List of Laguna Honda Hospital and Rehabilitation Center (LHH) Hospital-wide/Department Policies and Procedures Submitted to the Joint Conference Committee (JCC) for Approval on March 10, 2020

Hospital-wide Policies and Procedures

Revised Policies (page 5)

Policies	Comments
01-12 Compliance Program	Minor revisions and updated contact number for Compliance Officer.
22-03 Resident Rights	Revised to add new appendix for LGBTQ+ Long-Term Care Facility Bill of Rights.
70-01 A2 Emergency Preparedness	Revised to include alternate sources of energy to maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm systems.
70-01 B1 Emergency Response Plan	Revised to include a system to track the location of on-duty staff during and after an emergency; and sheltering in place for residents, staff, and volunteers who remain in the facility.
70-01 B3 Resident Evacuation Plan	Revised to include protocols on how to identify and locate missing residents during an emergency as part of the facility's risk assessment.

Deleted Policies (page 49)

Policies	Comments
20-02 Bed Hold	Incorporated into 20-06 Leave of Absence.

Department: Central Processing Department

Revised Policies (page 63)

Policies	Comments
B3 Oxygen and Compressed Air	Revised to include "Cylinders are used in order which they are received from the supplier."

Department: Nursing Services

Revised Policies (page 67)

Policies	Comments
A 8.0 Centralized Staffing	• Replaced Decentralized Staffing • The Nurse Staffing Office (NSO) is responsible for completing staffing schedules that meets the minimum budgeted

	staffing requirements based on the resident's care needs, daily census and nursing model. Likewise, the Nurse Operations Nurse Manager, Neighborhood Nurse Managers and the Nursing Staffing Assistants (NSA) will collaboratively maintain a daily staffing pattern that responds to variations in acuity and census. • The Nursing Staffing Assistants, under the supervision of Nursing Operations Nurse Manager and/or Nursing Director of Operations, will be responsible for directly entering changes in the schedule in a timely manner, producing Plan Sheets, Schedules and Productivity Reports as necessary to effectively manage the neighborhoods staffing. • All staff are responsible for reviewing their schedules.
D9 9.0 Maintaining Temperatures of Refrigerator via TempTrak	Added policy: Licensed Nurse is to clean medication refrigerator weekly with facility approved disinfectant.
G 5.0 Blood Glucose Monitoring	• Physician order indicates hypoglycemic value to treat hypoglycemia and hyperglycemic value for which requires physician notification. • Hypoglycemia is considered <70mg/dL, and hyperglycemia is considered >400mg/dL, unless otherwise specified in order. Whenever blood glucose values change from the resident's usual range, or the blood glucose value is not consistent with resident condition, the nurse is to repeat the test, assess for symptoms of hypoglycemia or hyperglycemia, treat according to order and inform the physician STAT. • Glucometer machine is cleaned after each use and in between patient with facility-approved disinfectant wipes for the glucometer. • Daily quality control (QC) test with low and high glucose solutions will be performed daily by licensed nurse (LN) on AM shift. • Added: "Newly hired LN's will complete the competency at time of hire, 6 months after, then annually." • Added: "Test strip vial should be used prior to opening a new vial, even if the barcode number is the same." • Added: "Proper infection control procedures are followed when using the facility-approved glucometer machine and testing with blood glucose monitoring equipment." • Glucometer machine is cleaned after each use and in between patient with facility-approved disinfectant wipes (such as Super Sani-Cloth Germicidal Disposable Wipes® or Clorox Germicidal Wipes®) for the glucometer.

J 1.0 Medication Administration	• New policy: "Select residents can use identification (ID) cards in lieu of ID wristbands. The ID cards will be used by staff to correctly identify resident for the purpose of barcode medication administration (BCMA), and point of care testing (POCT)." • New policy: "All medications delivered via transdermal (patch) will be labeled with date and initial at time of application of the patch. If resident currently has a patch on, the old patch should be removed before applying a new patch." • "Successful scan of identification card for resident who meets criteria (see appendix II)" added as verification of resident. • Added: "Pill crushers will be cleaned with alcohol wipe at end of medication pass prior to returning to medication room for charging and PRN."
J 8.0 Blood Product Administration	Major changes to reflect electronic health record (EHR) workflows.

Deleted Policies (page 119)

Policies	Comments
D1 2.1 Attachment 4 Daily Nursing Care Record	No longer relevant with EHR.

Department: Pharmacy Services

Revised Policies (page 121)

Policies	Comments
07.02.00 Preparation, Handling, and Disposal of Hazardous Drugs	Revised to add definition of qualified personnel; updated procedures for use of containment primary engineering control (C-PEC) for compounding non-sterile hazardous drugs; and updated hand hygiene procedures.

Department: Rehabilitation Services

Revised Policies (page 131)

Policies	Comments
60-02 Procedure for Outpatient Referral Registration and Treatment	Revised to reflect EHR workflows – the referring provider shall order outpatient therapy via the EHR.

Deleted Policies (page 135)

Policies	Comments
50-03 Verbal Orders	No longer relevant with EHR.

Revised Hospital-wide Policies and Procedures

COMPLIANCE PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) maintains a Compliance Program consistent with the Department of Public Health (DPH) Compliance Office's policies and procedures and with federal and state regulations, including the Federal and California False Claim Acts.

2. The Compliance Program at the LHH campus applies to LHH employees, and LHH campus contractors and agents who, on behalf of LHH, furnish or authorize the furnishing of Medicare or Medi-Cal services, perform billing or coding functions, or monitor the provision of health care services.

3. LHH works with the DPH Office of Compliance and Privacy Affairs to meet LHH's compliance objectives.

PURPOSE:

1. To ensure the integrity of LHH campus clinical and business activities by adhering to the following goals:

   a. To promote an understanding of and compliance with Medicare, Medi-Cal, and other applicable federal and state laws and regulations;

   b. To use education and training to improve compliance with documentation, coding, billing and reimbursements rules and regulations;

   c. To work with providers, managers, and staff to integrate compliance into the daily operations of LHH and promote patient safety and quality of care; and

   d. To promote compliance with the CMS Value-Based Purchasing, including accurate and timely reporting of clinical assessments.

PROCEDURE:

1. LHH is committed to comply with all applicable federal and state statutes and regulations related to billing for services and reimbursement programs. To this end, it maintains a Compliance Program that includes procedures 2 through 8.

2. **Compliance Officer**

   The Compliance Officer is responsible for the daily operation of the Compliance Program at the LHH campus that includes:

a. Overseeing and monitoring the implementation and maintenance of the Compliance Program.

b. Reporting on a regular basis to the LHH Compliance Steering Committee (no less than quarterly) to review and conduct compliance activities.

c. Periodically reassessing the Compliance Program to identify necessary changes due to findings from compliance activities, changes in business practices or processes, and new regulations and risks.

d. Coordinating internal compliance review and monitoring activities.

e. Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.

3. **Compliance Committee**

The LHH Compliance Steering Committee, chaired by the Compliance Officer, is responsible for ensuring integrity in the clinical and business operations of LHH. The Committee, through the Compliance Officer, shall report to the LHH Executive Quality Council at least once a year, and function as an oversight committee with sub-committees and work groups tasked to research/resolve particular issues as they arise. This includes ensuring that the Compliance Program is effective at identifying and mitigating risks by:

a. Approving Compliance Program policies and procedures, annual risk assessments, and the annual work plan, including periodic updates of those documents.

b. Monitoring compliance program activities through regular reports from the Compliance Officer and compliance monitoring project owners.

c. Allocating adequate resources to address compliance risks, including designating department staff to partner with the Compliance Office on compliance monitoring projects, and tasking work groups as necessary.

d. Support value-based quality initiatives and reporting.

4. **Compliance Training**

LHH, through its Compliance Officer and its Department of Education and Training, shall ensure that all staff receive compliance training upon hire and annually.

a. Training and education are key components of the Compliance Program. Training ensures the LHH workforce and governing bodies receive information about the

Compliance Program when they begin employment and at least annually as "refreshers" that reinforce the culture of compliance.

b. The Compliance Officer is responsible for developing, coordinating and participating in education and training efforts to ensure that staff are knowledgeable about the Compliance Program. Additionally, the Compliance Officer shall recommend that targeted training is provided to specific audiences when warranted due to identified compliance risks.

5. **Compliance Standards and Policy and Procedures**

LHH, through its Compliance Officer, shall ensure that LHH has developed and distributed written policies and procedures that establish Compliance standards. Policies and procedures are also created and/or updated in response to new laws and regulations that affect the Compliance Program.

a. DPH Code of Conduct: The DPH Code of Conduct applies to LHH employees and volunteers. The Code of Conduct is provided by Human Resources to new employees at the time of hire with signed acknowledgment. Staff are also required to review with signed acknowledgement annually through the annual compliance training module. Training and education are key components of the Compliance Program.

b. Compliance Program Policies: In addition to adherence to the DPH Compliance Policies, LHH maintains specific compliance policies and procedures for issues that may be pertinent to LHH campus operations.

   i. Departments within the LHH campus shall also maintain their own department-specific policies and procedures for ensuring proper controls and monitoring of activities that impact billing and reimbursement such as documentation of medical necessity, selection of procedure (CPT) and diagnosis (ICD-10) codes, accuracy of data submitted to government agencies for claims reimbursement, etc.

6. **Reporting Compliance Issues**

a. LHH, through its Compliance Officer, shall make lines of communication available for employees to report fraud and compliance concerns with the option of remaining anonymous. This includes a confidential Compliance Hotline at 855-729-6040.

b. LHH also maintains a strict non-retaliation policy for employees who report compliance violations. Staff are expected to report concerns by first discussing with their supervisor or manager, then either through the Compliance Hotline or by contacting the Compliance Officer directly at 415-759-3374415-759-4072, email or interoffice mail: LHH Compliance Officer, Administration.

7. **Investigating Compliance Issues**

   a. LHH, through its Compliance Officer, shall promptly investigate reports of violations of the Compliance Program or federal or state laws and regulations related to billing for health care services**.**

   b. LHH ~~senior management~~ shall implement corrective measures up to and including dismissal for employees who are out of compliance with the Compliance Program or any federal or state law related to billing for health care services.

8. **Auditing and Monitoring Activities**

   LHH, through its Compliance Officer, shall conduct periodic auditing and monitoring of potential risk areas.

   a. The Compliance Officer monitors and coordinates responses to external billing audit requests to ensure that documentation is submitted timely in accordance with the various auditors' timelines and protocols, and corrective steps are taken as necessary in response to audit denials.

   b. LHH, through its Compliance Officer, also conducts monitoring and auditing activities to proactively ensure on-going compliance with federal and state regulations and guidelines related to billing and reimbursement for healthcare services. An internal monitoring plan is developed as part of the annual compliance work plan and includes areas of potential risk that have been identified through the annual risk assessment.

   c. Any findings of improper billing identified through the internal monitoring process shall be refunded as required by law to the payer, assessed for the root cause, and take corrective actions to resolve the matter.

   d. The Compliance Officer monitors corrective actions to ensure that improvements are sustained.

ATTACHMENT:
None.

REFERENCE:
DPH Compliance Program
DPH Compliance Program – Relevant Federal and State Compliance Related Statutes and Regulations
DPH Compliance Policy – Operation of a Compliance Program
DPH Compliance Program Code of Conduct
DPH Compliance Program – Employee Compliance Hotline
DPH Compliance Program – Employee Non-Retaliation Policy

DPH Compliance Program – Guide to Government Interviews and Investigations
Section 6102 of the Affordable Care Act

Revised: 15/05/12, 16/03/08, 17/11/14, 18/11/13, 20/03/10 (Year/Month/Day)
Original adoption: 13/03/26

RESIDENT RIGHTS

POLICY:

1. Patient/Resident rights are honored without regard to cultural, economic, educational, religious background, sexual orientation, gender identity, disability or the source of payment for his/her care.

2. LHH upholds patient/resident's rights to confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

3. Patient/residents are not to be required to perform services for the facility that are not included for therapeutic purposes in the plan of care.

~~2~~4. Laguna Honda Hospital and Rehabilitation Center (LHH) staff collaborates with the San Francisco Ombudsmen Office in their role as residents rights advocate.

~~3~~5. All residents of LHH are informed of their rights and responsibilities, and are further required to acknowledge receipt of having received a copy of those rights and responsibilities, as well as an explanation if requested.

~~4~~6. A list of residents' rights is posted or available in appropriate places within LHH.

PURPOSE:

To assure that each resident is knowledgeable about his/her rights and the methods and circumstances by which those rights can be withheld. These rights comply with Title 22, California Code of Regulations Section 70707 and 72527, and Code of Federal Regulations, Title 42, Section 483.10.

PROCEDURE:

1. Prior to, or upon admission to LHH, the (a) Admitting Clerk or (b) a member of the Admission & Eligibility staff will give to the resident, or her/his representative or responsible relative, a copy of the resident's rights form and will have a receipt acknowledged by the signature of the receiving party.

2. The receipt (acknowledgement) is placed in the resident's medical chart.

3. Discrepancies regarding these procedures should be brought to the attention of the Director of Admissions and Eligibility.

ATTACHMENT:

Appendix A: List of Residents' / Patients' Rights
Appendix B: LGBTQ+ Long-Term Care Facility Bill of Rights

REFERENCE:
LHHPP 24-06 Resident Complaints/Grievances
Resident Rights Web address:
http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph327-Attachment-A.pdf
Prohibiting Discrimination Against Lesbian, Gay, Bisexual, and Transgender Residents by Long-Term Care Facilities:
http://sfbos.org/ftp/uploadedfiles/bdsupervrs/ordinances15/o0047-15.pdf

Revised: 02/09/06, 08/09/30, 10/04/27, 15/11/09, 17/09/12, 19/03/12, 19/05/14, 19/07/09, 20/03/10 (Year/Month/Day)
Original adoption: 98/01/22

Appendix A:

LIST OF RESIDENTS' / PATIENTS' RIGHTS

I. Exercising Your Rights

1. You have the right to a dignified existence, self-determination, and communication and access to people and services both inside and outside of Laguna Honda. You have the right to be free of interference, coercion, discrimination, and retaliation from Laguna Honda in exercising your rights as a resident of Laguna Honda and as a citizen or resident of the United States, and Laguna Honda shall support you exercising your rights. You have the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source.

2. You have the right to designate a representative if you are competent to do so, who may exercise your rights, in accordance with, and to the extent provided by state law.

   a. Your representative has the right to exercise your rights to the extent you have delegated those rights to your representative.

   b. You retain the right to exercise any right not delegated to your representative, including the right to revoke a delegation of rights, except as limited by state law.

   c. Laguna Honda shall treat the decisions of your representative as your decisions to the extent required by either a court or as delegated by you.

   d. Laguna Honda shall not extend to your representative the right to make decisions on behalf of you beyond the extent required by either a court or as delegated by you. Laguna Honda shall report, as required by law, if it has reason to believe that your representative is not acting in your best interest.

3. Residents adjudged incompetent by a court with jurisdiction to do so, shall have their rights devolve to and exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative shall exercise your rights to the extent judged necessary by the court with jurisdiction, and in accordance with state law.

   a. In cases where a representative's decision-making authority is limited by state law or court appointment, you retain the right to make those decisions outside of the representative's authority.

   b. Your wishes and preferences must be considered in the exercise of your rights by the representative, and to the extent possible, you shall be provided with the opportunity to participate in the care planning process.

4. You have the right to exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care. The same-sex spouse or a resident shall be afforded treatment equal to that of an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

II. Planning and Implementing Your Care

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual and personal values, beliefs, and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you, and to be informed of the care to be furnished to you and the type of care giver that will furnish that care. You have the right to be informed and participate in your treatment.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in language you can understand. You have the right to be informed in advance of treatment of the risks and benefits of the proposed care, alternatives or options to the proposed treatment, and to choose the alternative or option if you prefer.

