par level of linen	Clean linen storage room in S1
Evacuation equipment	H2 emergency storage

Respirators and cartridges	H2 emergency storage
Emergency lighting	H2 emergency storage and each neighborhood/department
Personal patient care supplies	H2 Central Supply/Warehouse
Tent	Container in gravel parking lot
Cots (55)	Container in gravel parking lot

ATTACHMENTS:

Appendix A: Department Operating Status Report (DOSR)

Appendix B: Emergency Contact List

REFERENCES:

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

Revised: 14/11/25, 17/05/09, 18/03/13, 19/05/14, 19/09/10 (Year/Month/Day)

Original Adoption: 13/05/28

DEPARTMENT OPERATING STATUS REPORT

COMPLETE THIS FORM IMMEDIATELY FOR ALL DISASTER / EMERGENCY NOTIFICATIONS & PROVIDE TO THE COMMAND CENTER (Fax: 415-504-8313)

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

Department: _____ Location: _____ Telephone: _____

Contact Person _____ Title _____ Contact by phone _____ Pager _____

If no residents in your area, skip to Section 2 SECTION 1 – RESIDENTS	SECTION 2 – STAFFING	Resident Units, Clinic, Rehab Only SECTION 3 – CRITICAL RESOURCES															
<p>Current Census in Department:</p> <p>Number of residents accounted for</p> <p>Have any residents been injured? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list on the back of this form names of any injured or missing residents. Indicate type of injury or location/ likely whereabouts as applicable.</p> <p>Any anticipated Resident condition changes or problems resulting from this event? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p># of Patients eligible for discharge</p> <p># of Patients eligible for Transfer</p>	<p>Current Staffing in department (on duty)</p> <table border="0"> <tr> <td>RN#</td> <td>LVN#</td> <td>CNA/PCA#</td> <td>HHA#</td> </tr> <tr> <td>MD#</td> <td>EVS#</td> <td>Unit Clerk#</td> <td>FSW#</td> </tr> <tr> <td>HIS#</td> <td>AT#</td> <td>SW#</td> <td></td> </tr> </table> <p>Other staff: (List title and number of staff)</p> <p>Total Staff:</p> <p>Any injuries to staff? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", list number of injuries by severity:</p> <table border="0"> <tr> <td>Minor</td> <td>Delayed</td> <td>Immediate</td> </tr> </table> <p>Expired</p> <p>Number of staff available for Labor Pool:</p>	RN#	LVN#	CNA/PCA#	HHA#	MD#	EVS#	Unit Clerk#	FSW#	HIS#	AT#	SW#		Minor	Delayed	Immediate	<p>Open/Available Beds #</p> <p>Open/Available Negative Pressure Rooms#</p> <p>Open/Available Gurneys #</p> <p>Open/Available Wheelchairs #</p> <p>Available Portable O2 # Full #Partially Full</p> <p>Other Available Space, Equipment and Supplies</p>
RN#	LVN#	CNA/PCA#	HHA#														
MD#	EVS#	Unit Clerk#	FSW#														
HIS#	AT#	SW#															
Minor	Delayed	Immediate															

Please use back of form for additional information as needed

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

Emergency Contacts

Agency or Individual	Phone	Pager	Email
Director of Health	415-554-2525		
SFHN Director	415-554-2711		
DEM Duty Officer	<u>415-260-2591</u>	415-327-0543	
<u>PHEPR Director</u>	<u>415-802-7358</u>		
DPH Emergency Response Line	415-558-5949		Phepr.dph@sfdph.org
DPH DOC	Varies – call above number		
DPH Communicable Disease Urgent Reporting Line	415-554-2830		
ZSFG Incident Commander	628-206-9680		
ZSFG AOD	628-206-3519	413-327-0259	
ZSFG Emergency Prep Coord	415-694-9488 text/voice		
IT On Call Engineer			
IT MOD			
EOC Turk Street	415-487-5000		
SFSD – Sheriff	415-759-2319		
CDPH L&C District Office	415-554-0353		

RESIDENT EVACUATION PLAN

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. Decision to Evacuate

Any time ~~any~~ the resident care area(s) of the hospital becomes unsafe for residents, HICS shall be activated.

- a. Residents whose emergency plan indicates that evacuation may be harmful shall be evaluated by their physicians to determine the best course of action for the individual resident's well-being.
- b. ~~The~~All residents for whom evacuation is indicated shall be moved out of the unsafe area(s) and into an alternate care site.
- c. ~~Alternate~~ care sites shall be selected by the HICS Team using the information in Appendix A.
- d. A binder that includes a list of equipment and supplies and standard work instructions for the setup of each alternate care location is located in the emergency command center.
- a.e. If there is no safe area for care on the ~~Laguna Honda~~LHH campus, PHEPR will be notified of the need to move residents to another facility.

2. Horizontal Evacuation

Whenever possible, evacuation shall be done horizontally. The Nurse Manager or designee shall coordinate this process using the following procedure.

- a. Move ambulatory residents.
- b. Move semi-ambulatory residents and those in wheelchairs.

- c. Move residents who are bed-ridden using evacuation devices or emergency carriers.
- d. Check the area to ensure that all residents have been moved out of the unsafe area.
- e. Account for all residents, staff, and visitors.
- f. If anyone is missing, attempt to locate them and notify the command center, the Nursing Office, and the Sheriff's Department.

3. Vertical Evacuation

- a. If horizontal evacuation is insufficient to locate residents in an area that is safe for their care, vertical evacuation shall be initiated. If elevators are operational and safe to use, vertical evacuation shall be completed using a combination of stairs and elevators. In the event of a fire, earthquake, or other disaster that may compromise the safety of the elevators, elevators shall not be used and the procedures for stair evacuation shall be followed.
- b. Upon making the decision to evacuate, the command center shall designate a destination location(s) within the facility to which residents will be relocated and staff from the labor pool shall be used to set up the area for resident care.

4. Vertical Evacuation Using Elevators

- a. Elevators shall be controlled by staff from the labor pool with a key to override the elevators. These staff members shall remain in the elevators and use each elevator to clear one floor at a time. The order in which neighborhoods will be evacuated shall be determined by the Incident Commander and shall depend on the type and specific location of the emergency.
- b. Ambulatory Residents
 - i. Ambulatory residents who are able to walk up and down stairs shall be escorted to an exit stairwell by a member of the Nursing staff, who shall walk up or down the stairs with groups of 3-5 residents.
 - ii. The Nursing staff shall go back to the neighborhood to continue evacuation.
 - iii. Additional staff members from the labor pool will be waiting in the stairwell on the same floor as the designated relocation area and shall escort residents in groups of 5-10 from the stairwell to the relocation area.

c. Residents in Wheelchairs

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

d. Bed-bound Residents

- i. After the residents in wheelchairs have been evacuated, residents in beds may be brought to the elevators. This shall be coordinated by the charge nurse.
- ii. If time is of the essence, bed-bound residents may be brought down the stairs using evacuation devices or carriers.
- iii. Labor pool staff shall bring residents to the designated care area.

e. Wheelchair Retrieval

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

5. Vertical Evacuation Using Stairs Only

a. Ambulatory Residents

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

b. Non-ambulatory Residents

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

c. Wheelchair Retrieval

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

6. Accounting for Residents and Resident Tracking

- a. Labor pool staff shall greet residents at the designated relocation area and account for all residents arriving in the area and report to the Command Center.
- b. The Command Center shall work with Nurse Managers to account for any missing residents.
- c. For any resident who is evacuated, continuity of care document (CCD) shall be made available to providers at the receiving facility via the health information exchange. The document shall contain key information including problem list, allergies, medications, recent lab results.

7. Employee Training

- a. All LHH staff shall be made aware of general evacuation procedures in orientation and annual emergency preparedness in-services.
- b. A team of staff from Nursing, Rehab, and Activity Therapy shall be trained on the use of evacuation devices annually. This training shall include hands on practice using the equipment.

ATTACHMENT:

Appendix A: Alternate Care Sites

Appendix B: Evacuation Devices
Appendix C: Emergency Carriers

REFERENCE:

LHHPP 70-01 B1: Emergency Response Plan

Revised: 18/09/11, 19/03/12, [19/09/10](#) (Year/Month/Day)
Original Adoption: 14/07/29

APPENDIX A: Alternate Care Sites

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

<u>Location</u>	<u>HVAC</u>	<u>Generator Power</u>	<u>Water</u>	<u>Lighting</u>	<u>Shelter from Weather</u>	<u>Restroom</u>	<u>Bed Capacity</u>	<u>Able to Quarantine</u>	<u>Med Gases Available</u>	<u>Floor surface</u>
<u>Neighborhood Common Areas</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>		<u>N</u>	<u>N</u>	<u>Terrazzo</u>
<u>Clinic P1</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>		<u>12</u>	<u>Y</u>	<u>Y</u>	<u>Terrazzo</u>
<u>Rehab P3</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>13</u>	<u>N</u>	<u>N</u>	<u>Terrazzo</u>
<u>Wellness Gym PG</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>10</u>	<u>N</u>	<u>N</u>	<u>Rubber</u>

<u>Simon Auditorium H1</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>60</u>	<u>N</u>	<u>N</u>	<u>Concrete</u>
<u>Wellness Hub H3</u>	<u>Y</u>	<u>N</u>	<u>N</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>50</u>	<u>N</u>	<u>N</u>	<u>Carpet</u>
<u>Moran Hall H3</u>	<u>Y</u>	<u>N</u>	<u>N</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>50</u>	<u>N</u>	<u>N</u>	<u>Concrete, Carpet</u>
<u>Esplanade & Kanaley P1</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>40</u>	<u>N</u>	<u>N</u>	<u>Terrazzo</u>
<u>Cafeteria P1</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>Y</u>	<u>25</u>	<u>N</u>	<u>N</u>	<u>Terrazzo</u>
<u>Horseshoe Outside PG</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>Minimal</u>	<u>N</u>	<u>N</u>	<u>100</u>	<u>N</u>	<u>N</u>	<u>Grass, Pavement</u>
<u>NW Parking Lot</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>Minimal</u>	<u>N</u>	<u>N</u>	<u>100</u>	<u>N</u>	<u>N</u>	<u>Pavement</u>

APPENDIX B: Evacuation Devices

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

- a. **Reeves Stretchairs** (approximately 60) are stored in the emergency storage room in H2 and can be made available by request from the Command Center. Each Stretchair has a cover with a shoulder strap to facilitate easy transport of several devices at once. Open the Stretchair and place under the victim either on a flat surface (bed or floor) or on a chair. To use on a flat surface, roll the victim to one side and place the Stretchair beneath them, with the top aligned with the victims shoulder. Roll the victim to the opposite side and ease the Stretchair beneath them. Secure the shoulder and crotch/ hip straps. To use on a chair, place on a chair with the crotch strap near the edge of the seat and place the victim on the device by having the victim stand up momentarily and then sit down on the Stretchair or transfer the victim via a standing pivot with 1 or 2 assistants or via a mechanical lifting device. Assure that the top of the Stretchair is level with the victims' shoulders. Lift on the count of three ("1-2-3 lift") with 2-4 rescuers each firmly grasping one or two handles, depending upon the weight of the victim and the strength of the rescuers. The Reeves Stretchair is rated up to 1000 lbs.; however you must never lift more than you can easily manage
- b. **Medivac chairs** (approximately 30) are also stored in the emergency storage room in H2 and can be made available by request from the Command Center. They are rated at 450 lbs and they do not have a strap. Place under the victim as described above.
- c. **Paraslydes** (15) are available through the Command Center and can be used to evacuate down stairs. Pictorial directions appear on the device. Place the victim (500 lb weight limit) on the stair litter by rolling them to the side and placing the device beneath them. Roll the victim onto the device and center them on the device by sliding their shoulders, then legs, then hips to the middle of the litter. Fold the device around the victim and secure the straps, criss-crossing the chest straps. Use 2-4 rescuers to slide the Paraslyde to the stairwell and ease the device safely and slowly down the stairs. An additional harness is provided if needed for added control for lighter rescuers to ease a heavy victim down stairs.
- d. **Stryker Evacuation Chairs** (7) are available through the Command Center for evacuation down stairs (weight limit 500 lbs). Pictorial directions appear on the back of the chair. Fold the chair out as pictured, by squeezing the red bar to raise the handle and by squeezing the lower red bar while pulling out the stair track. Transfer the victim onto the chair and fasten the waist, chest, and ankle straps. Wheel the victim to the stairs. Tip the chair back to allow it to descend on the gliders down the stairs with 1 or 2 rescuers holding the handles to safely guide the chair down.

APPENDIX C: Emergency Carriers

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

- a. Cradle drop and blanket pull – 1 person (heavy resident)
 - i. Double a blanket lengthwise on floor parallel to bed. Slide arm nearest resident's head under the neck and grasp shoulder. Slide free arm under knees and grasp firmly. Place knee or thigh, depending on height of bed, against bed close to resident's thigh. Keep both feet flat on floor about six (6) inches from bed. Pull resident from bed; no lifting is necessary. Pull with both hands, push with knee or thigh against bed. The moment resident starts to leave bed, drop on knee nearest the head. When the resident is clear of bed, the extended knee supports knees of resident and the arm under neck supports arm and shoulders of resident. The cradle formed by the knee and arm protects the back. Let the resident slide gently to the blanket and pull blanket from the room.
 - ii. Rescuer cannot maintain the balance necessary if rescuer pulls the resident's buttocks instead of the knees or thighs out on rescuer's knee. This removal is for residents too heavy for one person to carry, for low beds and for bed fires.
- b. Swing – 2 persons
 - i. Carriers grasp wrists under the resident's knees and behind the resident's back. Resident's arms are along the two carriers' shoulders. Carry resident from room to safe place.
- c. Extremity – 2 persons
 - i. (To carry a person through a burning exit). One carrier grabs resident around knees (carrier's body between the resident's knees). Second carrier grabs resident under the arms and across upper abdomen. Carry resident from room. Use wet cover if possible.
- d. Using a gurney – 3 persons
 - i. Gurney placed parallel to bed. Three carriers to lift, one at shoulder level and upper back, one below waist and below hip, one at knee and at ankle. Lift resident and place on gurney. Wheel to safety.
- e. Without a gurney, using a blanket – 3 persons
 - i. First person spreads blanket on floor at right angles to bed. Resident is placed on blanket. First person positions at the head of the resident, placing own hands on blanket above the resident's elbows. Second and third persons position on the sides of the resident, placing their hands above and below the

resident's knees.

FIRE RESPONSE PLAN

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. When You See Smoke or Fire

- a. Follow the R.A.C.E. acronym below for basic fire response steps:
 - i. **Rescue** persons in immediate danger while announcing “Code Red” to nearby staff.
 - If a person is on fire, the best immediate response is to have them stop, drop and roll. However, if someone cannot drop and roll, you may wrap the person in bedding or clothing to smother the fire or use a fire extinguisher if it is safe to do so.
 - ii. **Alarm** by continuing to shout “Code Red” to nearby staff and by activating the alarm using the nearest manual pull station.
 - Any person may activate the Fire Plan by pulling a manual pull station. In addition, the fire detection system may be automatically activated via heat sensors and particle (smoke) detectors.
 - When the fire alarm goes off due to activation of a smoke detector, the annunciator panel at the nurse’s station will display the source of the fire and the light outside the resident’s room will flash red. Check the panel at the nurse’s station to find the fire quickly.
 - When the alarm activates, chimes will ring and strobes will flash in the building.
 - Once activated, the fire alarm automatically alerts the San Francisco Fire Department, which will respond immediately.

Dial 4-2999. Provide the following information:

- Location of fire
- What is burning
- Your name

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

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

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

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

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

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

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

*ABC Dry Chemical Fire Extinguishers contain monoammonium phosphate and ammonium sulfate. Exposure to these chemicals can cause irritation to the eyes, skin and respiratory pathways. Additionally, inhalation of the chemicals can aggravate existing respiratory conditions such as asthma, emphysema or bronchitis. For more information, refer to the safety data sheet available on the WSEM webpage.

Note: If a fire extinguisher is used, restrict access to the area and notify EVS. EVS shall then clean up the residue following standard procedures listed in Appendix D: EVS Fire Extinguishant Discharge Clean-Up Procedures.

- b. If evacuation of residents is necessary, follow the procedures in LHHPP 70-01-B3 Resident Evacuation Plan

2. Fire Response in the Hospital Buildings

a. Resident Safety

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

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

b. Fire Door Closure

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

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

c. Stairwell Doors

- i. Activation of the fire alarm by a smoke detector will cause exit doors in the neighborhoods of the affected building to automatically unlock to allow for evacuation.
 - ii. The doors will not automatically unlock during a drill or if the fire alarm is activated using a manual pull station; a heat or smoke sensor must also be activated.
 - iii. Stairwell doors can also be unlocked from the master lock outside of the medication room on each neighborhood.
 - iv. In case of fire activity in the North Mezzanine secure neighborhood, North 1, 2, 3 and 4 will send one staff member to North Mezzanine to monitor the fire stairwell doors to assure resident safety as follows:
 - **N1**: send staff to monitor NM **Cypress** household door
 - **N2**: send staff to monitor NM **Redwood** household door
 - **N3**: send staff to monitor NM **Cedar** household door
 - **N4**: send staff to monitor NM **Juniper** household door
 - v. Relock each of the stairwell doors after the "all clear" is announced over the public-address system.
- d. Elevators
- i. Never use elevators during a fire.
 - ii. Elevators are equipped with fire screens and systems to bring the elevator to the lowest safe floor automatically in case of fire in the building.

If you are in an elevator, exit the elevator once it reaches the lowest safe floor. If the fire screen is down, press the clearly marked button in the center to open the screen.

- iii. Elevators will be placed back in service by the Fire Department or the Watch Engineer once "all clear" has been declared.
- e. Evacuation of Hazardous Area
- i. An evacuation of a unit or department area shall take place if the fire cannot be safely extinguished or if smoke or other damage renders the area unsafe for residents.
 - ii. Residents shall be moved to a safe area 1-2 fire doors away from the fire on the same floor if possible (horizontal evacuation).

iii. Initiate horizontal evacuation in the following order:

- Ambulatory residents
- Semi-ambulatory residents and those in wheelchairs
- Residents who are more dependent/in bed.

iv. During horizontal evacuation, the Nurse Manager or designee shall:

- Coordinate the movement of residents.
- Perform a check of the unit to verify that all persons have been moved out of the hazardous area.
- Remove medical records from the hazardous area if safe to do so.
- Account for residents, staff, and visitors and take steps to locate anyone missing.

v. When vertical evacuation is necessary for the safety of residents, follow the procedures in LHHPP 70-01 B3 Resident Evacuation Plan.

f. In areas of the hospital where there are no resident care activities, including the production kitchen, pharmacy, and service area of the first floor of the south tower, staff shall evacuate according to their department plans.–

f.g. Post Fire Procedures

- i. Ventilate the area to clear any smoke by opening windows or using a fan if needed; do not block any fire doors.
- ii. If a fire extinguisher was used, any electrical equipment or wiring that is contaminated must be shut off and immediately cleaned up following procedures listed in Appendix D.,
- iii. Call EVS to clean up the discharge residue as soon as possible.

3. Fire Response in the Administration Building

a. When the fire alarm sounds in the administration building, the basic R.A.C.E. procedure shall be followed, but then all occupants in staff work areas must evacuate the building according to the following procedures:-

a. Staff Evacuation Procedures

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

b. If residents are present in Simon Auditorium or the Chapel when the fire alarm sounds in the Administration Building, the following procedures shall be followed:

- i. If smoke or fire are detectable in the immediate vicinity of the auditorium or chapel, residents shall evacuate through the exit doors leading to the front of the Administration building.
- ii. If additional staff are needed to assist with evacuating residents, Spiritual Care or Activity Therapy staff shall notify the Nursing Office at 4-2999 or the HICS command center at 4-4636 once HICS has been activated.

iii. If there is no fire in the immediate vicinity (i.e. there is no evidence of smoke or fire), residents shall be directed to shelter in place and Spiritual Care or Activity Therapy staff shall distribute ear muffs to residents in order to mitigate their noise exposure until the alarm is silenced. Ear muffs are available in boxes in the chapel.

viii-iv. SFFD may order evacuation of residents at any time.

4. HICS Activation in Response to a Fire

a. Designation of an Incident Commander

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

b. Incident Commander Responsibilities:

- i. Learn from the Nursing Office staff/telecommunications operator the LOCATION and NATURE of the fire. Verify that Nursing Office staff/telecommunications operator telephoned SFFD to confirm the automated alarm.
- ii. Ascertain the following from the Fireground Officer (watch engineer initially, then senior fire fighter once SFFD arrives)
 - Immediate danger to residents or staff
 - Arrival of SFFD at scene
 - Any need to consider additional evacuation
 - Resources required
- iii. Coordinate the hospital's response to the fire emergency, including activation of other HICS roles as necessary.

- iv. Upon receiving clearance from the Fire Department or watch engineer, authorize the announcement of “CODE RED ALL CLEAR (location)” by Nursing Office staff/ telecommunications operator.
- v. Authorize initialization of clean up and restoration of the affected area as required. This work should include removal of fire debris and immediate restoration of the rooms (unless arson is suspected, in which case crime scene must be preserved).
- vi. Manage the post fire clean-up operation by providing specific direction and resources. Assure the incident is completely documented for required reporting.
- vii. Schedule a post-fire debriefing as necessary.
- viii. Contact the Nursing Directors and Nurse Managers as needed to arrange for alternate accommodations for residents who may be temporarily displaced due to fire.

ATTACHMENT:

Appendix A: Nursing Operations Procedure
Appendix B: Watch Engineer Procedure
Appendix C: Sheriff’s Department Procedure
Appendix D: EVS Clean-up Procedure

REFERENCE:

LHHPP 70-01 B3 Resident Evacuation Plan
Safety Data Sheet Amerex ABC Dry Chemical Fire Extinguisher

Revised: 09/08/24, 11/09/27, 13/05/28, 14/07/29, 14/09/09, 18/03/13, 19/03/12, 19/09/10 (Year/Month/Day)
(Previously numbered as LHHPP 71-02)

Appendix A: Nursing Operations Fire Response Procedures

1. Upon Notification of a Code Red on the Emergency Phone Line:
 - a. NOTIFY the fire department of the fire and location by telephone call to 911.
 - b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED (location)"
 - c. Page the Emergency Response Group (Stationary Engineers, SFSD, Emergency Management Coordinator, Nursing Program Directors, Nursing Operations Managers).
 - d. If a live fire is discovered, notify the following:
 - i. Executive Administrator
 - ii. AOD (Administrator on Duty).
 - iii. Chief Operation Officer
 - iv. Chief Medical Officer
 - v. Chief Nursing Officer
 - vi. Emergency Management Coordinator
 - e. Keep telephone lines open to the incident.
 - f. Log all activity relative to the alarm for review by supervisor.
 - g. When instructed by senior SFFD firefighter and approved by Incident Commander, announce three times over paging system: "CODE RED (location) IS ALL CLEAR."
2. Upon alarm activation without a phone call from the affected area:
 - a. Expect to receive a call from SFSD regarding the location of the alarm activation. If you do not receive a call, call SFSD at 4-2319 to confirm location of the alarm.
 - b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED (location)"
3. Upon Notification of a Code Red Drill:
 - a. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED DRILL (location)"

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

Appendix B: Watch Engineer Fire Response Procedures

1. Upon activation of the fire alarm system, the Watch Engineer on duty shall:
 - a. Immediately respond to the location of the alarm and become the Fireground Officer if there is an actual fire.
 - b. Initial response to fire shall include the following:
 - i. Activate nearest fire alarm pull station if not already done.
 - ii. Tell others to close doors and windows.
 - iii. Tell others to turn off Oxygen cylinders and wall gases.
 - iv. Extinguish fire, if small.
 - v. Direct firefighting until SFFD arrives.
 - vi. If false alarm, locate source detector and possible causes.
 - c. If hazardous materials are involved, inform the SFSD to notify 911 responders.
 - d. If necessary, go directly to the location of the emergency shut-off breaker of the intake/exhaust fan(s) and shut them off. Immediately return to the fireground.
 - e. If HICS has been activated, carry out the Incident Command directives.
 - f. Determine whether adjacent areas are at risk and advise Incident Commander. When SFFD arrives, relinquish authority to the senior firefighter and inform Incident Commander of that person's name.
 - g. When the SFFD authorizes a "Code red (location) all clear".
 - i. Notify the Incident Command Center and Nursing Operations of all clear authorization.
 - ii. Reset the alarm system.
 - iii. Reset the elevators if not damaged by fire.
 - iv. Report completion of re-setting to the Command Center.
 - h. Secure fire sprinkler valves, if fire sprinklers activated and once fire is extinguished. All watch engineers are responsible for knowing where shut-off valves are located. Make immediate arrangements to have sprinkler heads replaced and system recharged.
 - i. Initiate clean up and restoration of the affected area as required.

Appendix C: San Francisco Sherriff Department Fire Response Procedures

1. Upon fire alarm activation or notification of fire:
 - a. SFSD staff shall gather information on the fire alarm panel including what caused the alarm and the location.
 - b. SFSD staff shall call the Nursing Office at 4-2999 and provide information gathered and broadcast this information over the radio to all SFSD units.
 - c. A Deputy shall respond to the location of the alarm.
 - d. Another Deputy shall respond to the Pavilion lobby to stand by to direct or escort responding SFFD personnel.
 - e. SFSD supervisor, in conjunction with the LHH AOD or Incident Commander, will determine if any evacuation procedures or other duties are required until the arrival of SFFD.
2. Documentation:
 - a. In the event of an actual fire emergency, SFSD deputy will complete an incident report. It will include the name of the SFFD Officer who authorized the Code Red all clear announcement. This report will be completed before the end of the shift. A request for a copy of this report may be made to SFSD Public Information Officer at City Hall by the hospital's Chief Operating Officer and/or Fire Safety Officer.

Appendix D: EVS Fire Extinguisher Discharge Clean-Up Procedures

1. Upon notification of the use of a fire extinguisher requiring clean up, the following steps must be followed immediately:
 - a. Ask individuals not associated with clean up to leave the area.
 - b. Wear the following personal protective equipment during clean up:
 - i. Gloves
 - ii. Safety goggles
 - iii. Disposable boot covers
 - iv. Coveralls/Gown
 - v. Use of either an N95 or reusable respirator is optional.
 - c. Use a HEPA vacuum to collect loose debris fire extinguisher discharge.
 - d. For cleaning surfaces with stuck-on residue, prepare a 1:1 mixture of water and baking soda and clean the affected areas using a wet rag if necessary.
 - e. If electrical equipment has traces of residue, clean external surfaces using a HEPA vacuum. However, if equipment is severely damaged, discard the equipment appropriately.
 - f. All waste generated during the clean-up process shall be disposed in regular trash.
 - g. After cleaning, wash your hands thoroughly.
 - h. Return the HEPA vacuum to EVS after use.
Note: This vacuum is solely for cleaning fire extinguisher residue and must not be used for any other purpose.

THEFT AND LOST PROPERTY ~~REPORTS~~

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide a means to help facilitate the return of personal belongings lost on the LHH campus.
2. The San Francisco Sheriff's Department (SFSD) shall be notified when items are missing due to theft is reported.
2. LHH is not responsible for lost items ~~of staff, volunteers, visitors, and/or contractors.~~
3. Personal belongings found that are unclaimed for 30 days shall be discarded or donated to the Volunteer Services department for processing.
4. The San Francisco Sheriff's Department (SFSD) at Laguna Honda Hospital and Rehabilitation Center (LHH) shall be notified when theft of property is reported.

PURPOSE:

To facilitate the return of property to the rightful owner and dispose unclaimed items. To promote property loss control, minimize theft through intervention, and provide a process to report resident loss of property.

PROCEDURE:

1. Lost and Found Items

- a. Any person who loses personal belongings or finds property shall:
 - i. Place items in the receptacles labeled "lost and found" located in the hospital lobby and atrium or bring items to the Administration office.
 - ii. The person(s) who located an item(s) shall provide as much information as possible to Administration staff.
- b. Administration staff shall record items brought to their attention or deposited in the bins on the Lost and Found log stored in the Administration Office.
- c. Items found will be stored for 30 days in the Administration Office.
- d. Items determined by Administration staff to be of more than nominal value (i.e. wallets, cash, jewelry, phones) shall be turned over to the San Francisco Sheriff's Department (SFSD) for processing.

- e. Administration staff shall contact the owner if sufficient identification is indicated on the item and check the lost items list to see if the item has been reported lost.
- f. Lost items may be claimed from the Administration Office after a description of the lost item and identification of the person claiming the item is provided.
- g. Persons who are unable to locate their lost items in the Administration Office may be referred to SFSD if appropriate.
- h. Disposition of items found:
 - i. Soiled items will be discarded immediately.
 - ii. Property not claimed after 30 days from date of log in shall be donated to the LHH Volunteer Services department.

2. Theft of Property

- a. ~~Hospital-LHH~~ staff ~~will~~ shall report theft of property to SFSD
- b. SFSD ~~will~~ shall follow their internal processes in responding to the report of theft that may include preparing a Police Incident Report that is processed through the criminal justice system or providing a liaison with the San Francisco Police Department to assist with further investigation.
- c. The SFSD ~~will~~ shall maintain theft reports and statistical data.
- d. ~~Hospital-The LHH a~~ Administration and SFSD shall meet twice a year to review statistical data to improve prevention of theft.

3. Claims and Liability

- a. The resident may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. Social Worker or any member of Resident Care Team may assist resident in completing claims form.
- b. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions, or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.

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

and Loss for more detail.

ATTACHMENT:

None.

REFERENCE:

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

~~None~~

Revised: 94/08/15, 12/09/25-, 19/09/10 (Year/Month/Day)

Original adoption: 93/05/20

LHH

Policies and Procedures

For Deletion

FOR DELETION

HANDLING LOST AND FOUND ITEMS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall provide a means to help facilitate the return of personal belongings lost on the Laguna Honda campus.
2. Laguna Honda is not responsible for lost items.
3. Personal belongings found that are unclaimed for 30 days shall be discarded or donated to Volunteer Services for processing.
4. Refer to LHHPP 75-07 regarding items missing due to theft.

PURPOSE:

To facilitate the return of property to the rightful owner and dispose of unclaimed items.

PROCEDURE:

1. Anyone who loses personal belongings or finds property shall:
 - a. Place items in the receptacles labeled "lost and found" located in hospital lobby and atrium, or bring items to the administration office
 - b. The person finding the items shall be prepared to furnish as much information as possible to Administration staff
2. Administration staff will record items turned in to Administration or deposited in the bins on the Lost and Found log that is stored in the Administration Office.
3. Items found will be stored for 30 days in the Administration Office
4. Items determined by Administration staff to be of more than nominal value (i.e. wallets, cash, jewelry, phones) will be turned over to the on-site San Francisco Sheriffs Department (SFSD) for processing.
5. Administration staff will contact the owner if sufficient identification is indicated on the item and will check the lost items list to see if the item has been reported lost.

6. Lost items can be claimed from the Administration Office after a description of lost item and identification of the person claiming the item is given.
7. Persons who are unable to locate their lost items in Administration Office may be referred to SFSD if appropriate.
8. Disposition of items found:
 - a. Soiled items will be discarded immediately.
 - b. Property not claimed after 30 days from date of log in will be donated to the Laguna Honda Hospital Volunteer Program..

ATTACHMENT:

None

REFERENCE:

LHHPP 75-07 Theft and Lost Property Reports

Revised: 93/05/10, 12/07/31, 14/03/25 (Year/Month/Day)

Original adoption: 92/05/20

Clinical Laboratory Policies and Procedures For Deletion

FOR DELETION

PATIENT, VISITOR AND STAFF RELATION

POLICY:

I. WE ARE PROFESSIONALS IN THE BUSINESS OF PROVIDING A QUALITY HEALTH CARE SYSTEM THAT IS THE PATIENTS CHOICE FOR PERSONAL AND FAMILY NEEDS.

- We picture ID badge at all times, for ease of visibility
- Maintain neat, clean, professional dress and good hygiene. Wear caps and shoe covers in designated areas only. Wear cover gowns closed with opening in back
- Maintain a neat and clean environment by picking up after yourself, and others as needed
- Refrain from holding conversation about patients or other employees in public areas (e.g., elevators, hallways, cafeteria)
- Respect public and patient areas by refraining from loud laughter, noise, or profanity
- Refrain from chewing gum when talking with someone.

II. EVERY EMPLOYEE ADDRESSES THE NEEDS OF EACH PATIENT, VISITOR AND CO-WORKER

- Offer assistance to patients, visitors and staff if there is the slightest indication that assistance is needed (e.g. walk patients to clinics, visitors to wards, etc.)
- Make an effort to resolve problems at the point of service, or refer to appropriate person.
- Listen carefully. Demonstrate patience. Obtain facts using open-ended questions
- Maintain focus on the problem in a professional and courteous manner.
- Obtain agreement on plan to solve problem with the individual
- Follow through on the plan
- Communicate the status of service. Assist in reducing delays or improving services, whenever possible

III. COMMENTS AND SUGGESTIONS FOR IMPROVEMENT ARE ENCOURAGE AND VALUED

- Seek input from others (from line staff, service customers/users) when making or anticipating changes
- Management support input/feedback proposed by their staff.
- Make suggestions for positive changes
- Demonstrate teamwork with other group members, supervisors and managers
- Willingly learn and participate in a variety of tasks

IV. ADVOCATING AND CREATING EASIER ACCESS TO SERVICES WILL BENEFIT PATIENTS, VISITORS AND STAFF

- Answer the telephone within 5 rings
- Respect co-workers by refraining from interrupting other employees when they are on the telephone
- When answering the telephone, answer with unit/department and first name
- When putting a caller on hold:
 - a. Tell the person the number of calls before him/her
 - b. Ask if they want to hold, call back, leave a message or wait for the answer
 - c. Make periodic checks to see if the caller wishes to continue to hold
- When taking a message for someone who is unavailable, write down the following:

- a. Name of the person being called
- b. Caller's full name, time, date, phone number. If unclear about the name of the caller, ask person to spell their name
- c. Message taker's initiates
- Return all calls the same day or follow-up at an agreed upon time.
- Before transferring a call:
 - a. Tell the caller that you are transferring them.
 - b. Give the caller the name and extension of the receiving department before initiating the transfer
- When placing a call, identify yourself and your department and explain the purpose of the call

V. RECOGNIZING EMPLOYEES WHO DEMONSTRATE POSITIVE HUMAN RELATIONS SKILLS IMPROVES MORALE AND PERFORMANCE.

- When a colleague or employee handles a complicated situation using customer relation's principles, compliment them either verbally or in writing
- Forward copies of written compliments to the employee's supervisor

VI. EVERY PERSON WILL BE TREATED WITH RESPECT AND COURTESY.

- Greet patients, visitors, and staff pleasantly and immediately
- Introduce yourself by name and title
- Address patients, visitors and staff by their surnames (e.g. Mr. Smith) unless asked to do otherwise
- Always knock before entering a closed room
- Yield to others in elevators and stairwells, holding doors open as necessary
- Always say "please" and "thank you".

Most recent review: 08//2008, 07/2009

Revised:

Original adoption: 02/2006

FOR DELETION

SPECIMEN PROCESSING TEST GUIDE

PROCEDURE:

I. TESTS NOT ON LIST:

If a test is requested that is not on this list REI as MSO-'TEST NAME (enter the test name as it appears on the request). Consult the Esoteric Test book, a Chemistry supervisor or LMR for additional information. All tests not listed require LMR approval. If information was not found, ask Inquiry look in Quest Entrée computer for the test information and print the information. Give the requisition and Quest information to the LMR and give to a supervisor to check the price, which is not available from Quest Entrée. The UC/SFGH price is only available using LIS function (NICOMM). If an MSOC is not approved, give to a supervisor to credit.