5. You have the right to effective communication and to participate in the development and implementation of your plan of care, and the right to receive the services and/or items included in the plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

6. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

7. Participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. You have the right to identify individuals or roles to be included in the

planning process, the right to request meetings, and the right to request revisions to the plan of care.

8. Choose your attending physician, provided that the physician meets the requirements of Code of Federal Regulations, Title 42.

9. See the plan of care and be informed in advance of any changes to the plan of care.

10. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

11. Self-administer medications if your care team has determined that this practice is clinically appropriate.

12. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

13. Reasonable responses to any reasonable requests made for service.

14. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve the pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

15. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

III. Respect and Dignity

You have the right to:

1. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

2. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

3. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

4. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

5. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided with this information also.

6. Know which hospital rules and policies apply to your conduct while a patient.

7. A safe, clean, and homelike environment including receiving treatment that supports your safe daily living. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Laguna Honda shall exercise reasonable care for the protection of your property from loss or theft.

8. Reside and receive services with reasonable accommodation of your needs and preferences except when to do so would endanger your health or safety or other residents.

9. Share a room with your spouse if your spouse also resides at Laguna Honda and you both consent to the arrangement.

10. Share a room with the roommate of your choice when practicable, and only when you are both residents at Laguna Honda and consent to the arrangement.

11. Receive written notice, including the reason for the change, before your room or roommate in the facility is changed.

12. Refuse to transfer to another room in the facility, if the purpose of the transfer is to relocate you from a skilled nursing unit to a non-skilled nursing unit within Laguna Honda, or if the transfer is solely for the convenience of Laguna Honda. This right shall not affect your eligibility or entitlement to Medicare or Medi-Cal benefits.

IV. Self-Determination
You have the right to:

1. Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with your interests, assessments, and

plan of care; and to make choices about aspects of your life at Laguna Honda that are significant to you.

2. Interact with members of the community and participate in community activities both inside and outside of Laguna Honda.

3. Organize and participate in resident groups within Laguna Honda. You have the right to participate in social, religious, and community activities provided that doing so does not interfere with the rights of other residents.

4. Receive visitors of your choosing at the time of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

    a. Laguna Honda reasonably determines that the presence of a particular visitor would endanger the health or safety of you, other residents, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.

    b. You have told Laguna Honda staff that you no longer want a particular person to visit.

    c. However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

5. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.

6. Participate in family groups and have family members or other representatives' meet with the families or representatives of other residents of Laguna Honda.

7. Choose to or refuse to perform services for Laguna Honda. You may perform services for Laguna Honda when:

    a. Laguna Honda has documented your need or desire for work in the plan of care;

    b. The plan of care specifies the nature of the services performed and whether the services are voluntary or paid;

    c. Compensation for paid services is at or above prevailing rates; and

    d. You agree to the work arrangement described in the plan of care.

    e. At no time shall you be required to perform services for Laguna Honda.

8. Manage your own financial affairs, including the right to know in advance, what charges Laguna Honda may impose against your personal funds.

9. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

V. Information, Communication, Privacy, and Confidentiality

You have the right to:

1. Be informed of your rights and the rules and regulations governing resident conduct and responsibilities during your stay at Laguna Honda.

2. Access your personal and medical records; and to secure and confidential treatment of all communications, personal records, and medical records pertaining to your care and stay in the hospital. You have the right to refuse the release of personal and medical records unless federal or state law requires the release of those records. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

3. Receive notices both orally and in writing in a format and language that you understand.

4. Have reasonable access to the use of a telephone in a place where you cannot be overheard, including the right to retain and use a cellular phone at your expense. You have the right to communicate with individuals and entities within and outside of Laguna Honda with reasonable access to the internet, to the extent available within Laguna Honda.

5. Send and receive mail, including letters, packages, and other materials delivered to Laguna Honda; and to have those communications be received and sent promptly and in private. You have the right to access stationery, postage, and writing implements at your expense.

6. Have access to, and privacy in, your use of electronic communications such as email and video communications, and internet research to the extent that it is available at Laguna Honda.

7. Privacy in your medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.

8. Examine the results of the most recent survey of Laguna Honda conducted by Federal or State surveyors and any plan of correction in effect, and to receive information from agencies acting as client advocates including the right to contact such agencies.

9. Voice grievances to Laguna Honda or other agencies that hear grievances without retaliation or discrimination, and without the fear of retaliation or discrimination, including grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and any other concern regarding your stay at Laguna Honda.

   If you want to file a grievance with this hospital, you may do so by writing or calling:

   Margaret Rykowski, RN, MS
   Acting Chief Executive Officer
   Administration Department
   Laguna Honda Hospital
   375 Laguna Honda Boulevard
   San Francisco, CA 94116
   (415) 759-4025

   You have the right to prompt resolution of grievances. The grievance committee will review each grievance and provide you with a written response within 10 business days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

10. File a complaint with the state Department of Public Health regardless of whether you use the hospital's grievance process. The state Department of Public Health's phone number and address is:

    Department of Public Health Licensing & Certification
    San Francisco District Office
    150 North Hill Drive Suite 22
    Brisbane, CA 94005
    Phone: (415) 330 6353
    Fax: (415) 330 6350

APPENDIX B

LGBTQ+ LONG-TERM CARE FACILITY RESIDENTS'

BILL OF RIGHTS

Residents in Long-Term Care Facilities have all the rights below without regard to a person's actual or perceived sexual orientation, gender identity, gender expression, or HIV status.

- Resident's admission to a facility, transfer within, or to another facility, cannot be based on a person's actual or perceived sexual orientation, gender identity, gender expression, or HIV status. A resident will not be involuntarily discharged based on above.
- Residents can share a room at their request.
- Where rooms are assigned by gender, an individual's request based on their gender identity will be honored.
- A resident will not be involuntarily reassigned to a different room based on any person's complaints or concerns about gender identity or gender expression.
- Resident's choice of restroom based on gender identity or gender expression will be respected.
- Resident's preferred name and pronouns will be used.
- Resident may wear or be dressed in clothing, accessories, or cosmetics of their choice.
- Residents have the right to associate with others of their choice and engage in sexual intimacy.
- Residents will receive medical and non-medical care that is appropriate to a resident's organs and bodily needs, and will be provided in a respectful and appropriate manner.

IF YOU BELIEVE THAT YOU HAVE BEEN DENIED RIGHTS GRANTED TO YOU UNDER THIS LAW

OR HAVE QUESTIONS ABOUT YOUR RIGHTS,
PLEASE CONTACT:

The San Francisco Long-Term Care Ombudsman: 415-751-9788

San Francisco Human Rights Commission: 415-252-2500; www.sf-hrc.org

The LGBTQ+ Bill of Rights "Liaison" at this location is:

Jennifer Carton-Wade
NAME

415-759-3015 jennifer.carton-wade@sfdph.org
PHONE EMAIL

ADDITIONAL INFORMATION:

The text of this ordinance can be found within the San Francisco Police Code, Article 33, Section 3304.01
http://www.sfbos.org/ftp/uploadedfiles/bdsupvrs/ordinances15/o0047-15.pdf

For more about the history and recommendations which lead to this law, please see the San Francisco LGBTQ+ Aging Policy Task Force Report, "Aging at the Golden Gate," issued March 2014.
http://sf-hrc.org/sites/default/files/LGBTQ+APTF_FinalReport_FINALWMAFINAL.pdf

housing, services, and community for LGBTQ seniors
openhouse

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. Food storage during emergency is stored in walk-in freezer #3 and walk-in refrigerator #6. Food service shall shift food items to emergency storage refrigerators.

   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. All medication refrigerators with the exception of PMS and PMA medication rooms are on emergency power. In the event of power outage, LHH to provide facility approved extension cords to PMS and PMA areas. ~~(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.

e. Alternate source of energy are located on site at LHH in the form of generators. The generators provide power to emergency lighting, fire detection, extinguishing and alarm systems, and boiler controls.

f. When an emergency or disaster in the community prevents LHH from having access to water service, LHH shall implement LHHPP 70-01 C8 Water Disruption Plan, section 5.g.

v.

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. 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, 20/03/10 (Year/Month/Day)
Original adoption: 13/05/28

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

7. Shelter in Place Plan

Mitigation/Preparedness: During certain emergency situations, particularly chemical/HAZMAT, biological, radioactive events or weather emergencies, it may be advisable for employees to shelter-in-place rather than evacuate the building. Shelter in-place is a strategy taken to maintain patient care within LHH and to limit the movement of staff and visitors to protect life and property from hazard. Shelter-in place is an ideal method of self-protection from airborne contaminants, such as a toxic airborne chemical or a person with a weapon. It may be necessary to evacuate certain parts of LHH and shelter-in-place in another part of the facility.

i. Criteria for Implementation: In situations posing an immediate threat to the safety of employees and visitors shelter in place procedures must take priority. Shelter in place will be determined by the Chief Executive Officer (CEO) or the Administrator On Duty (AOD).

ii. Pre-Event Information: Potential terrorist incidents, such as the release of a chemical hazard may be preceded by alerts issued by local or state authorities. Information may be disseminated to LHH via PHEPR. Notification may also be made from law enforcement, HAZMAT teams or fire department via telephone.

iii. Activation of Emergency Response Procedures: Upon notification that a suspected/confirmed airborne chemical/biological hazard is likely to impact LHH the Emergency Response Plan will be activated and "Shelter in Place" will be announced overhead. Notification may be made by Mass Notification system and email.

Response Measure
Identify nature of incident and determine necessary level of response and protection.
Coordinate safety and security with law enforcement entities as appropriate.
Implement the following activities: • Close air vents, windows, and doors.

• Facilities department to shut down hospital Vacuum and Air Conditioning Unit. (HVAC)
Notify employees, visitors and vendors as to nature of the danger and reason for the shelter-in-place.
Assess capabilities and identify personnel resource requirements and staff availability.
Develop and implement public-information plans for employees and the media to provide information on disease recognition, necessary infection-control measures, treatments, and home-care/after-care instructions.

iv. Reassessment of Event: External communication via, news media, California Health Alert Network (CAHAN) notifications, ReddiNet, email notification, landline communication may provide additional information critical to the assessment and reassessment of the shelter in place response activities.

v. Recovery Strategies: Assess staffing requirements and provide an organized reporting structure. Ensure that the HVAC system and ventilator systems have returned to normal operations. Take down signs from all building entrances and exits. Notify employees, patients and vendors of the ability to enter and exit the building. Provide safe reentry pathways to the building in an organized manner.

vi. Education & Training: New employees at LHH receive emergency preparedness training at new employee orientation. All staff shall receive emergency preparedness training annually with e-learning module.

ATTACHMENT:
Appendix A: Department Operating Status Report (DOSR)
Appendix B: Emergency Contact List

REFERENCE:
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, 20/03/10 (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**
Current Census in Department: Number of residents accounted for Have any residents been injured? ☐ Yes ☐ No 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. Any anticipated Resident condition changes or problems resulting from this event? ☐ Yes ☐ No # of Patients eligible for discharge # of Patients eligible for Transfer	**Current Staffing in department (on duty)** RN# LVN# CNA/PCA# HHA# MD# EVS# Unit Clerk# FSW# HIS# AT# SW# Other staff: (List title and number of staff) ***Complete staff name and title on next page*** Total Staff: Any injuries to staff? ☐ Yes ☐ No If "Yes", list number of injuries by severity: Minor Delayed Immediate Expired Number of staff available for Labor Pool:	Open/Available Beds # Open/Available Negative Pressure Rooms# Open/Available Gurneys # Open/Available Wheelchairs # Available Portable O2 # Full #Partially Full Other Available Space, Equipment and Supplies

Please use back of form for additional information as needed

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

Employee Name	Classification

Appendix B: Emergency Contact List

Agency or Individual	Phone	Pager	Email
Director of Health	415-554-2525		
SFHN Director	415-554-2711		
DEM Duty Officer	415-260-2591	415-327-0543	
PHEPR Director	415-802-7358		
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 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. 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.

~~c.~~

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.

e. If there is no safe area for care on the LHH campus, Public Health Emergency Preparedness and Response (PHEPR) ~~PHEPR~~ will be notified of the need to move residents to another facility.

   i. LHH resident evacuation and transportation shall align with PHEPR. For PHEPR protocols on evacuation or extended closure refer to San Francisco Department of Public Health (SFDPH) Emergency Response Activation & Notification Protocol.

ii. Care at alternate sites shall align with PHEPR. For PHEPR care at alternate sites protocols refer to SFDPH Continuity of Operations Plan (COOP), section 3. 3.1. Phase II.

iii. In the event that the Secretary of Health and Human Services (HHS) declares a waiver in accordance with section 1135 of the Social Security Act that identifies LHH as an approved 1135 waiver. LHH will adhere to the policies and procedures for care at alternate sites PHEPR protocol. For PHEPR care at alternate sites protocols refer to SFDPH COOP, section 3. 3.1. Phase II.

iv. In accordance with section 1135 of the Act, LHH shall adhere to PHEPR processes to inform the community of care operations at alternate care sites. For PHEPR community communication of LHH care operations at alternate sites refer to SFDPH Crisis and Emergency Risk Communication Guide, section I and III.

v. In accordance with section 1135 of the Act, LHH shall provide reporting information as indicated by PHEPR.

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. Shelter in Place Plan

a. Mitigation/Preparedness: During certain emergency situations, particularly chemical/HAZMAT, biological, radioactive events or weather emergencies, it may be advisable for employees to shelter-in-place rather than evacuate the building. Shelter-in-place is a strategy taken to maintain patient care within LHH and to limit the movement of staff and visitors to protect life and property from hazard. Shelter-in-place is an ideal method of self-protection from airborne contaminants, such as a toxic airborne chemical or a person with a weapon. It may be necessary to evacuate certain parts of LHH and shelter-in-place in another part of the facility.

i. Criteria for Implementation: In situations posing an immediate threat to the safety of employees and visitors shelter in place procedures must take priority. Shelter in place will be determined by the Chief Executive Officer (CEO) or the Administrator On Duty (AOD).

ii. Pre-Event Information: Potential terrorist incidents, such as the release of a chemical hazard may be preceded by alerts issued by local or state authorities. Information may be disseminated to LHH via PHEPR. Notification may also be made from law enforcement, HAZMAT teams or fire department via telephone.

iii. Activation of Emergency Response Procedures: Upon notification that a suspected/confirmed airborne chemical/biological hazard is likely to impact LHH the Emergency Response Plan will be activated and “Shelter in Place” will be announced overhead. Notification may be made by Mass Notification system and email.

Response Measure
Identify nature of incident and determine necessary level of response and protection.
Coordinate safety and security with law enforcement entities as appropriate.
Implement the following activities: • Close air vents, windows, and doors. • Facilities department to shut down hospital Vacuum and Air Conditioning Unit. (HVAC)
Notify employees, visitors and vendors as to nature of the danger and reason for the shelter-in-place.
Assess capabilities and identify personnel resource requirements and staff availability.

Develop and implement public-information plans for employees and the media to provide information on disease recognition, necessary infection-control measures, treatments, and home-care/after-care instructions.

iv. Reassessment of Event: External communication via, news media, California Health Alert Network (CAHAN) notifications, ReddiNet, email notification, landline communication may provide additional information critical to the assessment and reassessment of the shelter in place response activities.

v. Recovery Strategies: Assess staffing requirements and provide an organized reporting structure. Ensure that the HVAC system and ventilator systems have returned to normal operations. Take down signs from all building entrances and exits. Notify employees, patients and vendors of the ability to enter and exit the building. Provide safe reentry pathways to the building in an organized manner.

vi. Education & Training New employees at LHH receive emergency preparedness training at new employee orientation. All staff shall receive emergency preparedness training annually with e-learning module.

7. 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.

i. Primary methods of communication include regular telephone services.
ii. Alternate methods of communication include 800 MHz radios and METS phone (Mayors Emergency Telephone System) are tested monthly.

6.8. 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.

i. If any residents are identified as missing Code Green shall be activated. For Code Green protocol, refer to LHHPP 24-22.

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.

7.9. 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 24-22 Code Green Protocol
LHHPP 70-01 B1: Emergency Response Plan

Revised: 18/09/11, 19/03/12, 19/09/10, 20/03/10 (Year/Month/Day)
Original Adoption: 14/07/29

APPENDIX A: Alternate Care Sites

Location	HVAC	Generator Power	Water	Lighting	Shelter from Weather	Restroom	Bed Capacity	Able to Quarantine	Med Gases Available	Floor surface
Neighborhood Common Areas	Y	Y	Y	Y	Y	Y		N	N	Terrazzo
Clinic P1	Y	Y	Y	Y	Y		12	Y	Y	Terrazzo
Rehab P3	Y	Y	Y	Y	Y	Y	13	N	N	Terrazzo
Wellness Gym PG	Y	Y	Y	Y	Y	Y	10	N	N	Rubber
Simon Auditorium H1	N	N	N	Y	Y	Y	60	N	N	Concrete
Wellness Hub H3	Y	N	N	Y	Y	Y	50	N	N	Carpet
Moran Hall H3	Y	N	N	Y	Y	Y	50	N	N	Concrete, Carpet
Esplanade & Kanaley P1	Y	Y	Y	Y	Y	Y	40	N	N	Terrazzo
Cafeteria P1	Y	Y	Y	Y	Y	Y	25	N	N	Terrazzo
Horseshoe Outside PG	N	N	N	Minimal	N	N	100	N	N	Grass, Pavement
NW Parking Lot	N	N	N	Minimal	N	N	100	N	N	Pavement

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

d. **Stryker Evacuation Chairs** (7) are available through the Command Center for evacuation down stairs (weight limit 500 lbs). Pictoral directions appear on the back of the chair. Fold the chair out as pictured, by squeezing the red bar to raise the handle and by squeezing the lower red bar while pulling out the stair track. Transfer the victim onto the chair and fasten the waist, chest, and ankle straps. Wheel the victim to the stairs. Tip the chair back to allow it to descend on the gliders down the stairs with 1 or 2 rescuers holding the handles to safely guide the chair down.

APPENDIX 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.

Hospital-wide
Policies and Procedures
For Deletion

FOR DELETION

BED HOLD

POLICY:

1. The Laguna Honda Hospital and Rehabilitation Center (LHH) Patient Flow Coordinator shall coordinate both bed hold and bed reservation procedures in conjunction with Admissions and Eligibility (A&E) department and the neighborhood physician representing the neighborhood Resident Care Team (RCT).

2. Leave of Absence (LOA)/Pass is the responsibility of each neighborhood 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 (Out on Pass or OOP) – 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. Upon admission, A&E provides the resident, or family member, or legal representative with the California Standard Admission Agreement, which includes written information regarding bed hold. The Social Worker 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.

4. Medi-Cal and some other insurances pay for up to seven days of bed hold. Further clarification regarding insurance coverage shall be routed to Utilization Management.

5. A resident whose hospitalization or therapeutic leave exceeds the bed hold 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.

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

7. The facility shall submit claims for resident bed hold days based on allowable reimbursement.

PURPOSE:

1. To accurately track and monitor residents discharged to acute facilities.
2. To accurately track and monitor residents on LOA/Pass.
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

DEFINITION:

1. LOA/Bed Hold: When resident is transferred from a skilled nursing facility (SNF) to a general acute care hospital, which may be either Laguna Honda Hospital and Rehabilitation Center (LHH) or an outside hospital, the SNF shall afford the resident a bed hold of up to seven (7) days. After 7 days, the Bed Hold may be changed to Bed Reservation at the discretion of the Nursing Bed Coordinator and the RCT.
2. LOA/Out on Pass: A planned absence of a resident from LHH authorized by a physician's order, which extends past midnight.
3. Leaving Hospital Against Medical Advice (AMA): A resident is discharged AMA when he/she leaves LHH against the advice of the physician.
4. Absent Without Leave (AWOL): A resident who leaves LHH without notification or without an approved LOA.
5. Missing Cognitively Impaired (MCI): The Physician has documented that the resident is unable to understand the potential risks of leaving the hospital without permission, in case of elopement the resident shall be considered Missing Cognitively Impaired.
6. Bed Reservation: 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.

PROCEDURE:

1. Census Management

   a. Nursing Department is responsible for census management which is done in the electronic health record (EHR).

b. Refer to Appendix A for census management by Medicine, Nursing, Medical Records, Admissions and Patient Accounting Services for the following case scenarios:

   i. ER Visit,

   ii. PES,

   iii. Elopement-MCI,

   iv. Elopement, and

   v. Go on Pass (applying Medi-Cal and Medicare Rules about SNF stays)

2. Bed Hold

a. Requirements for bed hold for acute hospitalization:

   i. A physician's order that the resident is discharged and that the resident is at the acute care hospital.

   ii. The day of departure from SNF is counted as day 1 of bed hold; the day of return is not counted.

   iii. LHH shall hold the bed up to seven (7) days during hospitalization.

   iv. Bed hold must terminate on the resident's date of death.

   v. LHH claims must identify the inclusive date of the bed hold.

b. LHH residents discharged to acute care at another hospital:

   i. The staff nurse on the neighborhood shall call the acute care hospital before doing the final discharge after the seventh day of bed hold to ensure that resident was not discharged from acute care hospital before the seventh day to reflect accurate bed hold days.

   ii. The Admissions Department shall contact acute care hospitals three times a week (Monday, Wednesday, Friday) to which a LHH resident has been admitted and will verify the bed hold status of the LHH resident. The Admissions Department shall complete the Status Report on Discharges form and email the report to the HIS Department, Nurse Managers, and Nursing Directors. When the seven-day bed hold is exhausted and the resident has not returned to LHH, the Admissions Department shall notify the Eligibility Department that the resident is being removed from bed hold and is still at the acute care hospital.

c. If the resident does not return after the 7th day from acute hospitalization:

   i. Nursing Bed Coordinator shall release the bed hold for utilization of the bed vacancy.

3. Requirements for LOA/Pass and Bed Hold Reimbursement Status for Residents on Approved LOA/Pass

a. The day of departure from SNF is counted as day 1 of the leave and the day of return is not counted as a leave day.

b. A bed shall be held during a resident's authorized LOA/Pass.

c. A current physician's order for LOA/Pass is required.

d. LHH will not be reimbursed for bed hold in the event a resident is discharged within 24 hours of return from LOA/Pass.

e. 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:

   i. Maximum time period: 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:

      - 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.

      - At least five days of SNF inpatient care must be provided between each approved LOA/Pass.

      - Maximum of 73 days per calendar year for developmentally disabled recipients.

      - 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.

      - The return from LOA/bed hold must not be followed by discharge within 24 hours.

   ii. LHH will not receive reimbursement for any LOA/Pass days exceeding the maximum number of leave days per calendar year.

f. Medicare does not provide for bed hold reimbursement.

g. A resident who does not return from an authorized LOA/Pass shall be discharged from the Admissions Discharge Transfer system.

h. Refer to LHHPP 20-06 Leave of Absence (Out on Pass) for procedures related to LOAs and passes.

4. Status of Residents Without an Approved Therapeutic LOA (Out on Pass) (AMA, AWOL Elopements, or MCI Elopements)

a. Against Medical Advice (AMA)

i. A resident who leaves LHH against medical advice is considered AMA and shall be discharged.

ii. Physician completes AMA form (MR 804) and documents the reason resident left.

iii. If possible, resident shall be asked to sign the AMA form where indicated.

iv. Physician writes AMA discharge order.

v. LHH will not hold the resident's bed.

b. AWOL Elopements

i. A resident who leaves without notification or without an approved LOA is considered AWOL.

ii. A resident who goes AWOL past midnight may result in a discharge. LHH is not permitted to place a bed hold for a resident who is not on an approved leave of absence or pass.

iii. Physician writes discharge order: Discharged – AWOL.

iv. The nurse shall complete the Confidential Report of Unusual Occurrence form.

c. Resident identified as MCI (Missing Cognitively Impaired) Elopements

i. Refer to LHHPP 24-01 Missing Resident Procedures for resident elopements while on campus or off campus.

ii. If a resident who has been identified as MCI by the neighborhood RCT does not return by midnight or the resident has not been found or returned to the

facility, LHH shall discharge the resident and reserve the bed via the bed reservation process.

~~5.~~ Bed Reservation

a. Beds may be reserved under the following circumstances:

i. Temporary transfer of a resident to another LHH care neighborhood due to change in the resident care needs, such as an isolation room, with anticipated return to the original neighborhood as clinically necessary based on bed availability.

ii. Resident length of stays at acute care hospital greater than seven (7) days with the resident's anticipated return to LHH. See procedure 2.c.i.

iii. Missing resident at the discretion of LHH's CEO, CMO, CNO or designee.

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. Are MCI, 4. AWOL, and 5. Go on Pass

REFERENCE:
LHHPP 20-06 Leave of Absence (Out on Pass)
LHHPP 20-07 Against Medical Advice
LHHPP 24-01 Missing Resident Procedures
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold
State Operations Manual related to Notice of bed-hold and return and Permitting residents to return to facility

Revised: 09/07/17, 09/10/27; 14/01/28, 14/03/25, 17/11/14, 19/05/14 (Year/Month/Day)
Original adoption: 01/07/12

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-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 *Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours*
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 *Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours*
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: Neighborhood 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 *Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours*
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.	No EHR activity; 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 *Note: SNF PPS day cannot be billed to Medicare if patient not in SNF at 0000 hours*
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 missing 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 neighborhood staff nurse of resident's return	No EHR activity	Open	No EHR activity	LTC Day

d) Returns from elopement after midnight on July 18 or successive days and is not re-admitted	Not re-admitted	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.	Chart remains closed	No EHR activity	N/A Account closed on July 17
e) Returns from elopement after midnight on July 18 or successive days and is re-admitted	Re-admitted	On Call MD in collaboration with RCT readmits resident 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 no MD documentation that resident was notified of the AMA and Pass policies.	If nurses receive instructions from MD to re-admit resident, only A & E can re-admit in EHR.	New chart if re-admitted	Re-admit the resident on EHR system if resident is re-admitted	LTC Day if re-admitted

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) *Note: No overnight passes shall be ordered for residents covered by Medicare SNF PPS*	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 neighborhood 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 *Note: No overnight passes shall be ordered for residents covered by Medicare SNF PPS*	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 neighborhood 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 neighborhood staff nurse that resident went to ER	LOA code is maintained and code changed back to neighborhood 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" shall be done based on date/time resident was admitted to acute.	Bed Hold

Revised

Central Processing Department

Policies and Procedures

B3. OXYGEN AND COMPRESSED AIR

POLICY:

1. Oxygen and compressed air cylinders are handled and stored consistent with LHH Policy and Procedure 70-05, "Gases: Handling and Storage of Medical Gases."

PURPOSE:

1. To ensure a safe environment for residents, visitors and staff.

PROCEDURE:

I. Oxygen Concentrators

A. Oxygen concentrators for resident use are provided on a rental basis from a contract vendor.
B. On receipt of a telephone request from either the Unit Nurse or Respiratory Therapy, a Central Supply (CS) Technician contacts the vendor by phone and places the order:
   i. Concentration required: 5L or 10 L,
   ii. Resident's Unit, Bed # and Name.
C. Delivery by the vendor is directly to the resident's Unit and Bed.
D. When the concentrator is no longer needed, a CS Technician notifies the vendor who picks up the equipment.

II. Compressed Oxygen Cylinders

A. Ordering and Receiving
1. A designated CS Technician orders cylinders of compressed oxygen from the contract vendor on a regular schedule, usually 3 times per week.
2. Deliveries of full cylinders and pick-up of empty cylinders are made by the vendor to a single designated, locked Oxygen Receiving room. The Oxygen Receiving Room contains a fire extinguisher and a smoke alarm.
3. Cylinders are stored upright and secured in the Oxygen Receiving Room. Cylinders are stored without regulators and with safety caps. Separate areas are designated by signage for storage of full cylinders and for storage of empty cylinders.
4. Full cylinders are differentiated from empty cylinders by a green tag or blue wrap covering the valve.
~~4.~~5. Cylinders are used in order which they are received from the supplier

B. Storage

1. Oxygen cylinders are green and are labeled "No smoking, Oxygen." Full cylinders are differentiated from empty cylinders by a green tag or blue wrap covering the valve.

2. Full cylinders are stored secured s in designated, labeled and locked Oxygen storage rooms. Cylinders are stored without regulators and with safety caps.
3. Storage rooms contain fire extinguishers and smoke alarms.
4. Supplies for oxygen delivery, such as tubing and masks, are also stored in Oxygen storage rooms.
5. Unit staff obtains full cylinders from CSR staff or Nursing Staff with Key Access.
6. Empty cylinders are returned to hallway outside of Oxygen storage rooms by Unit staff. CSR staff returns empty cylinders to Oxygen Receiving room.

C. Stocking
1. Both EE size cylinders and H size cylinders are stocked.
2. CS Technicians stock designated Oxygen storage rooms with full cylinders and remove empty cylinders 3 times per day, 7 days per week.
~~2.~~3. Cylinders are used in order which they are received from the supplier

D. Transport of Cylinders

1. Full and empty cylinders are secured to individual carriers for transportation throughout the hospital. All cylinders, empty or full, shall be properly fastened at all times during site delivery and storage.
2. Persons transporting full or empty gas cylinders must ensure that the safety cap is secured at all times except when cylinders with regulators in place are prepared and transported in the care units.
3. Valve protection devices shall not be used for lifting cylinders.

II. Compressed Air Cylinders

A. Procedures for ordering, storing, stocking and transporting cylinders of compressed air are identical to those outlined above for Oxygen cylinders above with the following exceptions:

1. Compressed Air is provided in one size cylinder, the H size.
2. Compressed Air cylinders are stored separately from oxygen cylinders in Oxygen storage rooms.
3. Compressed Air cylinders are yellow and are labeled "No smoking."

Most recent review: 08/01/2016

Revised: 08/01/2016, 02/08/2020

Original adoption: 02/09/2009

Revised Nursing
Policies and Procedures

DECENTRALIZED STAFFING

POLICY:

1. The ~~Nurse Manager (NM)~~Nurse Staffing Office (NSO) ~~of each neighborhood~~ is responsible for completing ~~4 weeks of~~ staffing schedules that meets the minimum budgeted staffing requirements based on the residents care needs, daily census, and nursing model. Likewise, the ~~NM~~ Nurse Operations Nurse Manager, Neighborhood Nurse Managers and the Nursing Staffing Assistants (NSA) will collaboratively maintain a daily staffing pattern that responds to variations in acuity and census.

2. The ~~Nurse Manager~~Nursing Staffing Assistants, under the supervision of Nursing Operations Nurse Manager and/or Nursing Director of Operations, will be responsible for directly entering changes in the schedule in a timely manner, ~~completing 4 weeks staffing,~~producing Plan Sheets, Schedules and Productivity Reports as necessary ~~for the Nurse Manager~~ to effectively manage ~~their~~ the neighborhoods staffing.

3. All staff are responsible for reviewing their schedules.

PURPOSE:

To provide adequate staffing needs in each neighborhood.

RELEVANT DATA:

ANSOS ONESTAFF is the automated staffing software used at Laguna Honda Hospital Department of Nursing. Hours per Patient Day (HPPD) is the budgeted hours of care designated for neighborhoods. The hardware for the ANSOS ONESTAFF is managed at Zuckerberg San Francisco General Hospital (ZSFGH) campus.

PROCEDURE:

A. STAFFER: ANSOS ONESTAFF'S ~~Definition of Daily Staffing Calculations~~DEFINITION OF DAILY STAFFING CALCULATIONS. Once the computer has been updated and reset, what was known as Scheduler/Plan Sheet now becomes the final posted schedule in Staffer.