II. ALIQUOT:

All aliquots are serum or plasma unless otherwise indicated. If sample is serum or plasma, the amount of whole blood to be collected is twice the amount of the aliquot.

Most recent review: 08/2008, 07/2009
Revised: 07/2009
Original adoption: 02/2006

**TEST UPDATES, REVISIONS, AND NEW TEST INFORMATION
 SPECIMEN PROCESSING TEST GUIDE**

The latest updates, revisions, and new test information will be referenced here as well as in the alpha order of this test guide. A new edition will be printed as this page becomes full. Please check here FIRST for the best before looking up the information about the test in the rest of the guide.

Test	Code/CP T	Tube Type	Vol/Aliquot	Lab/Rack	Approval	Availability	Stability	Comments

Revised Nursing Policies and Procedures

RESTORATIVE NURSING CARE PROGRAM**POLICY:**

1. Restorative ~~nursing-nursing~~ care is carried out by Therapy Aides (TAs), Certified Nursing Assistants (CNAs) and Patient Care Assistants (PCAs), and/or other trained ~~and competent~~ staff ~~and volunteers~~ under the direction and supervision of a licensed nurse (LN).
2. Staff who have been trained in restorative ~~nursing-~~ care interventions ~~and have demonstrated competency~~ can implement and document restorative interventions.
3. ~~Group~~ When restorative ~~nursing~~ activities ~~are limited to done with a group of residents (e.g., restorative dining and active range of motion programs) the staffing ratio must be no more than 14:44 staff to residents to staff.~~
4. A resident may participate ~~concurrently in a Restorative Nursing Program~~ restorative nursing care, the Restorative Nursing Program, or Skilled Rehabilitation Therapy ~~concurrently with Skilled Rehabilitation Therapy~~ if deemed therapeutic and beneficial in maximizing the resident's functional status.
5. Restorative treatments ~~are~~ reviewed monthly ~~and as needed~~ by the LN and quarterly by the Resident Care Team (RCT).
6. Any member of the ~~Resident Care Team (RCT)~~ may recommend to a LN or physician that a resident be evaluated for ~~a~~ restorative ~~-~~ care program.
7. ~~Restorative nursing care does not require a physician's order and can be initiated by a licensed nurse. A physicians order is not required for the nursing restorative program.~~ However, for residents with complex clinical conditions such as ~~fractures or severe contractures~~ or fractures, a consultation with a physician and/or licensed ~~rehabilitation~~ therapist may be appropriate.

~~7-8. Residents are referred to the Restorative Nursing Program by rehabilitation therapists.~~

9. ~~If a lack of no~~ progress, ~~a decline, or the achievement of goals~~ is noted in the ~~unit's~~ monthly ~~summary~~ or the Restorative Nursing Program's quarterly summaries, ~~the treatments or program may be reevaluated for discontinued or modification for a resident at the time or modified to be more appropriate for the resident.~~

~~8.~~

PURPOSE:

~~To define and describe a~~
~~program or~~ treatments provided to residents to ~~maintain, and/or improve to their highest level of range of motion (ROM), mobility status, functional independence and ADLs, and prevent declines unless clinically unavoidable.~~

~~To define and describe a program of preventive, restorative, and supportive nursing care.~~

BACKGROUND:

Restorative Nursing Program

A. Skilled Rehabilitation Therapy is a rehabilitation therapy that is provided by a licensed therapist such as Physical Therapist (PT), Occupational Therapist (OT), and Speech Language Pathologist/Therapist (SLP/PT).

B. Restorative Nursing Care:

1. Nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible
2. Focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
3. The overarching goal of restorative nursing is for the resident to attain or maintain the highest practicable functional, physical, mental, and psychosocial well-being. Restorative nursing care is directed toward the conservation of resident's abilities, restoration of maximal levels of function and independence, promotion of quality of life, adaptation to an altered life style, and prevention of deterioration and complications of disability.
—Planned, implemented and facilitated by the RCT to achieve the best individual outcomes. In order to achieve this, the skills and expertise of the RCT are used to plan, implement and facilitate all pathways for the best individual outcomes.
- 4.
5. Restorative nursing treatments must be Licensed Nurses performed regularly by a TA, CNA or PCA, under the direction of a LN, with or without consultation by a licensed therapist that addresses one or more of the following Restorative Program's components provide direction, oversight and follow up for restorative nursing interventions performed regularly by CNAs/PCAs and other trained staff or volunteers, with or without consultation by a licensed therapist.
6. The exercises, treatments or activities are individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.
(Refer to Appendix 1 for Restorative Program Description):

1. Range of Motion: Active Range of Motion (AROM) or Passive Range of Motion (PROM)
2. Splint or Brace Assistance
3. Amputation or Prosthesis Care
4. Activities of Daily (ADL) Training
 - a. Bed Mobility
 - b. Transfer
 - c. Walking
 - d. Dressing and/or Grooming
 - e. Eating and/or Swallowing
- a. Schedule Toileting Program and/or Bladder Retraining Program
6. Communication
7. Other: any other activities used to improve or maintain the resident's self-performance in functioning (i.e., teaching self-care for diabetic management, self-administration of medications, ostomy care, etc.)

C. The Restorative Nursing Program:

is composed of the following staff:

1. Restorative care provided regularly by Therapy Aide (TAs under the supervision of a LN) is a rehabilitation nursing assistant (RNA). The TAs provide restorative treatment in Wellness Gym, Neighborhood (unit-based restorative programs), and Aquatics with treatments recommended by a licensed rehabilitation therapist and requires an initial consult request from the physician.
2. TAs provide restorative treatment in the wellness gym, on the neighborhoods (unit-based) and in the aquatics pool, under the supervision of a LN with initial recommendations and follow up consultations provided by the licensed therapist.

Restorative therapy is reviewed quarterly- and as needed for modifications and/or discharge by the LN and/or the RCT.

- a. Wellness gym: Restorative treatment in the wellness gym utilizes specialized equipment
- b. Neighborhood (unit-based) restorative programs: depending on the medical or physiological complexity of the resident, the restorative program can be done one-to-one or in a small group.
- c. Aquatics: This restorative program can be used for residents who may not tolerate therapy on land due to pain or other movement issues. The licensed therapist may be present for all sessions of this type of programming (refer to LHH PP 28-03 Aquatic Services).

	RESTORATIVE NURSING CARE	
	RESTORATIVE NURSING CARE	RESTORATIVE NURSING PROGRAM
STAFF	<u>LN, CNA/PCA, ATether staff or volunteers</u>	<u>TA</u>
PLAN OF CARE	<u>Determined by LN</u>	<u>Recommended by licensed rehabilitation therapist</u>
TREATMENTS	<u>Can be safely carried out by nursing staff or trained staff</u>	<u>Complex treatments or specialized equipment</u>
LOCATION	<u>On unit</u>	<u>Wellness gym, on unit, aquatics</u>
COMPONENTS	<u>AROM, PROM, splint/brace assistance, amputation/prosthesis care, bed mobility, transfer, walking, dressing/grooming, eating/swallowing, communication, bowel/bladder training</u>	<u>AROM, PROM, splint/brace assistance, amputation/prosthesis care, bed mobility, transfer, walking</u>

D. Restorative Care Components

1. **Technique:** Restorative aActivities provided by restorative nursing staff and trained staff.
 - a. **Active Range of Motion (AROM):** exercises performed by the resident, with cueing, supervision, or physical assist by staff. Includes AROM and active-assisted range of motion (AAROM).
 - i. **AROM:** performance of an exercise to move a joint without any assistance or effort of another person to move-t the muscles surrounding the joint.
 - ii. **AAROM:** the use of the muscles surrounding the joint to perform the exercise but requires some help from the staff or equipment.
 - b. **Passive Range of Motion (PROM):** provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. PROM is the movement of a joint through the range of motion with no effort from the patient.
 - c. **Splint or Brace Assistance:** provision of:
 - i. verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
 - ii. a scheduled program of applying and removing a splint or brace.
2. **Training and Skill Practice:** Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

Restorative Nursing Program

a. Amputation or Prosthesis Care: activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses.

b. Activities of Daily (ADL) Training

i. **Bed Mobility:** activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning self-himself or herself in bed.

ii. **Transfer:** activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

iii. **Walking:** activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.

iv. **Dressing and/or Grooming:** activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks with or without assistive devices.

v. **Eating and/or Swallowing:** activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids with or without assistive devices, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

c. Communication: activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

d. Bowel and Bladder Training:

i. **Urinary Toileting Program:** implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern targeted at decreasing or resolving incontinence (ex: bladder rehabilitation or retraining, prompted voiding, and habit training or scheduled voiding)

ii. **Bowel Toileting Program:** implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern targeted at maintaining bowel continence.

1. ~~_____ Certified Nursing Assistant (CNA) and Patient Care Assistant (PCA): A CNA or PCA provides restorative treatment on the neighborhood.~~

2. ~~_____ Nursing Liaison: Point person or people to help coordinate care between nursing, restorative and rehabilitation programs from a nursing perspective.~~

3. ~~_____ Rehab Liaison: Point person or people to help coordinate care between nursing, restorative and rehabilitation programs from a rehabilitation/therapy perspective.~~

4. ~~_____ Other Staff and volunteers: Volunteers and other staff must be trained and demonstrate competency. They provide restorative treatments in designated areas.~~

PROCEDURE:

A. Assessment for restorative nursing needs

~~1. Registered nurses assess restorative needs at the time of admission, quarterly, annually, and when a full MDS is required due to a significant change of condition.~~

1. The minimum data set (MDS) and Resident Assessment Instrument (RAI) process are the baseline functional assessment for restorative nursing.

2. Registered nurses (RN) assess restorative needs at the time of admission, **monthly**, quarterly, annually, and with significant change of condition.

Restorative Nursing Program

~~3. Assessment data is considered in relation to the restorative program components to determine the restorative program planning needs of the individual resident. Refer to Appendix 1 for Restorative Program Description.~~

4.3. Assessment includes any of the following that apply:

- a. Functional activities in which the resident has recently declined.
- b. Functional activities in which the resident believes there is potential for increased independence or a need for maintenance to prevent decline.
- c. Activities in which the nurse, licensed therapist, physician, or other member of the interdisciplinary team identifies that the resident has potential for improvement or a need for maintenance to prevent decline.
- d. Consideration of conditions that commonly cause functional decline such as stroke, Parkinson's Disease, Multiple Sclerosis, peripheral neuropathy, Muscular Dystrophy, spinal cord injury, or coma.
- e. Review of data that contributes to the assessment process such as the Minimum Data Set (MDS), the Care Area Assessments (CAA), Certification and Survey Provider Enhanced Reports (CASPER), and assessment or progress notes from any clinical discipline.
- f. If the resident has a progressive illness/condition in which a decline in function is anticipated and the restoration in function is not realistic, and/or has goals of care that are primarily focused on comfort measures, ~~a restorative~~ interventions nursing program may be utilized for preservation of function.

B. Planning restorative care

~~1. Using the assessment data, The plan of care is developed with restorative component after the assessment data is gathered and may include PROM, AROM, or other restorative treatments individualized to the residents.~~

~~1.~~

~~a. The LN develops a care plan:~~

~~i. Problem statements are determined by the functional assessment and are generally functionally oriented.~~

~~ii. Goals must be specific, measurable, and time oriented. Both maintenance and improvement goals are appropriate for restorative nursing.~~

~~b. Restorative care: Informal consultation is often useful with the interdisciplinary team and clinical services such as PT, OT, or SPT for care planning and decision making related to restorative nursing.~~

~~2. Restorative Nursing Program: rehab referral consult to the Restorative Nursing Program includes recommended treatments that the LN will incorporate into the care plan~~

~~c.~~

~~3. Planning for a comprehensive restorative nursing program often includes both unit-based and wellness-based activities provided by trained TAs/CNAs/PCAs, other staff, or volunteers under the supervision of a LN, with consultations and recommendations by the Therapist. In this case, the care plan can be combined and the All restorative minutes may be counted in section O of the MDS, regardless if they are provided as part of restorative care or the Restorative Nursing Program. as restorative nursing as long as nursing staff are responsible for the overall coordination and supervision of restorative nursing programs.~~

~~4. The licensed nurse writes "Restorative Care Plan" at the top of the care plan page and indicates the restorative program (i.e., "Ambulation"). Multiple restorative problems can be combined per care plan. Restorative Care Planning templates are also available for this purpose.~~

~~2.~~

Restorative Nursing Program

- a. ~~Problem statements are determined by the functional assessment and are generally functionally oriented.~~
- b. ~~Goals must be specific, measurable, and time oriented. Both maintenance and improvement goals are appropriate for restorative nursing.~~

~~C. Restorative interventions~~

1. ~~TAs provide restorative treatment in the wellness gym, on the neighborhoods (unit-based) and in the aquatics pool, under the supervision of a LN with initial recommendations (when appropriate) and follow up consultations provided by the licensed therapist. Restorative therapy is reviewed quarterly for modifications and/or discharge by the LN, licensed therapist and RCT.~~
 - a. ~~Wellness gym: Restorative treatment in the wellness gym utilized specialized equipment and requires an initial consult form from the physician for an evaluation by a therapist.~~
 - b. ~~Neighborhood (unit-based) restorative programs: Restorative programs on the neighborhoods can be initiated by a LN, with consultations by the licensed therapist. Depending on the medical or physiological complexity of the resident, the restorative program can be done one to one or in a small group. This program requires an initial evaluation by a licensed therapist (either informally or via consult form).~~
 - c. ~~Aquatics: This restorative program can be used for residents who may not tolerate therapy on land due to pain or other movement issues. The licensed therapist may be present for all sessions of this type of programming. Aquatics requires an initial consult from the physician to ensure that the resident meets the basic criteria (refer to LHH PP 28-03 Aquatic Services).~~
2. ~~Licensed staff provide direction, oversight and follow up for restorative nursing interventions performed by CNAs/PCAs/TAs and other trained staff or volunteers.~~
3. ~~Resident specific staff training may be requested by the unit on an as-needed basis and is generally provided by the therapist whenever a resident is transitioning from skilled therapy to a wellness-based or unit-based nursing restorative program.~~

~~D.C. Documentation~~

1. Monthly Summary by the unit LN and Quarterly Summary by Restorative Nursing Program RN:
 - a. For all residents receiving restorative nursing care or in-participating in the restorative nursing program, the licensed nurse evaluates the effectiveness of the restorative treatments by documenting the progress toward or away from restorative goals, and describing the resident's related clinical status or changes to the interventions or goals as needed. (e.g., "Restorative goal of ambulating 60 feet BID with 1 assist and gait belt has been met. Goal increased to 60 feet TID").
 - i. Periodic evaluation of restorative activities is demonstrated by routine documentation in the summaries and RCT notes. Progress toward or away from the restorative goal is documented followed by reason and/or modifications to the interventions or goals.
 - ii. Resident and staff teaching related to the restorative program.
 - iii. Consultation with the interdisciplinary team and therapies, as needed, to modify the program.
 - iv. Consultation with ancillary services, interdisciplinary team members, and/ or a Clinical Nurse Specialist or Clinical Resource Nurse trained in

restorative assessment and programming when the need for initial or additional staff development is identified.

2.—The TA may initiate a Quarterly Summary for the Restorative Nursing Program that must be reviewed and co-signed by the RN.

b.

2. Care Plan:

- a. The unit's LN responsible for the restorative nursing care problems, goals and interventions.
- b. The Restorative Nursing Program's RN responsible for the restorative nursing program problems, goals and interventions.
- c. Collaboration with RCT members or the resident as needed to determine the resident's preferences and choices.
- d. Care plans developed by other disciplines are appropriate to use for nursing restorative programs with the agreement of the discipline and by identifying nursing as one of the responsible services (e.g., Residents with individualized feeding plans written by the SLP are often restorative in nature and require nursing implementation).
- e. Individualized feeding plans for thickened liquids or special diet only are not appropriate for restorative nursing care.

3. Minimum Data Set (MDS):

- a. The MDS coordinator completes section O, "Nursing rehabilitation/ restorative care" of the MDS to indicate the number of days the restorative techniques or practices were provided for equal to or greater than 15 minutes per day in the last 7 days.
- b. The MDS coordinator records bladder retraining and scheduled toileting in section H0200 Urinary Toileting Program.

4. ~~Daily Nursing Care Record (DNCR)~~Electronic Health Record (EHR) ADL and Restorative Documentation:

- ~~a. The licensed nurse records the restorative interventions that the CNA/PCA is to implement on the DNCR.~~
- a. The licensed nurse indicates in writing the restorative intervention(s) that CNA/PCAs/TAs are to perform in the EHR on the Daily Nursing Care Record (DNCR).
- ~~b. Bladder retraining and scheduled toileting are documented on the "Interventions" page of the DNCR. All other restorative activities are documented on the "Restorative Nursing" page of the DNCR.~~
- ~~c. Scheduled toileting and bladder retraining are written on the "Interventions" page of the DNCR.~~
- ~~d. All other restorative interventions are written on the "Restorative" page of the DNCR~~
- e.b. The CNA/PCA/TA documents in the EHR, the completion of restorative interventions and the total number of minutes spent doing the activity per restorative component, except for bladder and bowel training. initials the DNCR to indicate the shift on which the restorative intervention(s) were completed.
- ~~f. The CNA/PCA also notes the total number of minutes spent doing the activity for each restorative activity, except for bladder retraining and scheduled toileting.~~
- c. Observations of problems, reasons for not performing or participating in restorative interventions, or resident complaints during restorative care are reported to the licensed nurse and documented in the supplemental notes section of the DNCR in the EHR (i.e., dizziness, pain, shortness of breath, resident refusal, etc.).
- a.—Restorative Nursing Program:
- d.

—
5. Resident Care Plan (RCP):
—

- a. The licensed nurse, responsible for the restorative nursing care plan (Refer to the Planning Restorative Care Section).
- b. Collaboration with members of the RGT is often necessary.
- c. Care plans developed by other disciplines are appropriate to use for nursing restorative programs with the agreement of the discipline and by identifying nursing as one of the responsible services (e.g., Residents with specialized feeding plans written by the speech therapist are often restorative in nature and require nursing implementation).
- d. When specialized feeding plans are only for thickened liquids or special diets, a restorative nursing program may not be appropriate.

—
6. Therapy Aide documentation:
—

- b. For wellness-based and unit-based restorative programs by TAs, the licensed therapist initiates the care plan, goals and interventions that the TAs are to perform. Follow up and supervision are provided by a LN.
- c. Restorative treatment provided by TAs will be documented on a daily basis (e.g., attendance, time spent on therapy) in the electronic database. If the treatment is refused or withheld, the TA will write a brief note explaining the reason. The electronic database, which is maintained by the Therapists and TAs, will have documentation including:
 - i. Activity provided
 - ii. Minutes of activity
 - iii. Level of assistance and support
 - iv. Problems, progress, outcomes
 - v. Unusual occurrences (i.e., pain, refusal, withholding of treatment, change in condition)
- d. The TAs will provide a copy of the monthly attendance for the license nurse to review
- e.i. The TAs will document in a note at least quarterly at a minimum, in the electronic database, the resident's progress towards goals, the response to treatment and functional status of each resident in the TA restorative program. The documentation may compare the previous quarter's note for any changes. Documentation should reflect how the resident responds to the program in relation to behavior (e.g., refusal, anxious, combative, etc.), along with physical response (e.g., fatigue level, attention, distractibility, etc.). Content may include:
 - i.1. Activity provided
 - ii.2. The specific distance or repetitions
 - iii.3. Use of assistive devices
 - iv.4. Resident response to activity (endurance and tolerance level)
 - v.5. Amount of assistance needed and why (i.e., verbal cues, stand by assist of one, moderate assist of one, etc.)
 - vi.6. Outcomes, progress or lack of progress
- ii. The TA will document and communicate any unusual occurrences, significant resident problems or significant changes to the Restorative Nursing Program Nurse Manager, and the RN Nurse Liaison and Rehab Liaison and/or referring licensed therapist.

f.

E. Evaluation of restorative care

1. Each resident's restorative nursing program is carried out under the supervision of a licensed nurse and includes:

- a. ~~_____ Evaluation of the resident's response to restorative interventions in relation to the restorative goals on the care plan, which includes evaluation of the CNA's/PCA's documentation on the DNCR and the TA's documentation on the electronic database.~~
 - b. ~~_____ Resident and staff teaching related to the restorative program.~~
 - c. ~~_____ Consultation with the interdisciplinary team and therapies, as needed, to modify the program.~~
 - d. ~~_____ Consultation with ancillary services, interdisciplinary team members, and/ or a Clinical Nurse Specialist or Clinical Resource Nurse trained in restorative assessment and programming when the need for initial or additional staff development is identified.~~
2. ~~_____ The frequency for program evaluation is determined by the individual resident's needs as indicated by the target dates in the "goals" section of the Restorative Care Plan.~~
3. ~~_____ Periodic evaluation of restorative activities is demonstrated by routine documentation in the summaries and RCT notes. Progress toward or away from the restorative goal is documented followed by reason and/or modifications to the interventions or goals.~~
- a. ~~_____ Wellness-based (TA): quarterly by the TA~~
 - b. ~~_____ Unit-based (TA): quarterly by the TA~~
 - c. ~~_____ Unit-based (CNA/PCA, other staff, volunteers): monthly by the LN~~
 - d. ~~_____ Licensed nurse: monthly summaries evaluating restorative treatments~~
 - e. ~~_____ RCT: quarterly evaluation of restorative treatments~~

APPENDIX:

Appendix 1: Restorative Program Description

REFERENCES:

~~The American Association of Nurse Assessment Coordinators MDS Education Program Manual, Accurately Assessing for Restorative Nursing and the MDS 3.0, 2012.~~

CMS's RAI Version 3.0 Manual [v1.16](#) (2018~~2~~).

[Medicare and Medicaid requirements for participation for Long Term care facilities \(2017\)](#)

CROSS REFERENCES:

NPP F1.0 Assistance with Elimination
NPP F2.0 Assessment and Management of Urinary Incontinence
NPP F3.0 Assessment and Management of Bowel Functions
NPP F4.0 Application and Management of Condom Catheters
NPP E1.0 Oral Management of Nutritional Needs
NPP D5 2.0 Limb Care following Amputation
NPP D5 5.0 Braces - Leg
NPP D6 2.0 Transfer Techniques
NPP D6 3.0 Range of Motion Exercise
NPP D6 4.0 Positioning and Alignment in Bed and Chair
NPP D6 5.0 Ambulation
C 3.1 Guidelines for Documentation of Resident Care by the Licensed Nurse
C 3.2 Documentation of Resident Care by Nursing Assistant
F 6.0 Colostomy Management

D1 2.0 Resident Activities of Daily Living (Basic Care)
D5 4.0 Arm Sling

LHPP 20-37 Management of Dysphagia and Aspiration Risk
LHPP 20-48 In-house Requests for Rehab Consultations and Services
LHHPP 28-03 Aquatic Services

Original: 12/2004

Revised: 09/2008; 03/10/2015

Reviewed: 03/10/2015

Approved: 03/10/2015

BATTERY OPERATED LIFT TRANSFER

POLICY:

1. ~~1.~~ 4.—The licensed nurse or designee will assess each resident to be transferred by the EZ Lift to determine the most appropriate material, style and size of sling. The results of their assessment will be entered on electronic health record (EHR).
- ~~4.2.~~ Two nursing staff members are always required for operation of the EZ Lift.
- ~~2.3.~~ ~~32.~~ Residents will be reassessed for appropriate slings after a change of condition including but not limited to ability to control the head, an amputation, leg sores, significant weight change, difficulty or refusal to follow directions.
- ~~3.4.~~ ~~43.~~ For residents with aggressive behavior, lacking the ability to follow directions, or whenever otherwise clinically indicated, additional nursing staff will assist with lift transfer (see also #2).
- ~~4.5.~~ ~~54.~~ Each resident will have his/her own sling(s) which will be identified with his/her name.
- ~~5.6.~~ All nursing staff will receive training and demonstrate competency in the safe use of the equipment prior to transferring a resident at a minimum during new employee orientation and annually thereafter.
- ~~6.7.~~ EZ Lift slings should only be used for the EZ Lift.

PURPOSE:

To provide safe transfers.

PROCEDURE:

A. The licensed nurse or designee will assess each resident prior to the first transfer and reassess as needed to determine the most appropriate sling for the battery operated lift.

1. Resident factors to be considered regarding type of sling:
 - a. Resident's weight
 - b. Resident's measurements:
 - i. Length of Trunk: maximum distance 2 inches from resident's tailbone to base of neck.
 - ii. Resident's girth / width of shoulders – resident's body should not overlap the sides of the sling
 - c. The resident's ability to support and control his/her head
 - d. If the resident has an amputation(s) above the knee or contractures
 - e. If the resident has large fleshy thighs or delicate skin or sores on the legs
 - f. Difficulty or refusal to follow directions
2. Determining type of sling (See Attachment 1b: EZ Way Sling Sizing Chart)
 - a. Regular
 - i. Without padded legs
 - ii. Made of canvas or mesh for bathing and quick drying
 - b. Deluxe (standard)
 - i. Have padded legs for comfort and support

Battery Operated Lift Transfer

- ii. Made of canvas
 - c. Multi-purpose
 - i. Made of canvas with padded legs or mesh
 - ii. Use for persons with –
 - Lower body contractures
 - With amputation
 - Large fleshy thighs
 - Delicate skin
 - iii. Special Head Support slings are available on special order for residents with weak head control
3. Determining the sling size
- a. Select size of sling based on: (See Attachment 1b: EZ Way Sling Sizing Chart):
 - i. Weight of the resident, and/or
 - ii. Measurement from maximum distance from resident's tailbone to base of neck (see attachment 1). ***Not applicable with belted mesh or multipurpose slings*
 - iii. When determining the appropriate sling size, based on resident's measurement, it is important to evaluate the width of the resident's shoulder in relation to the width of the sling and no portion of the resident's body should overlap the sides of the sling.

*Note: The size/weight designations stated by the manufacturer are merely estimates and basic guidelines. A proper and safe fit will depend on factors in addition to weight measurement including the height and girth of a resident.
 - b. How to measure resident:
 - i. The base of the sling must be positioned 2 inches below the tailbone and top of the sling parallel with the top of the shoulder (base of neck). See attachment 1.

B. Documentation

1. Care Plan
 - a. Document the type of transfer technique used.
2. EZ Lift Sling Assessment Form (See Attachment 1a: EZ Lift Assessment Form)
 - a. Complete prior to use of sling and EZ lift, and include in RCP.
 - b. Licensed Nurse to update any sling changes based on significant change in resident's condition (Refer to Procedure A: Section 1 "Resident factors to be considered when selecting a sling").

C. Prior to transfer

1. Check the resident's care plan.
2. Inspect the lift for damage and the sling for fraying or other signs of wear.
3. Identify the resident's sling by name and check style and size using the information in the resident's care plan.
4. Prepare the surface the resident is being transferred to and lock all the wheelchair gurney brakes.
5. Positioning the sling:
 - a. Position sling under the resident with the handles facing outward from the resident's skin.
 - b. Check that the resident is centered on the sling:

Battery Operated Lift Transfer

- i. The sling wraps around the shoulders like a shawl.
 - ii. Is not more than 3 inches below the coccyx.
 - iii. The resident will not be sitting on the sling.
 - iv. The resident's body and arms fit and remain in the sling during transfer.
 - c. Lift the resident's left thigh; and pull the left wing of the sling under the thigh. Then place it on top of the left thigh. Repeat for the other leg. You may choose to do the right leg first, using the right wing and placing it over the right thigh.
6. Positioning the lift:
 - a. Wheel must be unlocked during the transfer.
 - b. Position the green nosecone 2 inches above the abdomen.
7. Attaching the Regular and Deluxe Sling to the lift:
 - a. First attach the two shortest loops at the shoulders. (The other loops are used to move from a reclining position to a reclining position).
 - b. Take the wing lying on the left thigh and using the middle loop attaches it to the right lift hook. Repeat for the other leg. You may choose to do the right leg first attaching the loop to the left lift hook.
8. Attaching the Multipurpose Sling to the lift:
 - a. Check that the center of the commode hole is one inch below the tailbone.
 - b. The wings of the sling are threaded through each other.
 - c. The middle or longest loop may be used depending upon the resident's comfort and sense of comfort.
9. Moving the resident to the chair:
 - a. Ensure that the resident's arms are in the sling.
 - b. Push the "Up button" on the hand control.
 - c. Once there is tension and the resident is 1 inch off the mattress:
 - i. Check that loops are secure in the hooks
 - ii. The sling is smooth under the resident
 - d. Move the lift to the chair and standing behind the chair use the handles to guide the resident.
 - e. Push the "down" button.
10. Emergency Lowering:
 - a. If the hand held controls or the controls on the lift fail:
 - i. Pull up on the emergency button 1-3 times
 - ii. Pull up on the emergency lowering handle until the resident is placed on the desired surface.

REFERENCES:

EZ Lift Operating Instructions [Manufacturers Manual]. (2005). Clarinda, IA: EZ Way, Inc.

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Battery Operated Lift Transfer

Nursing P&P D6 2.0 Transfer Techniques
Nursing P&P D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

Attachment 1a: EZ Lift Sling Assessment Form
Attachment 1b: EZ Way Sling Sizing Chart
Attachment 2: EZ Lift Operating Instructions
Attachment 3: Competency Check List for Battery-Operated Lift

Revised: 1/2008, 4/2010, 6/2010, 8/2010, 02/14/2011; 07/22/2014; 09/23/2016; 09/10/2019

Reviewed: 09/23/2016

Approved: 09/23/2016

OBTAINING, RECORDING AND EVALUATING RESIDENTS WEIGHTS

POLICY:

1. Any nursing staff except for Home Health Aide may obtain residents' weights.
2. ~~All Palliative care resident's will be weighed on admission, then monthly, using the bed scale. Should obtaining weights have a negative impact on the resident's comfort causing undue pain or stress, the weight will not be taken and the reason will be documented. Each Palliative care resident will have a care plan that addresses potential anticipated weight loss as well as the Resident's nutritional needs.~~
- 2.3. Resident weight is obtained on the day of admission/readmission, monthly, as clinically indicated, and during the observation period of the Minimum Data Set (MDS) unless otherwise indicated by a physician order.
- 3.4. Residents are weighed by the receiving neighborhood upon relocation.
- 4.5. Reweighs are performed each time the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g., planned weight loss).
- 5.6. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.
- 6.7. Monthly weights shall be obtained every first weekend of each month.

PURPOSE:

To obtain accurate weight measurements and identify unintended weight changes to facilitate effective care planning.

PROCEDURE:

A. Obtaining Weights

1. Check previous weight prior to weighing resident to immediately identify any potential discrepancy.
2. To obtain accurate weight, weigh resident in the day shift at a consistent time and have resident wear consistent clothing and/or devices.
3. Resident will be weighed using the same scale, clothing, and/or linen with each reweigh.
 - a. Use the scale's manufacturer's instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the Central Supply Room (CSR)
 - b. If the manufacturer's instructions are not readily available, contact Facility Services.
 - c. Improperly functioning scales are reported to Facility Services through a work order.

Obtaining, Recording and Evaluating Residents Weights

4. Immediately prior to weighing resident, staff shall zero the scale.

B. Reweighing

1. If there is a weight change greater than 5 pounds (+/-), immediately reweigh resident.
2. Continue to reweigh resident daily for the next 2 consecutive days.

C. Frequency of Weights

1. On admission/readmission, nursing will obtain resident weights on the day of admission/readmission.
2. Residents shall be weighed weekly for 4 weeks after admission, then monthly, unless otherwise prescribed by physician.
3. Nursing will weigh resident for a significant change in condition, change in food intake, and other evidence of altered nutritional status or fluid and electrolyte imbalance.

D. Reporting

1. Weights must be reported to the licensed nurse during the shift it was obtained
2. If the weight variation is greater than or less than five pounds (2.27 kilograms) and is unanticipated weight change, the licensed nurse notifies the physician and dietitian.
3. The nurse reports unintended weight loss or gain to the dietitian and physician:
 - a. 5% or greater over 30 days
 - b. 7.5% or greater over 90 days
 - c. 10% or greater over 180 days
4. The licensed nurse will notify the MDS Coordinator or Nurse Manager to include resident with significant weight change on the list of resident's for discussion at the next Resident Care Team meeting.

E. Documentation

1. The type of scale (e.g. wheelchair or floor scale, EZ-Lift scale, or electronic bed scale) to be used is noted on Care Plan
2. ~~Licensed staff~~**Nursing Staff** documents all weights, in kilograms, on the resident's electronic health record.
3. Licensed nurse will document on the electronic health record the assessment and actions taken for unintended weight changes.

REFERENCES

NONE

Obtaining, Recording and Evaluating Residents Weights

File: **G 7.0, March 12, 2019**, Revised
LHH Nursing Policies and Procedures

CROSS REFERENCES:

Nursing Policy and Procedure
G 4.0 Measuring the Resident's Height and Weight

ATTACHMENT/APPENDIX:

NONE

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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,

Medication Administration

[For JCC Approval on 9/10/19](#)

strength, amount and name of person preparing.

10. Medication administration times may be modified to accommodate residents' clinical need or with resident's preferences. Licensed nurse will notify pharmacy via Electronic Health Record (EHR) with medication administration time 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. 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. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).
15. 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.
16. It is the legal and ethical responsibility of the licensed nurse to prevent and report medication errors.
17. Topical creams/ointments available in the neighborhood (e.g., Dimethicone, Enzo) do not require a physician's order.
18. 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 J 1.4
 - 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-sfqhweb01/Nursing/Documents/PushMedicationGuidelines.pdf>
6. RIGHT DOCUMENTATION
- 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.

Medication Administration

[For JCC Approval on 9/10/19](#)

- 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.
2. Stat medication orders are processed immediately, and administered no later than four

Medication Administration

[For JCC Approval on 9/10/19](#)

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 on 9/10/19](#)

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.).

Medication Administration

[For JCC Approval on 9/10/19](#)

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.

Medication Administration

[For JCC Approval on 9/10/19](#)

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 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.

Medication Administration

[For JCC Approval on 9/10/19](#)

- 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 (Don 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

Medication Administration

For JCC Approval on 9/10/19

- 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 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.

Medication Administration

For JCC Approval on 9/10/19

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).
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.
3. Narcotics/controlled substances that are removed and not administered and/or are only partially administered, ~~must be promptly~~ 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.
 - a.d. Both LNs shall document the waste in Omnicell and eMAR.
 - ~~b. The 2nd LN should visually confirm the medication type and the amount being wasted is accurate and will co-sign in eMAR and/or Omnicell of waste.~~
 - ~~c. If only partial medication is given, 2nd LN should verify at time of medication pull the dose is split and being wasted.~~
4. If resident refuses medication, LN shall medication return 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

Medication Administration

For JCC Approval on 9/10/19

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.
 - 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

Medication Administration

[For JCC Approval on 9/10/19](#)

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>

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](#)

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

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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

[LHHPP File: 25-11 Medication Errors and Incompatibilities](#)

[LHHPP File: 25-08 Management of Parental Nutrition](#)

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

Medication Administration

[For JCC Approval on 9/10/19](#)

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

Medication Administration

[For JCC Approval on 9/10/19](#)

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

DRAFT



Standard Work Instructions

Title: LN Wasting Controlled Substance (**Partial Dose**)

Performed By: LHH Licensed Nurses

Date First Created: 07/18/19





Owner: Licensed Nurses

Revised By: M. Valencia

Revision #: 2

Takt Time: 10
mins

Purpose: To establish steps to ensure efficient and safe process when performing controlled substance waste at each shift.