1. **Daily Staffing Changes:** The ~~Nursing Staffing Assistant~~NSA ~~and/or Nursing Office Support Staff~~ will enter sick calls, tardy calls, self- cancellation, and AWOLs.
   a. Plan sheets are posted for four weeks for staff to request changes
   ~~1.~~b. Requests for time off and other rules on neighborhood scheduling are addressed in the centralized staffing guidelines and will be followed according to Union MOUs (Memorandum of Understanding).

2. **Daily Staffing Worksheet:** The ~~Nursing Staffing Assistant~~NSA will be responsible for printing and completing a QA of the staffing worksheet per shift daily to ensure that each neighborhood's core coverage and staffing needs are met. The Nursing Operations Nurse Manager ~~o~~ is responsible for reviewing this documentation for completeness.

B. CONTROLLER: ANSOS ONESTAFF'S definition for database personnel information

1. Entry of Controller information will be the responsibility of the ONESTAFF ~~Coordinator~~ Specialist or a designated Staffer.

2. Nurse Managers have access to all functions **EXCEPT:**

   a. Transfer/terminate
   b. Budget positions
   c. Create template
   d. Change Controller Date

3. Newly hired employees shall fill out the Employee Data information as part of the processing done by the Nurse RecruiterHuman Resources. This form is then submitted to the Staffing Office for entry into the computer.

4. Information regarding transferred or terminated employees will be submitted by Human Resources personnel to the ONESTAFF Specialist Coordinator via e-mail for entry into ONESTAFF. (Official COB date is determined by HRS). The ONESTAFF Specialist Coordinator assigns all UPOS numbers and creates master schedules for the employees.

C. PRODUCTIVITY REPORTS (under management report on the main menu)

Nurse Operations Nurse Managers/Neighborhood Nurse Managers have access to this function and may print.

D. APPROVAL OF TIME OFF:

The Nursing Staffing Assistants, in collaboration with Nursing Operations Nurse Manager, will direct staff to their respective Neighborhood Nurse Managers or Program Nursing Directorsreview request for approval of benefit time off. In collaboration with the neighborhood Nurse Manager and/or Nursing Director, the Nursing Operations Nurse Manager will ensure that emergency request for time off are approved in a timely manner and communicated in writing with all parties involved.

E. DELINEATION OF ROLES AND DUTIES:

1. Nursing Director of Operations

a. The Nursing Director of Operations oversees and supervises the nursing office staff including: Operations Nurse Managers, Nursing Staffing Assistants and other clerical support staff.
a.
b. The Nursing Director of Operations is available 24/7 for consultation related to staffing issues and problems. He/she will make the decision regarding utilization of staff up to and including authorization for overtime usage to ensure deployment of sufficient staffing on all units.

2. Operations Nurse Manager:

a. The Nursing Operations Nurse Manager, in collaboration with Nurse Managers and Nursing Directors, will assess and evaluate for completion of daily staffing and will monitor for trends to meet the needs of neighborhoods, taking into account both administrative and clinical impact.

b. If staff is re-assigned from their initial assignment made by Nurse Managers, the Nursing Operations Nurse Manager or NSA, Nursing Supervisor or Nursing Staffing Assistant will review as necessary with the Nurse Manager send an e-mail or text page notification to the Nurse Manager of the reason for the re-assignment before the end of the shift.

c. The Nursing Operations Nurse Manager will assess the on-going clinical needs of the neighborhood during the shift and collaborate with the Nursing Director of Operations and/or the Chief Nursing Officer to ensure the provision of sufficient staffing.

d. The Nursing Operations Nurse Manager will be available as a resource for the ~~neighborhood, Nurse Managers~~NSA and other nursing office support staff.

e. For sick calls and emergency time off, the ~~Nursing Staffing Assistant~~NSA will consult the Nursing Operations Nurse Manager, who will act as a resource in backfilling sick calls and strategizing and reassigning staff according to clinical need.

f. The Nursing Operations Nurse Manager will determine if mandatory overtime is needed to meet resident care needs and will notify staff. Mandatory overtime will be selected based on least senior status on a rotational basis within the neighborhood

.

g. Without a Nursing Staffing Assistant:

a. The Nursing Operations Nurse Manager will backfill sick calls and reassign or reallocate staffing to meet the needs of the hospital. The Nursing Operations Nurse Manager will make reassignments with the goal to staff the hospital appropriately, adequately and safely.

b. The Operations Nurse Manager designated to oversee the Temporary Transitional Work Assignment (TTWA) employees will inform the unit Nurse Managers via e-mail if their employee is on TTWA status, including the duration of time.

3. Program Nursing Directors:

a. In the absence of the ~~Neighborhood~~ Nurse Manager, the ~~Program~~ Nursing Director will designate another nurse manager to collaborate with NSO to maintain adequate staffing for the neighborhoods cover the neighborhood's decentralized staffing.

b. The ~~Program~~ Nursing Director will oversee the appropriateness, adequacy and safety of the neighborhood.

~~c. Nurse Managers are responsible for approval of benefit time off for support staff assigned to their clinical programs~~

4. Neighborhood Nurse Managers:

~~a. The Nurse Manager of each nursing neighborhood is responsible for completing 4 weeks staffing that meets the minimum budgeted staffing requirements based on the residents care needs, daily census and nursing model.~~

~~b.~~a. The ~~Neighborhood~~ Nurse Manager will collaborate with the Nursing Operations ~~Manager~~ Supervisor~~or~~ and NSA ~~As Needed Nursing Supervisor and Nursing Staffing Assistant~~ to maintain a daily staffing pattern that responds to variations in residents care needs and census. To ~~provide~~ ensure that sufficient staffing is achieved, the Nurse Managers will inform the ~~Nursing Staffing Assistant~~NSA at least fourteen (14) days in advance if ~~assistance~~ urgent staffing changes is needed in completing their neighborhood staffing.

b. As necessary, the Nurse Manager will collaborate with the Nursing operations Nurse Manager and/or NSA in determining approval, and backfill of benefit time off request including but not limited to; floating holidays, holiday in-lieu days, longevity days, vacations, and educational days.

~~c. The Neighborhood Nurse Manager will be responsible for directly entering changes in the schedule in a timely manner, completing and posting 4 weeks of staffing after each reset, and Productivity Reports necessary for the Nurse Manager to effectively manage neighborhoods.~~

~~i. The Neighborhood Nurse Manager will enter into OneStaff the 28-day scheduling plan to reflect the budgeted requirements for census, and skill mix on the reset day (every twenty eight days).~~
~~ii. Staff requests for changes after Update/Reset will be limited to emergencies and require approval and backfill by the Nurse Manager.~~
~~iii. Any schedule changes made after Update/Reset will have to be directly entered into the ANSOS ONESTAFF Staffer module.~~
~~iv. The Operations Nurse Manager making staff assignment changes will promptly inform the Nurse Manager of the affected neighborhood.~~
~~v. The Neighborhood Nurse Manager will post the scheduling plan. Staff will review and initial the staffing plan to confirm that it is accurate.~~

~~d. The Neighborhood Nurse Manager will approve, and backfill all benefit time off request including but not limited to; floating holidays, holiday in-lieu days, longevity days, vacations, and educational days.~~

~~e.~~c. The Neighborhood Nurse Manager will obtain approval from the ~~Program~~ Clinical Nursing Director, then from Nursing Director of ~~Nursing~~ Operations and/or CNO ~~Chief Nursing Officer~~ and notify the Nursing office staff in writing (via email) of any temporary changes in unit's staffing level, including the utilization of coach staff hours, neighborhood floor waxing, neighborhood relocation (i.e. household to another household or to a different neighborhood), outbreaks related to infection control, and the complexity of resident care needs. The ~~neighborhood Nurse Manager~~NM must specify the duration of the temporary change.

~~f. The Neighborhood Nurse Manager designated to oversee the Temporary Transitional Work Assignment (TTWA) employees will inform the Neighborhood Nurse Managers via e-mail if their employee is on TTWA status, including the duration of time.~~

~~g.~~d. The Neighborhood Nurse Manager will notify the Nursing Office staff and Human Resources via email in the event of employee's resignation, termination, retirement, and death.

5. Nursing Staffing Assistant:

a. Under professional nursing supervision, implements and coordinates, under professional nursing supervision, the daily staffing schedules of inpatient nursing neighborhoods according to census, ~~patient~~ resident acuity, residents' care needs, and availability of regular and per diem nursing personnel.

b. Prints and reviews staffing worksheets per shift.

c. Receives and records phone calls from nursing personnel that impact on staffing and informs the nursing supervisor and neighborhood staff of changes in staffing ~~in a timely manner~~. Will replace sick calls up to five days per episode, OT/P103 cancellations, jury duty, bereavement, military leave, and leave of absence. FMLA's will be covered in collaboration with the Nursing Operations Nurse Manager or Neighborhood Nurse Manager.

d. Maintains a variety of data regarding staff and ~~unit~~ neigborhood characteristics to assist in the planning, implementation and coordination of daily nursing staffing levels.

e. Prepares and distributes various computer reports such as neighborhood time schedules, license monitoring reports and maintains all records pertaining to staffing and payroll.

~~f. Monitors license expiration for licensed personnel; monitors CPR expirations for all personnel. Notifies staff in writing of impending license and certificate expirations and copies is sent to the Neighborhood Nurse Manager and/or Program Nursing Director and maintains a copy on file in the Nursing Office. Nursing Staffing Assistant will notify the Nurse Manager, Nursing Director, and Human Resources Department in writing of any expired license and/or certificate.~~

~~g.~~f. Collaborates with TTWA coordinator regarding schedules of affected employees.

~~h.~~g. Provides coverage for escort requests submitted in writing by the unit's staff at least 72 hours in advance.

~~i.~~h. ~~Immediately N~~notifies the Nursing Operations Nurse Manager of any AWOL ~~employees~~ and telephones the employee to determine his/her whereabouts.

~~j.~~i. Communicates with Nursing Operations Nurse Manager in troubleshooting staffing issues in promoting the organization's value that our residents come first.

Adopted: 10/2007

Revised: 05/13/2011; 03/10/2015

Reviewed: 03/10/2015

Approved: 03/10/2015

MAINTAINING TEMPERATURE OF MEDICATION and NOURISHMENT REFRIGERATORS VIA TEMPTRAK & CLEANLINESS OF REFRIGERATORS

POLICY:

1. The types of refrigerators in the neighborhoods are: medication, nourishment, and employee's refrigerators.

2. Temperature Ranges:

   - Medication refrigerator: between 36 and 46 degrees Fahrenheit.
   - Nourishment refrigerator: between 33 and 41 degrees Fahrenheit.
   - Galley freezer: between -10 and 0 degrees Fahrenheit.

3. Licensed Nurse is to check the temperature of nourishment refrigerators, medication refrigerators and galley freezers twice a day, on the AM and PM shifts, by logging on to TempTrak.

~~3.~~4. Licensed Nurse is to clean medication refrigerator weekly with facility approved disinfectant.

~~4.~~5. If these equipment go out of range continuously over 2 hours, an additional online check via TempTrak must be done

~~5.~~6. If the nourishment refrigerators and galley freezers out of range:

   a. Licensed nurse needs to check the refrigerator/freezer and close door if opened or do other corrective action as needed.
   b. The licensed nurse will log into TempTrak database to document action taken.
   c. Licensed nurse shall check the refrigerator after an hour to ensure temperature correct. If still NOT within range, call Facilities and create a work order

~~6.~~7. Medication refrigerators are only used for medication requiring refrigeration. The medication refrigerators are located in the medication rooms and must be kept locked at all times.

~~7.~~8. If the temperature of a refrigerator containing medications is out of range, the licensed nurse is to contact the pharmacy for instructions on what to do with the refrigerated medications.

~~8.~~9. Nourishment refrigerators are only used for storage of resident's nourishments / supplements. The nourishment refrigerators are located in the Great Room and Galley in each neighborhood, Nourishment refrigerators in the Great Room must be kept locked at all times. The key is kept in the nursing station.

~~9.~~10. All food in refrigerators should be stored in covered containers. Food not in original container is to be clearly labeled and dated.

~~10.~~11. Licensed Nurses, Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) must check the dates of refrigerated foods before serving and discard immediately if outdated.

~~11.~~12. Employees must store their food in the designated refrigerator in the staff lounge.

PURPOSE:

To store substances that require refrigeration in a hygienic refrigerator environment at the correct temperature.

BACKGROUND:

Temperature readings are displayed in the monitor located at the bottom of the refrigerator doors. Temperatures are also displayed online on real time on TempTrak.

PROCEDURE:

A. Equipment

Obtain from ward supply: clean basin, mild soap, clean cloths

B. Cleaning of the Refrigerator

1. Remove food containers and medications prior to cleaning the refrigerators. Using warm water and mild soap wash inside refrigerator with clean cloth.
2. Wipe dry with clean cloth.
3. Racks or shelves must be thoroughly washed and dried.
4. After cleaning and drying inside of refrigerator, return contents.
5. Wipe off the outside of refrigerator.

C. Maintenance of the Refrigerator

1. It is the responsibilities of the A.M. and P.M. shift Licensed Nurses to check for correct temperature.
2. It is the responsibility of the A.M. shift Licensed Nurses to check for any outdated food or medications in the medication and nourishment refrigerators. The A.M. Nursing Supervisors and Nurse Managers will monitor for ongoing compliance for timely removal of outdated foods.
3. The A.M. shift assigned C.N.A. or P.C.A. is responsible for cleaning the nourishment and employees refrigerators. Cleaning of these refrigerators is neighborhood based as scheduled by the Nurse Manager or Charge Nurse.
4. All nursing staff are responsible for discarding any unlabelled or expired foods found during their shift.

D. Food Storage

Food sent by Nutrition Services for nourishments are stored in the Great Room or Galley refrigerators. All containers must be labeled with expired dates. Outdated and unmarked foods are to be discarded immediately.

E. Reporting and/or Documentation

1. On the Emergency Checklist, the AM and the PM shifts will initial TempTrak to signify that they logged on to TempTrak.

2. Report any malfunctions or incorrect temperature settings to Facility Services, Licensed Nurse to complete an online work requisition for repair.

REFERENCES:

TempTrak Reference Guide (Revision H, January 2010) © 2003-2010 Cooper-Atkins Corporation.

CROSS REFERENCES:

LHHPP File: 31-01 Wireless Refrigerator and Freezer Temperature Monitoring System
LHHPP File: 72-01 E8 Nutrition Services
LHHPP File: 72-01 F5 Standard for Refrigeration Equipment

ATTACHMENTS:

Attachment 1: Emergency Equipment / Wireless Temperature Monitoring System Checklist
Attachment 2: TempTrak: Quick Reference Guide for Nurses

Revised: 2003/04; 2006/03; 2006/12; 2009/03; 2010/11; 2011/11/29; 2015/01/13; 2017/01/10

Reviewed: 2017/01/10

Approved: 2017/01/10

BLOOD GLUCOSE MONITORING

POLICY:

1. A bar code scanner is used to enter patient ID and/or operator ID in the facility-approved glucometer machine.

2. ~~When the physician determines blood glucose "panic values," they are to be indicated on the resident care plan.~~Physician order indicates hypoglycemic value to treat hypoglycemia and hyperglycemic value for which requires physician notification.

3. Hypoglycemia is considered <70mg/dL, and hyperglycemia is considered >400mg/dL, unless otherwise specified in order. Whenever blood glucose values change from the resident's usual range, ~~or reach the panic value or when the resident's condition~~or the blood glucose value is not consistent with ~~the value obtained~~resident condition, the nurse is to repeat the test, assess for symptoms of hypoglycemia or hyperglycemia, treat according to order and inform the physician STAT.

~~2.~~4. Glucometer machine is cleaned after ~~every~~ each use and in between patient with facility-approved disinfectant wipes for the glucometer.