Major Steps	Reason(s)	Time	Diagram, Work Flow, Picture,
1. Review Controlled Medications pulled from OMNICELL if need partial wasting.	Identifying need to waste prior to leaving medication room for med pass.	3 mins	
2. Get a 2 nd License Nurse (LN) to initiate Controlled Substance Waste.	2 nd LN needed when initiating waste.	3 mins	
3. 2 nd LN shall witness both when the medication is still in the sealed packaging, and the actual wasting of the partial dose.	Ensuring correct medication being wasted	3 mins	
4. Both LN will document waste in OMNICELL	Complete the waste process.	1 min	



Standard Work Instructions

Title: LN Wasting Controlled Substance (**Resident Refuse Meds**)

Performed By: LHH Licensed Nurses







Date First Created: 07/18/19

Owner: Licensed Nurses

Revised By: M. Valencia Revision #:2

Takt Time: 10 mins

Purpose: To establish steps to ensure efficient and safe process when performing controlled substance waste at each shift.

Major Steps	Reason(s)	Time	Diagram, Work Flow, Picture
1. DO NOT open packaging of medication until resident okay to take medication.	This will avoid wasting medication if resident refuse medication prior to opening package.	3 mins	
2. Return medication to original package once resident refuse medication	To be able to identify medication and avoid misplacing pill.	1 min	
3. Get a 2 nd License Nurse to initiate Controlled Substance Waste	Assigning designated time ensures 2 nd LN present to witness waste.	3 mins	
4. 2 nd License Nurse to validate, and ID medication since packaging already opened. This can be done by either via looking up ID medication tag via Lexicomp.	Ensures actual medication to be wasted is correct.	5 mins	
5. 2 nd LN shall witness the actual wasting of controlled substance medication that was refused.	Ensuring correct medication being wasted.	3 mins	
6. Both License Nurse shall document waste in OMNICELL	Complete the waste process.	3 mins	

Revised Pharmacy Policies and Procedures

POLICY AND PROCEDURE FOR ORDERS FOR MEDICATIONS AND STANDING ORDERS

Policy:

Only medications prescribed by a physician, affiliated healthcare practitioners credentialed by the medical staff, dentist, or podiatrist will be administered to a resident and no standing orders* will be used.

Purpose:

To ensure proper administration of medications to-residents.

Procedure:

- I. All prescription orders must be ~~in writing or~~ electronically prescribed or in writing per downtime policy and should contain the following:
 - A. Date and time order is written
 - B. Patient name and medical record number
 - C. Medication name (generic preferred)
 - D. Strength or concentration
 - E. Dose
 - F. Frequency or time of administration of the medication
 - G. Route, e.g. PO, IM, SC, IV or rectal
 - H. Rate of administration for continuous IV medications
 - I. All orders (PRN and scheduled) must include the indication for use of the medication. PRN orders must also include how often the medication may be given.
 - J. Duration of therapy or quantity if applicable (e.g. antibiotics, outpatient prescriptions, pass medications)
 - K. Prescribing practitioner signature (written or electronic)
- II. All verbal or telephone orders to the nurse or pharmacist should be immediately recorded in the resident's chart and signed by the prescriber within 48 hours for the acute unit and within five days for SNF units.
- III. There will be no standing orders for medications or treatments.
- IV. ~~—The provider will complete a medication reconciliation each month. This will serve as the monthly medication renewal for SNF medications. The electronic health record (EHR) "Current Medication List" is the chart order for SNF residents of the~~

facility. EHR e-prescription function requires quantity dispense and number of refills to be populated before prescription data can be e-prescribed. Quantity dispensed will be per Pharm 02.01.00b. The “Current Medication List” verified by the provider each month (medication reconciliation) is considered the continuation order. If the medication is not able to be entered into the electronic health record (e.g. TPN,

~~compounded medications) a written order of the paper chart physician order sheet will be accepted. The provider signs a monthly re-cap (continuation) of these orders each month. Medications will be discontinued upon a discontinue order or per the automatic stop policy (Pharm 01.02.02).~~

V. Residents have a right to elect the dispensing pharmacy. When using an outside pharmacy, the family assumes the responsibility for supplying correct, properly labeled medications on a timely basis. Such medications will be delivered directly from the resident's pharmacy to Laguna Honda Pharmacy during our normal pharmacy hours. Such medications will be checked by Laguna Honda Pharmacy before delivery to the resident's unit. Only those medications which have been ordered by the resident's physician will be allowed.

A. Controlled Substances may not be obtained from another pharmacy unless approved by the Pharmacy Director.

~~VI. — All signed physician's orders will be sent to the pharmacy within 48 hours.~~

REVISED: 6/99DY, 9/00dy, 9/04dw, 4/11, 5/14, 2/15, 3/19
REVIEWED: 02/05DW, 02/06, 01/08, 04/09, 2/10, 4/12, 8/13,

*Standing orders are defined Per California Code of Regulations Title 22 §72109 Standing Orders are orders written which are used or intended to be used in the absence of a prescriber's specific order for a specific patient.

POLICY AND PROCEDURE FOR ACUTE CARE HOSPITAL ORDER PROCESSING AND MEDICATION DISTRIBUTION

Policy:

The Pharmacy at Laguna Honda Hospital will have sole responsibility for distributing medications in the acute care hospital and for establishing procedures for processing of medication orders. All compounding, packaging, distribution, and dispensing of drugs shall be consistent with federal and state laws, rules, and regulations and applicable law or regulation governing professional licensure and operation of pharmacies and professional standards of pharmacy practice.

Purpose:

To ensure proper supplies of medications are dispensed to acute care patients.

Procedures:

A. Persons who may Prepare, Dispense, Transfer Drugs, and make Labeling Changes

1. Drug preparation and dispensing is restricted to a licensed pharmacist or to a designee under the direct supervision of a pharmacist. A licensed pharmacist must monitor all drug preparation and dispensing by non-pharmacist personnel.
2. Only a pharmacist, or authorized pharmacy personnel under the direction and direct supervision of a pharmacist, shall fill and label containers from which drugs are to be distributed or dispensed, make labeling changes, or transfer drugs to different containers.
3. Supportive personnel (non-pharmacists) shall work under the direct supervision of a licensed pharmacist. The supervising pharmacist must be fully aware of all drug-preparation and drug-dispensing activities. Supportive personnel shall comply with facility and pharmacy policies and procedures.

B. Requirement for an Original or Direct Copy of a Drug Order

1. Drugs may be dispensed only from the original or a direct copy of the prescriber's drug order.
2. Orders for drugs shall be electronically prescribed. ~~transmitted to the pharmacy either by written prescription of the prescriber, by an order form which produces a direct copy of the order or by an electronically reproduced facsimile.~~ (Also see Hospital wide Policy on Verbal Orders, LHPP 25-03)
3. Orders that are incomplete, ~~illegible~~, or otherwise unclear shall not be filled and shall be verified or clarified prior to dispensing.
4. "Continue SNF meds" or "Resume previous orders" are not legitimate orders. Incomplete orders shall be clarified on admission to the acute care hospital.
5. If there is any question regarding a drug prescribed, dose, or strength (e.g., very high or very low), administration frequency, or dosage interval, a nurse or pharmacist shall contact the prescriber. Questionable orders shall be clarified prior to dispensing the drugs.

C. Reviews of Order by a Pharmacist

1. All medication orders must be reviewed by a pharmacist before administering to the patient unless a licensed independent practitioner (L.I.P.) controls the ordering, preparation, and administration of the medication *or* in urgent situations when the resulting delay would harm the patient.
2. If the order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, it should be reviewed by a pharmacist as soon thereafter as possible, preferably within 24 hours, following preparation and dispensing.

D. Patient Profiles: The pharmacy shall maintain a patient profile (drug therapy profile) for each patient.

1. Contents of Profiles shall include:
 - a) Name and location of the patient.
 - b) Sex and age (or birth date) of the patient.
 - c) Pertinent problems or diagnosis(es)
 - d) Drug allergies or sensitivities (or NKA).
 - e) Potential significant drug-food interactions:
 - f) Other information relating to the patient's drug regimen.
 - g) Current drug therapy including:
 - 1) Prescription and nonprescription drugs.
 - 2) Date ordered/reordered and stop date.
 - 3) Drug name, strength, and dose form.
 - 4) Quantity dispensed.
2. A pharmacist shall verify the correct entry of all orders.
3. Patient profiles (or the information in patient profiles) shall be available for review by staff responsible for the patient's care. Access to the information through telephone calls to an on duty or on-call pharmacist is acceptable.

E. Order Processing Procedure

1. The pharmacy shall process drug orders as follows:
 - ~~a) — Ensure that the patient's name, other identification (e.g., patient number and location), time and date are on the order form.~~
 - ~~b) — Review orders for appropriate dose, frequency, formulation, therapeutic indication, medication allergies, drug interactions, therapeutic duplication, and medication safety. Review the order for effective, appropriate including allergies, and safe drug therapy.~~
 - ~~e)a) Enter the order into the pharmacy computer system. Verify the order in the electronic health record (EHR).~~
2. Amounts to Dispense
 - a) Medications are stored in the Automated Dispensing Cabinet (ADC).
 - b) If a medication is not stored in the ADC:
 - 1) The pharmacy shall dispense enough doses to last until the next scheduled delivery of drugs to patients (up to a 7-day supply, but not to exceed the amount prescribed).
 - 2) For short-term medications written for a specific length of time only that amount which is required will be dispensed.
 - 3) For "PRN" medications the amount dispensed will be estimated by the pharmacist, taking into account the rate of usage by the patient in the past; the condition written

for e.g., pain, sleep, etc; and the fact that "PRN" orders may be refilled by the nurse when more medication is needed.

3. Dispensing in Ready-To-Administer Forms
 - a) Drugs shall be dispensed in ready-to-administer forms to the extent practical to minimize opportunities for error.
4. Unit Dose
 - a) Unit of Use packaging, which permits identification of the drug up to the point of administration, shall be used to the extent practicable.
5. Labels
 - a) The medication label when dispensing more than a 48 hour supply will include at least:

<ul style="list-style-type: none"> ✓ Patient's name. ✓ Name of medication (generic or brand). ✓ Drug strength ✓ Dosage form 	<ul style="list-style-type: none"> ✓ Quantity of medication ✓ Expiration date ✓ Initials of technician or pharmacist filling prescription ✓ Appropriate accessory and cautionary statements
<ul style="list-style-type: none"> or ✓ Shape and color of drug if applicable 	<ul style="list-style-type: none"> supplemental labels that address storage requirements, administration procedures, safety precautions, etc.
6. Verifying Order Filling Accuracy
 - a) A pharmacist shall perform a final check after the order has been filled or refilled. This check shall verify that the order was filled and labeled correctly.
7. Drug Availability to Patient Care Areas
 - a) The pharmacy shall ensure that drugs arrive to patient care areas and are available for administration at the scheduled times. If the pharmacy is unable to provide a drug prior to the scheduled administration time, the pharmacy shall inform the nurse responsible for the area and/or the nurse responsible for the patient.
8. STAT Orders & Pharmacy Response Time:
 - a) Nursing service and pharmacy shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered. Drugs ordered "STAT" which are available in the emergency drug supply shall be administered immediately.
 - b) Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.
 - c) Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.
 - d) Refills shall be available when needed.
9. Discontinued Medication Orders
 - a) By the end of shift during which the medication is discontinued, the nursing unit will ~~send or fax the order to Pharmacy,~~ print "DC" on the prescription label and place the medication in the drug pick-up box. This also applies to the medications of residents who expire. The pharmacy will process discontinued orders within 4 hours of receiving.
10. Floor Stock
 - a) Orders for certain medications will not be filled, but will be available as floor stock items. (See Section A, Floor Stock System).
11. Storage of Patient's Drugs in Patient Care Areas
 - a) Each patient's medication is placed in an individual cassette-held drawer which is labeled and designated for that patient.
12. Comparison with Medication Administration Records
 - a) Nurses shall compare drugs supplied with the Medication Administration Record (MAR) or prescriber's order and report irregularities to the pharmacy.
13. Return of Drugs from Patient Care Areas to the Pharmacy

- a) Discontinued drugs, drugs remaining after a patient is discharged; excessive drugs, and unusable drugs shall be returned to the pharmacy.
14. Disposition of Drugs Returned to the Pharmacy
- a) Drugs returned to the pharmacy shall not be placed in active stock or dispensed unless they can be absolutely identified and there is no evidence (or suspicion) of contamination or potential contamination.

F. Patient Transfers

- 1. When a patient is discharged / admitted to or from an acute unit, the patient's medications must be returned to pharmacy by the sending unit. New medications will be obtained by the receiving unit. If the pharmacy is closed at time of discharge / admission to or from the acute care unit, the nurse will send the medications to the receiving unit and these medications may be used temporarily until the pharmacy re-opens. Once the pharmacy reopens new medications must be obtained.
- 2. When a patient is temporarily moved within LHH from a SNF unit to a bed within the acute hospital for a "come & go" visit (e.g. "boarders" for blood transfusion):
 - a) New orders are not needed since this is not an acute care admission
 - b) The nurse will send the patient's medication to & from the receiving SNF unit.
 - c) ~~The Chart, MAR and other pertinent care records from the SNF unit are used to chart information about medication use, vital signs, etc.~~

G. All medications of a deceased patient will be returned to the pharmacy for disposal.

H. Controlled Substances: All scheduled medications must be initiated with a written order.

- I. Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room. (See Policy 02.03.00 for Supplemental Drug Room procedure.)

New 08/07dw
Reviewed: 01/08, 04/09, 2/10, 5/11, 4/12, 8/13, 5/14, 8/15
Revised: 10/09, 5/17, 3/19

See HWP 25-02 Safe Medication Orders

LAGUNA HONDA HOSPITAL
DEPARTMENT OF PHARMACEUTICAL SERVICES

02.01.00b

POLICY AND PROCEDURE FOR SKILLED NURSING DISTRIBUTION OF MEDICATIONS AND
MEDICATION ORDER PROCESSING

Policy:

The Pharmacy at Laguna Honda Hospital will have sole responsibility for distributing medications in the hospital and for establishing procedures for processing of medication orders.

Purpose:

To ensure proper supplies of medications to residents.

Procedures:

I. The Individual Resident Prescription System:

- A. The physician electronically prescribes new orders for residents. Monthly renewals for medications is accomplished thru the medication reconciliation process in the electronic health record.
- B. New orders are transmitted electronically . These orders are maintained electronically in the pharmacy module of the electronic health record (EHR).
- C. The pharmacy will check each order against the resident's medication profile for incompatibilities, allergies, unusual dosages, and errors. The pharmacist shall require physician clarification of orders prescribed for unusual uses, as well as any other medication irregularities.
- D. Each order is filled with the appropriate amount of medication.
 1. For Skilled Nursing Facility residents, not more than a 48 hour supply of medication is issued for regularly scheduled medications.
 2. For short-term medications written for a specific length of time only that amount which is required will be dispensed.
 3. For "PRN" medications the amount dispensed will be estimated by the pharmacist, taking into account the rate of usage by the resident in the past; the condition written for e.g., pain, sleep, etc; and the fact that "PRN" orders may be refilled by the nurse when more medication is needed.

E. Resident Transfers

1. When a resident is transferred within LHH from a SNF unit to another SNF unit, the nurse will send the resident's medication to the receiving unit.
2. When a resident is discharged / admitted to or from an acute unit, the resident's medications must be returned to pharmacy by the sending unit. New medications will be obtained by the receiving unit. If the pharmacy is closed at time of discharge / admission to or from the acute care unit, the nurse will send the medications to the receiving unit and these medications may be used temporarily until the pharmacy re-opens. Once the pharmacy re-opens new medications must be obtained.

F. A record of medications dispensed should be made in the resident's medication file to include: quantity of medication, prescription number, date and initials of pharmacist filling or checking the meds filled by a technician.

G. The prescription label for greater than 48 hour supply of medication for each resident will include:

- | | |
|---|--|
| ✓ Resident's name. | ✓ Amount of medication. |
| ✓ Prescription number. | ✓ Prescribing physician's name. |
| ✓ | ✓ Date filled. |
| ✓ Resident's medical record number. | ✓ Manufacturer's name (if generic). |
| ✓ Directions including rate of administration for IV medications. | ✓ Expiration date. |
| ✓ Name of medication (generic or brand). | ✓ Initials of technician or pharmacist filling prescription. |

H. Discharges:

1. Cassette medications may be sent with the resident upon discharge unless one of the following situations exists:
 - a) Physician specifies otherwise.
 - b) Resident leaves without physician approval.
 - c) Resident discharged to acute hospital or health care facility other than LHH.
 - d) Medication discontinued prior to discharge.
 - e) Labeled directions substantially differ from current orders.
 2. Discharge meds will be dispensed in child-proof containers. Labels will be typed in lay-language
 3. A record of the medications sent with the resident should be made in the resident's file to include: name of medication, prescription number, quantity of medication, date, and initials of pharmacist filling or checking the meds filled by a technician.
- I. Pass meds: Medication Orders will be filled for resident's use on short-term passes, provided the physician has given orders for such medication use. (See Policy and Procedure 02.01.04, Pass Medication)

- J. Orders for certain medications will not be filled, but will be available as floor stock items. These items include laxatives, vitamins, A & D ointment, petrolatum, antacids, acetaminophen, aspirin, or other approved medications. (See Section A, Floor Stock System)
- K. Each resident's medication is placed in an individual envelope which is labeled and designated for that resident.
- L. The medications in the individual labeled envelope are delivered to the appropriate Unit. Nursing staff on the Unit will place the medications from the envelope into the patient's labeled cassette drawer.
- M. The duplicate envelopes are returned to the pharmacy.
- N. New physician's orders that are written during the interim period are accommodated in the following manner:
 - 1. Orders that add medication to a resident's drug regimen are sent to the pharmacy to be filled and delivered to the Unit.
 - 2. Orders that discontinue medication from a resident's drug regimen are sent to the Pharmacy, along with the discontinued med from the resident's drawer.
- O. If a resident is transferred to a different Unit, the Unit nurse will include all of the resident's medications in the transfer to the new Unit.
- P. All medications of a deceased resident will be returned to the pharmacy for disposal.
- Q. All orders received will constitute a prescription and will be kept as required by State and Federal law.
- R. Emergency and non-emergency medications needed after hours can be obtained from the Nursing Supervisor who has access to the Supplemental Drug Room. (See Policy 02.03.00 for Supplemental Drug Room procedure.)

NOTE: Normal pharmacy hours are Monday through Friday, 8 a.m. to 5:30 p.m. and 9 a.m. to 4 p.m. on Sunday. On legal holidays the Pharmacy will be open from 8 a.m. to 4:30 p.m. The pharmacy will be closed on Thanksgiving and Christmas.

Reviewed 06/03dw, 02/06, 01/08, 04/09, 4/12, 8/13

Approved by P&T Committee 2/2019

Revised 06/07, 02/08, 05/08, 2/10, 5/11, 4/14, 2/15, 5/17, 3/19

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 ~~ist~~ 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 partially full or used medication (e.g. pills, capsules, ointments, paste, and patches) 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.~~Their~~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: 0403dw, 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

LAGUNA HONDA HOSPITAL
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR BEDSIDE STORAGE OF MEDICATIONS

Policy: Bedside Storage of Medications shall comply with State and Federal regulations governing such activity. The Pharmacy and Therapeutics Committee is responsible for approving policies and procedures related to the safe storage of bedside medications.

Purpose: To give residents more freedom of choice with regard to their medical treatment and to prevent unauthorized use or handling of bedside medications.

Procedure:

- I. Prior to replacing medications at the bedside, the ~~multi~~ interdisciplinary team shall determine that the resident can safely self-administer medications and an appropriate plan of care shall be written.
- II. Only medications prescribed by physicians for bedside storage may be kept at bedside. In general, the following may be prescribed for bedside use.
 - A. Sublingual or inhalation medications for immediate use.
 - B. Ophthalmic medications (eyedrops or ointments)
 - C. Over-the-counter (nonprescription) medications.
 - D. Other legend items approved by the ~~Multidisciplinary~~ Interdisciplinary Team.
 - E. Medication intended for a trial of resident self-administration prior to discharge and approved by the ~~Multidisciplinary~~ 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).
- III. All legend 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.
- IV. No controlled drugs shall be kept at bedside.
- V. The Pharmacy will label all bedside medications in appropriate lay-language.
- VI. 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.
 1. 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.
 2. The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time the medication is supplied.

10/91

Revised: 6/98, 3/19

REVIEWED: 02/05dw, 02/06, 01/08, 04/09, 2/10, 5/11, 4/12, 8/13, 5/14, 8/15

POLICY AND PROCEDURE FOR CONTROLLED SUBSTANCES

Policy:

Record maintenance for controlled substances shall conform to requirements established by regulatory agencies.

Purpose:

To assure proper storage and handling of controlled substances.

Procedures:

I. Automated Dispensing Cabinets (ADCs): *See PHAR 09.00*

II. Floor Stock

- A. All controlled substances (Schedules II, III, IV, and V) not dispensed from ADCs must be issued by the Pharmacy on a sign-out Narcotic Hypnotic sheet. Controlled substances are obtained as follows:
1. The order ~~may shall be faxed e-prescribed directly to Pharmacy or, alternatively, the Registered Nurse (RN), Licensed Vocational Nurse (LVN) or Licensed Psychiatric Technician (LPT) with picture identification will take the original signed physician's order to the Pharmacy.~~
 2. To refill an established supply of controlled drugs, the Narcotic-Hypnotic Drug record sheet may be sent via FAX to Pharmacy or the RN, LVN or LPT with picture identification will take the current Narcotic-Hypnotic Drug record sheet to the Pharmacy.
 3. The Pharmacy will issue to the RN, LVN or LPT a new supply of medication with a new Narcotic-Hypnotic sheet.
 4. The RN, LVN or LPT with picture identification will verify the correct count and sign for all controlled substances when received from Pharmacy.
 5. Emergency or "STAT" controlled substances may be dispensed immediately upon receipt of physician order, provided that the dispensing Pharmacist takes responsibility for filling out the appropriate sign-out sheet and getting the nurse's signature within one hour of dispensing the medication.
 6. Each dose administered shall be signed out on the Narcotic - Hypnotic sheet with the date, time, patient name, dose, and signature of the RN, LVN or LPT administering the dose.
 7. To return discontinued controlled drugs, the RN, LVN ~~OR~~ or LPT with picture ID will deliver
 8. Completed sheets are returned to the Pharmacy and filed for a minimum of three years.

the remaining drug in its Container and the Narcotic-Hypnotic Drug record sheet to Pharmacy.

9. Liquid controlled substances shall be dispensed in unit of use containers.
10. Inventories of controlled substances shall be conducted each shift by nursing staff and documented on the inventory sheets.

B. Each drug dispensed by the Pharmacy shall be logged into the Unit Inventory Log Book by date.

1. Before leaving the Pharmacy, the RN, LVN or LPT must sign the Log Book for the controlled substance(s) being dispensed.
2. Completed sheets from the Log Book are filed by unit along with the completed Narcotic - Hypnotic sheets for a minimum of three years.
3. Annually, the Log Book entries shall be reconciled with the Narcotic - Hypnotic sheets to assure that all sheets have been returned.

III. Pharmacy Inventory

A. A perpetual inventory shall be maintained for all Schedule II-V drugs.

1. All schedule II-V drugs dispensed to the units, on pass, or for discharge shall be signed out on the perpetual inventory form.
2. A second count is conducted for all items that have been dispensed or added to stock at the end of the shift and documented by the technician's initials next to the line item.
3. Returned drugs and drugs received from the wholesaler shall be entered as soon as possible on the perpetual inventory.
4. Every month the perpetual inventory shall be reconciled with the actual inventory on hand. Discrepancies shall be investigated and follow-up immediately. Discrepancies shall be reported to the Hospital CQI Committee quarterly.
5. A quarterly inventory reconciliation report of all Schedule II medications will be maintained that includes a physical count, and a review of all acquisitions and dispositions records since the last inventory. The inventory reconciliation report shall be maintained in the pharmacy for at least 3 years in a readily retrievable form.
6. The perpetual inventory sheets shall be filed and retained for a minimum of three years.

B. Outdated and expired controlled substances shall be removed from stock, inventoried and handled as stated in Policy and Procedure 02.02.01.

C. A biennial inventory of all controlled substances on hand shall be conducted. Inventory records shall be kept on file for minimum of 2 years.

RESOURCES:

File: **J 11.0** Controlled Drugs, *LHH Nursing Policies and Procedures*

New: 6/91

Revised: 3/96, 1/07, 10/09, 5/11, 8/18, 3/19

REVIEWED: 02/05dw, 02/06, 01/08, 04/09, 2/10, 4/12, 8/13

POLICY AND PROCEDURE FOR INVESTIGATIONAL DRUGS

Policy:

Investigational drugs shall be used in a manner consistent with the Medical Staff Policy and Procedure on Research, and in accordance with policies established by regulatory agencies.

Purpose:

To protect the right's of residents who participate in research and to assure supervision for the distribution, handling, storage and administration of investigational drugs.

Procedure:

- I. Drugs used as part of an investigational research protocol at Laguna Honda Hospital shall comply with the Hospitalwide Policy and Procedure on Approval Process for Human Subject Research.
- II. One set of copies of the approved research protocol and the informed consent signed by the resident or surrogate decision-maker shall be placed in the resident's chart. Another set of copies shall be forwarded to the Pharmacy Director.
- III. All drugs used as part of a research protocol shall be forwarded to the Pharmacy Department for proper storage, labeling and dispensing.
- IV. Record keeping for doses dispensed and received, as required by the research protocol, shall be the responsibility of the Pharmacy staff.

Drugs used as part of a research protocol shall be dispensed or administered only upon the ~~written~~ electronic prescription or order of the Principal Investigator or co-investigators as authorized by the study, and/or the Laguna Honda Hospital primary care physician.

- V. The following drug information shall be communicated by the Principal Investigator or co-investigator(s) to nursing staff requested to administer research protocol drugs:
 - a. drug action and uses
 - b. side effects, signs and symptoms of toxicity
 - c. dose
 - d. strengths available
 - e. any special cautions or warnings regarding handling or use
- VI. Upon conclusion of the study or discharge of the resident(s) from the Hospital, the Principal Investigator or co-investigator(s) shall contact the Pharmacy Director to arrange for disposition of remaining study drug(s).

New: 8/94sk
Reviewed: 2/06, 01/08, 04/09, 2/10, 5/11, 4/12, 8/13,
8/15 Revised: 8/14, 3/19

POLICY AND PROCEDURE FOR MED PASS OBSERVATION

Policy:

The pharmacist shall perform observations of nursing medication administration passes.

Purpose:

To ensure medications are administered as ordered, and in accordance with applicable LH Pharmaceutical Services and Nursing Department policies and procedures.

Procedure:

1. One or two pharmacist(s)/pharmacy student(s) will be assigned ~~on a rotational basis by a Clinical~~ the Supervising Pharmacist to perform medication pass observation.
2. The location will be selected for observation according to the Medication Pass Observation Schedule.
3. At minimum, four med passes will be observed every month. The goal is to observe med pass on each unit at least once during every calendar year.
4. Med passes for a minimum of 20 medications per unit will be observed.
5. Errors observed during med pass will be communicated to the licensed nurse involved, and/or the Nurse Manager.
6. All observation will be reported on the Medication Pass Observation Competency Assessment form (attachment)
7. The Medication Pass Observation Competency Assessment form will be forwarded to the ~~Clinical Pharmacists~~ Supervising Pharmacist for review and follow-up.
8. Results of the med pass observations will be part of the monthly Nursing Drug Regimen Review report forwarded to the Nursing ~~Supervisor-Director~~ and ~~Director of Nursing~~ Chief Nursing Officer.
9. Results will also be documented monthly in the Pharmacy Department Report to the Medication Error Reduction Subcommittee and Pharmacy and Therapeutics Committee

New: 9/93CO

Reviewed: 2/05dw, 04/09, 2/10, 5/12, 8/13, 7/15

Revised: 6/99, 2/06, 01/08, 10/09, 6/11, 8/18

Laguna Honda Hospital
Department of Pharmacy
Medication Pass Observation

Date: _____ Ward: _____ RN/LVN name: _____

Resident Name: _____

Med: _____

Med: _____

Med: _____

Med: _____

Med: _____

Med: _____

Resident Name: _____

Med: _____

Med: _____

Med: _____

Med: _____

Med: _____

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Resident Name: _____

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Med: _____

Med: _____

Medication Pass Observation Competency Assessment

RN/LVN Specific Competency Assessment

Indicator	Yes	No, Describe	N/A
• Consistently administers medication with 5 rights (patient, drug, time, dose & route)			
• Demonstrates good infection control by: <ol style="list-style-type: none"> 1. Consistently washes hands with alcohol gel or soap and water between residents if any skin contact; 2. Keeps top of med cart clean, and 3. Does not take glove boxes or other clean materials to resident bedside that are not for resident's use only 			
• Locks medication cart when unattended and does not leave medications unattended			
• Closes MAR when unattended to protect privacy of residents			
• Uses disposable spoon, not tongue depressor, to administer pudding/applesauce with meds if resident unable to take fluids to swallow meds			

Medication Specific Competency Assessment

Indicator	Yes	No, Describe	N/A
• Sustained release and Enteric coated Medications: Administer intact tab/cap (do not crush)			
• Liquid Medications: Shake bottle before pouring; accurately calculate dose of liquid medications; pour at eye level through direct observation			
• Medication via enteral tube: <ol style="list-style-type: none"> 1. Position resident's upper body to $\geq 45^\circ$ 2. Verify tube placement by both auscultation and aspiration 3. Flush tube with 20-60mL tap water before medications are delivered by gravity (unless GT may push meds) 4. Flush tube with 20-60mL tap water after giving meds 			
• Dilantin® suspension administration needs to be separated from the enteral feeding by at least one hour			
• Inhaled Medications: <ol style="list-style-type: none"> 1. Request that resident sit up straight 2. Shake the container and place inhaler into resident's mouth 3. Actuate inhaler to coincide with a slow deep breath and instruct the resident to hold breath for 5-10 seconds 4. Separate at least one minute between multiple puffs (from same metered dose inhaler (MDI)) 5. Separate at least 5 to 10 minutes between multiple MDIs 			
• The sequence of administration is Beta2 adrenergic agonist (e.g. Albuterol) first, followed by anticholinergic agent (e.g. Atrovent®) and then lastly steroid (e.g. QVAR®)			
• Rinse mouth after steroid inhaler use			
• Eye Drop administration: <ol style="list-style-type: none"> 1. Wash hands with soap and water or use alcohol gel before and after instillation 2. Wait 5 minutes between instilling multiple eye drops 			
• Antineoplastic/Cytotoxic Medications: <ol style="list-style-type: none"> 1. Avoid direct contact to the skin or mucous membranes with the powder contained in capsules or tablets 2. Do not open or crush capsules or tablets. Contact pharmacy for alternative preparations. 			
• Other: (e.g. water but not juice with meds to diabetic patient; check apical pulse with digoxin, etc.)			

POLICY AND PROCEDURE FOR INFECTION CONTROL

Policy:

The pharmacy is responsible for the prevention of contamination of medications or other pharmacy products, whether caused by faulty manufacturing, handling, storage or compounding.

Purpose:

To prevent the dissemination of contaminated medications or other pharmacy products to patients.

Procedure:

1. Storage
 - a. Medications, chemicals and other pharmaceutical products are stored in accordance with US Pharmacopeia, National Formulary and manufacturer's recommendations.
2. Dispensing Oral Medications
 - a. The touching of medications by hands is prohibited.
 - b. A counting tray and spatula will be used when dispensing tablets and capsules.
 - c. Counting trays and spatulas will be cleaned daily with 70% Ethyl Alcohol.
 - d. Tablets, capsules, or liquids will be dispensed in fresh clean containers with clean labels.
3. Medication Prepacking
 - a. When prepacking tablets and capsules into unit doses, disposable ~~latex~~ gloves shall be worn.
4. Compounding Ointments and Creams
 - a. The compounding surface and utensils shall be cleaned with 70% Ethyl Alcohol prior to and after use.
 - b. Compounding will be done in accordance with the standards of pharmaceutical practices. [Refer to Pharm 02.01.08.](#)
5. ~~Manufacturing~~ Compounding Topical Solutions
 - a. Solutions will be compounded in accordance with the standards of pharmaceutical practices.
 - b. Sterile water for irrigation U.S.P. is the water to be used in the compounding of topical solutions.
 - c. ~~Unless otherwise specified or indicated, compounded topical solutions will have an expiration of 30 days from the date of compounding and a 72-hour discard after opening.~~ [Refer to Pharm 02.01.08 for expiration date for non-sterile compounding.](#)
6. Expiration Dates
 - a. No medications or pharmacy products will be dispensed beyond the manufacturer's recommended expiration date.
 - b. Medications or pharmacy products that will expire within 30 days of the expiration date will be recalled from the wards and will be removed from pharmacy stock.

7. Sterile Product Preparation, Handling and Disposal
 - a. Sterile products will be prepared, handled and disposed in accordance with the standards of pharmaceutical practices to ensure the appropriate surveillance, prevention, and infection control procedures. *Also see Pharmacy Policy & Procedure 07.01.00.*

New: 10/91

Revised: 12/96, 05/97, 07/03, 08/18

Reviewed: 02/06, 01/08, 04/09, 2/10, 6/11, 5/12, 8/13, 8/14, 7/15

LAGUNA HONDA HOSPITAL 05.03.00
POLICY AND PROCEDURE FOR THERAPEUTIC INTERCHANGE AND GENERIC SUBSTITUTION

Policy:

The Pharmacy and Therapeutics Committee shall determine drugs that may be therapeutically interchanged by the pharmacist without consultation with the physician. Generic substitution of bioequivalent drugs is permitted unless a ~~written~~ written order by the physician specifies that the drug is to be dispensed as written.

Purpose: To provide timely, efficacious, and cost efficient pharmaceutical care services.

Procedure:

1. The Pharmacy and Therapeutics Committee shall review all pertinent literature and analyze the cost benefit relationship of drugs proposed for therapeutic interchange.
2. Upon determination of efficacy, safety and cost effectiveness, the Pharmacy and Therapeutics Committee shall approve the addition of the proposed drugs to the Laguna Honda Hospital Therapeutic Interchange List.
3. The Pharmacy and Therapeutics Committee may also remove drugs from the Therapeutic Interchange List at its discretion.
4. The Chairman of the Pharmacy and Therapeutics Committee and the Pharmacy Director shall communicate changes to the Therapeutic Interchange List to the Medical, Pharmacy, and Nursing staff of the Hospital.
5. Pharmacists may interchange drugs listed on the Therapeutic Interchange List without first consulting with the physician.

The pharmacist shall document the therapeutic interchange in the patient's chart (electronically or written if electronic chart is not available) and subsequently communicate the change to the ordering provider (electronically or written if the electronic chart is not available)

7. Unless specifically prohibited by a written or electronic physician order, pharmacists may dispense bioequivalent generic medication.
8. Medication orders with directions from the provider to "dispense as written" shall require non-formulary approval (see pharmacy policy 05.01.00) if the medication ordered is not covered by the patient's insurance or if it is a medication (or specific brand) not routinely carried by the pharmacy

NEW: 3/94 sk

Revised: 4/97, 6/99, 5/00dy, 8/01dy, 10/03dw, 2/15, 7/15, 3/18, 3/19

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

POLICY AND PROCEDURE FOR DRUG-FOOD INTERACTION COUNSELING

Policy:

Patients, hospital staff and other care givers shall receive information and be counseled on clinically significant drug-food interactions.

Purpose:

To prevent the potential risk of harm or a compromise in therapy posed by clinically significant drug-food interactions.