5. ~~Quality control tests of the check strip, the high, and the low glucose control solutions are to be performed every AM shift by the Licensed Nurse who is to enter an individually assigned ID code.~~ Daily quality control (QC) test with low and high glucose solutions will be performed daily by LN on AM shift.

6. LN will perform a QC:
   a. If a test strip vial has been left opened.
   b. Anytime a LN wants to test the performance of the meter.
   c. Each time a new vial of tests strips is opened.

~~3.~~7. Quality control tests that fall outside of designated parameters are reported to ~~Central Supply Room (CSR)~~Point of Care Services.

~~4.~~8. The Point of Care Coordinator or designee coordinates any updates or changes to the initial setup of the facility-approved glucometer machine.

~~5.~~9. The Point of Care Coordinator or designee is responsible for coordinating facility-approved glucometer machine quality management tracking and reporting.

~~6.~~10. AC (Meal time) blood glucose checks should be taken no more than 30 minutes before meal.

~~7.~~11. Insulin being administrated prior to meal:

   a. Regular insulin should be given no more than 30 minutes before meal unless otherwise specified
   b. Rapid Insulin (Lispro /Humalog and Aspart/Novolog) should be given no more than 15 minutes before or immediately after a meal.

~~8.~~12. If fasting blood glucose check is missed and taken instead after resident has already eaten, and the order was to check blood glucose pre meal (AC), do not give rapid insulin (Lispro/Humalog, Aspart/Novolog), regular insulin or intermediate(NPH) acting insulin per the scale. Notify physician.

~~9.~~13. Long acting insulin is not held unless patient is hypoglycemic. After treatment per protocol and BG ≥100, it can be given unless there is an order to hold by physician.

~~10.~~14. All licensed nurses will complete an annual competency review of Point of Care blood glucose testing. Newly hired LN's will complete the competency ~~review~~ at time of hire, 6 months after, then annually.

~~11.~~15. Meter should be placed on docking station after use and when not in use.

PURPOSE:

1. To accurately monitor blood glucose levels using facility-approved glucometer machine.

2. To initiate appropriate nursing intervention when blood glucose levels are not within normal range. Refer to medication orders for treatment of hypoglycemia and hyperglycemia.

PROCEDURE:

A. Equipment:

Refer to the facility-approved glucometer machine user's manual for the following procedures:

1. Patient Preparation
2. Coding (Calibration)
3. Patient Testing
4. Quality Control Testing
5. Facility approved disinfectant wipes for the glucometer for infection prevention
6. Instrument Care/Maintenance
7. Linearity (performed by Point of Care Coordinator or designee)
8. Troubleshooting

B. Blood Glucose Check

1. Test strip
   a. Test strips are available through the Central Processing Distribution (CPD~~SR~~).
   b. Test strips must be stored at room temperature. Test strips are stored in the same tightly capped vial in which they are packaged. The vial cap is immediately replaced after removal of a test strip. Test strips are stable until the expiration date on the vial. Outdated test strips are discarded. Test strip vial should be used prior to opening a new vial, even if the barcode number is the same.
   c. The test strip code displayed by the facility-approved glucometer machine must match the code of the test strips in use.
   d. Test strip code information must be verified in the facility-approved glucometer machine by the operator whenever a patient or quality control test is performed.

2. Proper infection control procedures are followed when using the facility-approved glucometer machine and testing with blood glucose monitoring equipment.
   a. Glucometer machine is cleaned after ~~every~~ each use and in between patient with facility-approved disinfectant wipes (such as Super Sani-Cloth Germicidal Disposable Wipes® or Clorox Germicidal Wipes®) for the glucometer.
      i. Use a damp wipe to clean entire machine. Never drench machine with cleaning solution.
      ii. Allow to dry for 2 minutes in order to disinfect machine.
      iii. Verify that the meter is dry and there is no solution left on the meter. If meter is still wet use gauze to thoroughly dry the glucometer after cleaning and disinfecting.
      ~~a.~~iv. Disinfectant wipes are available from~~in~~ ~~Central Supply~~CPD.
   ~~b. Using gauze, thoroughly dry the glucometer after cleaning and disinfecting. Verify that the meter is dry and there is no solution left on the meter.~~

3. If the meter is not functioning properly:
   a. Consult the "Trouble Shooting" section of the User's Manual.
   b. For problems that cannot be resolved, contact ~~CSR~~POCS.
   c. Meters that are not functioning properly will be exchanged through POCS~~CSR~~.

~~4.~~ The most recent facility-approved glucometer machine available on each neighborhood is referenced for procedural information.

4.

~~5.~~ When preparing a resident for discharge, glucose monitoring teaching must be done using the type of device that the resident will be using when discharged.

5.

~~C.~~ **Hypoglycemia**:

C.

~~1.~~ For blood glucose less than 70 mg/dL or for value identified by physician order, treat with 8 oz of juice orally if resident is able to take PO or if resident has G tube, via G tube~~.~~. Recheck BG in 15 minutes. Repeat treatment and fingerstick every 15 minutes until blood glucose is greater than or equal to 100 mg/dL.

1.
   a. Notify physician if resident does not respond to treatment or condition worsens.

D. Documentation

1. Check mark date column on the emergency equipment checklist to indicate quality control tests on the glucometer were done.

2. Guidelines for Hypoglycemia Documentation:
   ~~(i)~~(1) Dock the meter after ~~checking blood glucose~~~~after~~ use to upload blood glucose values into EHR. ~~Blood glucose value will download to Electronic Health Record (EHR).~~
      ~~(2) Glucometer:~~
      ~~(i) Always record actions taken in the glucometer using codes provided. Information documented in the glucometer, must be consistent with information documented on MAR or in chart.~~

(2) Hypoglycemia event should be documented in Hypoglycemia flowsheet in the EHR.
(a) Additional actions can be documented in progress notes

(3) Review and/or update care plan with individualized goals and interventions.

Unusual Occurrence
- Use of D50 to treat hypoglycemia
- Use of Glucagon to treat hypoglycemia
- The patient's symptoms require a call to provider to come to bedside to assess patient
- Significant change requirement code blue call
- Any episode thought to have occurred from a medication error

(3) A UO is not necessary if the hypoglycemia responds to juice/glucose tabs.

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

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Reviewed: 2002/08, 2010/03, 2010/10 2014/03/25, 2016/09/13, 2017/03/14; 2019/05/14

Revised: 2019/05/14

Approved: 2019/05/14

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. Select residents can use identification (ID) cards in lieu of ID wristbands. The ID cards will be used by staff to correctly identify resident for the purpose of barcode medication administration (BCMA), and point of care testing (POCT). (see appendix II)

~~5.~~7. Medication preparation should be performed at the resident's side (i.e. If resident is in bed, preparation will be at bedside).

~~6.~~8. Medication should only be prepared at the time just prior to administration. Do not prepare medications prior to administration or store out of package.

~~7.~~9. Medication separated from original package and stored for administration at later time is considered pre-pouring and is not acceptable.

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10. IV medications must be labeled with resident name, date and time of preparation, medication name, strength, amount and name of person preparing.

~~8.~~ All medications delivered via transdermal (patch) will be labeled with date and initial at time of application of the patch. If resident currently has a patch on, the old patch should be removed before applying a new patch

~~9.~~11. Medication times are standardized in the EHR. 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 request.

~~10.~~12. 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.

~~11.~~13. 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.

~~12.~~14. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Non-hazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

~~13.~~15. 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.~~16. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

~~15.~~17. 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 documents in the EHR.

~~16.~~18. It is the legal and ethical responsibility of the licensed nurse to prevent and report medication errors.

~~17.~~19. Topical creams and ointments that are ordered "until healed" can be discontinued by LN via an order in EHR and ordered "per protocol, co-sign required".

~~18.~~20. Topical creams/ointments available in the neighborhood (e.g., Dimethicone, Enzo) do not require a physician's order.

~~19.~~21. 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

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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. Or, successful scan of identification card for resident who meets criteria. (See appendix II)
            - 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 J1.3

- Enteral Tube Drug Administration: Refer to NPP E 5.0
- Eye/Ear/Nose Instillations: Refer to J1.4

o IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

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

B. OVERRIDE OF MEDICATION ADMINISTRATION

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

C. TWO LICENSED NURSE INDEPENDENT CHECK OF MEDICATIONS:

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

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

1. Crushing medications is based on nursing judgement and resident care plan.
2. Hazardous, enteric, sustained release medications may not be crushed.
3. Medications labeled “do not crush” may not be crushed.

4. Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.

~~4.~~5. Pill crushers will be cleaned with alcohol wipe at end of medication pass prior to returning to medication room for charging and PRN.

~~5.~~6. Staff may choose to wear mask when crushing or cutting pills.

~~6.~~7. 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.~~8. 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

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

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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 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.

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ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

1. Request medications be in liquid form whenever possible. If liquid form is not available from Pharmacy and tablet form must be used, crush tablets (except for enteric coated or sustained release medications).

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.).

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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. <u>Compressor/ Nebulizer (brand name Misty-Fast)</u>

   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 (CO_2) retainer: Oxygen may be used as a delivery method. If using oxygen, set liter flow at 8 liters per minute for 3-4 minutes or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.
   d. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until nebulizer stops producing mist.

C. Assessing Resident during treatment and for the effectiveness of treatment.

1. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed, and suction as clinically indicated.

2. Assess the resident's response to treatment.

SPECIAL CONSIDERATIONS:

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

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2. If not given within the time schedule, review “Appendix II: Specific Medication Administration Times and Abbreviations” to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.

3. Other medications should be reviewed for modification of times (see Policy Statement #9.)

4. If non time sensitive medications are given outside the time schedule, document the rationale in override section of eMAR.

5. If medications have been prepared/removed from packaging, and resident does not take, medication must be wasted and documented in eMAR.

6. Request from pharmacy any missing doses and/or need for replacement.

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

1. IV medication prepared by pharmacy and IV fluid bags will have medication label which includes bar code for administration.

2. In urgent situations, if RN needs to prepare IV drip, it must be labeled with resident name, date and time of preparation, medication name, strength and amount, name of person preparing.

3. Prepare parenteral medication and fluids in a clean work space away from distractions.

4. Prepare IV as close as possible to administration time and administer no more than 1 hour after reconstitution . Such as spiking IV fluid bag, spiking prepared IV antibiotic bag, reconstituting antibiotic.

5. *Exception:* Insulin and IM injections should be drawn into syringe at time of administration.

SHAKING MEDICATIONS OR MIXING A SUSPENSION

1. Medications labeled “shake well” must be shaken vigorously to dilute the dose thoroughly immediately before administration.
2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”
3. Any rolling motion used is acceptable as long as the suspension appears milky and the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

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

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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.

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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 us 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 e MAR.

3. Verification of patch placement and monitoring
    a. Inspect site of application every shift to verify that the patch remains in place every shift.
    b. Document verification in the eMAR.
    c. If the patch has come off, attempt to locate the patch and dispose. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.
    d. Do not apply heat source to patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.
    e. If resident is diaphoretic, patch may come off. In some instances transparent dressing covering patch may keep it in place.
    f. The resident may shower, wash and bathe with the patch in place as long as not scrubbing over the patch area which will disturb the adhesive.

4. Disposal
    a. Fold the old patch in half so that the adhesive sides are in contact and discard in medication disposal container.
    b. Document disposal on the eMAR. A waste/witness co-signature is not required for a used patch.

SELF-ADMINISTRATION AND BEDSIDE MEDICATION

Resident must be assessed by Resident Care Team (RCT) and determined to safely self-administer medications before medications are kept at bedside.

1. **Self-Administration**
    a. Licensed Nursing and other disciplines, as indicated, will collaborate to assess the resident's ability to participate in medication self-administration.
    b. Nursing, and/or other disciplines, will discuss the assessment of the resident's ability to self-administer medication with the RCT.
    c. The nurse will follow the 6 Rights of medication administration including scanning of resident and medications resident will be taking.
    d. The resident will prepare and take own medications, which are kept in medication cart, under the supervision of the LN. (Unless ordered for bedside by physician as indicated in the care plan.)
    e. The nurse will observe self-medication preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated. If the nurse notices the resident is about to make an error, he/she will intervene to stop the preparation. He/she will also discuss and clarify with the resident the accurate manner of self-administering medications.

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The RCT will be kept informed of any change in the resident's ability to self-administer medications safely, or the need to re-evaluate the resident for self-administration of medications.

f. The LN observing the resident taking the appropriate medications, LN will document in eMAR as given and will note "self administered".

g. Documentation will also include the following;
   i. Topic/training skills taught and resident's progress with learning in the EHR education section.
   ii. Resident's agreement for participation in the self-administration of medications on the care plan.
   iii. Any follow-up plan identified by the RCT necessary to reinforce safe and skilled medication self-administration will be documented in the education section of EHR.

2. **Bedside Medication (Refer to Pharmacy Policy 02.01.03: Bedside Storage of Medications)**

1. Prior to placing medications at the bedside, the interdisciplinary team shall determine that the resident can safely self-administer medications and an appropriate plan of care shall be written.

2. Only medications prescribed by physicians for bedside storage may be kept at bedside. In general, the
   a. following may be prescribed for bedside use.
      i. Sublingual or inhalation medications for immediate use.
      ii. Ophthalmic medications (eyedrops or ointments)
      iii. Over-the-counter (nonprescription) medications.
      iv. Other prescription items approved by the Interdisciplinary Team.
      v. Medication intended for a trial of resident self-administration prior to discharge and approved by the Interdisciplinary Team.
         1. Discharge medications will be dispensed and labeled by Pharmacy in accordance with State and Federal laws.
         2. For oral dosage forms, no greater than a 7-day supply of medication will be stored at bedside. (Greater than 7-day supply is permitted for topical agents, inhalers and ophthalmics).

3. Prescription drugs other than sublingual or inhalation forms of emergency drugs shall be stored on the resident's person or in a locked cabinet or drawer.

4. No controlled drugs shall be kept at bedside.

5. The Pharmacy will label all bedside medications in appropriate lay-language.

6. The registered nurse or LVN assigned to medication duty will supervise the use of self medications and chart the medications used on the medication and treatment record.

   a. The medications used will be recorded in the resident's health record, based on observation of self-administration by nursing personnel and/or information supplied by the resident.
   b. The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time the medication is supplied.

WASTING MEDICATION

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

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Drugs management).

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

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, shall be immediately wasted in pharmaceutical waste container with witness of a 2nd LN.

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

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

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

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

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the EHR for each out-on-pass medication, including controlled substance medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.
   a. The nurse will have the order filled at the hospital Pharmacy.
   b. The pharmacist will dispense the medications in properly labeled child-proof containers.
   c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.
   d. controlled substance prescriptions

2. When the Pharmacy is closed the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record.

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

3. When Resident is on therapeutic leave/out on pass, the MAR will be on hold status.

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:
   a. Will be given to family or guardian to take home.
   b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.
   c. Pharmacy manages the medications and may dispose of as necessary.
   d. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.
   e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by LHH Pharmacy.

2. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside unless approved for self-administration.

3. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

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

EXCESS MEDICATIONS

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

ATTACHMENTS:

Appendix I Specific Medication Administration Times

Appendix II Use of Identification Cards for Resident Identification for Bar Code Medication Administration

Appendix III – LN Wasting Controlled Substance (Partial Dose)

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

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LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal Telephone Medication Orders
LHHPP File: 25-04 Adverse Drug Reaction Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-11 Medication Errors and Incompatibilities
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines: Infection Control Manual
LHHPP File: 73-11 Medical Waste Management Program

LHH Pharmacy P&P 01.02.02 Stop Orders
LHH Pharmacy P&P 02.01.02 Disposition of Medications
LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets
LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P 02.02.00 Controlled Substances
LHH Pharmacy P&P 02.02.00b Distribution of Medications and Medication Order Processing

Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds
Nursing P&P J 1.3 Aerosol/Nebulizer Medications.
Nursing P&P I 5.0 Oxygen Administration
Nursing P&P J 7.0 Central Venous Access Device Management

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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
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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

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Use of Identification Cards for Resident Identification

Select residents can use identification (ID) cards in lieu of ID wristbands. The ID cards will be used by staff to correctly identify resident for the purpose of barcode medication administration (BCMA), and point of care testing (POCT).

Criteria for resident selection:

1. Resident declines to wear ID band.
2. Resident is alert and oriented.
    a. Resident does not need to be own decision-maker, but can reliably provide name, DOB and the correct time medications are administered.
3. Resident must be able to safely store ID card.
4. Resident must be able to present the ID card when asked by staff.

Documentation around the use of the card

1. Nursing staff that determine a resident meets criteria for ID card will discuss with the RCC team and document planned usage in Resident Care Team (RCT) note.
2. Use of ID card can be noted in MAR note.
3. If at any time, resident fails to meet criteria, the team will re-evaluate its' use to determine plan for continuation or discontinuation.

Providing Care

1. Prior to medication administration or POCT, the LN will ask the resident to present the ID card.
    a. The resident must be able to state their name and DOB.
    b. Licensed Nurse (LN) will confirm information matches.
2. The LN will scan the card and confirm the information is consistent with Epic resident information.
    a. Observe photo, name, DOB and MRN on card matches Epic.

Storage of the card

1. Resident is responsible for the safekeeping of the ID card.
2. The ID card can be kept ~~in a wallet/pouch~~ on their person, or in bedside drawer

New Card Requests or replacement for lost cards

1. The nurse manager will **email** the request for a new or replacement card to the Clinical Liaison team: DPH-LHH-NSG Clinical Liaison (**DPH-LHH-NSGClinicalLiaison@sfdph.org**)
2. Prior to distributing the card, the nurse manager or designated person will scan both barcodes to ensure accuracy and functionality of the card.
3. If a resident is readmitted to the hospital, the nurse manager will need to email the Clinical Liaison Team to print new barcodes with the new CSN numbers.

BLOOD PRODUCT ADMINISTRATION

POLICY:

1. The transfusion of blood products is restricted to Pavilion Mezzanine Acute (PMA).

2. The trained~~Only the skilled and knowledgeable~~ Registered Nurse (RN) is responsible for the safe administration of blood products upon physician orders.~~may administer blood products upon written physician order, utilizing the blood transfusion order set.~~

3. Packed Red blood cells (RBCs) are the only blood component transfused at Laguna Honda Hospital~~l and Rehabilitation Center~~ (LHH).

~~3.~~4. Staff will observe standard precautions and any indicated enhanced precautions will be observed for all aspects of blood product administration.

PURPOSE:

1. To describe the procedure for ordering and receiving of blood products from the Zuckerberg San Francisco General Hospital (ZSFG)~~SFGH~~ Blood Bank/Transfusion Service.

2. To describe the procedure for safe administration of blood products, including pre-transfusion checks, setting-up and starting transfusion, monitoring patients during the procedure, documenting transfusions, and initiating assessment, treatment and laboratory investigation in case of suspected transfusion reactions.

PROCEDURE:

A. Equipment ~~**Obtain From**~~

EQUIPMENT:	OBTAINED FROM:
IV pump and stand	Central Supply (CSR)/PMA
0.9% Normal saline 250 mL bag	PMA/Omnicell
Blood administration set (tubing) with filter for each unit	CSR/PMA
IV kit/supplies (angiocatheter, alcohol wipes, etc.)	PMA/Omnicell

~~1. Blood Bank Requisition — LHH Laboratory/PMA~~
~~2. IV pump and stand — CSR/PMA~~
~~3. Normal Saline (250 mL) bag — PMA~~
~~4. Two Y-blood administration sets with filters — CSR/PMA~~
~~5. I.V. tray/supplies (I.V. catheters, Alcohol wipes, etc.) — PMA~~
~~6. Blood transfusion documentation — PMA~~

B. Physician Orders/Consent

1. Physician must obtain consent prior to each blood transfusion from the patient or surrogate decision maker (SDM). It is preferred that a Laguna Honda Hospital (LHH) staff sign as a witness.
    a. LHH provides all patients that require a blood transfusion with information concerning alternative blood donation options.
        i. These options include autologous donation (donating for one's self), designated donation (a friend or relative is donating specifically for the recipient), or volunteer donation (blood donated to the community by a volunteer).
        ii. Exceptions for autologous and designated blood donation include life-threatening emergencies and medical contraindications.

iii. The patient may waive the right to pre-donate blood if he/she chooses not to delay medical treatment.
iv. The patient shall be provided with a copy of the brochure "A Patient's Guide to Blood Transfusion." Use of this brochure is required by law; no other information or pamphlet will satisfy the physician's legal obligation. Refer to Appendix D.

b. The physician will document any refusals.

2. The physician will order blood electronically ~~when possible~~.
   a. ~~Physician orders for blood transfusion must be written. The resident's SNF physician must write the following:~~If the patient is from the acute unit, the acute physician will enter the order entirely.
   b. If the patient is from a Skilled Nursing Facility (SNF) unit:
      i. The SNF physician will order:
         1. Type and screen for PRBCs
         2. Number of units for transfusion (prepare and transfuse RBC units)
         3. Transfusion date, if not to be administered when blood is ready from the blood bank. For resident centered care, blood transfusions may be scheduled between the hours of 0900 – 1800 on the day following completion of the type & screen or when the blood is available. Blood transfusions may be performed 7 days/week.
      ii. The acute physician will order the pre-medication (if indicated) and any ancillary/treatment orders, including IV access, IV fluids, etc. The SNF physician may place these orders as needed.
3. The SNF physician informs the resident and family or SDM about the transfusion, and when and where it will take place.
~~1.~~4. The SNF physician will provide a hand off to the PMA physician including any information regarding previous transfusion reactions and any other pertinent information about current medical status and history.

~~a. Type & cross match for PRBCs & number of units to for transfusion,~~
~~b. Date transfusion to be administered,~~
~~c. Length of duration of transfusion for each blood product unit,~~
~~d. If indicated, pre-medication (such as acetaminophen or diphenhydramine to prevent or mitigate simple febrile or allergic reactions). Note: Caution should be utilized in those over age 65 years with the use of diphenhydramine (Beers Criteria).~~

C. B~~Request for B~~lood Specimen Collection~~from SFGH Blood Bank~~

1. Obtained by lab technician, RN or physician. If the resident has Central Venous Access Device (CVAD), RN will obtain the tubes from the lab and draw the blood specimen.
2. Blood specimen must be collected in a 10 mL pink tube, which must be filled completely.
3. Label the blood specimen with a patient label in the presence of the patient. Date, time and signature on the label if a generic label is used.
~~1.~~ All type and screens must be sent with a requisition for blood bank~~d~~ records. Print and sign name and date and time of specimen collection on the requisition.~~The RN or physician completes the blood bank requisition form with the following information:~~

~~a. Resident addressograph stamp(first/last name; medical record number, date of birth),~~
~~b. Physician identification: name, ID code # and beeper extension number.~~
~~c. LHH unit and phone number.~~
~~d. Transfusion request section must contain: Type & Cross (ABO, Rh, antibody screen); number of units of PRBCs; pre-transfusion lab results; reason for transfusion.~~
~~e. Signature of the person who collected the Blood Bank specimen from the resident with date and time of the blood collection.~~

2. ~~The resident's blood specimen is obtained by the lab technician, RN, or physician. If the resident has Central Venous Access Device (CVAD), RN will draw the blood sample.~~

   a. ~~Specimen must be collected into a 10 mL pink Blood Bank tube which must be filled completely.~~
   b. ~~The person collecting the blood must:~~
      i. ~~Date, time, and sign in the appropriate filed on the blood requisition form.~~
      ii. ~~Date, time and signature on the ID sticker on the blood tube are optional.~~
      iii. ~~Label the Blood Bank specimens in the presence of the resident.~~

4.
~~3.~~5. Collection hours:~~Blood specimens and requisition are delivered to SFGH Blood Bank by courier:~~ 6 am – 6 pm:
   a. ~~During the hours of 0600 – 1759,~~ the lab tech will draw the blood specimen~~Blood~~ unless via CVAD~~,~~, take it to LHH lab, and contact a courier ~~f~~tor~~r~~ delivery to the ZSFG blood bank.~~ it.~~
   b. 6 pm – 6 am: ~~Between the hours of 1800 – 0659,~~ the ~~unit nurse~~ RN or physician will draw the ~~the~~ blood specimen~~, appropriately label and sign,~~ and if STAT, notify the nursing supervisor to arrange for a courier ~~pick up~~ for delivery to the ZSFG blood bank.~~.~~
6. The Licensed Nurse (LN) will inform PMA that the blood specimen was drawn.
7. If the blood bank requests a 2nd specimen, the 2nd specimen must be collected at a different time, preferably by a different RN or phlebotomist. If the lab receives the 2nd specimen with the same collection time as the first specimen, one will be discarded.

~~b.~~

D. ZSFG Blood Bank - Blood Issue and Return

~~1. Blood transfusion will be scheduled for PMA preferably between the hours of 0900 – 1800 on the day following completion of the type & cross match and when the blood is available. The SNF neighborhood Licensed Nurse will notify PMA RN when the type and cross has been sent.~~

1. The PMA RN ~~personnel~~ will notify~~contact~~ the ~~SFGH B~~blood ~~B~~bank when the patient is ready for the transfusion by phone.
2. The blood bank will arrange for a courier (cab driver) to deliver the blood directly to PMA.

~~3. Blood transfusion may be performed 7 days/week.~~

~~4. The PRBCs will be delivered by the cab driver directly to PMA.~~

3. When the blood product is delivered to PMA:
   a. An RN or MD reviews the Blood Bank Delivery Receipt for Blood or Blood Products (attached to cooler) and verifies that the blood has not expired, checks the stamped date and time to determine how long the blood has been in the insulated blood bank cooler.
   b. An RN or MD must write the time when the blood product was received on the Blood Bank Delivery Receipt for Blood or Blood Products (cooler label), and sign the form.
   c. The courier must sign the Blood Bank Delivery Receipt for Blood or Blood Products form to document that the messenger has made timely delivery of the blood product. Refer to Appendix C.
   d. The cooler keeps the temperature safe for administration for 12 hours, or for the duration specified on the cooler. For example, if the blood was placed in the cooler at 8 am, all the blood must be removed from the cooler for administration before 8 pm.

~~5. PRBCs are sent to LHH with a computer label attached for checking resident and unit.~~

~~6. The RN receiving the blood delivery verifies that the blood has not expired, checks the stamped date and time on the cooler label to ensure that no more than 4 hours has elapsed since the blood was placed in an insulated blood bank cooler (which keeps the temperature safe for administration within 12 hours of being placed into the cooler) and signs the delivery receipt.~~

~~7. Blood that is outdated or received past 4 hours from issue of the SFGH Blood Bank will not be accepted and is returned to the SFGH Blood Bank.~~

~~8.~~4. PMA RN attaches the delivery receipt and a patient label to a sheet of paper for scanning.~~ onto the yellow laboratory report page in the resident's medical record.~~

~~9.~~5. If the blood will not be~~is not to be~~ transfused within the time frame due to late delivery, patient refusal or any other reason~~, or for some other reason is not transfused~~, return the unused/unopened~~, unopened~~ blood to the Z~~S~~FGH Blood Bank via courier.

E. Resident Preparation

~~1. The SNF physician informs the resident and family or SDM about the transfusion, and when and where it will take place.~~

1. The SNF neighborhood ~~-~~LN will:
   - a. ~~provide~~Provide a hand off to the PMA RN prior to sending the patient to PMA.
   - b. Coordinate with the PMA RN for the administration of SNF medications during the transfusion.
   - c. ~~-~~Verify that the patient has a legible identification band.
   - d. Not transfer the patient to PMA until the blood has arrived on PMA.
   - e. Verify that the patient has a signed consent. Send a copy of the consent with the patient to PMA if the consent has not been scanned.
   - f. Update the resident's location in EHR.
   - ~~2.~~

~~3. The SNF neighborhood physician will provide a hand off to the PMA physician including any information regarding previous transfusion reactions and any other pertinent information about current medical status and history.~~

~~4. Standard precautions and any indicated enhanced precautions will be observed at all times.~~

~~5.~~1. In preparation for the transfusion, the PMA RN will complete the following:

   - a. Verify that the resident has an identification band securely attached to his/her body.
   - b. Notify the kitchen if the blood transfusion will occur during a meal time.
   - ~~a.~~c. Orient~~s~~ the resident to the unit and the transfusion procedure.
   - ~~b.~~d. Ask~~If the resident is able to provide a reliable history, ask~~ about previous transfusion reactions or allergies if the resident is able to provide a reliable history.
   - ~~c.~~e. Educate~~s~~ the resident about any changes or new signs and symptoms to report to the nurse during the transfusion and documents in EHR.~~.~~
   - ~~d.~~f. Perform~~s~~ resident physical assessment and document~~s~~ i~~o~~n ~~the nursing transfusion administration form~~EHR, including~~-~~ vital signs (temperature, blood pressure, pulse, respiratory rate, and oxygen saturation) and other baseline body system assessments as appropriate (e.g., cardiovascular, respiratory, genitourinary, skin, intake and output)
   - g. Administer~~s~~ any pre-medication as ordered.

~~e.~~

~~6. Set up a 250 mL I.V. bag of Normal Saline with Y-blood tubing and in-line filter.~~

   - ~~a. Prime the tubing per manufacturer's directions~~
   - ~~b. Administer via CVAD, or obtain I.V. access~~
   - ~~c. Use an I.V. infusion pump to ensure steady flow and a controlled rate of infusion~~

F. Required Pre-Transfusion Verification ~~Responsibility~~

At the bedside, 2 staff (RN/RN or RN/physician) will positively identify the patient and verify all the information linking the order, blood product, and intended recipient matches. One person will read out loud the information (item by item) from one source (patient ID or container label), while the 2nd person verifies the information against the Blood Bank Transfusion Report (red slip attached to blood container). Refer to Appendix C.

1. **Check the medical record for signed informed consent** ~~completed by the SNF physician~~.
2. **Name, medical record and Blood Bank Transfusion Report**: Positively identify the patient and verify that the resident's first and last name and medical record number matches the Blood Bank Transfusion Report. Positive patient identification sources are identification band, patient correctly stating his/her first and last name and birthdate, or patient photo in the EHR.
3. **Donor and patient ABO/Rh compatibility**:
   a. Verify the blood component and any applicable special requirements match the physician's order and crossmatch results in the EHR.
      ~~1.~~
      i. ~~Make sure the blood component matches the physician's order.~~ Special requirements include autologous, designated, irradiated, sickle cell screen negative or RBC antigen matched
      ii. Autologous or designated blood units are labeled with an extra tag signifying autologous (green tag) or designated donor (orange tag).These tags must not be removed from the blood units.
4. **Donor ABO/Rh type on Blood Bank Transfusion Report match the unit label**: Compare the blood type (ABO) and Rh type on the container label with the ABO/Rh of the intended recipient on the Blood Bank Transfusion Report.
   a. Blood types do not need to be identical, but must be compatible. However, the donor blood type on the container label must match the donor blood type on the Blood Bank Transfusion Report.
   b. O-negative blood can be given to any patient. However, the blood bank may release O- blood to female patients and O+ blood to male patients.
   c. Rh negative blood can be given to an Rh positive patient.

ABO Group of Recipient	Compatible Donor ABO Group for Red Blood Cells
A	A, O
B	B, O
AB	A, B, AB, O
O	O

5. **Unit numbers on the container label match the Blood Bank Transfusion Report.**
6. **Scan barcode on the blood container label.** Barcode scanning a unit of blood verifies that the unit of blood being scanned matches what the blood bank sent for the patient.