Procedure:

- A. Counseling guidelines for well-documented drug-food interactions shall be prepared in a cooperative effort between Pharmacy and Nutrition Services (~~Attachment 1~~). Prior to use in a counseling program, the dietary instructions shall be reviewed and approved by the medical staff through the Pharmacy and Therapeutics Committee (~~Appendix A through F~~).
- B. ~~Pharmacy shall notify~~ Nutrition Services shall be notified via a report from the electronic health record (EHR) when a LHH resident receives a new prescription for a ~~in writing of the residents receiving medications that~~ require dietary instructions (~~Attachment 2~~). ~~The documentation shall include the name of the drug, date Nutrition Services was notified, and initials of the person completing the notation.~~
- C. The dietician shall review the patient's diet to ensure it is consistent with the dietary instructions.
- D. The dietician shall inform residents of the special dietary considerations and provide them with the appropriate written dietary instructions approved by the medical staff.
- E. An approved dietary instruction sheet shall be given to nursing personnel by Nutrition Services to ensure appropriate diet and administration of medications. Nursing personnel shall assist Nutrition Services by ensuring that residents or their care givers have a copy of dietary instructions if discharged on one of the designated drugs.
- F. Pharmacy shall affix appropriate auxiliary labels to prescription containers for all discharge medication orders. Pharmacy shall assist Nutrition Services by ensuring that patients receiving designated discharge medications have a copy of the dietary instructions and are further counseled regarding the drug-food interaction.
- G. All significant drug-food interactions that occur, i.e., those which result in a major change in the patient's condition or require a change in drug therapy shall be documented and reported on an Unusual Occurrence Report by clinical staff who first recognizes the problem. Each occurrence shall be investigated by Pharmacy and reported to the Pharmacy and Therapeutics Committee.
- H. A policy and procedure on Drug-Food Interaction Counseling shall be part of the Clinical Nutrition and Food Services Policy 1.13 Nutrition Protocol (Attachment 3).

New: 8/95/

REVIEWED: 02/05dw, 04/09, 2/10, 8/11, 5/12, 8/13, 8/14, 8/15

Revised: 05/06, 01/08, 3/19

References: Clinical Nutrition Department Policy 1.13 Drug -Food Interactions

Drug Name	Dietary Significance	Recommended Actions
<i>Anticoagulants</i> Warfarin Coumadin	Excessive intake of food with high Vitamin K content may inhibit effect of drug.	Patient should be cautioned about sudden changes in dietary intake of foods containing Vitamin K.
<i>Antibiotics, Misc.</i> Metronidazole Flagyl	Causes unpleasant, metallic taste; may cause nausea, vomiting; alcohol may cause flushing.	Take oral medications with food to minimize GI effects; avoid alcohol during administration and for at least one day following.
Isoniazid	Food reduces drug absorption; may cause nausea, vomiting; has mild MAOI effect.	Take on an empty stomach, if possible; if GI distress occurs take with food; avoid foods high in tyramine.
Tetracyclines/Fluoroquinolones Achromycin, Sumycin, Others Ciprofloxacin, Levofloxacin	Calcium inhibits absorption of drug.	Dairy products should not be taken one hour before or after drug; may be taken with small amounts of low-calcium food to minimize GI distress if necessary.
<i>Antineoplastics</i> Procarbazine Matulane	Alcohol may cause flushing; tyramine-containing foods may cause acute hypertension.	Avoid alcohol and foods high in tyramine.
<i>Monamine Oxidase Inhibitors</i> Pargyline Eutonyl	Tyramine-containing foods cause acute hypertension, headache, tachycardia.	Avoid foods high in tyramine.
Pargyline with Methyclothiazide Eutron		
<i>Monamine Oxidase Inhibitors</i> Phenelzine Nardil	Tyramine-containing foods cause acute hypertension, headache, tachycardia.	Avoid foods high in tyramine.
Selegiline Eldepryl	Tyramine-containing foods cause acute hypertension, headache, tachycardia.	Avoid foods high in tyramine.
Tranlycypromine Pamate	Tyramine-containing foods cause acute hypertension, headache, tachycardia.	Avoid foods high in tyramine.
<i>Psychotherapeutic Drugs</i> Lithium Eskalith	Salt restricted diet potentiate drug toxicity. Increased sodium intake decreases therapeutic response to drug.	Extremely large or small salt intake must be avoided.

**Laguna Honda Hospital and Rehabilitation Center
Department of Pharmaceutical Services**

Date:

To: _____ Nutrition Services

From: _____ Pharmacy

Re: _____ Potential Drug-Food Interactions

Patient Name/Room No.	Designated Drug With Potential Drug-Food Interactions
	<input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Phenelzine <input type="checkbox"/> Isoniazid-Lithium <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Procarbazine <input type="checkbox"/> Levofloxacin Selegiline <input type="checkbox"/> Metronidazole Tetracycline <input type="checkbox"/> Pargyline Tranyleypromine <input type="checkbox"/> Warfarin
	<input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Phenelzine <input type="checkbox"/> Isoniazid-Lithium <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Procarbazine <input type="checkbox"/> Levofloxacin Selegiline <input type="checkbox"/> Metronidazole Tetracycline <input type="checkbox"/> Pargyline Tranyleypromine <input type="checkbox"/> Warfarin
	<input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Phenelzine <input type="checkbox"/> Isoniazid-Lithium <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Procarbazine <input type="checkbox"/> Levofloxacin Selegiline <input type="checkbox"/> Metronidazole Tetracycline <input type="checkbox"/> Pargyline Tranyleypromine <input type="checkbox"/> Warfarin
	<input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Phenelzine <input type="checkbox"/> Isoniazid-Lithium <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Procarbazine <input type="checkbox"/> Levofloxacin Selegiline <input type="checkbox"/> Metronidazole Tetracycline <input type="checkbox"/> Pargyline Tranyleypromine <input type="checkbox"/> Warfarin

Instructions to Pharmacists: Date the form and place a patient label or write the patient name and room number in the appropriate section and mark (X) the appropriate drug the patient has been prescribed. Place your initials in the column designated. The pharmacy secretary shall xerox one copy to file and will forward the original to Nutrition Services DAILY.

06.04.00

(APPENDIX A)

Food Drug Interaction Alert

Warfarin (Coumadin)

Your doctor has prescribed an oral anticoagulant medication for you. Oral anticoagulants interact with certain foods or nutrients, resulting in a reduction in effectiveness. Please read and follow the recommendations below while taking this medication. Check with your physician before you take any vitamin/mineral supplements. Large amounts of vitamin K and vitamin E may affect how your medicine works.

1. _____ M
Maintain a consistent eating pattern. If it is necessary for you to make a major dietary change, such as a vegetable-rich weight reducing diet, please notify your physician first.

2. _____ If
If you want more information about this medicine, contact your physician or pharmacist.

3. _____ If
If you have any questions about the dietary recommendations, contact the Registered Dietitian at (415) 759-3300.

8/95

Food Drug Interaction Alert

Drugs that may interact with Tyramines

Your doctor has prescribed a drug that may interact with Tyramines, a substance found in certain foods and beverages, which are found in most diets. Examples of drugs in this category are Tranylcypromine (Parnate), Pargyline (Eutonyl), Pargyline with Methclothiazide (Eutron), Furazolidone (Furoxone), Phenelzine (Nardil), Isoniazid (INH), Procarbazine (Matulane) and Selegiline (Eldepryl). These medications are known to interact with a variety of substances, foods and other drugs which may result in a hypertensive crisis, characterized by headache, nausea, diarrhea, and high blood pressure. Please read and follow the recommendations below while taking this medication.

1.

In general, eat only fresh and freshly prepared frozen or canned foods to avoid the risk of eating foods that may have aged or fermented to any degree.

2.

Restrict the consumption of the following foods:

Beverages: Alcoholic beverages, especially Chianti wine, sherry, sauterne, beer and ale, acidophilus milk, buttermilk; caffeine in excess.

Caffeine-containing beverages such as chocolate, coffee, tea, and colas should be used in moderation because of their stimulant effect.

Breads: Homemade yeast breads with large amounts of yeast; breads or crackers containing cheese.

Meat, Fish, Poultry: Aged game, chicken and beef liver, dry sausages, salami, pepperoni, dried meats, commercial meat extracts such as Bovril; pate; salted dried and pickled fish such as kippered herring, cod, etc. Meats prepared with meat tenderizer.

3.

No restriction needed on the following foods: Cereals and eggs

Food Drug Interaction Alert

Metronidazole (Flagyl)

Your doctor has prescribed an oral antibiotic medication for you. This medication interacts with alcohol. Please read and follow the recommendations below while taking this medication. Do not consume alcohol or alcohol containing preparations (for example, elixirs, cough syrup) while taking this medication and for at least one day following administration. You may experience a headache, facial flushing, sweating and nausea/vomiting.

1. If this medicine upsets your stomach, it may be taken with meals or a snack.
2. Take this medication with adequate fluids.
3. If you want more information about this medicine, contact your physician or pharmacist.
4. If you have any questions about the dietary recommendations, contact the Registered Dietitian at (415)759-3300.

8/95

~~Food Drug Interaction Alert~~

~~Tetracycline (Achromycin, Sumycin)~~

~~Your doctor has prescribed an oral tetracycline medication for you. Oral tetracyclines interact with certain foods or nutrients, resulting in an alteration of effectiveness. Please read and follow the recommendations below while taking this medication.~~

~~1. _____ D~~

~~do not consume milk, dairy products or antacids for one hour before or one hour after taking this drug.~~

~~2. _____ †~~

~~if you are taking an iron supplement, take it two hours before or two hours after taking tetracycline.~~

~~3. _____ †~~

~~if you want more information about this medicine, contact your physician or pharmacist.~~

~~4. _____ †~~

~~if you have any questions about the dietary recommendations, contact the Registered Dietitian at (415) 759-3300.~~

8/95

Food Drug Interaction Alert

Lithium

Your doctor has prescribed for you the medication Lithium. Please read and follow the recommendations below while taking this medication.

1. Take this medicine after a meal or a snack to reduce stomach upset. †
2. To prevent side effects and to make sure that the medicine is working properly, maintain a consistent eating pattern. Check with your physician before you go on a weight loss diet or make other changes in your diet that may cause you to lose water and salt from your body. †
3. Take this medication with adequate fluids. Limit your intake of caffeine-containing coffee, tea or colas to 2 cups per day. Large amounts of caffeine may affect how your medicine works. †
4. Use a normal amount of salt in your food, unless otherwise directed by your physician. U
5. If you want more information about this medicine, contact your physician or pharmacist. †
6. If you have any questions about the dietary recommendations, contact the Registered Dietitian at (415) 759-3300. †

8/95

~~Food Drug Interaction Alert~~

~~Ciprofloxacin (Cipro), Levofloxacin (Levaquin)~~

~~Your doctor has prescribed an oral antibiotic (a quinolone) for you. Oral quinolones interact with certain foods or nutrients, resulting in a reduction in effectiveness.~~

~~Please~~

~~read and follow the recommendations below while taking this medication.~~

~~1. _____ D~~

~~do not consume milk or dairy products for one hour before or one hour after taking this drug.~~

~~2. _____ †~~

~~if you are taking antacids, zinc, or an iron supplement, take these four hours before or two hours after ciprofloxacin.~~

~~3. _____ †~~

~~if you want more information about this medication, contact your physician or pharmacist.~~

~~4. _____ †~~

~~if you have any questions about the dietary recommendations, contact the Registered Dietician at (415) 759-3300.~~

~~8/95~~

For JCC Approval on 9/10/19
Original P&P is followed by this version

STERILE PRODUCT PREPARATION, HANDLING, AND DISPOSAL 07.01.00

<u>Title/content</u>	<u>Page</u>
Policy and Purpose	2
Definitions and Abbreviations	2
Pharmacy Areas for Preparing Sterile Products	4
Hand Hygiene and Garbing Procedure	4
Environmental Controls	5
Monitoring and Testing of Environmental Controls	7
Cleaning and Sanitizing of the workspaces	8
Master Compounding Formula	9
Aseptic Technique and Pharmacy Sterile Product Preparation	10
Beyond Use Dating	12
Qualifications of Personnel Who Prepare Sterile Products	12
Quality Assurance	14
Labeling	15
End Product Evaluation	15
Handling of Sterile Products Outside the Pharmacy	15
Administration of Sterile Products	16
Documentation and Recordkeeping	16
Appendix I: Sterile compounding competency assessment	17
Appendix II: Assessment of Environmental Services Personnel	19

Policy: The pharmacy shall ensure the sterility and integrity of sterile products prepared and used at Laguna Honda.

Purpose: To ensure the appropriate surveillance, prevention, and infection control procedures for sterile products.

Definitions and Abbreviations

Beyond use date (BUD) - the date or date and time, after which administration of a compounded drug product shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).

Primary engineering control (PEC) – a device that provides an ISO Class 5 or better environment through the use of unidirectional HEPA-filtered first air for the exposure of critical sites when compounding sterile preparations. Examples of PEC devices include, but are not limited to, laminar airflow workbenches, biological safety cabinets, sterile compounding automated robots, compounding aseptic isolators, and compounding aseptic containment isolators.

Compounding aseptic isolator (CAI) – a form of isolator specifically designed for non-hazardous compounding pharmaceutical ingredients or preparations while bathed with unidirectional air. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes

Compounding aseptic containment isolator (CACI) - a unidirectional compounding aseptic isolator designed to provide worker protection from exposure hazardous drugs airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. The exhaust air from the isolator is removed by external building ventilation

Containment primary engineering control (C-PEC): A ventilated device designed and operated to minimize worker and environmental exposures to HDs by controlling emissions of airborne contaminants through the following:

1. The full or partial enclosure of a potential contaminant source
2. The use of airflow capture velocities to trap and remove airborne contaminants near their point of generation
3. The use of air pressure relationships that define the direction of airflow into the cabinet
4. The use of HEPA filtration on all potentially contaminated exhaust streams

ISO- International Organization of Standardization (ISO) classification of particulate matter in room air. The number following ISO refers to air quality determined by the number of particles in a cubic meter of air. An ISO-5 environment level of quality must be maintained in the direct compounding area.

Direct Compounding Area (DCA) - Critical area within a primary engineering control exposed to unidirectional filtered air.

Isolator Gauntlet – A glove that is attached to the isolator sleeve intended for repeated use and changed at least monthly. Sterile gloves are donned over isolator gauntlets whenever engaged in compounding activities.

IV room – The designated area of positive pressure separate from routine work traffic that contains the primary engineering control (CAI) to compound non-hazardous sterile products. Refers specifically to room P2334 “IV PREP”

Hazardous drug room – The designated area of negative pressure separate from routine work traffic that contains the compounding aseptic containment isolator (CACI) used for compounding sterile and non-sterile hazardous drugs. Refers specifically to room P2332 “CHEMO PHARMACY”

Line of demarcation – A line on the floor marked with tape in both the IV and hazardous drug rooms that designates an ante-area for garbing towards the door separated from the clean working areas around the primary engineering control where personnel must be full gowned and garbed.

Qualified personnel – Pharmacists and pharmacy technicians that have completed required training and successfully passed all of the required competency assessments for sterile compounding

USP – United States Pharmacopoeia

RCRA – Resource Conservation and Recovery Act enacted in 1972 that governs the disposal of certain hazardous waste in the pharmacy.

CSP – Compounded sterile preparation

Pharmacy Areas for Preparing Sterile Products

1. Access to the IV room is limited to necessary/trained personnel.
2. Solutions, drugs, supplies and equipment used to prepare and administer sterile products shall be stored in accordance with manufacturer or USP requirements. Sterile products that require special storage conditions, for example, refrigeration and protection from light, shall be so stored. Refrigerator temperatures shall be wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
3. Outdated products should be removed from active storage areas.
4. Before each use, each drug, ingredient, and container should be visually inspected for damage, defects and expiration date.
5. Particle generating activities, such as removal of items from or manipulation of cardboard boxes, should be performed outside of the IV room.
6. Disposal of packing materials, used syringes, containers, and needles should be performed as needed.
7. Waste shall be disposed of in the appropriate container of pharmaceutical (blue), trace hazardous waste (yellow), of bulk hazardous/RCRA designated waste (black). Eating, drinking, and smoking are prohibited in the IV room.
8. Non-sterile to sterile “high risk” compounding shall not be performed by Laguna Honda Hospital Pharmacy

Hand Hygiene and Garbing procedure for IV room

1. See policy and procedure 07.02.00 for hand hygiene and garbing procedure for hazardous drug room
2. Prior to entering IV room inform a pharmacist of any change in eligibility to compound sterile preparations:
 - a. Personnel with signs or symptoms of respiratory infection, exposed rashes, sunburn, conjunctivitis, fever, open wounds, or weeping sores shall be excluded from sterile compounding until condition is resolved.
 - b. Any person wearing cosmetics, nail polish, or artificial nails shall not participate in sterile compounding. Fingernails should be kept clean and trimmed.
3. Remove any hand, wrist, finger, or other visible jewelry
4. Remove any neck lanyards, ties, or necklace jewelry
5. Don hair cover and face mask to cover bridge of nose down to the chin. Don additional facial hair cover if necessary.
6. Don shoe covers placing the first covered shoe over the line of demarcation to the clean side prior to donning the second shoe cover.
7. Dry hands with a non-shedding disposable paper towel and don a non-shedding gown.
8. Disinfect hands again using waterless surgical scrub and allows hands to dry before placing hands in isolator gauntlets.
9. If working in the IV room outside of the CAI then don gloves and disinfect with sterile 70% isopropyl alcohol making sure the elastic wrists of the gown covers the glove cuff. These gloves can be removed when hands are placed inside the isolator gauntlets to compound.
10. When preparing sterile products in the CAI sterile gloves must be donned over the isolator gauntlets prior to any compounding activities.
11. At the end of non-hazardous sterile compounding:
 - a. Remove and discard gloves, facial hair cover, mask, and hair cover in the regular trash.
 - b. Remove and discard gown in the regular trash or hang on a hook on the clean side of the line of demarcation to be re-used by the same personnel during the same shift only. Re-used gowns must be discarded by the end of shift.
 - c. Perform hand hygiene with soap and water for at least 30 seconds
 - d. Remove shoe covers one at a time ensuring that the uncovered foot is placed over the line of demarcation.
 - e. Discard shoe covers in the regular trash and disinfect hands prior to leaving the IV room.
 - f. Ensure all garb is removed and discarded appropriately before leaving the IV room.
 - g. Wash hands with soap and warm water up to the elbow scrubbing for at least 30 seconds and clean under nail bed with a clean nail pick whenever entering or re-entering the controlled area.

Environmental Controls in the IV room

1. Engineering controls reduce the potential for airborne contamination in workspaces by limiting the amount and size of contaminants in the CSP processing environment
2. The primary engineering control (PEC) at Laguna Honda Hospital Pharmacy is the compounding aseptic isolator (CAI)
 - a. Isolator gauntlets shall be changed at least every month or whenever there is damage or a tear according to the manufacturer's directions and specifications.
 - b. Isolator sleeves shall be changed every 6 months or whenever there is damage or a tear according to the manufacturer's directions and specifications
 - c. Pre-filter shall be changed at least every 3 months according to the manufacturer's directions and specifications
3. Secondary engineering controls are used reduce airborne particles in the areas surrounding the primary engineering control and include:
 - a. Separating the sterile compounding areas in rooms with a pressure differential relative to adjacent spaces (See next section for monitoring)
 - i. IV room will be maintained at positive pressure relative to adjacent areas
 - ii. Hazardous drug room will be maintained at a negative pressure between -0.01 and -0.03 inches water column relative to adjacent areas
 - b. Rigorous cleaning program (described in cleaning and sanitizing of the workspace)
 - c. Standardized gowning, garbing, and hand hygiene procedure
 - d. A line of demarcation to designate areas surrounding the primary engineering control that require qualified personnel to be fully gowned and garbed.
 - e. Only the furniture, equipment, supplies, and other goods required for the tasks to be performed may be brought into this room, and they should be non-permeable, non-shedding, and resistant to disinfectants.
 - i. Carts should be of stainless steel wire or sheet metal construction with good quality, cleanable casters to promote mobility.
 - ii. Storage shelving counters, and cabinets should be smooth, impervious, free from cracks or crevices, non-shedding, cleanable, and sanitary. Their number, design, and manner of installation should promote effective cleaning and sanitizing.
 - f. Maintaining an organized and uncluttered environment with minimal horizontal workspaces
 - g. The surface of ceilings, walls, floors, fixtures, shelving, counters, and cabinets in the IV room are to be smooth, impervious, free from cracks and crevices, and non-shedding, thereby promoting clean ability and minimizing spaces in which microorganisms and other contaminants may accumulate. The surfaces should be resistant to damage by sanitizing agents.
 - h. Items brought into the CAI disinfected with sterile 70% isopropyl alcohol prior to transporting.

4. Sterile product preparation will be performed in a CAI that provides at least ISO 5 air quality.
 - a. International Organization of Standardization (ISO) Classification of Particulate Matter in Room Air (Limits are in particles 0.5µm and larger per cubic meter (current ISO)
- 5.

Class Name		Particle Count	
ISO Class	US FS 209E	(ISO,m ³)	(FS 209E ft ³)
3	Class 1	35.2	1
4	Class 10	352	10
5	Class 100	3,520	100
6	Class 1000	35,200	1000
7	Class 10,000	352,000	10,000
8	Class 100,000	3,520,000	100,000

Testing and Monitoring of Environmental Controls in the IV room

1. Pressure Differential Monitoring
 - a. IV room relative to adjacent areas
 - i. Measured wirelessly and continuously by engineering via the TEMPTRAK system.
 - ii. If differential pressure becomes negative in the IV room engineering will be consulted to evaluate the potential causes and the supervising pharmacist will determine if any changes in workflow or beyond use dating are necessary until the desired pressure differential is restored.
 - iii. Pressure differential will be manually documented on a daily basis when the pharmacy is open on the "air pressure differential log"
 - b. CAI
 - i. Pressure differential of the antechamber and main workspace within the CAI will be checked daily when the pharmacy is open by qualified personnel and recorded on the "air pressure differential log"
 - ii. The CAI will sound an audible alarm in the event that pressure differentials fall out of the manufacturer specified operation ranges. When the alarm is sounded the supervising pharmacist will be informed to evaluate and troubleshoot before any sterile compounding activities are continued and will determine if any compounded preparations made at the time of the alarm were compromised.
2. Temperature monitoring
 - a. Refrigerator temperature in the IV room is wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
 - b. The temperature of the IV room and hazardous drug room are continuously monitored wirelessly with limits set for operator comfort and manufacturer recommended storage conditions for IV drugs.
 - c. Humidity gauges are present in the IV room to detect significant changes that would affect operator comfort.
3. Certification and testing of primary and secondary engineering controls shall be performed every six months and whenever a primary engineering control or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area.
 - a. Certification will be performed by a qualified operator to meet test standards of CETA Certification Guide for Sterile Compounding Facilities under dynamic conditions to include viable particle counts, non-viable particle counts, and smoke pattern testing.
 - b. Viable particle counts
 - i. Viable surface sampling is performed every six months in the primary engineering controls and the surrounding areas by an outside qualified operator as part of routine certification testing
 - ii. Viable particles in the air are tested by volumetric air sampling procedures by an outside qualified operator every six months as part of routine certification testing. Volumetric air sampling will test a sufficient volume of air (400 to 1,000 liters) at locations inside the PEC and surrounding area.

Cleaning and Sanitizing of the Workspaces

1. Procedure for cleaning of primary engineering controls (CAI in IV room)
 - a. The cleaning, sanitizing and organizing of the direct compounding areas (DCA) is the responsibility of qualified pharmacists and pharmacy technicians and is performed prior to any compounding activities and at least daily when the pharmacy is open.
 - b. Sanitize the gauntlets of the CAI with a germicidal detergent followed by sterile water and allow to dry.
 - c. Disinfect the gauntlets of the CAI with sterile 70% isopropyl alcohol
 - d. Replace the non-shedding pad on the isolator cleaning tool and utilize it during the following cleaning procedures to clean surfaces that would normally be out of reach.
 - e. Sanitize all surfaces in the primary engineering control (including the gauntlets again) with a germicidal detergent followed by sterile water to remove gross filth. A pre-saturated non-shedding wipe or spray may be used with the isolator cleaning tool.
 - f. Do not directly spray the ceiling towards the HEPA filter because it can cause damage and compromise its integrity. When cleaning surfaces use an overlapping horizontal motion in one direction starting at the top of the isolator working down. Clean the ceiling first, then the back, then the sides, and finally the bottom surface inside the primary engineering control. Be sure to clean the antechamber in addition to the direct compounding areas.
 - g. After sanitizing with a germicidal detergent and sterile water then disinfect the surfaces of the primary engineering control (including the gauntlets again) with sterile 70% isopropyl alcohol following the previous procedures.
 - h. Once a week replace the germicidal detergent with a sporicidal detergent for sanitizing all surfaces including the gauntlets in the primary engineering control.
 - i. After completing the cleaning process, document the activity in the “cleaning record for sterile compounding room”
 - j. Prior to donning sterile gloves and after the initial cleaning procedures for the surfaces of the CAI disinfect the gauntlets with sterile 70% isopropyl alcohol
 - k. If the primary engineering control has been turned off between aseptic procedures, it should be operated for at least 30 minutes to allow complete purging of room air from the direct compounding area, then cleaned with the above procedures before performing any compounding activities
 - l. Once a month the CAI will undergo a deep cleaning in which the front panel is opened and the bottom work tray is lifted out to clean area underneath working in a horizontal unidirectional motion from right to left starting from the back and working forward with overlapping strokes. The deep clean will consist of sanitizing with a sporicidal detergent and sterile water followed by disinfecting with sterile 70% isopropyl alcohol.

2. All ISO class 5 surfaces, work table surfaces, carts, counters, and floor shall be cleaned at least daily when the pharmacy is open using a germicidal detergent and sterile water followed by disinfecting with sterile 70% isopropyl alcohol. Once a week the germicidal detergent shall be replaced with a sporicidal detergent.
3. Floors in the compounding areas are sanitized and cleaned by mopping once daily when the pharmacy is open and when no aseptic operations are in progress. Mopping may be performed by trained and supervised custodial personnel using approved agents described in section 2 above. Only approved cleaning and sanitizing agents are used with careful consideration of compatibilities, effectiveness, and inappropriate or toxic residues. All cleaning tools, such as wipers, sponges, and mops, are non-shedding and dedicated a specific compounding area.
4. Walls and ceilings are sanitized with a sporicidal detergent and sterile water followed by disinfection with sterile 70% isopropyl alcohol at least weekly and documented on the appropriate cleaning log
5. Storage shelving is emptied of all supplies and sanitized with a sporicidal detergent and sterile water followed by disinfection with sterile 70% isopropyl alcohol at least weekly and documented on the appropriate cleaning log
6. Trash is collected in suitable plastic bags and removed with minimal agitation. Pharmaceutical waste is collected when approximately two thirds full.
7. Cardboard, shipping cartons, or high particle generating containers shall NOT be brought into the IV room or hazardous drug room. All supplies required for compounding and cleaning activities will be disinfected with 70% sterile alcohol prior to being introduced to the IV room.
8. Supplies required for compounding are disinfected with sterile 70% isopropyl alcohol before being placed in the antechamber of a primary engineering control.

Master Compounding Formula

1. Prior to any compounding activities a master formula approved by a pharmacist must be created or obtained from the library of master formulas stored on the pharmacy intranet.
2. A master formula must include the following:
 - a. Active and inactive ingredients to be used
 - b. Equipment to be used including the appropriate primary engineering control
 - c. The maximum allowable beyond use date for the preparation, and the rationale or reference source justifying its determination
 - d. Specific and essential compounding steps used to prepare the drug
 - e. Quality reviews required at each step in the preparation of the drug including:
 - i. Review calculations on master formula to confirm that the measurement of each additives and diluent will result in the final labeled concentration
 - ii. Visual inspection of all ingredients to be used for manufacturer expiration dating and integrity of manufacturer packaging such as broken seals on vials or punctures in a stopper or injection port.

- iii. Visual inspection of any reconstituted products for complete dissolution
 - iv. Visual inspection of any vial stopper or injection port punctured for evidence of leaking or coring.
 - v. Pharmacist to verify volume or measurement of any additive prior to final dilution and confirm it matches the master formula.
 - vi. Visual inspection after final dilution against a well-lit contrasting background to detect the presence of impurities such as particulate matter, unexpected change in color, precipitation, or coring.
- f. Instructions for storage or special handling requirements
- g. An “update log” section shall be included on every master formula to include the date of creation with pharmacist initials. Any modifications to an existing master formula shall be documented in the “update log” sections with the description of changes as well as the date and pharmacist initials.

Aseptic Technique and Pharmacy Sterile Product Preparation

1. Sterile preparations shall be compounded in a primary engineering control that maintains an ISO class 5 environment under dynamic conditions using aseptic technique.
2. Aseptic technique refers to standardized compounding procedures intended to decrease the risk of contamination of a compounded sterile product. Talking should be minimized during aseptic preparation.
3. Ingredients used to compound sterile products should be determined to be stable, compatible, and appropriate for the product to be prepared, according to manufacturer or USP guidelines or appropriate scientific references. Ingredients and compounding process for each preparation is determined in writing and reviewed by a pharmacist on a master formula before compounding begins.
4. All ingredients should be inspected for defects, expiration date, and product integrity before use. Expired or defective products should not be used for compounding. Defective products should be reported to the FDA Med Watch Program, <https://www.accessdata.fda.gov/scripts/medwatch/>, or 1- 800-FDA-1088.
5. Prior to performing any activities in the primary engineering control inspect the isolator gauntlets and sleeves for any defects or tears.
6. Any ingredient, equipment, or item required for sterile compounding shall be disinfected with sterile 70% isopropyl alcohol on all surfaces before placing inside the antechamber
7. Wait at least 10 seconds after placing items into the antechamber before opening the divider and bringing items into the work area inside the primary engineering control.
8. During any sterile compounding in the CAI or CACI all of the surfaces and isolator gauntlets are disinfected frequently with sterile 70% isopropyl alcohol including:
 - a. The beginning of each shift and before each lot
 - b. At least every 30 minutes when continuously compounding
 - c. After each spill or when surface contamination is suspected

9. All rubber stoppers of vials and bottles, the necks of ampoules, and injection ports into an IV bag are disinfected by wiping with sterile 70% isopropyl alcohol and waiting at least 10 seconds before they are used to prepare sterile products.
10. Only materials essential for preparing the sterile product should be placed in the primary engineering control. Products must be adequately separated so as not to disrupt the unidirectional airflow leaving the high efficiency particulate air (HEPA) filter. Overcrowding of materials should be avoided also to minimize disruption of clean airflow.
11. Extreme care must be taken to prevent obstruction of clean air across the critical area or site, defined as the area immediate to the point of entry area into a container, including the needle or device used to enter the container. The pharmacist or technician must be aware about the relation of other objects within the cabinet so that these objects never become an obstacle between the HEPA filter and critical area, as this can cause contamination of the critical area. Avoid reaching directly over the critical area because contaminants from the person or clothing may fall on the critical area. Only the cleanest air should be allowed to flow over the critical area of all the materials within the hood.
12. Avoid touch contamination of sterile needles, syringe parts, and other critical sites.
13. Solutions from ampoules must be properly filtered to remove particles.
14. Solutions from reconstituted powders should be mixed carefully, ensuring complete dissolution of the drug with the appropriate diluents.
15. Needle entry into vials should be performed at a 45-60° angle with the beveled side facing upwards to avoid coring of the vial closure.
16. After completion of the product, an additive cap or seal should be placed over the stopper or additive portal, to signify completion of the product as well as protect the portal from contamination.
17. Before, during and after the preparation of sterile products, the pharmacist or technician should carefully check the identity and verify the amounts and sequence of the additives in the sterile preparations detailed in the master drug formula against the original prescription, medication order, or other appropriate documentation before the product is released or dispensed.
18. After the preparation of every compounded sterile product, the contents of the container are thoroughly mixed and then inspected for the presence of particulate matter, evidence of incompatibility, or other defects.
19. After procedures are completed, used syringes, bottles, vials, and other supplies are removed, but with a minimum of exit and re-entry into the direct compounding area so as to minimize the risk of introducing contamination into the aseptic workspace.

Beyond Use Dating

1. Shall be defined the date or date and time, after which administration of a compounded drug product shall not begin , the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).
2. Single dose vials or containers shall not be stored for re-use unless approved by the pharmacist in charge at the time of opening in which case it may be stored for not more than 1 hour in an ISO class 5 environment. Single dose vials or containers shall not be re-used under any circumstance if exposed to a non-ISO class 5 environment after opening.
3. Multiple-dose vials containing antimicrobial preservative may be used for up to 28 days after initial puncture or opening unless otherwise specified by the manufacturer.
4. The rationale or reference source justifying the beyond use date of any compounded product shall be included on the master drug formula
5. The beyond use date of any compounded product shall not exceed those identified by California board of pharmacy regulation
6. The beyond use date of any compounded sterile product shall not exceed those identified in chapter 797 of the United States Pharmacopoeia.
7. The beyond use date of any compounded non-sterile products shall not exceed those identified in chapter 795 of the United States Pharmacopoeia.

Qualifications of Personnel Who Prepare Sterile Products

1. Qualified personnel that compound sterile products for patient use shall pass the following competency assessments at least annually. (See Appendix I)
 - a. Hand hygiene
 - b. Gowning and garbing
 - c. Sterile compounding calculations and terminology exam
 - d. Cleaning and disinfection of controlled compounding areas and equipment
 - e. Accurate documentation of compounding activities, cleaning, and monitoring of environmental controls
 - f. Pharmacy calculations and terminology exam
 - g. Sterile compounding knowledge assessment
 - i. Shall include review of most current policy and procedure
 - ii. Contents to be determined and re-evaluated annually or more frequently at the discretion of the pharmacist in charge
 - h. Gloved fingertip testing (see attached assessment for results recording and incubation process)
 - i. Defined as a process whereby compounding personnel lightly press each fingertip and thumb onto appropriate growth media, which are then incubated at a

- temperature and period of time conducive to multiplication of microorganisms as determined by the manufacturer.
- ii. Presence of any microbial growth shall require remediation and reassessment before personnel can continue to compound sterile products
 - iii. Gloved fingertip testing shall be performed with sterile gloves donned over the gauntlets of the compounding aseptic isolator prior to a media fill challenge and after a media fill challenge for both the right and left hands.
 - iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.
- i. Media fill challenge (see attached assessment for results recording and incubation process)
 - i. Shall consist of compounding procedures using a growth based media to mimic the most complex procedures performed by the pharmacy.
 - ii. The design of the media fill challenge shall be recorded in the IV competency binder located in the clinical pharmacist office and available on the pharmacy intranet.
 - iii. The design of the media fill challenge shall be re-assessed at least annually and any modifications recorded along with rationale.
 - iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.
 - j. Hazardous drug compounding assessments including decontamination as defined in hazardous drug policy 07.02.00
2. New personnel shall be oriented with the policy and procedure of compounding sterile products and receive adequate training consisting of audio/visual materials, shadowing a qualified compounder, and hands on practice under the supervision of a qualified compounder prior to initial competency assessment. The pharmacist in charge shall determine when new personnel have completed adequate training to begin competency assessment.
 3. New personnel shall complete gloved fingertip assessments on 3 separate occasions prior to compounding sterile products for patient use.
 4. Records of competency assessment shall be available for each individual qualified personnel and retained for three years.