~~2.~~

~~3. Two individuals (either a Physician and RN, or 2 RN's) must identify the blood component and the resident at the bedside:~~

~~a.~~

7. Verify ~~Check the~~ blood expiration date on the container label has not been exceeded. ~~and compare the blood type, Rh type~~

~~b. , and donor numbers on the blood bag label for matching information on the transfusion report form attached to the unit. ***In an emergency, O-negative blood can be given to any resident. Rh negative blood can be given to an Rh positive resident.***~~

~~c. Verify that the resident's first and last name and medical record number on the transfusion requisition and attached transfusion report form (unit tag) match.~~

8. Check the resident's identification wristband for matching first and last name and hospital number against the information on the requisition and transfusion report form. Ask the resident to state his/her name and date of birth **OR** check the resident's photo in the medical record. **Note**: Make sure that all available identifying information on the requisition, unit tag, wristband and information provided by the resident him/herself match before proceeding with the transfusionInspect the blood product for clots/clumps or discoloration (purplish/black color).

d.

e.9. If any discrepancies with the blood order or patient/blood identification are identified, or if the blood bag integrity or appearance of the blood raises suspicion that the unit may not be suitable for transfusion:
   a. Do not begin transfusionDO NOT BEGIN THE TRANSFUSION.
   b. NotifyInform the physician, nursing supervisor and
   b. Notify the B bllood bBank,k of the discrepancies and return the blood to ZSFGH Blood Bank via courier.
   c. Document in the medical record.

4. If autologous or designated transfusion has been ordered, look for the extra tag attached to the unit signifying **autologous** (green tag) or **designated donor** (orange tag).

5. Inspect the blood product for clots, cloudiness, foaming or purplish/black color. If present, do not begin the transfusion. Notify the SFGH Blood Bank and physician and document on the medical record.

6.10. Both individuals who performed the resident/blood unit double-checks will sign off in the EHR. their names on the transfusion report which is attached to the unit of blood and serves as attestation that it is labeled for the intended resident (see back of form for signature and double-check verification documentation).

The top copy of the signed transfusion report form is separated from the bottom copy and pasted in the resident's chart. The bottom copy must remain attached to the unit during the transfusion.

7.

G. Blood Administration

1. If the patient does not have a CVAD, the PMA RN will initiate IV access with gauge 18-22 catheter size. The risk for hemolysis increases as catheter size decreases.
   a. Prime a Y-blood administration tubing set and in-line filter with a 0.9% NS 250 mL IV bag. Blood transfusions must be administered through a blood administration set with an in-line blood filter designed to retain particles potentially harmful to the recipient. Each unit of blood requires a new administration set.
   b. Prime the tubing with blood and ensure that the blood level in the drip chamber is above the filter. RBCs can be damaged if blood drips directly onto the filter.
   c. Use an IV infusion pump to ensure steady flow and a controlled rate of infusion. Transfusionists using infusion pumps should be trained and competent on their use.

1. At the resident's bedside, before connecting the blood tubing to the patient , and before beginning administration of the blood product,– perform the two staff verification of the blood product a Physician and RN **OR** two RN's identify the blood product and the resident as detailed above underr *Required Pre-Transfusion Verificationn Responsibility*.

2. All nursing documentation is done on the PMA Nursing Blood Transfusion Administration record and the transfusion report attached to the blood product unit.

2. Obtain vitals (e.g., blood pressure, pulse, respiration and temperature):
   a. baseline (within 1 hour) vital signs prior to initiating the blood transfusion to serve as a reference point in case of suspected transfusion reaction

b. 15 minutes after the start of the transfusion
c. 1 hour after the start of the transfusion
~~3.~~d. 20 minutes post-transfusion~~.~~

~~4. For each blood product unit, vital signs will be performed Q 15 minutes for the 1st hour; and then hourly thereafter.~~

~~5.~~3. The RN will remain at the resident's bedside for the first~~1st~~ 15 minutes of the transfusion for each unit to monitor the resident's response and to assess for the signs and symptoms of a transfusion reaction.

a. During the 1st 15 minutes of transfusion, the rate of infusion is slow: 1-2 mL per minute.
b. If there are no signs of blood transfusion reaction~~,~~ or intolerance, the rate may be increased so the transfusion is completed within 1-2 hours, or according to physician orders.
c. Recommended infusion time for one unit of PRBCs is 1.5-2 hours.

TIME	RATE
0-15 minutes	30 mL/hr (1-2 mL/min)
15-120+ minutes	~175 mL/hr (use a slower rate if the ordered infusion time is > 2 hours)

~~c.~~

~~d. The transfusion must be completed within 4 hours because of the risk of bacterial contamination and red cell hemolysis.~~

4. Transfusion of each blood unit must be initiated within 30 minutes and completed within 4 hours of being removed from the cooler. This is to minimize the risk of bacterial contamination and growth and red cell hemolysis.
5. Warning: Do not add any medications to blood or blood components.
6. Record intake and output. Each unit of blood is approximately 350 mL.

~~6. If the resident develops an adverse reaction – STOP THE TRANSFUSION IMMEDIATELY and DISCONNECT THE BLOOD TUBING FROM THE I.V. OR CVAD PORT. NOTIFY THE PHYSICIAN. Document time of MD notification and resident's symptoms. Refer to Appendix A-Management of Blood Transfusion Reaction~~

~~a. Set up new I.V. tubing and a new I.V. bag of 250 mL 0.9% NS. **DO NOT** discontinue I.V. access. Monitor vital signs and other signs/symptoms for a possible transfusion reaction.~~
~~b. Document transfusion reaction and all interventions in the medical record, Transfusion Reaction Form, and nursing notes.~~
~~c. Save the tubing and blood unit bag – place in double plastic bag and send to SFGH Blood Bank~~

7. To prevent settling of blood components and help facilitate the flow, mix the cells and plasma by gently inverting the blood bag several times during the transfusion.

8. When the transfusion is completed, run 0.9% NS through the I~~.~~V~~.~~ line to clear the tubing and then discontinue the I~~.~~V~~.~~ unless resident needs a TKO line.

~~8.~~9. If ordered, additional units may be infused through the same needle/catheter, but the administration set will be changed for each unit.

~~9.~~10. Complete documentation ~~on all of the appropriate forms~~in the EHR, including the time the transfusion(s) ~~were complete~~were completed, and~~including~~ intake and output.

~~10.~~11. Once the blood is discontinued, double bag the container and tubing and ~~place~~discard~~d~~ in the red infectious waste container.

H. Post transfusion Observations

1. The resident shall remain on PMA for 1 hour after transfusion has been completed. The resident may stay longer for resident centered care.
2. If vital signs are stable, the resident may return to SNF neighborhood.
3. Vital signs on the SNF neighborhood will be performed once per shift for a minimum of 48 hours. Monitoring may be more frequent or extended if indicated.
4. The PMA RN will provide a hand off report to the SNF LN prior to sending the resident back to the SNF neighborhood.
5. The SNF LN will update the resident's location in the EHR.
6. Acute transfusion reactions may manifest themselves during transfusion or up to 6-24 hours after transfusion. Follow instructions in the *Transfusion Reaction* section below if signs or symptoms suggest a transfusion reaction in a recently transfused patient.

I. Transfusion Reaction

1. Transfusion reactions are any adverse reaction to blood products. Less than 10 mL of an incompatible product may cause a severe reaction. Patients with a history of previous transfusion reaction have a greater change of reaction with future transfusions.

Transfusion reaction signs and symptoms:			
Chills	Anxiety	Headache	Chest tightness/pain
Dyspnea	Back pain	Shock	Hemoglobinuria
Pruritis	Urticarial	Hypotension	Fever (> 1°C increase from baseline)
Nausea	Flushing	Oliguria	Generalized bleeding

2. If the resident develops an adverse reaction – Refer to Appendix A for more information.
   a. STOP THE TRANSFUSION IMMEDIATELY
   b. DISCONNECT THE BLOOD TUBING FROM THE IV OR CVAD PORT. Save the blood bag and IV tubing.
   c. **DO NOT** discontinue IV access.
   d. Set up a new IV administration set and IV bag of 250 mL 0.9% NS at TKO.
   e. NOTIFY THE PHYSICIAN and Nursing Supervisor.
   f. Check all labels, forms and resident identification to determine whether the resident received the correct blood.
   g. From the onset of the reaction, take vital signs every 15 minutes until vital signs stabilize. Monitor strict I/Os every hour. Monitor for other signs/symptoms for a possible transfusion reaction.
   h. If ordered, collect 1st urine specimen and a 10 mL blood specimen (pink top) for transfusion reaction work up. Label the samples at the bedside in the presence of the resident.
   i. After assessing the patient, the physician will determine if the blood transfusion can be continued.
      i. Discontinuing the transfusion is based upon the presence of any signs of a potentially life threatening transfusion reaction (i.e., anaphylactic shock, intravascular hemolysis, sepsis or pulmonary edema). In general, transfusions associated with febrile reactions should be discontinued and investigated, unless the fever can be clearly attributed to a cause unrelated to the transfusion.
      ii. Continuing the transfusion may be done if the resident has had previous mild allergic reactions, and can be treated with an antihistamine (i.e., diphenhydramine/Benadryl).
   j. Notify the blood bank.
   k. The physician will complete the Transfusion Reaction Form. Make a copy of the form for LHH records.

l. Save the tubing and blood container – double bag in red plastic bags and send to ZSFG Blood Bank with the Transfusion Reaction Form and blood specimen. Notify the blood bank if the physician decides not to send product back.
m. Document transfusion reaction, resident's symptoms, time of physician notification and all interventions in the EHR.
n. Resident should be monitored on their regular/SNF unit for the at least 48 hours post-transfusion for possible acute reactions, and (optionally) 5-7 days after transfusion for a possible delayed reaction (hemoglobin check).

Transfusion Reaction Type	Time Frame	Symptoms
Acute	Presents < 8 hours post-transfusion	Fever, shortness of breath, hypo- or hyper-tension, aches and pains, rash, gastrointestinal symptoms
Delayed	Presents 3-7 days (up to 14-21 days) post-transfusion	Falling hemoglobin, rarely oliguria, anuria, hemoglobinuria, jaundice

H. Post transfusion Observations

1. The resident shall remain on PMA for up to at least 1 hour after transfusion has been completed. Vital signs will be taken hourly, as needed, and just prior to transfer back to the SNF neighborhood.

2. If vital signs are stable, resident may return to SNF neighborhood.

3. Vital signs on the SNF neighborhood will be performed once per shift for 48 hours or more often if indicated.

4. The PMA RN will provide a hand off report to the SNF Licensed Nurse prior to sending the resident back to the SNF neighborhood.

I. Documentation forms for blood transfusion:

Form:	Completed by:
Informed consent	SNF MD
PMA Blood Transfusion Record	
Top portion	SNF MD
Middle portion	PMA RN
Bottom portion	PMA MD
Blood Transfusion Nursing Administration Record	PMA RN
Blood Product Delivery Receipt	PMA RN who receives blood from the courier
Original signed computer copy attached to blood product	RN and MD or 2 RN's
Blood Transfusion Reaction Form	PMA MD

J. Downtime Documentation

1. A checker and transfusionist must each certify integrity and successful completion of pre-transfusion checks by signing their legal names in the provided fields on the Blood Bank Transfusion Report. The Transfusionist will document the date and start time of the transfusion.
2. Tear off the top of the Blood Bank Transfusion Report (chart copy), making sure the last copy (unit tag) remains attached to the blood container. Affix the chart copy and a patient label to a sheet of paper for scanning. Do not overlap these sheets.

3. Record vital signs and other required information for the blood transfusion. Attach a blood bag unit sticker from each unit transfused to the documentation form. The completed paperwork will be scanned into the patient's medical record per standard unit procedure.

APPENDICES:

Appendix A: Transfusion Reaction AlgorithmManagement of Transfusion Reaction
Appendix B: Blood Bank Transfusion Reaction Report
Appendix C: Blood Bank Slips
Appendix D: A Patient's Guide to Blood Transfusion (English & Spanish)
Appendix E: Downtime paperwork (lab requisition, nursing flowsheet)
Appendix F: Blood Bank Consent (pending)

REFERENCES:

Elsevier Clinical Skills: Blood Product Administration: Red Blood Cells and Whole Blood
https://epm601.elsevierperformancemanager.com/Personalization/Home

Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures,* (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins
Department of Public HealthSan Francisco General Hospital and Trauma Center: Blood Bank Policies and Procedures 201907

Paul Gann Blood Safety Act, California Health and Safety Code Section 1645

CROSS REFERENCES:

SFGH Blood Bank Requisition (5788120-Rev 2/05)
SFGH Blood Bank Delivery Receipt
SFGH Blood Bank Blood Transfusion Report (5711101 f111 (2/00)
SFGH Blood Transfusion Reaction Report Form (5793499, f934-Rev8/05)

Revised: 8/2000; 9/2008; 02/2015; 10/23/2015; 07/2016

Reviewed: ________

Approved: ________

Patient Exhibits Signs & Symptoms of a Transfusion Reaction

1. **Stop the transfusion immediately and disconnect the i.v. tubing, leaving i.v. access intact**
2. **Keep i.v. site open with 0.9% saline TKO in different i.v. tubing**
3. **Contact Physician/authorized provider for medical assessment and to determine if transfusion should continue**
4. **Check vital signs at least every 15 minutes until stable (initiate continuous monitoring if reaction is severe)**
5. **Check all labels, tags and patient's identification band to determine if there is a clerical discrepancy**

Verify:

A. The patient's name and MRN on the ID band and blood tag match
B. The patient's ABO/Rh type is identical/compatible with the unit ABO/Rh type
C. The unit is not expired.

The physician/authorized provider will determine if transfusion should continue.

Serious Signs & Symptoms?

- ANY symptoms within first 15 min. of transfusion
- Fever (38°C or greater and1°C rise from baseline) – considered minor symptom if occurring in isolation
- Hypotension/shock
- Rigors/chills
- Unexplained anxiety / 'sense of doom'
- Back/chest pain
- Dyspnea/respiratory distress
- Tea colored urine (hemoglobinuria)
- Bleeding at i.v. site
- Nausea/Vomiting
- Tachycardia/arrhythmias
- Generalized flushing
- Hives/rash covering more than ¼ of body
- Any feeling different than usual

Clerical Discrepancy?

Do not restart the transfusion!

- Manage patient reaction as per order by the authorized provider
- **Notify Blood Bank and send the following immediately**
  - One 10 ml Pink Top Tube
  - Completed Transfusion Reaction Form
  - Blood container with attached administration set (w/o needle)
- **Consider:** Chest x-ray, ECG, ABG, Blood cultures, Urine specimen, Other Tests, as requested by authorized provider or Blood Bank

Think: Acute Hemolytic, Severe Allergic, Anaphylactic/Anaphylactoid, TRALI, TACO, Bacterial Contamination

Minor Symptoms Only?

- Hives/rash ONLY, covering max. ¼ of the body
- Temperature rise =>1°C from baseline to <=>38°C, onset >15 minutes into transfusion, AND NO OTHER SIGNS OR SYMPTOMS
- Mild dyspnea, responding to slowing down of transfusion rate

Per order by authorized provider ONLY

- Treat with Diphenhydramine 25-50 mg iv or po for hives; acetaminophen 650 mg po for fever
- Resume transfusion cautiously if clinical condition warrants and there is time to complete transfusion w/in 4 hours from start
- Document assessment, interventions and patient's response in patient's chart
- Remain with the patient for the first 5 min. after resuming transfusion , then observe every 5 min. for next 10 min.
- If any further signs & symptoms of reaction, IMMEDIATELY stop the transfusion. Follow serious signs & symptoms pathway
- For all cases send to Blood Bank upon completion of transfusion:
  - One 10 ml Pink Top Tube
  - Completed Transfusion Reaction Form
  - Blood container with administration set (w/o needle

Think: Minor Febrile Non-Hemolytic, Minor Allergic or Mild TACO

FOR DELETION

Blood Transfusion: Appendix A: Management of Transfusion Reaction LHH

RELEVANT INFORMATION:

Transfusion reactions are defined as any adverse reaction to blood products. Less than 10cc of incompatible product may cause a severe reaction. Residents with a history of previous transfusion reaction have a greater chance of reaction with future transfusions. Careful observation through presenting symptoms of fever and chills may be the same for a life-threatening reaction and a less serious febrile reaction. Definition of a febrile reaction is a rise of > 1º C in temperature from the pre transfusion temperature.