Quality Assurance

1. To ensure continued standardization of procedures any changes made to the pharmacy policy and procedure on compounding of sterile or hazardous preparations will be communicated to all qualified personnel via a learning module assignment which will require an acknowledgement signature which may or may not be electronic.
2. Qualified personnel shall not participate in sterile compounding activities until reviewing all changes to policy and procedure via a learning module assignment which will require an acknowledgement signature which may or may not be electronic.
3. Environmental service personnel that clean the floors, ceilings, and windows inside the IV room and Hazardous drug room shall be trained on cleaning, garbing, and accurate documentation. Evidence of competency to perform these activities shall assessed at least annually and documented. (See Appendix II)
4. Any facility workers, environmental sampling personnel, quality assurance personnel, or maintenance personnel shall only be allowed entry in controlled compounding areas under pharmacist supervision and only after being trained on appropriate garbing technique as well as policy and procedure relevant to their duties. This training shall be documented on the "Support Personnel training and entry log"
5. End product testing for sterility and potency for a single compounded sterile product shall be conducted at least annually and repeated upon receipt of any unacceptable results.
 - a. If end product sterility testing results in microbial growth the supervising pharmacist will recall all sterile preparations from the same lot number according to pharmacy policy and procedure 02.04.00 (drug recall).
 - b. If end product potency testing results in greater than 10% variability of actual concentration vs. labeled concentration the supervising pharmacist will recall all compounded products from the same lot number according to pharmacy policy and procedure 02.04.00 (drug recall).
6. Quality of aseptic technique for each personnel will be assessed by directly observed media fill challenge at least annually, whenever unacceptable technique is observed, or when end product sterility testing yields microbial growth.
7. Standard aseptic technique are described in the above policy and procedure
8. Action levels for colony-forming units (CFUs) detected during quality assurance activities:

Classification	Volumetric air sample	Fingertip sample	Surface sample
ISO Class 5	>1	Zero	>3
ISO Class 8	>100	N/A	>100

- a. When action levels are exceeded during fingertip sampling the employee shall not compound sterile products until remediation and successful resampling
- b. When action levels are exceeded during environmental sampling the pharmacy shall investigate the possible sources of contamination and document interventions along with results of resampling. The beyond use dating of sterile products compounded prior to

successful resampling shall be evaluated and potentially adjusted as determined by the pharmacist-in-charge.

- c. When action levels are exceeded during surface sampling or volumetric air sampling the colony-forming units will be sent for identification to at least the genus level.

Labeling

1. Finished products should be labeled with at least the following information:
 - Resident's name
 - Prescription number
 - Patient or medical record number
 - Directions including rate of administration for IV medications
 - Name & concentration of all ingredients (including primary solution)
 - Prescribing physician's name
 - Date filled
 - Expiration date
 - Pharmacist's, technician's initials
 - Pharmacy telephone number
 - Instructions for storage & handling
 - All hazardous or cytotoxic preparations shall bear a special label stating: "Chemotherapy – Dispose of Properly" or "Hazardous – Dispose of properly"
2. The label should be legible and affixed to the final container in a manner enabling it to be read while the sterile product is being administered.

End Product Evaluation

1. The final product should be inspected when preparation is completed and again when the product is dispensed. This inspection includes an evaluation for container leaks, container integrity, solution cloudiness or phase separation, particulates in the solution, appropriate solution color, and solution volume.
2. The pharmacist shall verify that the product was compounded accurately with the correct ingredients, quantities of each ingredient, containers, and reservoirs.

Handling of Sterile Products Outside the Pharmacy

1. Sterile products should be transported in a manner to protect the medication from extremes of temperature outside their range of stability and from light if they are photosensitive.
2. Delivery personnel should be instructed on special handling procedures.
3. Once delivered to the end user, sterile products should be appropriately stored before use.
4. Special instructions for storage shall be a part of the label or separate information sheet.
5. Sterile products that display evidence of contamination or instability, or are improperly labeled shall be returned to the pharmacy for disposition,
6. Pharmacists shall participate in training end users on the proper care and storage of sterile products, either directly or through written instructions.

Administration of Sterile Products

1. Medications will be competently and safely administered. The Nursing Service is responsible for the safe administration of sterile products. See LH Nursing Policies & Procedures: J 1.0-10.0 on Medication Administration.

Documentation and Recordkeeping

1. The following should be documented and maintained on file for an adequate period of time, according to organizational policies and state regulatory requirements:
 - a. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.
 - b. Refrigerator and freezer temperatures,
 - c. Certification of CAI and CACI.
 - d. Master formula compounding sheets
 - e. Lot number assignment log for sterile and non-sterile compounds
 - f. Results of annual end product testing for sterile and non-sterile products
2. A record of medications dispensed shall be made in the resident's medication file. (See LH Pharmaceutical Services Policy 02.01.00: P& P for Distribution of Medications and Medication Order Processing.) In addition, the following information relevant to parenteral therapy shall be maintained:
 - a. Resident's name, age, and sex,
 - b. Diagnosis related to prescribed therapy,
 - c. Relevant medication history, and
 - d. Relevant laboratory data.

New 08/03

Revised 06/07dw, 01/08, 04/09, 2/10, 10/10, 08/11, 5/14, 10/15,08/17, 7/19 (complete revision)

Appendix I
**Laguna Honda Hospital Department of Pharmacy
Sterile Compounding Competency Assessment**

Garbing and Hand Hygiene	
	Presents in clean appropriate attire with closed toe shoes and wearing no cosmetics
	Removes any jewelry or accessories upon entry to the controlled area and stores cell phone away
	Dons hair cover and uses mirror to make sure the majority of hair is covered
	Dons face mask to cover bridge of nose down to chin. Dons facial hair/beard cover if necessary.
	Dons shoe covers one at a time placing the first covered shoe on "clean side" of the line of demarcation and then the second shoe cover to cross the line completely
	Performs appropriate hand hygiene by washing hands and forearms up to the elbow with soap and warm water for at least 30 seconds and uses a nail pick to clean under nail beds while washing
	Dries hands and forearms using lint-free towel
	Dons appropriate gown ensuring full closure while inspecting for any holes or defects
	Sanitizes hands for 30 seconds with surgical scrub after gowning and before wearing gloves
	Dons gloves and pulls elastic of the gown over the glove cuff to minimize skin exposure while working outside of the CAI
	Inspects isolator sleeves and gauntlets for holes or defects prior to any work inside the CAI
	Dons sterile gloves over the isolator gauntlets prior to any compounding activities
	After completing compounding and cleaning activities removes gloves, bonnet, face mask, and gown. Then performs hand hygiene and steps over the line of demarcation prior to removing shoe covers
	Identifies that the only part of the garb that can be reused is the gown for one shift while it remains on the "clean side" of the line of demarcation
Knowledge of Engineering Controls	
	Identifies items that are prohibited in the controlled area such as cardboard, food, cell phone
	Identifies at least 3 ways the IV room is kept clean such as routine cleaning, air pressure, garbing, hand hygiene, and wiping down items before bringing them into the controlled area
	Explains how the CAI reduces the risk of product contamination by using constant stream of HEPA filtered laminar airflow
	Identifies how often primary and secondary engineering controls are cleaned and how often isolator sleeves, gauntlets, and pre-filter must be changed.

Gloved Fingertip Sampling									
Tryptic Soy Agar – Bacteria (TSA)				Malt Agar Yeast Extract – Fungus (MEA)					
Q.I. Medical, Inc, EnviroTest Media Paddles, #ET1000 (Red Top) Incubate 2 to 3 days (30 to 35 degrees Celsius)				Q.I. Medical, Inc, EnviroTest Media Paddles, #ET3000 (Yellow Top) Incubate 5 to 7 days (26 to 30 degrees Celsius)					
Lot # _____ Exp date: _____				Lot # _____ Exp date: _____					
Start incubation date/time:		Stop incubation date/time:		Start incubation date/time:		Stop incubation date/time:			
Results			Daily Inspection of Media						
			1	2	3	4	5	6	7
Media	Hands	Initials of Evaluator →							
		Incubator Temp (Celsius) →							
TSA	Left/Right	After hand hygiene and garbing							
TSA	Left/Right	After media-fill preparation							
MEA	Left/Right	After hand hygiene and garbing							
MEA	Left/Right	After media-fill preparation							

("- " for no growth or "+" for growth, cloudiness, turbidity or "x" for pharmacy closed)

Cleaning	
	Selects appropriate cleaning agents based on the day of the week using the wall chart
	Sanitizes AND disinfects all ISO-5 surfaces in the CAI with appropriate cleaning agents including the ante-chamber before and after any compounding activities
	Changes the pad on the isolator cleaning tool and cleans starting with the ceiling, then walls, then main surface of the direct compounding area. Uses overlapping strokes from top to bottom when cleaning the walls and unidirectional overlapping strokes when cleaning the ceiling and main surface such as front to back.
	Identifies the procedure for monthly deep cleaning as well as weekly cleaning of bins, carts, shelves
Aseptic Technique	
	Introduces only essential materials into the CAI and stages items to avoid creating turbulent airflow or impeding laminar flow of HEPA filtered first-air over critical sites
	Disinfects components/vials/supplies with an appropriate agent prior to placing into the ante chamber of the CAI
	Waits at least 10 seconds after placing items in the ante-chamber with the door closed before moving items into the work area of the CAI
	Ensures syringes, needles, and tubing remain in their individual packaging and are only opened in ISO Class 5 work area
	Disinfects stoppers, injection ports, and ampule necks by wiping with sterile 70% isopropyl alcohol and allows sufficient time to dry
	Affixes needles to syringes without contact contamination
	Punctures vial stoppers and spikes infusion ports without contact contamination entering with the bevel of the needle face up at an approximate 45 degree angle to minimize risk for coring
	Disinfects sterile gloves routinely with 70% sterile isopropyl alcohol between each compounded product, every time an item is transferred in or out of the work area to the ante-chamber, whenever there is a spill, whenever gloves are visibly soiled, or whenever compounder suspects contamination
	Disposes sharps and drug waste according to LHH pharmacy and procedure
Documentation	
	Identifies location of master compounding formulas on the pharmacy intranet and identifies the process for creating and editing
	Identifies the lot number compounding log located in the dispensing area of the pharmacy and can explain how new lot numbers are generated based on the date and the number of items compounded that day
	Identifies what information is required on the label for a compounded sterile product
	Defines "beyond use date" and explains how beyond use dates are assigned based on the master drug formula using manufacturer package insert, USP797, and reputable pharmacy literature sources.
	Accurately documents cleaning activities on the daily cleaning log
	Accurate documents air pressure differentials on the daily log
	Has read the most updated version of sterile compounding pharmacy policy THIS YEAR

Media Fill Challenge (incubate for 14 days)															
Q.I. Medical, Inc, GroMed TSB Growth Media 100ml								Lot #			Exp. Date:				
Q.I. Medical, Inc, GroMed Media #GM0200 20ml								Lot #			Exp. Date:				
Q.I. Medical, Inc, Sterile Vial #EV0200 20ml								Lot #			Exp. Date:				
Results		Start incubation date/time							Stop incubation date/time						
Daily Inspection of Media →		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Initials of Evaluator															
Incubator temp (Celsius)															

("–" for no growth or "+" for growth, cloudiness, turbidity)

07.01.00
STERILE PRODUCT PREPARATION, HANDLING AND DISPOSAL

<u>Title/content</u>	<u>Page</u>
Policy and Purpose	2
Definitions and Abbreviations	2
Pharmacy Areas for Preparing Sterile Products	4
Hand Hygiene and Garbing Procedure	4
Environmental Controls	5
Monitoring and Testing of Environmental Controls	7
Cleaning and Sanitizing of the workspaces	8
Master Compounding Formula	9
Aseptic Technique and Pharmacy Sterile Product Preparation	10
Beyond Use Dating	12
Qualifications of Personnel Who Prepare Sterile Products	12
Quality Assurance	14
Labeling	15
End Product Evaluation	15
Handling of Sterile Products Outside the Pharmacy	15
Administration of Sterile Products	16
Documentation and Recordkeeping	16
Appendix I: Sterile compounding competency assessment	17
Appendix II: Assessment of Environmental Services Personnel	19

Policy: The pharmacy shall ensure the sterility and integrity of sterile products prepared and used at Laguna Honda.

Purpose: To ensure the appropriate surveillance, prevention, and infection control procedures for sterile products.

Definitions and Abbreviations

Beyond use date (BUD) - the date or date and time, after which administration of a compounded drug product shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).

Primary engineering control (PEC) – a device that provides an ISO Class 5 or better environment through the use of unidirectional HEPA-filtered first air for the exposure of critical sites when compounding sterile preparations. Examples of PEC devices include, but are not limited to, laminar airflow workbenches, biological safety cabinets, sterile compounding automated robots, compounding aseptic isolators, and compounding aseptic containment isolators.

Compounding aseptic isolator (CAI)– a form of isolator specifically designed for **non-hazardous compounding** pharmaceutical ingredients or preparations while bathed with unidirectional air. It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes

Compounding aseptic containment isolator (CACI) - a unidirectional compounding aseptic isolator designed to provide worker protection from exposure **hazardous drugs** airborne drug throughout the compounding and material transfer processes and to provide an aseptic environment for compounding sterile preparations. The exhaust air from the isolator is removed by external building ventilation.

ISO- International Organization of Standardization (ISO) classification of particulate matter in room air. The number following ISO refers to air quality determined by the number of particles in a cubic meter of air. An ISO-5 environment level of quality must be maintained in the direct compounding area.

Direct Compounding Area (DCA) - Critical area within a primary engineering control exposed to unidirectional filtered air.

Isolator Gauntlet – A glove that is attached to the isolator sleeve intended for repeated use and changed at least monthly. Sterile gloves are donned over isolator gauntlets whenever engaged in compounding activities.

IV room – The designated area of positive pressure separate from routine work traffic that contains the primary engineering control (CAI) to compound non-hazardous sterile products. Refers specifically to room P2334 “IV PREP”

Hazardous drug room – The designated area of negative pressure separate from routine work traffic that contains the compounding aseptic containment isolator (CACI) used for compounding sterile and non-sterile hazardous drugs. Refers specifically to room P2332 “CHEMO PHARMACY”

Line of demarcation – A line on the floor marked with tape in both the IV and hazardous drug rooms that designates an ante-area for garbing towards the door separated from the clean working areas around the primary engineering control where personnel must be full gowned and garbed.

Qualified personnel – Pharmacists and pharmacy technicians that have completed required training and successfully passed all of the required competency assessments for sterile compounding

USP – United States Pharmacopoeia

RCRA – Resource Conservation and Recovery Act enacted in 1972 that governs the disposal of certain hazardous waste in the pharmacy.

CSP – Compounded sterile preparation

Pharmacy Areas for Preparing Sterile Products

1. Access to the IV room is limited to necessary/trained personnel.
2. Solutions, drugs, supplies and equipment used to prepare and administer sterile products shall be stored in accordance with manufacturer or USP requirements. Sterile products that require special storage conditions, for example, refrigeration and protection from light, shall be so stored. Refrigerator temperatures shall be wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
3. Outdated products should be removed from active storage areas.
4. Before each use, each drug, ingredient, and container should be visually inspected for damage, defects and expiration date.
5. Particle generating activities, such as removal of items from or manipulation of cardboard boxes, should be performed outside of the IV room and hazardous drug room.
6. Disposal of packing materials, used syringes, containers, and needles should be performed as needed.
7. Waste shall be disposed of in the appropriate container of pharmaceutical (blue), trace hazardous waste (yellow), of bulk hazardous/RCRA designated waste (black). Eating, drinking, and smoking are prohibited in the IV room and hazardous drug room.
8. Non-sterile to sterile "high risk" compounding shall not be performed by Laguna Honda Hospital Pharmacy

Hand Hygiene and Garbing procedure

1. Prior to entering hazardous drug room see policy and procedure 07.02.00 for additional garbing requirements specific to preparing, handling, and disposing of hazardous drugs
2. Prior to entering IV room or hazardous drug room inform a pharmacist of any change in eligibility to compound sterile preparations:
 - a. Personnel with signs or symptoms of respiratory infection, exposed rashes, sunburn, conjunctivitis, fever, open wounds, or weeping sores shall be excluded from sterile compounding until condition is resolved.
 - b. Any person wearing cosmetics, nail polish, or artificial nails shall not participate in sterile compounding. Fingernails should be kept clean and trimmed.
3. Remove any hand, wrist, finger, or other visible jewelry
4. Remove any neck lanyards, ties, or necklace jewelry
5. Don hair cover and face mask to cover bridge of nose down to the chin. Don additional facial hair cover if necessary.
6. Don shoe covers placing the first covered shoe over the line of demarcation to the clean side prior to donning the second shoe cover. When garbing in the hazardous drug room a don a second pair of shoe covers after crossing over the line of demarcation.

7. Wash hands with soap and warm water up to the elbow scrubbing for at least 30 seconds and clean under nail bed with a clean nail pick whenever entering or re-entering the controlled area.
8. Dry hands with a non-shedding disposable paper towel and don a non-shedding gown. A non-shedding blue splash resistant gown must be used in the hazardous drug compounding area. Disinfect hands again using waterless surgical scrub and allows hands to dry before placing hands in isolator gauntlets.
9. If working in the IV or hazardous drug room outside of the CAI or CACI then don gloves and disinfect with sterile 70% isopropyl alcohol making sure the elastic wrists of the gown covers the glove cuff. These gloves can be removed when hands are placed inside the isolator gauntlets to compound.
10. When using the compounding aseptic isolator sterile gloves must be donned over the isolator gauntlets prior to any compounding activities. When using the CACI in the hazardous drug room sterile gloves must be donned over isolator gauntlets prior to any compounding, cleaning, or decontamination activities.
11. At the end of non-hazardous sterile compounding:
 - a. Remove and discard gloves, facial hair cover, mask, and hair cover in the regular trash.
 - b. Remove and discard gown in the regular trash or hang on a hook on the clean side of the line of demarcation to be re-used by the same personnel during the same shift only. Re-used gowns must be discarded by the end of shift.
 - c. Perform hand hygiene with soap and water for at least 30 seconds
 - d. Remove shoe covers one at a time ensuring that the uncovered foot is placed over the line of demarcation.
 - e. Discard shoe covers in the regular trash and disinfect hands prior to leaving the IV room.
 - f. Ensure all garb is removed and discarded appropriately before leaving the IV room.

Environmental Controls

1. Engineering controls reduce the potential for airborne contamination in workspaces by limiting the amount and size of contaminants in the CSP processing environment
2. Primary engineering controls (PEC) at Laguna Honda Hospital Pharmacy include the compounding aseptic isolator (CAI) in the IV room and the compounding aseptic containment isolator (CACI) in the hazardous drug room.
 - a. Isolator gauntlets shall be changed at least every month or whenever there is damage or a tear according to the manufacturer's directions and specifications.
 - b. Isolator sleeves shall be changed every 6 months or whenever there is damage or a tear according to the manufacturer's directions and specifications
 - c. Pre-filter shall be changed at least every 3 months according to the manufacturer's directions and specifications
3. Secondary engineering controls are used reduce airborne particles in the areas surrounding the primary engineering control and include:
 - a. Separating the sterile compounding areas in rooms with a pressure differential relative to adjacent spaces (See next section for monitoring)
 - i. IV room will be maintained at positive pressure
 - ii. Hazardous drug room will be maintained at a negative pressure between -0.01 and -0.03 inches water column

- b. Rigorous cleaning program (described in cleaning and sanitizing of the workspace)
 - c. Standardized gowning, garbing, and hand hygiene procedure
 - d. A line of demarcation to designate areas surrounding the primary engineering control that require qualified personnel to be fully gowned and garbed.
 - e. Only the furniture, equipment, supplies, and other goods required for the tasks to be performed may be brought into this room, and they should be non-permeable, non-shedding, and resistant to disinfectants.
 - i. Carts should be of stainless steel wire or sheet metal construction with good quality, cleanable casters to promote mobility.
 - ii. Storage shelving counters, and cabinets should be smooth, impervious, free from cracks or crevices, non-shedding, cleanable, and sanitary. Their number, design, and manner of installation should promote effective cleaning and sanitizing.
 - f. Maintaining an organized and uncluttered environment with minimal horizontal workspaces
 - g. The surface of ceilings, walls, floors, fixtures, shelving, counters, and cabinets in the IV room are to be smooth, impervious, free from cracks and crevices, and non-shedding, thereby promoting clean ability and minimizing spaces in which microorganisms and other contaminants may accumulate. The surfaces should be resistant to damage by sanitizing agents.
 - h. Items brought into the CAI or CACI are disinfected with sterile 70% isopropyl alcohol prior to transporting.
4. Sterile product preparation will be performed in a CAI or CACI that provides at least ISO 5 air quality.
- a. International Organization of Standardization (ISO) Classification of Particulate Matter in Room Air (Limits are in particles 0.5µm and larger per cubic meter (current ISO)

Class Name		Particle Count	
ISO Class	US FS 209E	(ISO,m ³)	(FS 209E ft ³)
3	Class 1	35.2	1
4	Class 10	352	10
5	Class 100	3,520	100
6	Class 1000	35,200	1000
7	Class 10,000	352,000	10,000
8	Class 100,000	3,520,000	100,000

Testing and Monitoring of Environmental Controls

1. Pressure Differential Monitoring
 - a. IV room and hazardous drug room relative to adjacent areas
 - i. Measured wirelessly and continuously by engineering via the TEMPTRAK system.
 - ii. If differential pressure becomes negative in the IV room or out of range in the hazardous drug room engineering will be consulted to evaluate the potential causes and the supervising pharmacist will determine if any changes in workflow or beyond use dating are necessary until the desired pressure differential is restored.
 - iii. Pressure differential will be manually documented on a daily basis when the pharmacy is open on the “air pressure differential log”
 - b. CAI and CACI
 - i. Pressure differential of the antechamber and main workspace within the CAI will be checked daily when the pharmacy is open by qualified personnel and recorded on the “air pressure differential log”
 - ii. Pressure differential in the CACI will be checked daily by qualified personnel and recorded on the “air pressure differential log”
 - iii. The CAI and CACI will sound an audible alarm in the event that pressure differentials fall out of the manufacturer specified operation ranges. When the alarm is sounded the supervising pharmacist will be informed to evaluate and troubleshoot before any sterile compounding activities are continued and will determine if any compounded preparations made at the time of the alarm were compromised.
 - c. Temperature monitoring
 - i. Refrigerator temperature in the IV room is wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
 - ii. The temperature of the IV room and hazardous drug room are continuously monitored wirelessly with limits set for operator comfort and manufacturer recommended storage conditions for IV drugs.
 - d. Humidity gauges are present in the IV room and hazardous drug room to detect significant changes that would affect operator comfort.
 - e. Certification and testing of primary and secondary engineering controls shall be performed every six months and whenever a primary engineering control or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area.
 - f. Certification will be performed by a qualified operator to meet test standards of CETA Certification Guide for Sterile Compounding Facilities under dynamic conditions to include viable particle counts, non-viable particle counts, and smoke pattern testing.
 - g. Viable particle counts
 - i. Viable surface sampling is performed every six months in the primary engineering controls and the surrounding areas by an outside qualified operator as part of routine certification testing
 - ii. Viable particles in the air are tested by volumetric air sampling procedures by an outside qualified operator every six months as part of routine certification testing. Volumetric air sampling will test a sufficient volume of air (400 to 1,000 liters) at locations inside the PEC and surrounding area.

Cleaning and Sanitizing of the Workspaces

1. Procedure for cleaning of primary engineering controls (CAI in IV room)
 - a. The cleaning, sanitizing and organizing of the direct compounding areas (DCA) is the responsibility of qualified pharmacists and pharmacy technicians and is performed prior to any compounding activities and at least daily when the pharmacy is open.
 - b. *See hazardous drug policy for additional steps required for cleaning the hazardous drug compounding area.*
 - c. Sanitize the gauntlets of the CAI with a germicidal detergent followed by sterile water and allow to dry.
 - d. Disinfect the gauntlets of the CAI with sterile 70% isopropyl alcohol
 - e. Replace the non-shedding pad on the isolator cleaning tool and utilize it during the following cleaning procedures to clean surfaces that would normally be out of reach.
 - f. Sanitize all surfaces in the primary engineering control (including the gauntlets again) with a germicidal detergent followed by sterile water to remove gross filth. A pre-saturated non-shedding wipe or spray may be used with the isolator cleaning tool.
 - g. Do not directly spray the ceiling towards the HEPA filter because it can cause damage and compromise its integrity. When cleaning surfaces use an overlapping horizontal motion in one direction starting at the top of the isolator working down. Clean the ceiling first, then the back, then the sides, and finally the bottom surface inside the primary engineering control. Be sure to clean the antechamber in addition to the direct compounding areas.
 - h. After sanitizing with a germicidal detergent and sterile water then disinfect the surfaces of the primary engineering control (including the gauntlets again) with sterile 70% isopropyl alcohol following the previous procedures.
 - i. Once a week replace the germicidal detergent with a sporicidal detergent for sanitizing all surfaces including the gauntlets in the primary engineering control.
 - j. After completing the cleaning process, document the activity in the "cleaning record for sterile compounding room"
 - k. Prior to donning sterile gloves and after the initial cleaning procedures for the surfaces of the CAI or CACI disinfect the gauntlets with sterile 70% isopropyl alcohol
 - l. If the primary engineering control has been turned off between aseptic procedures, it should be operated for at least 30 minutes to allow complete purging of room air from the direct compounding area, then cleaned with the above procedures before performing any compounding activities
 - m. Once a month the CAI will undergo a deep cleaning in which the front panel is opened and the bottom work tray is lifted out to clean area underneath working in a horizontal unidirectional motion from right to left starting from the back and working forward with overlapping strokes. The deep clean will consist of sanitizing with a sporicidal detergent and sterile water followed by disinfecting with sterile 70% isopropyl alcohol.
 - n. The CACI will also undergo deep cleaning once a month as described above, but the front viewing panel will NOT be opened to minimize for potential exposure to hazardous drug residues.

- o. If the CACI viewing panel must be opened during a deep clean to access an area unreachable with the isolator tool or to manage a spill, then a properly fit cartridge respirator shall be worn to protect the operator.
2. All ISO class 5 surfaces, work table surfaces, carts, counters, and floor shall be cleaned at least daily when the pharmacy is open using a germicidal detergent and sterile water followed by disinfecting with sterile 70% isopropyl alcohol. Once a week the germicidal detergent shall be replaced with a sporicidal detergent.
3. Floors in the compounding areas are sanitized and cleaned by mopping once daily when the pharmacy is open and when no aseptic operations are in progress. Mopping may be performed by trained and supervised custodial personnel using approved agents described in section 2 above. Only approved cleaning and sanitizing agents are used with careful consideration of compatibilities, effectiveness, and inappropriate or toxic residues. All cleaning tools, such as wipers, sponges, and mops, are non-shedding and dedicated a specific compounding area.
4. Walls and ceilings are sanitized with a sporicidal detergent and sterile water followed by disinfection with sterile 70% isopropyl alcohol at least weekly and documented on the appropriate cleaning log
5. Storage shelving is emptied of all supplies and sanitized with a sporicidal detergent and sterile water followed by disinfection with sterile 70% isopropyl alcohol at least weekly and documented on the appropriate cleaning log
6. Trash is collected in suitable plastic bags and removed with minimal agitation. Pharmaceutical waste and hazardous drug/RCRA waste is collected when approximately two thirds full.
7. Cardboard, shipping cartons, or high particle generating containers will NOT be brought into the IV room or hazardous drug room. All supplies required for compounding and cleaning activities will be disinfected with 70% sterile alcohol prior to being introduced to the IV or hazardous drug room.
8. Supplies required for compounding are disinfected with sterile 70% isopropyl alcohol before being placed in the antechamber of a primary engineering control.

Master Compounding Formula

1. Prior to any compounding activities a master formula approved by a pharmacist must be created or obtained from the library of master formulas stored on the pharmacy intranet.
2. A master formula must include the following:
 - a. Active and inactive ingredients to be used
 - b. Equipment to be used including the appropriate primary engineering control
 - c. The maximum allowable beyond use date for the preparation, and the rationale or reference source justifying its determination
 - d. Specific and essential compounding steps used to prepare the drug
 - e. Quality reviews required at each step in the preparation of the drug including:
 - i. Review calculations on master formula to confirm that the measurement of each additives and diluent will result in the final labeled concentration
 - ii. Visual inspection of all ingredients to be used for manufacturer expiration dating and integrity of manufacturer packaging such as broken seals on vials or punctures in a stopper or injection port.

- iii. Visual inspection of any reconstituted products for complete dissolution
 - iv. Visual inspection of any vial stopper or injection port punctured for evidence of leaking or coring.
 - v. Pharmacist to verify volume or measurement of any additive prior to final dilution and confirm it matches the master formula.
 - vi. Visual inspection after final dilution against a well-lit contrasting background to detect the presence of impurities such as particulate matter, unexpected change in color, precipitation, or coring.
- f. Instructions for storage or special handling requirements
 - g. An “update log” section shall be included on every master formula to include the date of creation with pharmacist initials. Any modifications to an existing master formula shall be documented in the “update log” sections with the description of changes as well as the date and pharmacist initials.

Aseptic Technique and Pharmacy Sterile Product Preparation

1. Sterile preparations shall be compounded in a primary engineering control that maintains an ISO class 5 environment under dynamic conditions using aseptic technique.
2. Aseptic technique refers to standardized compounding procedures intended to decrease the risk of contamination of a compounded sterile product. Talking should be minimized during aseptic preparation.
3. Ingredients used to compound sterile products should be determined to be stable, compatible, and appropriate for the product to be prepared, according to manufacturer or USP guidelines or appropriate scientific references. Ingredients and compounding process for each preparation is determined in writing and reviewed by a pharmacist on a master formula before compounding begins.
4. All ingredients should be inspected for defects, expiration date, and product integrity before use. Expired or defective products should not be used for compounding. Defective products should be reported to the FDA Med Watch Program, <https://www.accessdata.fda.gov/scripts/medwatch/>, or 1-800-FDA-1088.
5. Prior to performing any activities in the primary engineering control inspect the isolator gauntlets and sleeves for any defects or tears.
6. Any ingredient, equipment, or item required for sterile compounding shall be disinfected with sterile 70% isopropyl alcohol on all surfaces before placing inside the antechamber
7. Wait at least 10 seconds after placing items into the antechamber before opening the divider and bringing items into the work area inside the primary engineering control.
8. During any sterile compounding in the CAI or CACI all of the surfaces and isolator gauntlets are disinfected frequently with sterile 70% isopropyl alcohol including:
 - a. The beginning of each shift and before each lot
 - b. At least every 30 minutes when continuously compounding
 - c. After each spill or when surface contamination is suspected

9. All rubber stoppers of vials and bottles, the necks of ampoules, and injection ports into an IV bag are disinfected by wiping with sterile 70% isopropyl alcohol and waiting at least 10 seconds before they are used to prepare sterile products.
10. Only materials essential for preparing the sterile product should be placed in the primary engineering control. Products must be adequately separated so as not to disrupt the unidirectional airflow leaving the high efficiency particulate air (HEPA) filter. Overcrowding of materials should be avoided also to minimize disruption of clean airflow.
11. Extreme care must be taken to prevent obstruction of clean air across the critical area or site, defined as the area immediate to the point of entry area into a container, including the needle or device used to enter the container. The pharmacist or technician must be aware about the relation of other objects within the cabinet so that these objects never become an obstacle between the HEPA filter and critical area, as this can cause contamination of the critical area. Avoid reaching directly over the critical area because contaminants from the person or clothing may fall on the critical area. Only the cleanest air should be allowed to flow over the critical area of all the materials within the hood.
12. Avoid touch contamination of sterile needles, syringe parts, and other critical sites.
13. Solutions from ampoules must be properly filtered to remove particles.
14. Solutions from reconstituted powders should be mixed carefully, ensuring complete dissolution of the drug with the appropriate diluents.
15. Needle entry into vials should be performed at a 45-60° angle with the beveled side facing upwards to avoid coring of the vial closure.
16. After completion of the product, an additive cap or seal should be placed over the stopper or additive portal, to signify completion of the product as well as protect the portal from contamination.
17. Before, during and after the preparation of sterile products, the pharmacist or technician should carefully check the identity and verify the amounts and sequence of the additives in the sterile preparations detailed in the master drug formula against the original prescription, medication order, or other appropriate documentation before the product is released or dispensed.
18. After the preparation of every compounded sterile product, the contents of the container are thoroughly mixed and then inspected for the presence of particulate matter, evidence of incompatibility, or other defects.
19. After procedures are completed, used syringes, bottles, vials, and other supplies are removed, but with a minimum of exit and re-entry into the direct compounding area so as to minimize the risk of introducing contamination into the aseptic workspace.

Beyond Use Dating

1. Shall be defined the date or date and time, after which administration of a compounded drug product shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored (other than for quarantine purposes).
2. Single dose vials or containers shall not be stored for re-use unless approved by the pharmacist in charge at the time of opening in which case it may be stored for not more than 1 hour in an ISO class 5 environment. Single dose vials or containers shall not be re-used under any circumstance if exposed to a non-ISO class 5 environment after opening.
3. Multiple-dose vials containing antimicrobial preservative may be used for up to 28 days after initial puncture or opening unless otherwise specified by the manufacturer.
4. The rationale or reference source justifying the beyond use date of any compounded product shall be included on the master drug formula
5. The beyond use date of any compounded product shall not exceed those identified by California board of pharmacy regulation
6. The beyond use date of any compounded sterile product shall not exceed those identified in chapter 797 of the United States Pharmacopoeia.
7. The beyond use date of any compounded non-sterile products shall not exceed those identified in chapter 795 of the United States Pharmacopoeia.

Qualifications of Personnel Who Prepare Sterile Products

1. Qualified personnel that compound sterile products for patient use shall pass the following competency assessments at least annually. (See Appendix I)
 - a. Hand hygiene
 - b. Gowning and garbing
 - c. Sterile compounding calculations and terminology exam
 - d. Cleaning and disinfection of controlled compounding areas and equipment
 - e. Accurate documentation of compounding activities, cleaning, and monitoring of environmental controls
 - f. Pharmacy calculations and terminology exam
 - g. Sterile compounding knowledge assessment
 - i. Shall include review of most current policy and procedure
 - ii. Contents to be determined and re-evaluated annually or more frequently at the discretion of the pharmacist in charge
 - h. Gloved fingertip testing (see attached assessment for results recording and incubation process)
 - i. Defined as a process whereby compounding personnel lightly press each fingertip and thumb onto appropriate growth media, which are then incubated at a

- temperature and period of time conducive to multiplication of microorganisms as determined by the manufacturer.
- ii. Presence of any microbial growth shall require remediation and reassessment before personnel can continue to compound sterile products
 - iii. Gloved fingertip testing shall be performed with sterile gloves donned over the gauntlets of the compounding aseptic isolator prior to a media fill challenge and after a media fill challenge for both the right and left hands.
 - iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.
- i. Media fill challenge (see attached assessment for results recording and incubation process)
 - i. Shall consist of compounding procedures using a growth based media to mimic the most complex procedures performed by the pharmacy.
 - ii. The design of the media fill challenge shall be recorded in the IV competency binder located in the clinical pharmacist office and available on the pharmacy intranet.
 - iii. The design of the media fill challenge shall be re-assessed at least annually and any modifications recorded along with rationale.
 - iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.
 - j. Hazardous drug compounding assessments including decontamination as defined in hazardous drug policy
2. New personnel shall be oriented with the policy and procedure of compounding sterile products and receive adequate training consisting of audio/visual materials, shadowing a qualified compounder, and hands on practice under the supervision of a qualified compounder prior to initial competency assessment. The pharmacist in charge shall determine when new personnel have completed adequate training to begin competency assessment.
 3. New personnel shall complete gloved fingertip assessments on 3 separate occasions prior to compounding sterile products for patient use.
 4. Records of competency assessment shall be available for each individual qualified personnel and retained for three years.

Quality Assurance

1. To ensure continued standardization of procedures any changes made to the pharmacy policy and procedure on compounding of sterile or hazardous preparations will be communicated to all qualified personnel via a learning module assignment which will require an acknowledgement signature which may or may not be electronic.
2. Qualified personnel shall not participate in sterile compounding activities until reviewing all changes to policy and procedure via a learning module assignment which will require an acknowledgement signature which may or may not be electronic.
3. Environmental service personnel that clean the floors, ceilings, and windows inside the IV room and Hazardous drug room shall be trained on cleaning, garbing, and accurate documentation. Evidence of competency to perform these activities shall be assessed at least annually and documented. (See Appendix II)
4. Any facility workers, environmental sampling personnel, quality assurance personnel, or maintenance personnel shall only be allowed entry in controlled compounding areas under pharmacist supervision and only after being trained on appropriate garbing technique as well as policy and procedure relevant to their duties. This training shall be documented on the "Support Personnel training and entry log"
5. End product testing for sterility and potency for a single compounded sterile product shall be conducted at least annually and repeated upon receipt of any unacceptable results.
 - a. If end product sterility testing results in microbial growth the supervising pharmacist will recall all sterile preparations from the same lot number according to pharmacy policy and procedure 02.04.00 (drug recall).
 - b. If end product potency testing results in greater than 10% variability of actual concentration vs. labeled concentration the supervising pharmacist will recall all compounded products from the same lot number according to pharmacy policy and procedure 02.04.00 (drug recall).
6. Quality of aseptic technique for each personnel will be assessed by directly observed media fill challenge at least annually, whenever unacceptable technique is observed, or when end product sterility testing yields microbial growth.
7. Standard aseptic technique are described in the above policy and procedure
8. Action levels for colony-forming units (CFUs) detected during quality assurance activities:

Classification	Volumetric air sample	Fingertip sample	Surface sample
ISO Class 5	>1	Zero	>3
ISO Class 8	>100	N/A	>100

- a. When action levels are exceeded during fingertip sampling the employee shall not compound sterile products until remediation and successful resampling
- b. When action levels are exceeded during environmental sampling the pharmacy shall investigate the possible sources of contamination and document interventions along with results of resampling. The beyond use dating of sterile products compounded prior to

successful resampling shall be evaluated and potentially adjusted as determined by the pharmacist-in-charge.

- c. When action levels are exceeded during surface sampling or volumetric air sampling the colony-forming units will be sent for identification to at least the genus level.

Labeling

1. Finished products should be labeled with at least the following information:
 - Resident's name
 - Prescription number
 - Patient or medical record number
 - Directions including rate of administration for IV medications
 - Name & concentration of all ingredients (including primary solution)
 - Prescribing physician's name
 - Date filled
 - Expiration date
 - Pharmacist's, technician's initials
 - Pharmacy telephone number
 - Instructions for storage & handling
 - All hazardous or cytotoxic preparations shall bear a special label stating: "Chemotherapy – Dispose of Properly" or "Hazardous – Dispose of properly"
2. The label should be legible and affixed to the final container in a manner enabling it to be read while the sterile product is being administered.

End Product Evaluation

1. The final product should be inspected when preparation is completed and again when the product is dispensed. This inspection includes an evaluation for container leaks, container integrity, solution cloudiness or phase separation, particulates in the solution, appropriate solution color, and solution volume.
2. The pharmacist shall verify that the product was compounded accurately with the correct ingredients, quantities of each ingredient, containers, and reservoirs.

Handling of Sterile Products Outside the Pharmacy

1. Sterile products should be transported in a manner to protect the medication from extremes of temperature outside their range of stability and from light if they are photosensitive.
2. Delivery personnel should be instructed on special handling procedures.
3. Once delivered to the end user, sterile products should be appropriately stored before use.
4. Special instructions for storage shall be a part of the label or separate information sheet.
5. Sterile products that display evidence of contamination or instability, or are improperly labeled shall be returned to the pharmacy for disposition,
6. Pharmacists shall participate in training end users on the proper care and storage of sterile products, either directly or through written instructions.

Administration of Sterile Products

1. Medications will be competently and safely administered. The Nursing Service is responsible for the safe administration of sterile products. See LH Nursing Policies & Procedures: J 1.0-10.0 on Medication Administration.

Documentation and Recordkeeping

1. The following should be documented and maintained on file for an adequate period of time, according to organizational policies and state regulatory requirements:
 - a. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.
 - b. Refrigerator and freezer temperatures,
 - c. Certification of CAI and CACI.
 - d. Master formula compounding sheets
 - e. Lot number assignment log for sterile and non-sterile compounds
 - f. Results of annual end product testing for sterile and non-sterile products
2. A record of medications dispensed shall be made in the resident's medication file. (See LH Pharmaceutical Services Policy 02.01.00: P& P for Distribution of Medications and Medication Order Processing.) In addition, the following information relevant to parenteral therapy shall be maintained:
 - a. Resident's name, age, and sex,
 - b. Diagnosis related to prescribed therapy,
 - c. Relevant medication history, and
 - d. Relevant laboratory data.

New 08/03

Revised 06/07dw, 01/08, 04/09, 2/10, 10/10, 08/11, 5/14, 10/15,08/17

Reviewed: 3/2013, 8/15

Appendix I
Laguna Honda Hospital Department of Pharmacy
Sterile Compounding Competency Assessment

Garbing and Hand Hygiene	
	Presents in clean appropriate attire with closed toe shoes and wearing no cosmetics
	Removes any jewelry or accessories upon entry to the controlled area and stores cell phone away
	Dons hair cover and uses mirror to make sure the majority of hair is covered
	Dons face mask to cover bridge of nose down to chin. Dons facial hair/beard cover if necessary.
	Dons shoe covers one at a time placing the first covered shoe on “clean side” of the line of demarcation and then the second shoe cover to cross the line completely
	Performs appropriate hand hygiene by washing hands and forearms up to the elbow with soap and warm water for at least 30 seconds and uses a nail pick to clean under nail beds while washing
	Dries hands and forearms using lint-free towel
	Dons appropriate gown ensuring full closure while inspecting for any holes or defects
	Sanitizes hands for 30 seconds with surgical scrub after gowning and before wearing gloves
	Dons gloves and pulls elastic of the gown over the glove cuff to minimize skin exposure while working outside of the CAI
	Inspects isolator sleeves and gauntlets for holes or defects prior to any work inside the CAI
	Dons sterile gloves over the isolator gauntlets prior to any compounding activities
	After completing compounding and cleaning activities removes gloves, bonnet, face mask, and gown. Then performs hand hygiene and steps over the line of demarcation prior to removing shoe covers
	Identifies that the only part of the garb that can be reused is the gown for one shift while it remains on the “clean side” of the line of demarcation
Knowledge of Engineering Controls	
	Identifies items that are prohibited in the controlled area such as cardboard, food, cell phone
	Identifies at least 3 ways the IV room is kept clean such as routine cleaning, air pressure, garbing, hand hygiene, and wiping down items before bringing them into the controlled area
	Explains how the CAI reduces the risk of product contamination by using constant stream of HEPA filtered laminar airflow
	Identifies how often primary and secondary engineering controls are cleaned and how often isolator sleeves, gauntlets, and pre-filter must be changed.

Gloved Fingertip Sampling									
Tryptic Soy Agar – Bacteria (TSA)				Malt Agar Yeast Extract – Fungus (MEA)					
Q.I. Medical, Inc, EnviroTest Media Paddles, #ET1000 (Red Top) Incubate 2 to 3 days				Q.I. Medical, Inc, EnviroTest Media Paddles, #ET3000 (Yellow Top) Incubate 5 to 7 days					
Lot # _____ Exp date: _____				Lot # _____ Exp date: _____					
Start incubation date/time:		Stop incubation date/time:		Start incubation date/time:		Stop incubation date/time:			
Results			Daily Inspection of Media						
			1	2	3	4	5	6	7
Media	Hands	Initials of Evaluator →							
		Incubator Temp (Celsius) →							
TSA	Left/Right	After hand hygiene and garbing							
TSA	Left/Right	After media-fill preparation							
MEA	Left/Right	After hand hygiene and garbing							
MEA	Left/Right	After media-fill preparation							

(“- “ for no growth or “+” for growth, cloudiness, turbidity or “x” for pharmacy closed)

Cleaning	
	Selects appropriate cleaning agents based on the day of the week using the wall chart
	Sanitizes AND disinfects all ISO-5 surfaces in the CAI with appropriate cleaning agents including the ante-chamber before and after any compounding activities
	Changes the pad on the isolator cleaning tool and cleans starting with the ceiling, then walls, then main surface of the direct compounding area. Uses overlapping strokes from top to bottom when cleaning the walls and unidirectional overlapping strokes when cleaning the ceiling and main surface such as front to back.
	Identifies the procedure for monthly deep cleaning as well as weekly cleaning of bins, carts, shelves
Aseptic Technique	
	Introduces only essential materials into the CAI and stages items to avoid creating turbulent airflow or impeding laminar flow of HEPA filtered first-air over critical sites
	Disinfects components/vials/supplies with an appropriate agent prior to placing into the ante chamber of the CAI
	Waits at least 10 seconds after placing items in the ante-chamber with the door closed before moving items into the work area of the CAI
	Ensures syringes, needles, and tubing remain in their individual packaging and are only opened in ISO Class 5 work area
	Disinfects stoppers, injection ports, and ampule necks by wiping with sterile 70% isopropyl alcohol and allows sufficient time to dry
	Affixes needles to syringes without contact contamination
	Punctures vial stoppers and spikes infusion ports without contact contamination entering with the bevel of the needle face up at an approximate 45 degree angle to minimize risk for coring
	Disinfects sterile gloves routinely with 70% sterile isopropyl alcohol between each compounded product, every time an item is transferred in or out of the work area to the ante-chamber, whenever there is a spill, whenever gloves are visibly soiled, or whenever compounder suspects contamination
	Disposes sharps and drug waste according to LHH pharmacy and procedure
Documentation	
	Identifies location of master compounding formulas on the pharmacy intranet and identifies the process for creating and editing
	Identifies the lot number compounding log located in the dispensing area of the pharmacy and can explain how new lot numbers are generated based on the date and the number of items compounded that day
	Identifies what information is required on the label for a compounded sterile product
	Defines "beyond use date" and explains how beyond use dates are assigned based on the master drug formula using manufacturer package insert, USP797, and reputable pharmacy literature sources.
	Accurately documents cleaning activities on the daily cleaning log
	Accurate documents air pressure differentials on the daily log

Media Fill Challenge (incubate for 14 days)															
Q.I. Medical, Inc, GroMed TSB Growth Media 100ml							Lot #			Exp. Date:					
Q.I. Medical, Inc, GroMed Media #GM0200 20ml							Lot #			Exp. Date:					
Q.I. Medical, Inc, Sterile Vial #EV0200 20ml							Lot #			Exp. Date:					
Results		Start incubation date/time						Stop incubation date/time							
Daily Inspection of Media →		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Initials of Evaluator															
Incubator temp (Celsius)															
Growth															

("- " for no growth or "+" for growth, cloudiness, turbidity)

Appendix II
Laguna Honda Hospital Department of Pharmacy
Assessment of hand hygiene, garbing, and cleaning of **EVS** personnel

Knowledge of IV room/Hazardous drug room operating policy and procedure	
	Identifies items that are prohibited in the controlled area such as cardboard, food, cell phone
	Identifies at least 3 ways the IV room is kept clean such as routine cleaning, air pressure, garbing, hand hygiene, and wiping down items before bringing them into the controlled area
	Explains the purpose of the line of demarcation that separates the “dirty” and “clean” sides
	Explains the main purpose of the IV room (protect sterile products) and Hazardous drug room (protect workers from hazardous drug)
Garbing and Hand Hygiene	
	Presents in clean appropriate attire with closed toe shoes and wearing no cosmetics
	Removes any jewelry or accessories upon entry to the controlled area and stores cell phone away
	Dons hair cover and uses mirror to make sure the majority of hair is covered
	Dons face mask to cover bridge of nose down to chin. Dons facial hair/beard cover if necessary.
	Dons shoe covers one at a time placing the first covered shoe on “clean side” of the line of demarcation and then the second shoe cover to cross the line completely
	Dons 2 pairs of shoe covers in the hazardous drug room
	Performs appropriate hand hygiene by washing hands and forearms up to the elbow with soap and warm water for at least 30 seconds and uses a nail pick to clean under nail beds while washing
	Dries hands and forearms using lint-free towel
	Dons appropriate gown ensuring full closure while inspecting for any holes or defects
	Dons spill resistant blue gown that closes in the back in the hazardous drug room
	Sanitizes hands for 30 seconds with surgical scrub after gowning and before wearing gloves
	Dons gloves and pulls elastic of the gown over the glove cuff to minimize skin exposure
	Dons 2 pairs of gloves and ensures the knit cuffs on the gown cover the cuff of the gloves in the hazardous drug room
	Removes garb placing it in the trash on the “dirty side” of the line of demarcation
	Removes all garb starting with the outer shoe covers, then outer gloves, then gown, then hat and mask, then inner gloves, and finally inner shoe covers and places in yellow hazardous drug waste prior to exiting the hazardous drug room
Cleaning	
	Selects appropriate cleaning agents based on the day of the week using the wall chart
	Changes mop head prior to cleaning
	Wets the mop head adequately prior to cleaning and periodically during cleaning as needed
	Starts cleaning activities with the ceiling and mops from the far end of the room towards the door while wearing protective goggles
	Repeats the same cleaning activity using sterile water for irrigation and then sterile 70% isopropyl alcohol
	Cleans the walls and windows starting with the back wall and working towards the door using overlapping mopping strokes from the ceiling to the floor
	Cleans floor with overlapping mop strokes starting at the far end of the room and working towards the door
	Changes mop head during cleaning if it looks visibly soiled
	Documents cleaning activities appropriately

**LAGUNA HONDA HOSPITAL
DEPARTMENT OF PHARMACEUTICAL SERVICES**

07.02.00

**PREPARATION, HANDLING AND DISPOSAL OF HAZARDOUS DRUGS
07.02.00**

POLICY:

The preparation, handling, labeling, dispensing, and disposal of hazardous drugs by the pharmacy shall meet or exceed standards set by the Occupational Safety and Health Administration (OSHA), United States Pharmacopeia (USP800), Guidelines adopted by the American Society of Hospital Pharmacists (ASHP), and California regulation

The pharmacy shall not compound sterile hazardous drug products

PURPOSE:

To limit exposure of pharmacy personnel and the environment to hazardous drugs

DEFINITIONS:

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.

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.

Chemotherapy glove: A medical glove that meets the ASTM Standard Practice for Assessment of Resistance of Medical Gloves to Permeation by Chemotherapy Drugs (D6978) or its successor.

Containment primary engineering control (C-PEC): A ventilated device designed and operated to minimize worker and environmental exposures to HDs by controlling emissions of airborne contaminants through the following:

1. The full or partial enclosure of a potential contaminant source
2. The use of airflow capture velocities to trap and remove airborne contaminants near their point of generation
3. The use of air pressure relationships that define the direction of airflow into the cabinet
4. The use of HEPA filtration on all potentially contaminated exhaust streams

Compounding aseptic isolator (CAI): An isolator specifically designed for compounding sterile, non-hazardous pharmaceutical ingredients or preparations. The CAI is designed to maintain an aseptic compounding environment throughout the compounding and material transfer processes.

Compounding aseptic containment isolator (CACI): A specific type of CAI that is designed for the compounding of sterile HDs. The CACI is designed to provide worker protection from exposure to undesirable levels of airborne drugs throughout the compounding and material transfer processes and to provide an aseptic environment with unidirectional airflow for compounding sterile preparations.

Deactivation: Treatment of an HD contaminant on surfaces with a chemical, heat, ultraviolet light, or another agent to transform the HD into a less hazardous agent.

Decontamination: Inactivation, neutralization, or removal of HD contaminants on surfaces, usually by chemical means.

Hazardous drug room – The designated area of negative pressure separate from routine work traffic that contains the C-PEC used for compounding sterile and nonsterile hazardous drugs. Refers specifically to room P2332 “CHEMO PHARMACY”

Line of demarcation – A line on the floor marked with tape in both the IV and hazardous drug rooms that designates an ante-area for garbing towards the door separated from the clean working areas around the primary engineering control where personnel must be full gowned and garbed.

RCRA – Resource Conservation and Recovery Act enacted in 1972 that governs the disposal of certain hazardous waste in the pharmacy.

Receipt of Hazardous Drugs

1. Pharmacy Personnel shall inspect shipping containers for signs of damage or breakage such as visible stains from leakage or the sound of broken glass. If a shipping container appears to contain damaged products it shall be moved to the hazardous drug room for storage for evaluation by a pharmacist and the supplier contacted for potential return.
 - a. If the unopened package is to be returned to the supplier then it shall be enclosed in an impervious container and labeled as hazardous.
 - b. If the supplier refuses return then it shall be disposed of as hazardous waste
 - c. If the pharmacist determines opening the container would not result in harmful exposure to hazardous drugs (such as in the case of just loose tablets in the container) it should be opened in the C-PEC and any products recovered deactivated and decontaminated prior to storage.
2. Pharmacy personnel wear a single pair of chemotherapy gloves when unpacking containers that may contain hazardous drugs.
3. Unpacking shipping containers that may contain hazardous shall occur in an area with access to a spill kit.

Storage of Hazardous Drugs

1. Oral and topical cytotoxic drugs shall be stored in yellow bins separate from the non-hazardous drug supply. Any reusable equipment used to count or repackage cytotoxic drugs shall also be separated and clearly labeled to prevent any cross contamination. Refrigerated cytotoxic drugs shall be stored in a dedicated refrigerator in the hazardous drug room.
2. Hazardous drugs that are not cytotoxic shall be stored in red bins and may be stored with non-hazardous inventory
3. Non-cytotoxic hazardous drugs may be stored with non-hazardous drugs in the same patient cassette
4. Cytotoxic drugs should be separated from other drugs in a patient cassette with an appropriately labeled plastic bag

Compounding and Manipulation of Non-sterile Hazardous Drugs

1. Any manipulation of hazardous drugs beyond repackaging whole dosage forms or counting (such as cutting tablets) shall be performed in a C-PEC in the hazardous drug room.
2. Compounding of non-sterile hazardous drugs shall occur in the hazardous drug room in a C-PEC in accordance with USP757 and USP800.

Environmental Controls in Hazardous Drug Room

1. The C-PEC in the hazardous drug room is a CACI, but it is only used for non-sterile compounding of hazardous drugs
 - a. The C-PEC shall be externally vented and operate continuously under negative pressure greater than -0.01 "WC
 - b. During a power outage or air handling maintenance that interferes with negative pressure in the room or C-PEC pharmacy personnel shall stop any compounding activities and exit the hazardous drug room after removing any PPE and performing hand hygiene. Once the C-PEC can be powered on it should be decontaminated and sanitized on all surfaces and wait the manufacturer-specified recovery time before resuming compounding activities.
2. Secondary engineering controls in the hazardous drug room include:
 - a. A rigorous deactivation, decontamination, and sanitation program
 - b. Negative pressure -0.01 and 0.03 inches water column relative to adjacent areas with at least 12 air exchanges per hour.
 - c. Equipment used to compound or clean in the hazardous drug room remains dedicated to the hazardous drug room to prevent possible contamination of other areas of the pharmacy with hazardous drug residues
 - d. Standardized gowning, garbing, and hand hygiene procedures including double shoe covers to help prevent tracking hazardous drug residues into other areas of the pharmacy

Testing and Monitoring of Environmental Controls in the Hazardous room

1. Pressure Differential Monitoring
 - a. Hazardous drug room relative to adjacent areas
 - i. Measured wirelessly and continuously by engineering via the TEMPTRAK system.
 - ii. If differential pressure falls out of range in the hazardous drug room engineering will be consulted to evaluate the potential causes and the supervising pharmacist will determine if any changes in workflow regarding personnel safety are needed until the desired pressure differential is restored.
 - iii. Pressure differential will be manually documented on a daily basis when the pharmacy is open on the "air pressure differential log"
 - b. CACI
 - i. Pressure differential in the CACI will be manually documented on a daily basis when the pharmacy is on the "air pressure differential log"
 - ii. The CACI will sound an audible alarm in the event that pressure differentials fall out of the manufacturer specified operation ranges. When the alarm is sounded the supervising pharmacist will be informed to evaluate and troubleshoot before any compounding activities are continued.
2. Temperature monitoring
 - a. The temperature of the hazardous drug room is continuously monitored wirelessly with limits set for operator comfort and manufacturer recommended storage conditions for drugs.
 - b. Humidity gauges are present in hazardous drug room to detect significant changes that would affect operator comfort.

3. Certification and testing of primary and secondary engineering controls shall be performed every six months and whenever a primary engineering control or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area.
4. Pre-filters, HEPA filters, gauntlets, and sleeves shall be changed in the CACI per manufacturer specification and documented on the "cleaning record for hazardous drug room"

Hand Hygiene and Garbing procedure

1. Remove any hand, wrist, finger, or other visible jewelry
2. Remove any neck lanyards, ties, or necklace jewelry
3. Don hair cover and face mask to cover bridge of nose down to the chin. Don additional facial hair cover if necessary.
4. Don shoe covers placing the first covered shoe over the line of demarcation to the clean side prior to donning the second shoe cover.
5. Don a second pair of shoe covers after crossing over the line of demarcation.
6. Don a non-shedding splash resistant gown
7. Disinfect hands again using waterless surgical scrub and allows hands to dry before placing hands in isolator gauntlets.
8. If working in the hazardous drug room outside of the C-PEC then don chemotherapy gloves making sure the elastic wrists of the gown covers the glove cuff. These gloves can be removed when hands are placed inside the isolator gauntlets to compound.
9. When using the CACI in the hazardous drug room chemotherapy gloves must be donned over isolator gauntlets prior to any compounding, cleaning, or decontamination activities.
10. At the end of hazardous compounding:
 - a. Remove and discard gloves, gown, facial hair cover, mask, hair cover, and first pair of shoe covers in the yellow hazardous drug waste container.
 - b. Perform hand hygiene with soap and water for at least 30 seconds
 - c. Remove second pair of shoe covers one at a time ensuring that the uncovered foot is placed over the line of demarcation.
 - d. Discard second pair of shoe covers in the yellow hazardous waste container and disinfect hands prior to leaving the hazardous drug room.

Deactivation, Decontamination, and Cleaning of the Workspaces in the Hazardous Drug Room

1. Schedule for cleaning activities (Deactivation, Decontamination, Sanitizing)
 - a. Trained environmental service personnel shall clean the hazardous drug room floors daily when the pharmacy is open and clean the ceilings, walls, and windows once a week
 - b. Pharmacy personnel shall clean the CACI daily when used for compounding and at least once a week regardless of use. A deep clean will occur once a month. Cleaning the CACI shall occur before and after compounding.
 - c. Pharmacy personnel shall clean the carts, bins, and shelves once a week
2. CACI
 - a. While wearing the appropriate PPE replace the non-shedding pad on the isolator cleaning tool and use it to deactivate the surfaces of the antechamber with diluted bleach followed by decontamination and sanitization with a germicidal detergent and then leave the isolator tool in the antechamber to pass to the work space.
 - b. Deactivate the gauntlets of the CACI with diluted bleach and then decontaminate and sanitize with germicidal detergent and allow to dry.

- c. Deactivate all the surfaces of the CACI with diluted bleach followed by decontamination and sanitization with a germicidal detergent using the isolator cleaning tool as needed using overlapping wiping motion from the top of the workspace to the bottom and then in the same direction horizontally
 - d. Avoid using sprays in the hazardous drug room since it can spread hazardous drug residues. Instead use pre-saturated wipes or pourable pull top bottles to wet a non-shedding wipe.
 - e. Once a month the CACI will undergo a deep cleaning in which the front panel is opened and the bottom work tray is lifted out to clean area underneath working in a horizontal unidirectional motion from the back and working forward with overlapping strokes. The deep clean will consist of deactivation with diluted bleach followed by decontamination and sanitization with a germicidal detergent. A properly fit cartridge respirator shall be worn during the deep clean.
3. Hazardous drug room
 - a. Floors shall be deactivated with diluted bleach followed by decontamination and sanitization with germicidal detergent daily when the pharmacy is open
 - b. Walls, windows, carts, bins, and shelves are deactivated with diluted bleach followed by decontamination and sanitization with a germicidal detergent weekly.
 4. After completing the any cleaning activities document in the "cleaning record for hazardous drug room"
 5. Dispose of all cleaning waste and PPE worn during cleaning in the yellow hazardous drug waste bin
 6. All equipment used to clean the hazardous drug room is dedicated to the room and cannot be used for cleaning activities elsewhere.

Use of CACI for compounding non-sterile hazardous drugs

1. All of the surfaces in the CACI work area and antechamber must be deactivated, decontaminated, and sanitized before and after compounding.
2. Place compounding equipment and ingredients in the CACI antechamber along with a pair of chemotherapy gloves and chemotherapy bags. Close the antechamber door and purge the air before placing hands in gauntlets and transferring materials into the work space.
3. Don a pair of chemotherapy gloves over the isolator gauntlets.
4. Prepare any compounds according to the master formula (See "Master compounding Formula in pharmacy policy 07.01.00), deactivate and decontaminate the container of the final product with diluted bleach and a germicidal detergent and place in a chemotherapy bag in the antechamber.
5. Deactivate and decontaminate any reusable compounding equipment with diluted bleach and a germicidal detergent and then place in a chemotherapy bag and place in the antechamber.
6. Gather any waste, disposable compounding supplies, cleaning supplies, and chemotherapy gloves in a chemotherapy bag and place in the antechamber
7. Purge the air from the CACI antechamber and then discard the waste bag in the yellow hazardous drug waste bin. Inspect the reusable equipment outside of the CACI for any gross filth or visible hazardous drug residues before storage.
8. A beyond use date shall be assigned based on the master formula and USP795 (See policy 07.01.00 "Beyond use dating")

Transport of hazardous drugs

1. Hazardous drugs shall be transported in containers that minimize the risk of breakage or leakage.
2. Liquid and semi-solid formulations shall be transported in plastic bags and handled with chemotherapy gloves
3. Non-cytotoxic hazardous drugs may be transported with non-hazardous drugs for the same patient in the same container
4. Solid dosage form cytotoxic drugs shall be separated from other patient medications by a plastic bag with appropriate labeling.
5. Non-solid cytotoxic dosage forms shall be transported in a plastic bag with appropriate labeling by personnel wearing chemotherapy gloves with a spill kit readily available.

Hazardous Drug Identification

1. The pharmacy shall maintain a list of hazardous drugs on the pharmacy and nursing intranet which shall include medications are on the National Institute Occupational Safety and Health (NIOSH) list of "antineoplastic and other hazardous drugs" as well as drugs determined to be hazardous by the supervising pharmacist.
2. The hazardous drug list shall be evaluated annually by a clinical pharmacist and supervising pharmacist and shall include assessment of drugs added or removed from the NIOSH list that is updated bi-annually
3. Hazardous drugs shall be assessed for cytotoxic designation
 - a. Cytotoxic drugs are handled with the same precautions as other hazardous drugs, but may have different storage and labeling requirements. In addition "chemoprecautions" shall be observed for patients receiving cytotoxic drugs per hospitalwide policy 25-05.
 - b. Cytotoxic designation is determined through collaborative evaluation between the clinical pharmacists, pharmacy supervisor and oncology pharmacist at Zuckerberg San Francisco General Hospital.
 - c. Evaluation of cytotoxic designation includes reviewing the mechanism of action, hazardous metabolites, American Hospital Formulary Service (AHFS) classification, relevant FDA and manufacturer warnings, NIOSH classification, and risk of adverse effects upon exposure.
 - d. Hazardous drugs that destroy cells or inhibit their function with indiscrete or non-specific mechanisms of action that do not have any safe level of exposure are typically designated as cytotoxic.

Administration of Hazardous Drugs – See Hospitalwide policy 25-05

Training

1. All pharmacy personnel handling hazardous drugs in any capacity shall be trained based on their job function
2. Training for pharmacy personnel shall be documented and occur:
 - a. Before a new employee independently handles hazardous drugs
 - b. Whenever new equipment is introduced such as PPE or C-PEC
 - c. Whenever there is significant changes in policy and procedure
 - d. Reassessed at least every 12 months
3. Training for pharmacy personnel shall include the following:
 - a. Identification of hazardous and cytotoxic drugs – location of the hazardous drug list
 - b. Storage, labeling, and dispensing requirements for hazardous drugs
 - c. Proper use of PPE
 - d. Spill management
 - e. Proper use and maintenance of environmental controls and compounding equipment
 - f. Proper disposal of hazardous drug waste and trace-contaminated materials such as packaging
 - g. Deactivation, decontamination, sanitization practices
 - h. Appropriate documentation of cleaning, monitoring, and maintenance activities in the hazardous drug room
 - i. Master formula and Beyond Use Dating (See Policy 07.01.00)
 - j. Non-sterile compounding competency and practical
4. Training for environmental service personnel shall be documented and occur:
 - a. Before a new employee cleans the hazardous drug room independently
 - b. Whenever there is significant changed to policy and procedure
 - c. Reassessed at least every 12 months
5. Training for environmental service personnel cleaning the hazardous drug room shall include:
 - a. Deactivation, decontamination, and sanitization practices
 - b. Proper use of PPE
6. Pharmacy personnel that handle hazardous drugs shall sign a hazardous drug acknowledgement form (Appendix 1)

Labeling and Dispensing

1. Hazardous drugs dispensed by the pharmacy shall be identified by the word HAZARDOUS printed on the packaging or with an auxiliary label and shall be identified on the medication administration record in the electronic health record
2. Cytotoxic drugs dispensed by the pharmacy shall be identified by an auxiliary label "Cytotoxic – Observe Chemo Precautions"
3. Hazardous drugs that are included in category 1 of the NIOSH list shall be dispensed as final dosage forms that do not require any manipulation prior to administration besides counting
4. Hazardous drugs may shall not be crushed or cut outside of the C-PEC in the hazardous drug room (unless there has been a documented assessment of risk), but some dosage forms may be dispensed in an oral syringe to be dissolved in the oral syringe prior to administration. The

medication administration record in the electronic health record shall include details on how to prepare a hazardous medication for administration and what PPE to utilize if needed.

Assessment of Risk

1. Hazardous drugs identified on the NIOSH list shall meet the containment strategies identified by USP800.
2. An assessment of risk shall be documented in cases where a hazardous drug does not meet the containment strategies in USP800.
3. Assessment of risk for alternative containment strategies must be approved by the pharmacy supervisor and re-evaluated every 12 months.
4. Assessment of Risk shall include:
 - a. Type of hazardous drug
 - b. Dosage form
 - c. Risk of Exposure
 - d. Packaging
 - e. Manipulation

Hazardous Drug Waste

1. Unless identified as RCRA waste (see below) all hazardous drug waste including any supplies, PPE, or containers potentially contaminated with hazardous drug residues should be disposed of in the yellow hazardous drug waste bin.
2. Hazardous waste containers shall be puncture resistant and appropriate for sharps disposal
3. The yellow hazardous waste container shall be replaced by environmental services when it is $\frac{3}{4}$ full or has been used for 90 days. New yellow hazardous waste containers shall be dated when they start being used.
4. Resource Conservation and Recovery Act (RCRA) waste
 - a. Some hazardous drugs need to be separated and disposed of in one of the black RCRA waste containers.
 - b. RCRA waste containers shall be labeled with their contents and shall be replaced by environmental services when it is $\frac{3}{4}$ full or has been used for 90 days. New RCRA waste containers shall be dated when they start being used.
 - c. Expired cytotoxic drugs or packaging/supplies contaminated with cytotoxic drug residue that have not been dispensed by the pharmacy shall be disposed of in the appropriate RCRA waste container
 - d. Nicotine, Warfarin, Silver sulfadiazine, silver nitrate, and selenium sulfide are considered "Listed waste" and shall be disposed of in the appropriate RCRA container.
 - e. All hazardous, cytotoxic, and listed waste dispensed by the pharmacy shall be considered "RCRA empty" and shall be disposed of in a yellow hazardous waste container.

Spill Management of Hazardous Drugs

1. Spill kits are located in the pharmacy and are available outside the pharmacy on the medical acute unit, the supplemental drug room, as well as the "chemo cart"
2. See hospital wide policy 25-05 for contents of the spill kit
3. Small spills of 5 ml or less or dropped pills may be wiped up with absorbent gauze while wearing chemotherapy gloves. Dispose of spill waste and chemotherapy gloves in the yellow hazardous drug container.
4. Spills larger than 5ml should be managed per hospital policy 25-05

Attachment:

Appendix 1: Hazardous Drug Risk Acknowledgement Form

Reference:

LHHPP 25-05 Hazardous drug Management

PPP 07.01.00 Sterile Product Preparation, Handling, and Disposal

United States Pharmacopeia and National Formulary (USP 800). Rockville, MD: United States

Pharmacopeial Convention; 2017. <https://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/general-chapter-800.pdf>. Accessed July 15, 2019

USP795

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

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

New 10/2015 (Separated from 07.01.00 sterile compounding)

Revised: 7/2019

Appendix 1

Hazardous Drug Risk Acknowledgement Form

Health care personnel involved with the preparation, handling, administration, transportation and disposal of hazardous drugs may be at an increased health risk, with exposure occurring through inhalation of drug dusts or aerosols, skin absorption and inadvertent ingestion through contact with contaminated food or cigarettes, and needle stick injuries. Aerosols of hazardous drugs can result in exposing not only the worker immediately involved, but also exposing other people in the surrounding areas. Workers may also be exposed to hazardous drugs when they handle contaminated equipment and supplies. The risks to workers handling hazardous drugs are a combined result of the drugs' inherent toxicity and the extent to which workers are directly exposed. Other factors include the susceptibility of the individual to the drugs' toxic effects, and co-factors such as dietary habits, smoking, and man-made or natural environmental contaminants.

The effects of these drugs can be acute or delayed. The acute effects of these drugs include, but are not limited to irritation of the skin, eyes and mucous membranes. Headaches, lightheadedness, dizziness and nausea have also been reported. The delayed effects can include mutagenicity, teratogenicity, and carcinogenicity. Those of reproductive age should understand that there may be a relationship between occupational exposure and reproductive outcomes, including miscarriage, birth defects and low birth weight.

Staff who are trying to conceive (male or female), are pregnant or breast-feeding, should not handle cytotoxic or hormonal agents labeled/classified as Hazardous Drugs. Staff who fit into the above categories should inform their immediate supervisor or an approved confidential contact person for work reassignment.

I have read the above statement and understand the possible health risk involved with occupational exposure to hazardous drugs.

Employee Name (Print)

Date

**07.02.00
PREPARATION, HANDLING AND DISPOSAL OF HAZARDOUS DRUGS****Preparation, Handling and Disposal of Hazardous Drugs**

1. The pharmacy will prepare, handle and discard cytotoxic agents, which include all chemotherapy products, in a manner which ensures aseptic preparation, employee protection from exposure, and safe handling of finished products and disposal of materials or waste products.
2. Pharmacy practices will meet or exceed the standards set by the Occupational Safety and Health Administration (OSHA), and the Guidelines adopted by the American Society of Hospital Pharmacists (ASHP). Cytotoxic agents are known or suspected carcinogens. Many of these agents are chemotherapy medications used to treat cancer. Proper handling and the use of protective wear reduces the risk of exposure to these agents to individuals preparing or administering chemotherapy products
3. Handling
 - a. Hazardous drugs shall be handled with caution at all times using chemotherapy gloves during receiving, distribution, stocking, inventorying, preparation for administration and disposal.
 - b. Pharmacy staff will be in serviced annually regarding the precautions related to handling these agents.
 - c. Spill kits will be placed in the IV room, pharmacy and nursing stations where cytotoxic agents are administered.
 - d. Staff involved in handling of hazardous drugs shall complete a hazardous drug risk acknowledgement form annually (Appendix 2).
4. Storage
 - a. Chemotherapy products will be stored in the pharmacy in a separate chemotherapy shelving area, in alphabetical order by generic name.
 - i. Chemotherapy products requiring refrigeration will be stored on a separate shelf in the pharmacy refrigerator.
 - b. Products will be reviewed routinely to assure expired medications are not dispensed.
5. Order Processing
 - a. Order Review
 - i. A pharmacist will review each chemotherapy order before preparation to ensure appropriateness, including dose, route, indication, compatibility, conflict with the resident's allergies, and legibility.
 - ii. The pharmacist will contact the prescriber if any inappropriate or unclear information is present.
 - iii. The product will not be prepared until the order is clarified, if clarification is needed.

- b. Label Preparation
 - i. A label will be prepared for each chemotherapy product to include information as specified in Labeling Policy.
 - ii. An auxiliary label, "CAUTION – CHEMOTHERAPY: HANDLE WITH GLOVES, DISPOSE OF PROPERLY" will be placed on the label of each chemotherapy product.
 - c. Product Preparation
 - i. All compounded chemotherapy products will be prepared in a negative pressure CAI.
 - ii. Only a pharmacist or a chemotherapy-certified technician may prepare compounded chemotherapy products.
 - iii. The pharmacist or technician will review the order and verify the accuracy of the label.
 - iv. The pharmacist or technician will ensure that the negative pressure CAI is cleaned thoroughly before beginning preparation of a single or a series of products according to procedure outlined above.
 - d. The pharmacist or technician will assemble all needed materials prior to beginning preparation in the negative pressure CAI.
 - e. The pharmacist or technician will wear a disposable gown and disposable gloves to prepare all compounded chemotherapy. Gowns and gloves are available in different sizes and are stored in the IV room. Staff may choose to double glove when preparing hazardous agents.
 - f. Using proper aseptic technique, the pharmacist or technician will prepare the product.
 - g. The final product will be inspected for particulate matter. If found, the product shall be discarded and a new product prepared.
 - h. For products compounded at LH, the pharmacist or technician will label the finished product, ensuring that the solution name printed on the final container is visible, if possible.
 - i. For products compounded at LH, a pharmacist must verify the accuracy and appropriateness of all products made before the product is released for delivery to the resident care area. The pharmacist will initial the label after verification.
 - j. Each chemotherapy product will be placed in a resealable plastic bag.
 - k. The pharmacist or technician will remove his or her gloves and wash hands again after working with chemotherapy agents.
6. Product Delivery
- a. Chemotherapy products will be delivered to the nursing station where they are to be administered.
7. Disposal

- a. All materials used in the preparation of chemotherapy products will be placed in a designated leak-proof chemotherapy container.
 - i. A designated chemotherapy container will be kept adjacent to the CAI. Items will be placed in a plastic bag and placed directly into the container.
 - ii. Needles will be placed in a puncture-proof sharps container. Full sharps containers may be placed in the chemotherapy container for disposal.
- b. Staff shall use a new container when the current container reaches $\frac{3}{4}$ full or 90 days from first use, whichever comes first. Notify environmental services when containers are $\frac{3}{4}$ full or after 90 days from first use.

Spill Management of Hazardous Drugs (HDs)

1. A spill kit will be provided to areas where cytotoxic agents are stored, transported, prepared and administered. The spill kit is provided for safety reasons. The kit contains a protective gown, latex gloves, a mask and goggles, towels and spill control pillows, a scoop and brush, disposal bags and biohazard labels. These items will be used to clean an area contaminated by a cytotoxic substance.
2. In case of spill or exposure to the cytotoxic substance, the following steps should be followed:

Spills are contained by the first competent staff person on the scene using the Cytotoxic Drug Spill kit maintained on Positive Care Units, Pharmacy, Supplemental Drug Room and CSR.

Small spills of 5 ml or less or dropped pills may be wiped up with absorbent gauze (4x4) using gloved hands. Place in a resealable plastic bag (e.g., Ziploc) and discard in the cytotoxic waste container

For spills greater than 5 ml, use personal protective equipment provided in the Spill Kit.

- (1) Caution bystanders to avoid the spill and immediately obtain the spill kit from the treatment room.
- (1) Open the kit. Use chemo spill caution sign to mark spill area.
- (2) Place spill pillows in a "V" position on the outer perimeter of spill to prevent spread.
- (3) Put on chemotherapy gown, N95 respirator mask, shoe covers chemical splash goggles and double chemotherapy gloves. Open the plastic chemo waste disposal bags.
- (4) Place absorbent towels over spill, being careful not to touch the spill.
- (5) Pick up saturated towels and spill pillows and place in small chemo waste bag. Use disposable scoop and brush as needed to pick up debris.
- (6) Place filled small chemo waste bag into spill kit box and seal the box with the chemo waste label.
- (7) Discard chemo spill kit box and outer gloves into large chemo waste bag.
- (8) Remove mask, goggles, gown and inner gloves and dispose of in large chemo waste bag.
- (10) Seal the bag and dispose of in the cytotoxic waste container.
- (11) Notify Environmental Services for a final mop-down according to EVS procedures.
- (12) Report the spill to the Industrial Hygienist.
- (13) Complete a Confidential Report of Unusual Occurrence.

New: 2015/10 (separated from sterile compounding)

Hazardous Drug Risk Acknowledgement Form

Health care personnel involved with the preparation, handling, administration, transportation and disposal of hazardous drugs may be at an increased health risk, with exposure occurring through inhalation of drug dusts or aerosols, skin absorption and inadvertent ingestion through contact with contaminated food or cigarettes, and needle stick injuries. Aerosols of hazardous drugs can result in exposing not only the worker immediately involved, but also exposing other people in the surrounding areas. Workers may also be exposed to hazardous drugs when they handle contaminated equipment and supplies. The risks to workers handling hazardous drugs are a combined result of the drugs' inherent toxicity and the extent to which workers are directly exposed. Other factors include the susceptibility of the individual to the drugs' toxic effects, and co-factors such as dietary habits, smoking, and man-made or natural environmental contaminants.

The effects of these drugs can be acute or delayed. The acute effects of these drugs include, but are not limited to irritation of the skin, eyes and mucous membranes. Headaches, lightheadedness, dizziness and nausea have also been reported. The delayed effects can include mutagenicity, teratogenicity, and carcinogenicity. Those of reproductive age should understand that there may be a relationship between occupational exposure and reproductive outcomes, including miscarriage, birth defects and low birth weight.

Staff who are trying to conceive (male or female), are pregnant or breast-feeding, should not handle cytotoxic or hormonal agents labeled/classified as Hazardous Drugs. Staff who fit into the above categories shall inform their immediate supervisor for work reassignment.

I have read the above statement and understand the possible health risk involved with occupational exposure to hazardous drugs.

Employee Name (Print) _____ Date _____

Employee Signature _____

Revised Social Services Policies and Procedures

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.2 Social Services Department: Services

Policy: The Social Services Department at Laguna Honda Hospital and Rehabilitation Center provides social services to all residents and/or families upon admission and throughout their stay at Laguna Honda.

Purpose: To enable residents to utilize health care to achieve their optimal level of functioning in the least restrictive setting.

Procedure:

1. Direct Service: –Social services may be provided directly to the resident and/or family and friends. These direct services include:
 - a. Initial Assessment/Resident Social History Initial Assessment: –To determine strengths and weaknesses in personal, family, and social functioning and resources.
 - b. Counseling: –To assist the resident and family to define and cope with problems created or aggravated by illness, disability, and hospitalization.
 - c. Discharge Planning: –To guide resident, family, and significant others in the development and implementation of a plan for post-hospital care, using the appropriate community resources to address medical and psychosocial needs.
 - d. Financial Counseling: –To assist resident and family in evaluating their financial situation in the context of needs and services, and to refer to additional service and funding resources.
 - e. Group Services: –To develop or participate in the occasional offering of group services to residents and families as a means of meeting social and emotional needs.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

2. Consultation: Social workers participate in neighborhood care conferences with attending physician, nurse manager, resident and other support services team members. Additional informal consultation is held as needed to share an understanding of the social, psychological, cultural, and environmental factors affecting a resident's needs.
3. Community Liaison: –The social worker serves as liaison to, and participates in, community organizations for the following purposes:
 - a. To obtain appropriate services for residents and families.
 - b. To participate with the Laguna Honda residents, other agencies, and/or community services in developing resources that will benefit Laguna Honda Hospital residents.
4. The Social Services Department offers orientation and in-service education to other hospital staff members.

The Director, as determined, may coordinate field placements in the Social Services Department for students in graduate schools of social work.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.4 Social Services Department: Recording

Policy: It is Social Services Department policy to have a written social history on all residents and a social services plan for those who need such services.

Purpose:

1. To provide continuity of care.
2. To provide better communication among staff members.
3. To document a history of social assessments and services provided to each resident.
4. To assess each resident for discharge potential to a lower level of care.

Procedure:

1. A ~~written~~ Resident Social History Initial Assessment is part of the resident's Electronic Health Record (EHR) and social services record. This assessment must be in the record within five (5) working days of admission and is the basis on which a social work treatment plan is developed. If resident is coded as a short stay resident, the assessment must be in the record within two (2) working days of admission.
2. By day 5, the Social Worker will complete and digitally sign Sections A & Q ~~on~~ in the MDS ~~page~~ section of the EHR. If #7 Psychosocial Well-Being, #8 Mood State, #9 Behavioral Symptoms, or #20 Community Referral are triggered, a CAA must be completed. The Social Worker is responsible for completing the Summary section and indicating if we are proceeding with care planning.
3. ~~A computerized Discharge Assessment is completed within 14 days of admission or re-admission and updated if resident's condition changes. If resident is coded as short stay resident, the Discharge Assessment must be completed within seven (7) days of admission. Discharge Considerations and interventions are listed for all residents. The Discharge Planning and Expected Discharge sections under the Social Work tab in the EHR must be completed within 48 hours of admission or re-admission (if the resident returns after a 7-day Bed Hold) for all service codes.~~

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.4 Social Services Department: Recording (cont.)

4. Quarterly progress notes and a semi-annual ~~progress note~~assessment which update the goals and plans outlined in the annual assessment will be in the resident's EHR under Consults Notes within 30 days of the due date. The semi-annual ~~progress note~~assessment will verify correct address and phone number of any next-of-kin, emergency contact and conservator, if applicable, and update face sheet information ~~with Admissions and Eligibility staff.~~
5. Annual assessments are documented in the resident's EHR under Consults Notes within 13 months of the date of the prior annual assessment. The annual assessments update any activities or changes, which have occurred since the resident's last assessment. The annual assessment will verify correct address and phone number of any next-of-kin, emergency contact and conservator, if applicable, and update face sheet information ~~with Admissions and Eligibility staff.~~
6. ~~Progress-Consults (formerly progress)~~ notes are documented as appropriate in the EHR of those residents who are actively receiving assistance from Social Services.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.5 Social Services Department: Discharges to the Acute Care Unit (PMA)

Policy: The Social Services Department shall chart within 1 business day of ~~receiving ADT notice~~ Admission Report when a resident has been admitted to the Acute Care Unit for acute care treatment so that a final disposition note will be part of the permanent medical record.

Purpose:

1. To ensure continuity of care for the resident and to apprise the physician and interdisciplinary team of social service contact with the family and families' concerns.

Procedure:

A. Admission and Discharge Note

1. The social worker will receive a ~~daily Admission, Discharge and Transfer notice~~ face sheet in their mailbox with the resident's name that requires a note in the EHR.
2. The social worker will chart a consult note under the Notes section in the EHR within 1 business day of being notified on all residents who are transferred from SNF to Laguna Honda's Acute Care Unit.
3. The note should document date and reason for transfer and any assistance provided by the social worker.
4. The social worker will include a discharge disposition and any psychosocial changes that have occurred due to the acute episode under the Expected Discharge section under the Social Work tab in the EHR. ~~documenting anticipated discharge destination and any psychosocial changes that have occurred due to the acute episode.~~
5. A ~~stamped copy of the Psychosocial~~ Resident Social History Initial Assessment (~~MR 703~~) will be ~~uploaded into~~ completed in the EHR acute medical record.
6. A resident who tests positive for MRSA (Methicillin-resistant Staphylococcus aureus) infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.7 Social Services Department: Discharge Planning and Implementation

Policy: The Social Services Department is responsible for coordinating discharge planning. Discharge Planning is a process that includes collaboration of the Resident Care Team, residents, families and residents' legal decision makers.

Purpose: To ensure continuity of care, sustain the optimal level of health gained through hospitalization, and provide care in the least restrictive setting.

Procedure:

1. All residents on admission will be assessed by Social Services for discharge potential ~~within five working days (two working days for short stay residents)~~ and ~~†~~This will be documented in the Resident Social History Initial psychosocial Assessment within five (5) working days of admission. If resident is coded as a short stay resident, the assessment must be in the record within two (2) working days of admission (MR-703). If there is discharge potential, 1) a care plan will be completed under the Care Plan tab in the EHR, 2) the Discharge Planning and Expected Discharge sections under the Social Work tab must be completed within 48 hours of admission. The Resident Care Team will further assess for discharge potential and identify residents appropriate for discharge to the community. Social Workers will actively coordinate discharge plans at the request of the Attending Physician.
2. After assessment process is completed, MSW will coordinate an interdisciplinary determination of a discharge care plan to assist the resident in the transition to the community and in identifying discharge considerations and interventions that impact the discharge plan.
3. A Resident Discharge Information sheet including projected discharge date and equipment needed will be placed in resident's room with resident's permission and updated as needed.
4. If the resident is conserved, the permission of the Conservator must be obtained prior to discharge. Conservators will be invited to team meetings to participate in the discharge planning process.
5. Counsel resident, family, and caregivers regarding resident's needs and options for services. This includes psychosocial support to deal with issues of loss and

INTERDEPARTMENTAL POLICIES AND PROCEDURES

transition and education about the resident's diagnosis and what services will need to be implemented for a safe discharge to a lower level of care.

6. Coordinate with hospital staff and community care providers to enable the resident to return to the community with the necessary supportive shelter, health, medical, and other services. Referrals include housing, substance abuse treatment programs, outpatient counseling, In-Home Support Service and home care services, case management, durable medical equipment, Adult day health programs and meal and transportation programs. Coordinate home evaluation with resident/caregiver, OT and PT. Email the Rehab team and A&E via "DPH-LHH Discharge Address" list when discharge date and location is established to start DME ordering process. Hospital beds and hooyer lifts require a minimum one month notification. [A Discharge Checklist will be reviewed by all team members to review to ensure resident is ready to go.](#)
7. When a discharge date is finalized, the MSW will initiate and provide the resident or legal representative with a 30-day notice (Notice of Proposed Transfer/Discharge). The signed notice will be uploaded into the EHR. If a resident should refuse to sign, the MSW will so note this and furnish the resident with one copy. A copy will be faxed to the Ombudsman program at 415-751-9789 and if any changes are made to the notice, all recipients will be updated.
- ~~8. A Discharge Checklist will be uploaded into the EHR for all team members to review to ensure resident is ready to go.~~
- ~~9.8. An medical social services Post-Discharge Plan of Care (MR-705) After Visit Summary (AVS) is given to resident at the inception of the discharge planning process and a finalized version at discharge delineating all community services arranged to facilitate their transition to community living. A copy of the written discharge instructions (MR-313A Post-Discharge Plan of Care/Home Instructions) will be given to the resident and/or resident representative and box will be checked off on the MR-705.~~

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.8 Social Services Department: Resident Care Conferences

Policy: Social workers shall participate in Resident Care Conferences as a member of the resident care team.

Purpose: To assure representation of the Social Service Department and present issues relevant from a social service perspective during the care planning for each resident.

Procedure:

1. The social worker assigned to each neighborhood program will participate in their Resident Care Conferences for that neighborhood. In the event of absence, the department will send a representative to cover.
2. Social workers will document their presence at Resident Care Conferences on the [Resident Care EHR Team Conference form](#) by adding themselves as a participant and completing their note section.
3. Any problems identified during the meeting requiring social service intervention shall be documented in [the resident care plan](#) and a [follow up consult note](#).
4. If no specific problems are identified, the social worker may summarize information from the conference on the next Quarterly [Progress Note](#) [consult note](#). If anything urgent requiring immediate attention occurs, a [progress-consult note](#) and a notation in the resident care plan is required.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.9 Social Services Department: Readmission Assessments

Policy: Residents readmitted following either an acute medical or acute surgical transfer to another facility or to Laguna Honda's Acute Care Unit will be reassessed for change in psychosocial status and discharge planning status requiring social service intervention.

Purpose: To record any changes due to acute episode, analyze psychosocial, discharge or other needs that have arisen and provide more comprehensive social service interventions.

Procedure:

I. Readmission from acute care to SNF:

1. The case will be assigned to the previous social worker, if possible, who provided coverage to allow for continuity of care. ~~The An~~ initial assessment will be ~~updated~~ completed addressing any significant psychosocial changes ~~and uploaded into~~ the EHR.
2. A brief readmission ~~progress consult~~ note is to be completed within five (5) days of readmission and address any significant psychosocial changes.
3. Readmission notes will be reviewed by a social service supervisor and/or the Social Service Director as part of the quality improvement activities of the department and as part of the employee evaluation process.

II. Readmission from the community to SNF:

1. ~~If the~~ Upon readmission, ~~occurs six months and under from the date of discharge,~~ the Resident Social History ~~Initial a~~ Assessment will be updated in the EHR under Notes section by copying a previous note and addressing any significant psychosocial changes, ~~and uploaded into the EHR and a~~ readmission note outlining any significant psychosocial changes will be recorded in ~~the progress~~ consult notes.
2. ~~If the readmission occurs after six months, a new initial assessment will be completed vs. a readmission note. If there are prevailing reasons why the case should be reassigned to a previous worker, the supervisor may authorize this and adjust the rotation schedule accordingly.~~

- | 32. Readmission assessment will be reviewed by a social service supervisor and/or the Social Service Director as part of the quality improvement activities of the department and as part of the employee evaluation process.

LAGUNA HONDA HOSPITAL
SOCIAL SERVICES DEPARTMENT MANUAL

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.10 Social Services Department: Confidentiality of Resident Information

Policy: No copies of EHR information shall be provided to residents or others by a social worker. Social workers may not request copies of medical records from other institutions or health care providers.

Purpose: To comply with ~~Medical Record Department~~Health Information Services (HIS) record keeping requirements and assure protection of resident confidentiality.

Procedure:

1. All requests for information or copies of information contained in the resident Medical Record at Laguna Honda shall be referred to ~~the Medical Record Department~~Health Information Services (HIS).
2. All information contained in the Medical Record of another institution required for the care of residents at Laguna Honda shall be requested through ~~the Medical Record Department~~Health Information Services (HIS) at Laguna Honda.

LAGUNA HONDA HOSPITAL
SOCIAL SERVICES DEPARTMENT MANUAL

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.11 Social Services Department: Inservice Training

Policy: The Social Services Department maintains ongoing inservice and training programs.

Purpose:

1. To develop and ensure high ~~stands~~standards of performance in the delivery of social services to Laguna Honda residents.
2. To encourage staff from different departments in developing an integrative understanding of psychosocial aspects of care planning and care management for hospital residents.
3. To comply with State regulations on inservice training.

Procedure:

1. Inservice programs are provided to the Social Services Department in the forms of presentation by outside speakers, case presentations by staff, and administrative meetings.
2. Individual staff members are encouraged to participate in additional educational and training programs and may be supported in their efforts by the hospital.
3. Orientation and inservice education are provided to staff of other departments in coordination with their department directors.
4. Documentation of staff attendance at inservices provided during work hours will be maintained in the Department.
5. All staff will attend regular or makeup sessions of inservices scheduled to meet Title 22 topic requirements.
6. Mandatory staff business meetings are held twice a month and the staff is responsible for notifying a supervisor or the department director if they are unable to attend.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.14 Social Services Department: Resident Self-Determination Act (PSDA)

Policy: In accordance with OBRA regulations and Laguna Honda Hospital and Rehabilitation Center policy, the Social Services Department shall ensure that information and explanation of written information regarding advance directives and resident's rights is afforded to all residents and families.

Purpose: To answer questions residents and families may have about written materials received upon admission about their rights regarding medical treatment. To direct detailed discussion around advanced directives to the unit physician.

Procedure:

1. Within 5 days of admission ([2 days for those coded as short stay](#)), the social worker will document in the [Psychosocial Resident Social History Initial Assessment](#) under Items Reviewed that a discussion was held about Advance Directives ~~and check the box~~.
2. If the resident and/or responsible family member wishes additional information, the social worker will give them a more detailed pamphlet entitled, "Advance Directives: Preparing for the Unexpected" and discuss this. Documentation of any questions or concerns they have will be detailed in the "[Psychosocial Problems Affect/Mood \(Include Conservator Issues\)](#)" section of the [Resident Social History Initial Assessment](#) and relayed to the unit physician.
3. If the resident wishes to fill out a DPAHC (Durable Power of Attorney for Health Care), the social worker will notify the physician. The social worker will then notify the Ombudsman who will need to witness this document. The Ombudsman will be advised that the physician is available for consultation.
4. If a DPAHC is selected, the social worker will notify the Admissions and Eligibility department, update the face sheet information and verify that the address and phone number of the DPAHC is correct twice a year via phone contact with the DPAHC.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.15 Social Services Department: Addressing Resident's Spiritual Needs

Policy: The Social Service Department recognizes and assesses the need for spiritual care for residents in a long term care setting.

Purpose:

1. To ensure that all residents have the opportunity to benefit from spiritual counseling in adjusting to a long term care setting or in a dealing with personal situations in which spiritual counseling would provide relief.
2. To work interdepartmentally and provide comprehensive care of residents' psychosocial and spiritual needs.

Procedure:

1. The social worker will obtain information about the resident's religion and the role it plays in their life during the [Resident Social History](#) Initial ~~Psychosocial~~ Assessment.
2. The social worker will document the information obtained and develop a plan with the resident's permission to refer them to Spiritual Care or Activities Therapy to incorporate spiritual activities into their routine. The social worker will document on future semi-annual and annual assessments the resident's participation in spiritual activities.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.16 Social Services Department: SNF Neighborhood Transfers

Policy: The Social Services Department shall participate in evaluating residents' physical, mental, social and emotional needs and placement in an environment that best suits their skilled nursing needs.

Purpose: To facilitate the residents' adjustment to change and minimize the impact of transfer trauma.

Procedure:

1. Prior to the transfer, the assigned social worker shall participate in a Resident Care Conference and offer input on the residents' social and emotional needs and behavioral issues that may impact the transfer.
2. The social worker when needed will assist in talking to the resident and family about the proposed transfer and field any concerns they may have to the team. The social worker is available to take the resident to the new neighborhood and introduce them to other residents and the team.
3. The social worker will inform the resident who their new social worker is.
4. The sending social worker will ~~write complete~~ a ~~consult transfer~~ note within 48 hours of the ~~move-transfer/move~~ summarizing what has been done to date and specifying any psychosocial issues that will need addressing by the new neighborhood social worker. The ~~transfer-consult~~ note will also detail concerns the resident has about the ~~transfer/move~~ and counseling interventions that work well with the resident.
5. The receiving social worker will review the ~~transfer transfer-consult~~ note and meet with the resident within five days to introduce themselves and provide necessary follow-up.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.17 Social Services Department: Notifications to San Francisco Sheriff's Department (SFSD)

Policy: It is the policy of the Social Service Department to immediately report any residents who are 1) convicted felons, 2) on parole or 3) known sex offenders to SFSD.

Purpose: To keep SFSD aware of new admissions who could have parole officers involved in their care. The information is treated as "confidential, for law enforcement use only" and does not violate issues of confidentiality.

Procedure:

1. The social worker will review any records from the sending hospital and complete an [Resident Social History](#) ~~Initial psychosocial~~ assessment.
2. If information about parole status or prior convictions is known at this time, a call shall be placed to SFSD as soon as practicable. The name and number of the parole/probation officer would be helpful, if known. Any behavioral issues should be discussed with SFSD and the Resident Care Team.
3. If information is obtained at a later date a call shall be placed to SFSD and resident care team as soon as practicable upon receipt of information.

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.18 Social Services Department: Discharge Database Information

Policy: It is the policy of the Social Services Department to track information relevant to residents' discharges in a centralized tab in the Electronic Health Record ([HEREHR](#)).

Purpose: To maintain an active log of all residents who have discharge potential and to track aggregate statistics on age, [ward-unit](#) location, accessibility needs and barriers to discharge to better advocate for resources to assist residents in relocating to lower levels of care.

Procedure:

1. Social Workers upon hire obtain a password to access the database through Epic.
2. Any resident in the social workers' caseload who expresses a desire for discharge or whom the Resident Care Team feels has potential to be discharged will be entered into the Discharge Planning Module of Epic.
3. Ongoing discharge plans and referrals are entered into the [Progress-Consults](#) Notes section of the [discharge-databaseEHR](#).

INTERDEPARTMENTAL POLICIES AND PROCEDURES

7.19 Social Services Department: Burial and End of Life Care Arrangements

Policy: It is the policy of the Social Services Department to ascertain pre-need or burial arrangements of residents upon admission and if none are in place, to check in with residents on a quarterly basis to offer continued resources and assistance in end of life care planning.

Purpose: To document and maintain communication with key departments about burial plans that are in effect and should be followed per resident wishes.

Procedure:

1. Social Workers will document Religious Preferences and Funeral Plans if known in the [Resident Social History](#) Initial ~~Psychosocial~~ Assessment. If no plans have been made, by default it will be designated as a Public Administrator referral. ~~A copy of the Initial Psychosocial Assessment is sent to the Admissions and Eligibility worker who is assigned to the resident.~~ If residents transfer to another Unit during the course of their stay, this information will be reviewed with the new Social worker upon hand-off of the case.
2. Education and resource materials will be provided to interested residents and family members about the process of funeral planning and burial and cremation services.
3. Social workers will check in with residents on a quarterly basis when doing spend-downs of funds to see if residents are willing to put aside monies for a pre-need burial trust. This information is communicated to the Admissions and Eligibility worker via a change of face sheet information [and verbal communication](#). It is also to be relayed to Nursing manager or charge nurse to enter this information unto the nursing care plan.
4. If resident's condition is declining and no plans have been executed, special efforts will be made to discuss plans with residents with capacity, surrogate decision makers or conservators who have decision making powers.
5. Social workers will coordinate provision of spiritual support with the Spiritual Care Department and relay information about special religious/cultural preferences to the nursing manager/supervisor.
6. In the event of a resident expiration, the social worker will meet with the nurse manager/supervisor and Admissions and Eligibility Worker the next business working day, to clarify what funeral plans are in place, ascertain what monies are available in resident's trust account and determine the disposition of clothing and

LAGUNA HONDA HOSPITAL
SOCIAL SERVICES DEPARTMENT MANUAL

INTERDEPARTMENTAL POLICIES AND PROCEDURES

personal effects. The outcomes of this discussion will be documented in ~~the~~ [progressa Consults](#) notes by the social worker.

New Spiritual Care Services Policies and Procedures

Fire Alarm During Chapel Service

Fire Alarm During Chapel Service

POLICY: The SCD shall have a pre-planned response in case of a fire alarm during Chapel services.

PURPOSE: To protect residents, employees, and visitors from fire while they are attended Chapel services.

PROCEDURE:

1. Once the fire alarm sounds hand out the ear muffs to all residents.
2. Call the Sheriff to get location of the alarm. 4-5900 and/or 4-2319.
3. Shelter in place until the alarm stops.

IF YOU CAN SEE FIRE AND/OR SMELL SMOKE:

4. If you have not heard the alarm pull fire alarm and call 4-2999 to report fire.
5. Start evacuation out the side doors of the Chapel to the outside. Get all residents down the ramp and out of the building to the sidewalk.
6. Call 4-2319 and 4-1502 to request assistance evacuating Chapel.
7. Once all residents are outside wait with them until hospital staff and or fire department arrive to assist.

Original adoption: 2019/08/26

Revised Volunteer Services Policies and Procedures

VOLUNTEER RECRUITMENT PROCESS LIFE CYCLE

POLICY:

The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center is responsible for the full business life cycle of volunteers, including recruitment, placement, ~~encouragement and~~ retention, and dismissal.

PURPOSE:

1. To outline formal steps involved in developing and maintaining a general pool of volunteers available to the hospital.
2. To meet the specific human resource needs of hospital departments requesting the assistance of Volunteer Services Department.
3. To ensure that hospital residents receive volunteers of the highest quality ~~volunteers~~ to provide companionship and support.

PROCEDURE:

Volunteer Recruitment

1. Friends of Laguna Honda Website
 - a. Friends of Laguna Honda (a private non-profit auxiliary that supports the functions of the Volunteers Services Department), maintains a website with information about volunteer opportunities, registering for orientation and requirements at Laguna Honda Hospital.
2. Outreach
 - a. The Volunteer Coordinators go to schools, health and career fairs, and other organizations as they are identified, to present information on volunteer opportunities at the hospital. Brochures, signage when appropriate, orientation dates, and contact information are used as presentation materials.
 - b. When a specific need or request is identified, the Volunteer Coordinators will target key organizations in an effort to tailor the volunteers to the particular request.
3. Media
 - a. The Volunteer Services Department and Friends of Laguna Honda may utilize ~~Public Service Announcements~~ written and electronic media (i.e. public service announcements) for recruitments of volunteers as needed. The Volunteer Services Department plan to continue to increase our internet presence through strategically placed links on volunteer related and career websites.
4. ~~Volunteer Organizations~~

- ~~a. The Volunteer Services Department maintains listings of volunteer opportunities at Laguna Honda Hospital with local community volunteer organizations such as the Volunteer Match, San Francisco Volunteer Center and Hands on Bay Area.~~

Volunteer Placement

1. Orientation
 - a. Each prospective volunteer is required to participate in the volunteer orientation prior to placement.
 - b. At the conclusion of the orientation, the volunteer is scheduled for an interview with a Volunteer Coordinator.
 - c. Each volunteer is required to complete a volunteer application prior to the interview.
2. The Interview
 - a. Content of the interview include:
 - i. Review information on the application
 - ii. Visual inspection of a picture ID
 - iii. Reasons and motivations for doing volunteer work
 - iv. Discussion of areas of interest and hospital placement need
 - v. Review abuse reporting policy and sign form
 - vi. Review volunteer agreement and sign form
 - vii. ~~Review statement of privacy laws and acknowledgement of responsibility and sign form~~
 - viii-vii. Arrangements for TB test, ID badge, and parking permit
 - ix-viii. Criminal background check and fingerprinting
 - b. During the interview the Volunteer Coordinator will observe the prospective volunteer's ability to appropriately interact and understand directions.
 - c. The decision to accept a prospective volunteer is made at the discretion of the Volunteer Coordinator and the department ~~of~~ where he/she will volunteer ~~in~~.
 - d. The Volunteer Coordinator contacts specific hospital departments to confirm the need for volunteers in the area discussed with the volunteer.
 - e. A pre-placement interview with hospital staff is arranged for volunteers working in sensitive assignments.
3. Placement
 - a. The Volunteer Coordinators make every effort to accommodate the schedule and the specific areas of interest of the volunteer, while addressing the specific scheduling needs of the unit, activity, or resident involved.
 - b. Volunteers are assigned a supervising staff member from the department in which they are placed for accountability ~~and liability~~. All volunteers are required to have a schedule, notify their supervisor if they are sick or plan to be on vacation and must comply with all hospital rules and regulations (e.g. annual tuberculosis ~~test~~ and flu vaccination).

- c. If the volunteer is placed within Volunteer Services, one of the Volunteer Coordinators will ~~assumes~~ responsibility for the supervision of the volunteer.
 - d. The Volunteer Coordinator will introduce the volunteer to the appropriate point of contact (POC) or the supervising staff member in the specific department he/she is interested in. The POC/~~supervising staff member~~ and the volunteer will then further discuss logistics (commitment, time, schedule, etc.) to finalize placement. ~~Occasionally the Volunteer Coordinator may not be available at the proposed meeting time, and may arrange a meeting between the volunteer and supervising staff member.~~
 - e. The ~~N~~ number of volunteer hours ~~_~~ per week or month is negotiated between the volunteer and the supervising staff member taking into consideration ~~of~~ the needs of the activity, neighborhood, resident, and the availability of the volunteer.
 - f. The Supervisor is given contact information for their volunteer. Volunteers are given explicit instructions that once placed, to contact the supervising staff member and/or department to report absences or schedule changes.
 - g. Supervising staff members are responsible for reporting excessive absences, tardiness, or other concerns back to Volunteer Services. Volunteer Services will, in turn, work with the department or Supervisor to address and resolve these types of issues. Resolution of performance issues may include the reassignment or termination of the volunteer (per Dismissal Policy).
4. The Volunteer Services Department remains aware of the need for volunteers within the organization through formal assessment, volunteer requests, and informal communications with hospital staff.

Encouragement and Retention

1. The Volunteer Services Department, in conjunction with Friends of Laguna Honda, take actions through several events during the annual National Volunteer Week in April to express appreciation toward all volunteers.
 - a. These actions may include an appreciation luncheon/dinner or other similar event.
 - b. Banners or posters will be displayed throughout the hospital recognizing National Volunteer Week.
2. The appreciation Luncheon/dinner will recognize volunteers for the number of annual cumulative hours served, and the number of years given in service.
 - a. Certificates will be awarded with the total number of annual volunteer hours ~~as of~~ ~~April~~ ~~March 1st~~ (i.e. March 2018 – March 2019 total annual volunteer hours). These certificates are signed by the president of Friends of Laguna Honda Executive Administrator Chief Executive Officer of Laguna Honda Hospital & Rehabilitation Center.
 - ~~b.~~ b. — Service pins are awarded to Volunteers with the following years of service
 - i. Five years

- ii. Ten years
 - iii. Fifteen years
 - iv. Twenty years
 - v. And so on in increments of 5 years
3. Volunteer supervisors are given the opportunity to nominate a volunteer(s) from his/her department to be recognized at the event called "Special Awards". These awards nominations are based on the Volunteer Coordinator's discretion for the volunteer's commitment to ongoing volunteer service and who feel have made a significant impact on the hospital.
 4. Volunteers who are on duty during the day are entitled to a 50% discount at the hospital's Hospital's cafeteria for one meal during their shift.
 4. a. Volunteers must show their volunteer identification badge to the cashier to receive the discount.
5. Thank You cCards will may be sent to individual volunteers to recognize those who help above and beyond the call of duty (i.e., special events volunteers, special projects, Holiday Programs and those who come in on days they are not scheduled).
 6. Volunteer Coordinators will make an effort to respond to volunteer questions, concerns or needs in a timely manner.

Volunteer Dismissal

Volunteers who do not adhere to the policies and procedures of the program or who fail to satisfactorily perform their volunteer assignment are subject to dismissal. At the discretion of the Volunteer Coordinator or Volunteer Supervisor, any volunteer not meeting the requirements of what was agreed upon in their application can be dismissed at any given time.

Corrective Action

Corrective/disciplinary action may be taken if the volunteer's work is unsatisfactory. The procedure for disciplinary action is usually a three step process but the Volunteer Coordinator or Volunteer Supervisor has the authority to dismiss a volunteer at his/her discretion at any given time.

1. First a formal written notice is sent to the volunteer from the Volunteer Supervisor.
2. Second formal notice is sent and a meeting is scheduled with the volunteer and their supervisor from the area they volunteer (and the may include the Volunteer Coordinator if needed is set up).

3. Notice is sent to the volunteer ~~being of~~ ~~dismissed~~ of their duties from their Supervisor. A copy will be given to the Volunteer Services Department to be placed in the volunteer's record. The volunteer will be responsible to turn in their ID Badge and a parking permit (if they have one).

Conduct or behavior which may lead to disciplinary action includes, but is not limited to:

- Poor Timekeeping and ~~/or unreliability of their time.~~
- ~~Not Failing to~~ following rules, policies or procedures as described in the Orientation Packet.
- Rudeness or hostility towards, residents, staff or other volunteers.
- Intoxication ~~through on~~ alcohol or other illegal substances
- Theft of property ~~of~~
- ~~-Accepting~~ compensation for assisting residents
- Failure to perform volunteer duties as agreed
- Bringing illegal substances ~~in on~~ to the hospital campus
- Breach of confidentiality
- Falsification of any materials

ATTACHMENT:

None.

REFERENCE:

None.

Revised: 2019/205/087, 2015/20/03, 2015/08/19, 2017/02/05 ~~07/12~~

Original Adoption: 1998/06/01

VOLUNTEER FINGERPRINTING

POLICY:

The Volunteer Services Department ~~will have~~requires that all ~~potential-prospective adults~~
volunteers (18 years or
older)volunteers to
~~undergo~~complete a criminal conviction Live Scan
background check ~~with~~through the City and County of San Francisco, Department of
Human
~~RR~~Resources (DHR), prior to starting their volunteer service.

PURPOSE:

1. To meet the specific human resource needs of the department and the organization.
2. To ensure that Laguna Honda Hospital (LHH) residents and staff receive the highest
quality of careprotection and safety.

PROCEDURE:

~~4.~~1. The Volunteer Coordinator will ~~coordinate~~schedule an appointment (time and date)
for the perspective volunteer to receivefor fingerprinting ~~a background check at the~~
Department of Human Resources (DHR) through DHR's ~~the online County of San~~
Francisco, Department of Human Resources (DHR)-Fingerprinting Appointment
Scheduling Link.: www.genbook.com/bookings/slot/reservation/30108158

~~1.~~
~~2.~~2. The Volunteer Coordinator will then click onto the “fingerprinting” link followed by
clicking “no preference” to schedule an appointment by selecting the month and day
for the volunteer to undergo a fingerprint. The Volunteer Coordinator will also add
the volunteer’s personal information (fFirst name, Last name, contact phone, email
address, Job Code, Appointment type, and the last 4 digits of the volunteer’s
SSN). ~~The Volunteer Coordinator contact number will be entered before confirming~~
~~the appointment.~~

~~3.2.~~3.2. The Volunteer Coordinator will then inform the volunteer of the
appointment and the address via email and ~~/-or~~verbally during the interview.

~~4.3.~~4.3. The City and County of San Francisco, Department of Human Resources,
Fingerprinting office is located at:

One South Van Ness on the corner of Market and South Van Ness
~~(back of Bank of America)~~4th Floor (back of Bank of America),
City & County Human Resources Department

If the prospective volunteer misses a scheduled fingerprinting appointment they will receive one additional opportunity to reschedule his/her appointment. If a second fingerprinting appointment is missed, the prospective volunteer will be disqualified.

~~5. To reschedule a fingerprinting appointment, the prospective volunteer must be punctual for the background check appointment and must call notify the Volunteer Coordinator a minimum of 24 hours in advance to cancel the appointment. We can accommodate rescheduling fingerprinting appointment only if we are notified a minimum of 24 hours in advance. The Volunteer Coordinator will reschedule the prospective volunteer's appointment using the online appointment scheduler. the DHR (415-557-4976) a day ahead if cancelling the appointment.~~

~~6.4. The resulting report from DHR of the a prospective volunteer's conviction history (if any) will be used to determine if a volunteer will be disqualification is appropriateed.~~

~~7.5. The Volunteer Services Department The DHR will consider many factors before disqualifying a volunteer based on the conviction or arrest such as:~~

~~a. Nature and gravity of the offense~~

~~b. Volunteer-relatedness of the offense~~

~~— Time elapsed since the conviction or release from sentencing~~

~~• _____ (Note:~~

~~— Convictions offor -murder, attempted murder, mayhem, an arson-~~

~~_____ related offenses, or and a sex offenses requiring registry, will be are considered disqualifying convictions reg~~

~~• _____ regardless of the time elapsed since the conviction or release from sentencing~~

~~8. DHR will notify the Volunteer Services Department whenever a prospective volunteer is disqualified. DHR will also notify the prospective volunteer of their disqualification directly.~~

~~9. If it is determined by the Volunteer Services Department that a volunteer is disqualified, he/ she will be contacted by a Volunteer Coordinator and be given other volunteer opportunities in other communities or organizations separated from their service at LHH.~~

ATTACHMENT:

None

REFERENCE:

CCSF – DHR

Revised: 2019/08/20, 14/10/07, 2016/08/11
Original Adoption: 2015/10/07

VOLUNTEER ORIENTATION REGISTRATION

POLICY:

The Volunteer Services Department will register all prospective volunteers for an orientation via one of the three methods below:

- ~~the~~ Friends Of Laguna Honda website, (<http://friendsoflagunahonda.org/volunteer/>)
- Main email, lagunahondavolunteers.org, via email: volunteers@sfdph.org ~~or~~
- Main via telephone, 415-759-3333.

PURPOSE:

To provide potential volunteers an opportunity to sign up for an orientation through various channels.

PROCEDURE:

1. Volunteer Orientations are scheduled on the first Saturday of each month from January through October.
- 1.2. Volunteer Coordinators (VC) will be responsible to screen and review all incoming calls from the Volunteer general phone line (415.759.3333) to register possible probable volunteers on a daily basis. The VC will also be assigned to check the general Volunteer email (volunteers@sfdph.org) daily to respond to inquiries and to help register prospective future volunteers.
2. ~~The Friends of Laguna Honda website (lagunahondavolunteer.org) is linked with the email address (volunteers@sfdph.org) therefore when a prospective volunteer signs up for an orientation through the website, it will automatically appear on the email. Prospective volunteers that have signed up signing up for a volunteer orientation online will with receive a volunteer confirmation email (regarding time, date, location, etc.) 24 to 48 hours prior to the selected orientation date. If the prospective volunteer calls to confirm via the main volunteer phone line they will receive verbal information and confirmation. and volunteers who phoned will receive a verbal confirmation.~~
3. _____
4. The maximum capacity for each orientation is 25 attendees. When the number of attendees exceeds ~~ere are 25 attendees registered for an orientation,~~ the VC will contact the prospective volunteers to register for a different orientation date.
3. ~~website will no longer have an option to choose that month's orientation date. The Volunteer Coordinator will suggest and enroll potential volunteers in the future month's orientation registration book and will stop~~

~~enrolling volunteers when there are 25 attendees for an orientation.~~

- ~~4. The Volunteer Coordinator will recommend other orientations as there are 2 orientations each month for prospects when enrollment has reached its maximum capacity.~~

AATTACHMENT:

None

REFERENCE:

None

Most Recent Review:

08/20/2019, 04/25/2019/
12/08/17, 2016/06/20

VOLUNTEER INFECTION PREVENTION

POLICY:

The Volunteer Services Department will comply with infection control policies established by the Infection Control Committee and Medical Staff at Laguna Honda Hospital (LHH).

PURPOSE:

To protect the health of residents, employees and their families, volunteers, and visitors by preventing the transmission of tuberculosis (TB), influenza and other infectious diseases.

PROCEDURE:

1. All volunteers receive instruction about infection control at the volunteer orientation.
 - a. Topics covered include:
 - i. Hand washing
 - ii. Standard precautions related to bodily fluids
 - iii. Staying away from LHH when a volunteer is ill
2. All new volunteers are required to have two TB/ PPD skin test or one Quantiferon/TB Gold blood test prior to beginning their volunteer service at the Hospital.
 - a. Volunteers may get the TB test at the LHH Medical Clinic or with their own provider.
 - b. If a volunteer has documentation of a prior PPD negative test that was completed within a year, validated by the Medical Clinic, then only one test result is required.
3. If a volunteer has a positive reaction to the TB test, they must submit a chest x-ray result. They must also complete the TB Symptoms Screening Questionnaire.

4. All active volunteers will be required to receive an annual TB test/screening. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptoms review for those with prior positive skin tests.
5. The Medical Clinic will maintain all volunteer TB documentation and create a spreadsheet to share with the Volunteer Services Department.
6. Annual TB testing will take place from April 1st through June 30th of each year.
7. Volunteers who fail to get an annual TB test will be contacted by Volunteer Services and their volunteer service will be temporarily suspended until he/she submits an updated TB test result. Once the volunteer has received TB clearance from the medical clinic, the Volunteer Coordinator (VC) will reactive his/her badge and the volunteer can resume his/her volunteer duties.
8. All volunteers are required to receive an annual influenza vaccination.
 - a. Volunteers are required to get an influenza vaccination by the beginning of flu season as identified by the hospital's Infection Control Committee.
 - i. Volunteers can receive the flu vaccinations at the Medical Clinic if supplies of the vaccine are available.
 - ii. Volunteers can also get the flu vaccination from their provider and submit proof of vaccination to the Medical Clinic.
 - b. Volunteers who have received the flu vaccination at the Medical Clinic will be provided with a sticker to be placed on the ID badge which will allow access to resident areas during flu season.
 - c. Volunteers who decline the flu vaccination will have to:
 - i. fill out a declination form
 - ii. wear a mask in applicable areas when volunteering
 - iii. If the volunteer fails to complete the two items above, his/her volunteer privileges will be terminated

ATTACHMENT:

None

REFERENCE:

LHHP 72-01 Infection Control Manual

LHHP 72-04 Employee Annual Health Examination
Volunteer Services policy A 1.0 Volunteer Orientation

Revised: 2019/08/20, 2014/06/09, 2015/08/19,
2016/07/12 Original Adoption: 2012/08/14

VOLUNTEER INJURY

POLICY:

1. Volunteer Services will assist in the proper handling of an onsite injury sustained by an on duty Laguna Honda Hospital volunteer.
2. Volunteers are not Laguna Honda Hospital Employees, and are not covered by Workers' Compensation.

PURPOSE:

1. To ensure that volunteers are treated according to protocol in the event of an injury while at Laguna Honda Hospital.
2. To prevent injuries to volunteers while at Laguna Honda Hospital.

PROCEDURE:

1. In the event that a volunteer sustains an injury, 911 should be called if necessary.
2. To access medical care, volunteers must go to their own medical provider.
3. The supervisor is responsible for investigating the circumstances of the injury that may include interviewing the volunteer and any staff person, non-staff person, or resident involved. The Volunteer Services Department may be contacted and notified if further investigation or information is needed.
4. The volunteer or the volunteer's supervisor must notify the Volunteer Coordinator.
5. The volunteer's supervisor and/or Volunteer Coordinator will complete an Unusual Occurrence Report (via intranet) and the Quality Management Department will investigate any appropriate preventative measures.

ATTACHMENT:

None

REFERENCE:

Volunteer Agreement Checklist

Most recent review:

08/20/2019, 12/08/15

Revised: 12/08/15,
2016/06/20

Original adoption: 08/08/25

Revised 15/08/27

RECORD KEEPING

POLICY:

Laguna Honda Hospital Volunteer Services maintains records of participating volunteers.

PURPOSE:

To adequately record volunteer activity for recognition, operations improvement and volunteer references.

PROCEDURE:

1. The Volunteer Services Department utilizes the Volgistics database system in managing volunteer records.
 - a. The Volunteer Services Department also maintains a scanned e-copy of the hand-written application binder with information from each active volunteer. The following information is maintained in the Volunteer Services offices a secured location on the computer Activity Volunteer Binders.
 - i. Application form
 - ii. Adult Abuse Reporting Requirement form
 - iii. Volunteer Agreement/Checklist
 - iv. Volunteer Confidentiality form
2. Upon acceptance and placement within the volunteer program, the Volunteer Coordinator (VC) is responsible to ensure that the volunteer's information is entered into Volgistics including, but not limited to, assignment, schedule, and emergency contact information.
3. The Volunteer Coordinator is responsible to scan an e-copy of file all hard copy forms in a secured computer location available to all staff within the Active Volunteer Services Department office Binders. All hard copy forms will be securely shredded.
4. All volunteers are required to log onto Volgistics ~~at~~ the beginning of their shift and log out at the end of their shift using the kiosk located in the lobby of the Pavilion building, outside of the Medical eClinic on the first floor and outside Volunteer Services offices in the lobby of the Administrative building.
5. If the computer is not operational ~~off line~~, volunteers are required to either 1) report their enter their name, time in/out to his/her on to the Volunteer Sign in Sheet located by the kiosk supervisor and asked that the supervisor reports back

-
- to one of the VC, or 2) report their time in/out directly to one of the VC, contact the Volunteer Coordinator by email or phone so that the Volunteer Coordinator can manually input the hours into the Volgistics database.
6. The Volunteer Services Department is able to generate reports from Volgistics to be used for recognition activities and productivity reports.
 7. Volunteers are required to notify the Volunteer Services Department when they plan to discontinue their volunteer service.
 - a. Records for volunteers who have completed their service or who are have separated are archived within Volgistics.
 - b. Hard E-copy files are removed from the binder storage and discarded-deleted appropriately.
 8. At the end of each each fiscal year quarter of the fiscal year three to six months, a Volunteer Coordinator runs an inactivity report to identify volunteers who have not reported to their assignment within the past over the preceding four 3 months.
 - a. The Volunteer Coordinator VC makes a determination as to whether the record s should be archived or to maintain the volunteer's active status.
 9. Volunteers who resume their service after a period of inactivity have their files restored within Volgistics by the Volunteer Coordinator VC.
 - a. The information is reviewed and up-dated as appropriate.
 10. Volunteers who resume their service after a period of inactivity must complete all applicable hard copy forms, which will be scanned into an e-copy and stored in a secure location. which are filed in the Volunteer Services office Active Volunteer Binders.
 - 10-a. After an inactive period of 1 year, volunteers will need to re-do orientation, background check, and other on-boarding processes.

ATTACHMENT:

None

REFERENCE:

None

Revised: 2019/04/20, 2014/06/09, 2015/08/19, 2018/05/05
Original Adoption: 1998/06/01

Non-Designated In-Kind Donations

POLICY:

The Volunteer Services Department is routinely responsible for accepting and processing in-kind donations for the hospital.

Laguna Honda Hospital~~The hospital~~ (LHH) does not arrange for the pick-up of donated items. The donors are responsible for getting donated items to the hospital.

PURPOSE:

To process donations in an effective and efficient manner; ~~to~~ and ensure that donations are allocated to appropriate areas of the hospital.

PROCEDURE:

1. In-kind donations are non-financial donations of items such as clothing, furniture, ~~medical equipment~~, books, etc.
- ~~2. The Volunteer Services Department maintains a list of suggested donation items; as well as a list of items that can not be used at the hospital. The Volunteer Services Department makes the list of suggested donations available to a potential donor upon request. The Department may also use the list of suggested donations to advertise or solicit for donations in support of resident programs.~~
2. Donations are accepted ~~in front of the~~ by the Volunteers Services Department, Monday through Friday, from 8:30AM to ~~4:30:00PM~~ 4:30PM. Donations may be dropped off in front of the Volunteer Services Department Bulletin Board even if staff are unavailable.
3. ~~A Laguna Honda Hospital and Rehabilitation Center Gift Receipt Form is completed for all donations~~ All donations received by LHH will have a Gift Receipt form completed.
 - a. Gift Receipt forms filed for donations will be kept on file.
~~Gift Receipt forms are available outside the Volunteer Services Department on the volunteer/donation area underneath the Volunteer Services Department Bulletin Board. offices in a prominent place with instruction to accommodate donors.~~
 - b.
 - c. Donations that are distributed to the Gift Shop for sale will be indicated on the Gift Receipt form.

- ~~d. If donations are dropped off when Volunteer Services staff are unavailable and no Gift Receipt Form is completed by the donor, Volunteer Services staff document the donor as being "anonymous" on the form.~~
- ~~4. The Volunteer Services Department provides the Finance Department with files all copies of all the completed Gift Receipt forms on a quarterly basis for donations.~~
 - ~~a. The donor may request an acknowledgement letter unless information is unknown.~~
- ~~4.~~
- ~~5. Donations may be dropped off in front of the Volunteer Services Department even if staff are unavailable.~~
 - ~~a. Gift Receipt forms are left in a prominent place with instruction to accommodate donors.~~
 - ~~b. If donations are dropped off when Volunteer Services staff are unavailable and no Gift Receipt Form is completed by the donor, Volunteer Services staff document the donor as being "anonymous" on the form.~~
- ~~5. Acknowledgement letters are prepared by the Volunteer Services Department and signed by a Volunteer Coordinator member of the and the Executive Team Administrator with the exception of anonymous donors.~~
- ~~6. Completed Gift Receipt Forms are kept on file for three years.~~
- ~~7. The Volunteer Services Department provides the Finance Department with copies of all completed Gift Receipt forms on a quarterly basis for donations, received as of the last day of January, April, July, and October, of each year.~~
- ~~6. A Volunteer Services staff Department or volunteers are responsible for processing or distributing donations.~~
 - ~~a. Donated items determined to be inappropriate for use within the hospital will be either donated to other community organizations or distributed to the hospital Gift Shop for sale.~~
 - ~~b. Proceeds from the sale of non-cash value items in the Gift Shop will be distributed to the Resident Gift Fund.~~
- ~~8.7. Donated items evaluated determined to be inappropriate for use within the hospital will be donated to other community organizations, shall follow appropriate processing guidelines, or discarded.~~
 - a. Clothing and Shoes
 - i. Are taken to the Clothing Room for processing.
 - ii. Must be in good, clean condition.

- iii. Larger sizes in men's and women's clothing are preferred.
 - iv. Practical and functional clothing and shoes will be stored in the Clothing Room and distributed to residents per Clothing Room Policies and Procedures.
- b. Books are evaluated for appropriateness and are either taken to the Resident Library, recycled or donated to another organization, ~~with a need.~~
- c. Medical Equipment
- i. Medical supplies and food items are not accepted (i.e., bandages, gauze, Ensure or any other supplemental drink.)
 - ii. LHH does not accept beds, prescription drugs, diapers, syringes, tubing and commodes.
 - iii. Durable medical equipment accepted include but are not limited to: manual wheelchairs, electric wheelchairs, canes, crutches and other assisted devices.
 - iv. The equipment must be clean and in good condition.
 - v. Upon receipt of donated medical equipment, the Volunteer Services Department will contact Rehabilitation Services to evaluate equipment for appropriateness.
 - vi. Central Supply does not accept donated medical products (and miscellaneous equipment) due to quality control issues.
 - vii. Any equipment deemed inappropriate by Rehabilitation Services will either be disposed of or donated to another community organization.
 - viii. ~~Community organizations who accept medical equipment include:~~
 - ~~Foundation for Sustainable Development at 415-283-4873~~
 - ~~Home Care at 415-487-5405~~

9.d. Food

a.i. Due to food safety concerns, food items are generally not accepted as a donation.

b.ii. All donated foods must be from a commercial source, which may be accepted at the discretion of the Volunteer Services Department.

10.e. Miscellaneous items are distributed to resident neighborhoods, the Activity Therapy Department or used ~~as~~ as holiday gifts for residents.

11. Desired for donation

a. ~~Women: housecoat, costume jewelry, lipstick, lotion, nightgown, perfume, and knee high socks.~~

b. ~~Men: electric razor, shirt, wallet, cologne, and after shave.~~

File: A7.0B-4.0 Non-Designated In-kind Donations

Revised ~~August 31 July 1019, 2015~~ August 20, 2019 ~~January 6, 2015~~

- ~~c. Unisex: pajama, hat and scarf set, bathrobe, stationery, stamps, pen, booties with soft soles, bedside clock, radio, camera, wrist watch, cardigan, sweater, and afghans (lap robes) 40" x 40" or larger.~~
- ~~d. Other Items: bulbs and seedlings, flowers, small plant, foreign language dictionaries, large print books, music compact discs, paperback books, ~~books on tape~~ audiobooks and headphones, reference books, picture calendars, playing cards, greeting cards, and games for adults (dominos, chess, checkers).~~
- ~~e. Magazine subscriptions such as Ebony, Jet, Smithsonian, Games, Crossword Puzzles, People, Playboy, Inquirer, Star, Esquire, Sierra Club, Wilderness, Pacific Discovery, Reader's Digest (large print), and foreign language (Russian, Italian, Spanish, Chinese, Japanese, French).~~
- ~~• Subscriptions n are mailed to:~~

~~— Resident Library~~

- ~~— Laguna Honda Hospital~~
- ~~— 375 Laguna Honda Blvd.~~
- ~~— San Francisco, Ca. A 94116~~

ATTACHMENT:

None

REFERENCE:

LHHPP 8545-03 Donations

Most recent review and revision: 2019/20/08, 15/01/06

Revised: 12/05/21, 15-9/808/19, 18/05/05

Original Adoption: 98/06/01

CLOTHING ROOM

POLICY:

Laguna Honda Hospital (LHH) will provide a process for distribution of clothing ~~and~~ to ~~residents~~Residents.

PURPOSE:

To provide clothing for Laguna Honda ~~the needs of the~~

~~r~~Residents of LHH. **PROCEDURE:**

- ~~1.~~ 1. The Clothing Room is under the management of the Volunteer Services Department and is staffed by LHH volunteers.
- ~~1.~~ 2. All clothing brought to the Clothing Room is ~~either donated or recycled from resident~~
- ~~2.~~ units. Clothing is sorted, cleaned if necessary, and organized for selection by LHH
- ~~3.~~ 2. ~~volunteers~~Volunteers or staff.
- ~~4.~~ 3. Any clothing determined to be inappropriate is donated to other community organizations or disposed of.
- ~~4.~~ Residents must be accompanied by a staff member or unit volunteer, or provide a signed clothing room form from unit staff to receive clothing, which must indicate the items needed.
- ~~4.~~ 5. Hospital staff, Clothing Room Volunteers or Unit Volunteers must accompany the ~~resident~~Resident in selecting clothing at the Clothing Room.
- ~~5.~~ 6. The Rresident is not to be left alone in the Clothing Room.
- ~~5.~~ 7. Residents should be actively involved in selecting clothing, if this is not feasible, nursing
- ~~7.~~ 6. staff members or volunteers may assist the resident in selecting clothing.
- ~~8.~~ 8. The Clothing Room Form must be completed by hospital staff or volunteers and submitted to the Clothing Room.
- ~~9.~~ 9.
- ~~10.~~ 9. If a Clothing Room Volunteer is unavailable, hospital staff (Social Worker, Nursing staff,
- ~~7.~~ Activity Therapist or Neighborhood Volunteer may obtain the key from the Nursing Station.

~~11. All Neighborhoods have access to the clothing room 24/7. An ID badge which gives access to the 4th floor entrance as well as a key to the clothing room was is made available to all neighborhoods as well as the Social Work Department and the Administrative Office.) or Unit Volunteer may obtain the key from the Social Work Department or Volunteer Services by signing the sign out sheet. Hospital staff and volunteers must return the keys to the Department key was obtained from, and sign~~

~~12. them back in.~~

~~13.~~

~~8.~~

~~14. Hospital staff and volunteers must ensure that the Clothing Room is left in an orderly fashion.~~

~~15.9. fashion.~~

~~10. Clothing room forms will be compiled, and quarterly reports of clothing usage will be made to the volunteer coordinator.~~

~~101. Clothing Room Hours are Mondays and Fridays from 10AM to 2PM. The extension to reach the Clothing Room at Laguna Honda Hospital is x44036.~~

ATTACHMENT:

None

REFERENCE:

None

Most Recent Review:

08/21/2019, 12/08/17 Revised:
12/08/17, 15/07/01, 18/05/05

RESIDENT LIBRARY

POLICY:

Laguna Honda Volunteer Services manages the operations of the Resident Library. This may include the acquisition and organization of donated and purchased reading materials, coordinating the maintenance of the library computers, the provision of computers and internet access, and volunteer staffing of the library. Depending on library security needs modified workers may be enlisted to help staff the library.

PURPOSE:

To enhance the quality of life for the LHH Residents of Laguna Honda Hospital (LHH).

PROCEDURE:

1. The Library is open Monday to Friday 8:00 a.m. to 4:30 p.m. During the week, the library is opened by the Activity Therapy Department Supervisors clerk and closed by EVS Staff automatically, after cleaning. On weekends, Activity Therapy Staff open the Library. Library is open at 9:30am and closes it at 4:30pm. The door is set to a timer for opening and closing during the designated hours of operation.
2. The Volunteer Services Department acquires books for the library through a book share program with the San Francisco Public Library, and the Friends of the San Francisco Public Library. The library also acquires books from donations from the public.
3. The Volunteers Services Department maintains subscriptions of periodicals, newspapers and magazines financed by through Friends of Laguna Honda, a private non-profit volunteer auxiliary organization.
4. Computing:
 - a. Computers with internet access are available to the residents during regular library hours. The library computers are for use by residents only, or staff assisting residents who are present.
 - b. The library iPad is for resident use only.
 - c. The use of the library computers including the iPad and is limited to one hour at a time if other residents are waiting.

~~b.d.~~ The internet access is restricted from accessing adult pornography in the library. Although internet access is not restricted, Residents & visitors have the right not to be exposed to sexually explicit materials or behaviors, under the LHH Resident's Sexual Rights and Responsibilities Policy.

~~e.e.~~ Library computer, s internet, access are are is maintained by Volunteer Services staff and volunteers. IT staff at Laguna Honda Hospital does maintain problems with access to the internet. Volunteer Services with technical assistance from IT staff.

~~5.~~ The Resident Library has a large selection of enlarged print books, and has equipment designed to magnify text for the visually impaired.

~~6.5.~~ The Resident Library is staffed by volunteer coordinators and volunteers. The librarians staff the library providing assistance to and supervision of responsibilities. ~~R~~responsibilities of the volunteers staffing the library may librarians include the following:

- a. Assist residents with locating reading materials
- b. Enforce library policies
- c. Assist residents with the use of the computers (internet, email, etc.)
- d. Enforce the rule that the computers are for resident use only
- ~~e.~~ Shelve books appropriately (by genre, then alphabetically, by author, then title)
- ~~e.~~
- f. Organize periodicals magazines and newspapers in a manner that enhances access and utilization by residents.
- g. Organize/clean resident computers, lpad, up tables and chairs to provide the greatest access possible for residents.

~~7.6.~~ The Resident Library may not be used as a staff break room, or for any staff-related functions, unless approved by Volunteer Services.

ATTACHMENT:

None

REFERENCE:

None

Most Recent Review: 2019/08/21, 1544/0708/2320

Revised: 14/08/20, 18/05/05

Original Adoption: 98/06/01

HOLIDAY GIFT PROGRAM

POLICY:

Friends of Laguna Honda supports an annual gift program to be distributed to residents during the holiday season between November and December.

PURPOSE:

To ensure that each resident receives a holiday gift that is appropriate for enhancing their quality of life.

PROCEDURE:

1. The Volunteer Services Department is responsible maintaining an accurate inventory of gifts.
2. A catalog of items is created by the Volunteer Department to determine what residents can select from (e.g. clothing, backpacks, etc.)
 - a. Activity Therapists are given a catalog so that they can discuss with the resident what he/she would like to receive.
 - b. Each resident can choose gifts totaling up to a pre-determined amount.
3. The Volunteer Services Department will begin to process the orders in the month of October.
4. The shipment of merchandise will begin arriving from October through November. The Volunteer Services Department is responsible for recruiting volunteers to assist with the inventory and packaging of gifts.
5. Once the orders are filled, the Volunteer Services Department will contact the assigned neighborhood Activity Therapist to arrange a gift delivery schedule and gifts are delivered as appropriate.
6. If items ordered are not available, the Volunteer Services Department will inform the Activity Therapist of substitutes. If these substitutions are not appropriate, Activity Therapist will contact the Volunteer Coordinators who will offer other items available in the inventory.
7. The gifts are to be distributed to residents by nursing staff and/or Activity Therapists generally during the holiday parties. Activity Therapists are responsible for ensuring that each resident receives their gifts.

8. After the holiday gifts are processed and distributed, the Volunteer Services Department is responsible for taking inventory for the next year.

ATTACHMENT:

None

REFERENCE:

None

Most recent review: 14/08/20

Revised: 19/08/21, 15/03/20,

15/08/19 Original adoption:

08/08/25

VOLUNTEER ID BADGE PROCEDUREHOLIDAY GIFTS

POLICY:

The Volunteer Services Department at Laguna Honda Hospital & Rehabilitation Center (LHH) is responsible for issuing identification badges to fully process volunteers prospects wwho intend tocan make a -volunteer for 6 months or longer commitment to volunteer at LHH. Friends of Laguna Honda provides \$30,000.00 annually for resident gifts to be distributed during the holiday in December.

PURPOSE:

To ensure that each volunteer resident-is given an identification badge to wear at all times when volunteering at LHH.aguna Honda Hospital & Rehabilitation Center. receives gifts that is appropriate for each individual resident.

PROCEDURE:

4.—The Volunteer Services Department will issue an identification badge in the Facilities Department. is responsible maintaining an accurate inventory of gifts.

1.

2. The following procedure are the steps taken when creating and issuing an ID badge to volunteers:

- a. Set up the volunteers profile in the Volgistics Database
- b. Create and issue volunteer ID badge at the Facilitiesy Department
- c. Walk volunteer through sign in/out process at a volunteer kiosk
- d. Confirm badge access is activated by checking that badge can access one of the locked doors

—Volunteer Coordinators (V.C.) will click onto the desktop icon “P2000.”

—V.C. will log into the icon with the username and password as “Volunteers.”

—V.C. will click onto “add” and input the volunteer’s information (first name, last name, and the amount of time the badge is valid for as well as their picture.

The V.C. will manually type in the date the badge was issued and will also type in an expiration date of 6 months after the date was issued.—Volunteer badges are valid for 6 months at a time. In the event when-a badge has expired and if-he/she is still an active volunteer, the V-olunteer Coordinator- will reactivate the badge for another 6 months.

3. Volunteers are responsible for returning their badges to the Volunteer -Coordinator- or their respective department supervisors once they decide to end his/her volunteer serviceare no longer a volunteer.

~~4. Deactivated Bbadges s-are appropriately disposed of then given the Facilities Department for disposal.~~

ATTACHMENT:

None

Original adoption: 05/02/17

Revised Date: 2019/08/21



~~2. The shipment of merchandise will begin arriving during the end of summer and beginning of Fall. The Volunteers Services Department (VSD) is responsible for recruiting volunteers to assist with inventory and packaging of the gifts.~~

~~3. A catalog of items is created by the VSD to determine what residents can select from — (e.g. g. clothing, jewelryperfumes, stationary, etc.)~~

~~a. Activity Therapists are given a the catalog so that they can discuss with the resident what he/she would like to receive.~~

~~b. Each resident will be offered to choose gifts totaling up to \$30.00.~~

~~4. 4. The Volunteer Services DepartmentVSD will begin to process the orders in the monthh of Novembof November.~~

~~5. Once the orders are filled, the Volunteer Services DepartmentVSD will contact the Activity Therapist to arrange a gift~~

~~— delivery schedule and gifts are delivered as appropriate.~~

~~6. If items ordered are not available, the Volunteer Services DepartmentSD will inform the Activity Therapist of~~

~~— substitutes. If these substitutions are not appropriate, Activity Therapists will contact the Volunteer Coordinators who will offer other items available in the inventory.~~

~~7. The gifts are to be distributed to residents by nursing staff and/or Activity Therapists generally during the holiday parties. Activity Therapists are responsible for ensuring that each resident receives their gifts.~~

~~8. After the holiday gifts are processed and distributed, the Volunteer Services DepartmentSD is responsible for taking an g accurate inventory for the next year.~~

ATTACHMENT:

None

REFERENCE:

None

Most recent review: 14/08/20

Revised: 15/03/20, 15/08/1920

Original adoption: 08/08/25

Revised

Wellness & Activity Therapy

Policies and Procedures

CALL-IN PROCEDURE

POLICY:

~~Staff will communicate unscheduled absences that will assist in the coverage process. Employees are required to notify the Activity Therapy Department Office prior to 8:30 a.m. or at least two (2) hours before the start of their shift.~~

PURPOSE:

~~Enable departmental leadership to assess services needs and deploy resources as needed. To allow for department leadership to provide adequate coverage for unplanned staffing shortages staff absences and that promotes supports the provision of -quality resident care Activity Therapy services.~~

RELEVANT DATA:

~~This policy applies to all employees of the Activity Therapy Department, including Activity Therapy Supervisors, Activity Therapists, Utility Workers, Department Clerk, and Patient Care Assistants (PCA)/ Bus Drivers.~~

PROCEDURE:

~~1.~~

A. Call-in for Unplanned Sick / Intermittent Family Medical leave of Absence (FMLA)

- ~~1. Activity Therapy Staff Employees will~~ must notify the Activity Therapy Department Office of their unplanned use of sick time or approved use of FMLA time off no later than 8:30 a.m. (or two hours before the start of their shift) by phone or email.
 - a. For phone notification
 - i. The designated contact number is 415-682-5600.
 - ii. ~~/ email is activitytherapy.lhh@sfdph.org. Staff who leave a voicemail must also leave a call back number.~~
 - iii. ~~Staff who speak directly to the department clerk or an activity supervisor do not need to leave a phone number.~~
 - b. For email notification
 - i. Staff shall send an email to activitytherapy.lhh@sfdph.org.
- ~~2. Department staff will call or email back personnel who call in to verify receipt of their message. Staff who speak directly to the department clerk or activity supervisor do not need to leave a phone number.~~
- ~~3. Employees report an unscheduled absence by c~~Calling 415-682-5600, the department's main number, to report the unscheduled absence between 8:30 and 9:00 a.m. regardless of your normal shift hours. ~~—~~ must inform the Activity Therapy Department of the number of sick days that are needed (no more than five days). Staff may call in for consecutive days as necessary. Requests for sick leave in excess of five (5) continuous working days shall be certified (i.e. submission for of a signed letter/certificate of completed City and County of San Francisco request for Leave Form) by a qualified health care provider. Family Medical Leave requests (intermittent or continuous) are processed in the same manner.
- ~~4. Employees calling-in for unplanned absences should make an attempt to directly communicate the following information:~~

- a. Activities or tasks that need to be covered (including outings).
 - b. Expected volunteers that need to be supported or cancelled.
 - c. Food orders to be picked up.
 - d. Any other important information.
5. The Activity Therapy Department Clerk/ or designated Activity Therapy Supervisor will receive calls and screen emails. They will convey the staffing absence to affected teams. Activity Staff is encouraged to inform their neighborhood clerk of the absence ASAP, especially when an outing is planned. In the event of a planned outing; Activity Staff will direct the nursing team to consult with the Activity Therapy Supervisor and/or Nursing Director to evaluate a need for cancelation.

B. Tardy Call-In

1. Staff who call in prior to their starting time to inform the Activity Therapy Department that they will be reporting late may be allowed up to a thirty (30) minutes time extension from their regular reporting time to report to duty. Staff will not be docked, provided the time is made up.
2. Staff who have a pattern of tardiness may be denied the opportunity to stay over and make up the time, but will be docked instead.
3. Regardless of whether staff are allowed to make up the time or are docked, incidents of tardiness may result in disciplinary action. Whether or not the employee is allowed to make up the time is a management decision depending on the department/neighborhood's operational and/or staffing needs.
4. Time records must accurately reflect the time employee's start work and the number of hours worked in every work day. Employees who fail to report arriving to work late, may be subject to disciplinary actions for falsification of hours' time worked.

~~Flu Season Disclosures~~Clerk and/or Activity Therapy Supervisors will receive calls during

~~During the designated Flu Season (October 1st to April 31st, and extended as needed) Activity Therapy Employees are asked to voluntarily disclose, during their unplanned absences, any flu symptoms that may be deemed contagious to our residents. These include:~~

~~Fever (if yes, temperature)~~

~~Cough~~

~~Sore Throat~~

~~"Did you have a flu swab done? If "yes", was it positive"~~

2. ~~"Where have you worked in the past 2 days before you became ill?" those hours.~~

3. ~~Staff should make an attempt to directly communicate with someone and include the following information.~~

a. ~~Activities or tasks that need to be covered.~~

b. ~~Whether you are scheduled for an outing.~~

Call-in Procedure

- ~~c. Whether volunteers need to be contacted.~~
- ~~d. Whether you have a food ordered.~~
- ~~e. Any other important information.~~

~~Because the Activity Therapy Department is not staffed 24/7, if one is unable to reach another staff member while calling, a voice message would be acceptable.~~

~~4.~~

REFERENCE:

~~LHH NPP A9.0~~ ~~None~~ ~~Nursing Sick -Leave / Intermittent FMLA and Tardy Call-In~~ ~~A9.0, Infection Control~~

ATTACHMENT:

None

Most recent review: ~~5/21/2015~~~~8/23/19~~
Revised: 9/2013, 8/29/2014, ~~3/25/2019~~~~8/23/19~~
Adopted: 9/2013