PROCEDURE:

1. Observe resident closely for the following signs and symptoms:

   a. chills
   b. fever
   c. anxiety
   d. dypsnea
   e. chest tightness/pain
   f. back pain
   g. shock
   h. hemoglobinuria
   i. pruritis
   j. urticaria
   k. hypotension
   l. headache
   m. nausea
   n. flushing
   o. oliguria
   p. generalized bleeding

2. Take the following immediate action at the 1st signs/symptoms noted above:

   a. STOP THE TRANSFUSION. Clamp the tubing; change IV administration set. Keep IV line open with 250cc 0.9 % NS
   b. Notify MD and Nursing Supervisor
   c. Check all labels, forms, and resident identifications to determine whether the resident received the correct blood. Save the blood bag and IV tubing.

      i. Discontinuing the transfusion is based upon whether there are any signs of a potentially life threatening transfusion reaction (i.e. anaphylactic shock, intravascular hemolysis, sepsis or pulmonary edema. In general transfusion associated with febrile reactions should be discontinued and investigated, unless the fever can be clearly attributed to a cause unrelated to transfusion. The decision to continue with the transfusion has to be made by the responsible physician after assessing the resident.)
      ii. If the resident has had previous mild allergic reactions, the physician may choose to continue the transfusion and give an antihistamine, i.e. diphenhydramine (Benadryl).
      iii. Take complete vital signs and temperature at the beginning of the reaction and document; continue vital signs Q 15 minutes until vital signs stabilize. Monitor strict I/) (Q1hour); send 1st urine specimen to the lab.
      iv. Collect a 10 ml pink top tube for transfusion reaction work-up. Label the blood sample at the bedside in the presence of the resident.
      v. Place the disconnected blood bag and IV tubing in a double plastic bag and ask the Nursing Supervisor to arrange for a courier to pick up the blood bag, transfusion reaction blood sample and completed transfusion form (to be completed by the physician, see below) for delivery to the SFGH Blood Bank.

3. Physician must complete and sign the Blood Bank Transfusion Reaction Report form (5793400, F394). Place “pink” preliminary report in the resident’s chart and send the original white copy and yellow copy with the lab specimens and blood bag. (Once the Investigation is completed, the original form will be returned to the resident’s chart).

4. Nursing Documentation

   a. All actions taken in response to the transfusion reaction will be documented on the nursing blood administration form (medications, resident signs/symptoms, strict I/O, notification of MD and Nursing Supervisor, etc)
   b. Acute transfusion reactions, presenting with fever, shortness of breath, hypo or hypertension, aches and pains, rash or gastrointestinal symptoms may manifest up to 8 hours after the transfusion. A delayed reaction typically presents 3-7 days (up to 14-21 days) post transfusion with signs/symptoms of falling hemoglobin, rarely oliguria, anuria, hemoglobinuria, jaundice. Therefore the resident should be monitored on the home unit for the first 48 hours after transfusion for possible acute reactions, and (optionally) 5-7 days after transfusion for a possible delayed reaction (hemoglobin check).

APPENDIX B

SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

NAME

DOB

MRN

PCP

Patient ID/ Addressograph

Blood Bank Transfusion Reaction Report

Provider Name: ______________________________ Patient Location: ______________

Print Name CHN ID Pager/Extension

SIGNATURE OF STAFF WHO COLLECTED POST-TRANSF. SPEC. (REQUIRED)

Date: __________ Time: __________ RN: ______________________________

Print Name Signature INV ID

Report all suspected reactions promptly to blood bank. Follow these instructions:

- Stop the transfusion **and** immediately notify the responsible MD to assess the patient.
- Fill out this form completely.
- Send completed form to Blood Bank ***with post-transfusion specimens (2 pink top tubes, 10ml each) and blood bag(s) with clamped-off administration set still attached.***

Patient Diagnosis: ______________________________

Check Signs And Symptoms Noted:

General: ☐ Fever ☐ Chills ☐ Pain at I.V. Site ☐ Nausea ☐ Back Pain

Respiratory: ☐ Dyspnea/SOB ☐ Wheezing

Cardiovascular: ☐ Hypotension ☐ Shock ☐ Chest Pain

Genitourinary: ☐ Hemoglobinuria ☐ Oliguria ☐ Anuria

Skin: ☐ Urticaria ☐ Flushing ☐ Rash

Hematological: ☐ Generalized Bleeding

☐ ***Other:*** ______________________________

Pre-Transfusion	**Post-Transfusion**
Temp. ________	Temp. ________
B/P ________	B/P ________
Pulse ________	Pulse ________
Resp. Rate ________	Resp. Rate ________
O2 Sat. ________	O2 Sat. ________
O2 Admin ________	O2 Admin ________

Donor Unit Number(s) and Blood Component(s), (RBC, FFP, PLT, CRYO) Associated With Reaction

Unit No. ____________________ Comp. ______ Unit No. ____________________ Comp. ______

Unit No. ____________________ Comp. ______ Unit No. ____________________ Comp. ______

Unit No. ____________________ Comp. ______ Unit No. ____________________ Comp. ______

Date of Transfusion: ____________________

Transfusion Start Time: ________ / **Stop Time:** ________

Amount Given: ____________________

When Was The Reaction Noted? – Time: __________

☐ **During Transfusion** ☐ **After Transfusion Completed**

If After, How Long After? ________________

I.V. Solution Used in the Tubing With Bood?

☐ No ☐ Yes What? ____________________

Medication Added to Donor Unit or Tubing?

☐ No ☐ Yes What? ____________________

Blood Warmer Used? ☐ No ☐ Yes

Additional Comments (Use reverse side if needed):

***The Final Report will be under the Patient's Name in the Lifetime Clinical Record (LCR);*
***See Patient Menu Section - Results - Lab - Blood Bank - Transfusion Reaction Work-up.*

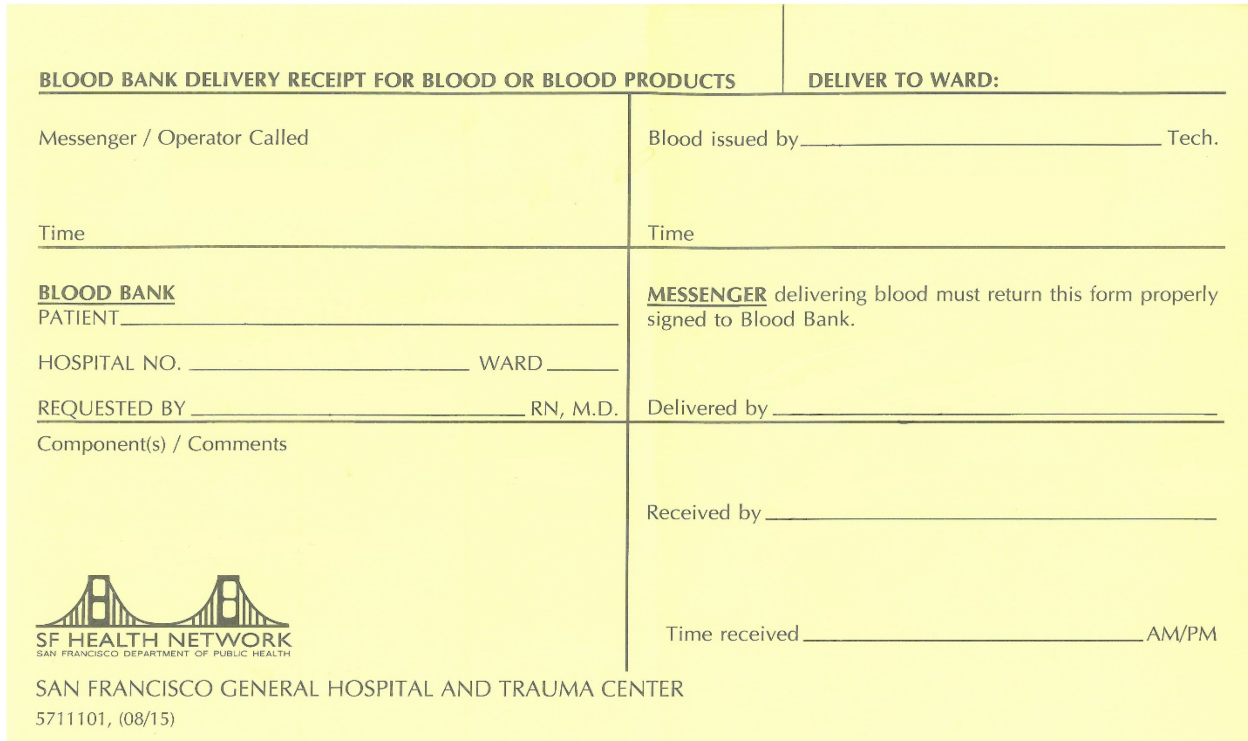
NOT A PART OF MEDICAL RECORD

SFGH CLINICAL LABORATORY, 1001 Potrero Ave., Bldg. 5, Rm. 2M, San Francisco, CA 94110

BARBARA HALLER, MD, PHD, DIRECTOR

NPP J 8.0 Blood Product Administration Appendix C

Blood Bank Delivery Receipt for Blood or Blood Products



BLOOD BANK DELIVERY RECEIPT FOR BLOOD OR BLOOD PRODUCTS

DELIVER TO WARD:

Messenger / Operator Called

Time

Blood issued by ______ Tech.

Time

BLOOD BANK
PATIENT ______

HOSPITAL NO. ______ WARD ______

REQUESTED BY ______ RN, M.D.

Component(s) / Comments

MESSENGER delivering blood must return this form properly signed to Blood Bank.

Delivered by ______

Received by ______

Time received ______ AM/PM

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
5711101, (08/15)

Blood Bank Transfusion Report

BLOOD BANK TRANSFUSION REPORT

INFUSION

CHECKER(S):
I (we) checked the patient's identification, transfusion order, consent, information on this form and the blood unit label according to SFGH's Nursing Blood Administration P&P 3.1, and found all items matching.

______ MD or RN

TRANSFUSIONIST:
I verified with the checker(s) the items listed under their attestation before I started the transfusion.

______ MD or RN

DATE ______ TIME STARTED ______

AFTER SIGNING THIS FORM INSERT IN PATIENT'S CHART

San Francisco General Hospital and Trauma Center
Clinical Laboratory, Director:
B. Haller, MD, PhD

NAME
HOSPITAL NO.
BIRTHDATE
ACCOUNT NO.

ACC. NO.
SEX
WARD

RECIPIENT TYPE
DONOR TYPE

UNIT NO.

COMPONENT
CROSSMATCH
ANTIGENS

COMMENTS

DATE TECH

CHART COPY

5793211 (Rev. 12/15)

References:

- Circular of Information for the Use of Human Blood and Blood Components. AABB. Nov 2013 (revised April 2014)
- AABB Technical Manual. 18th Edition.

This brochure was developed by the California Department of Public Health, Laboratory Field Services (850 Marina Bay Parkway, Richmond, CA 94804)

In partnership with the Medical Technical Advisory Committee of the Blood Centers of California.

For information about brochure contents, please call Laboratory Field Services:
(213) 620-6574

This brochure is provided as a source of information and is not considered a replacement for the Informed Consent process prior to the transfusion of blood.

Distributed by the
Medical Board of California

To place an order for this brochure, please FAX your request to:
(916) 263-2497

This information may be obtained electronically at:

http://www.mbc.ca.gov/Publications/Brochures/Blood_Transfusions.aspx

Revised 06/2018

A Patient's Guide to Blood Transfusion

California
Department of Public Health

June 2018

This document provides written information regarding the benefits, risks, and alternatives of transfusion of blood products (including red blood cells, plasma, platelets, or others) collected from the patient (autologous) or another person. This material serves as a supplement to the discussion you have with your physician. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your physician prior to consenting to receive a transfusion.

Information about the treatment

Transfusions of blood products are provided to increase the amount of blood components in your body when they are below a reasonable level for your health. The transfusion may be made up of red blood cells, plasma, platelets or other specialized products made from blood. Your physician will decide on the right amount and type of blood product based on your medical condition or diagnosis.

Potential benefits of the treatment

Transfusion of blood products may be necessary to correct low levels of blood components in your body, and may also make you feel better. In some cases, failure to receive transfusion(s) may result in death.

Risks of the treatment

Known risks of this treatment include, but are not limited to:

- Irritation, pain, or infection at the needle site
- Temporary reaction such as a fever, chills, or skin rashes.

Other rare but more serious complications include severe allergic reactions, heart failure due to fluid overload, acute pulmonary edema (fluid leaking into the lungs), hemolysis (destruction of red blood cells), shock, or death.

Transfusion of blood products carries a very small risk of transmission of infectious diseases such as HIV (about 1 in 1.5 million), Hepatitis C (about 1 in 1.2 million), and Hepatitis B (about 1 in 1 million). Other significant infections may also be transmitted by transfusion, but overall this risk is low.

Treatment Options/Alternatives

If you need blood you have several options. Most patients requiring transfusion receive blood products donated by volunteer community donors. These donors are extensively screened about their health history and undergo numerous blood tests as mandated by state and federal regulations in order to ensure the safest possible blood supply. Alternatives to transfusion with blood products from volunteer community donors include:

- Pre-operative autologous donation (using your own previously donated blood), see below for more information

- Directed donation (blood donated by people who you have asked to donate for you), see below for more information

- Intra-operative autologous transfusion/ Hemodilution (collecting your own blood during surgery to be given back to you)

- Medications (certain medications may increase blood volume prior to surgery or reduce active bleeding to lessen the need for transfusion)

These options may be available only if your health, time, and procedure permit. They may not be available at all locations or for all patients. You may also choose not to receive blood transfusion; however this decision may hold life-threatening consequences.

Pre-operative autologous donation is not appropriate for all patients. Autologous donation involves collecting your own blood prior to a planned surgery for storage in the hospital blood bank. It is important to discuss with your physician if it is safe for you to donate and the likelihood of needing a transfusion based on your surgery and current transfusion guidelines. Receiving your own blood may reduce, but will not eliminate, the risk of transfusion-related complications. Insurance company policies may vary regarding reimbursement for this service. Overall, although autologous donation is an option to consider for those who qualify, the number of autologous donations in the United States has significantly decreased in the last few decades mainly due to major advances in blood safety and efforts to decrease unnecessary blood transfusions.

Directed donation refers to blood collected from "directed donors" who are donating blood for a specific patient by request. Directed donors are often family and friends of the patient. Directed donors go through the same qualification process as volunteer donors. Directed donations are not considered to be safer than the general blood supply.

Referencias:

- Circular of Information for the Use of Human Blood and Blood Components. AABB. Nov 2013 (revised April 2014)
- AABB Technical Manual. 18th Edition.

Este folleto fue elaborado por el Departamento de Salud Pública de California, Servicios de Campo de Laboratorio (850 Marina Bay Parkway, Richmond, CA 94804)

En asociación con el Comité de Asesoría Técnica Médica de Blood Centers of California.

Para obtener información sobre el contenido del folleto, llame a Servicios de Campo de Laboratorio: (213) 620-6574

Este folleto se entrega como fuente de información y no se considera que sustituye el proceso de Consentimiento Informado previo a la transfusión de sangre.

Distribuido por el
Junta Médica de California

Para hacer un pedido de este folleto, envíe su solicitud por fax al:
(916) 263-2497

Esta información se puede obtener electrónicamente en:

http://www.mbc.ca.gov/Publications/Brochures/Blood_Transfusions.aspx

Revisado 06/2018

Guía para pacientes sobre la transfusión sanguínea

California
Departamento de Salud Pública

Junio 2018

Este documento proporciona información por escrito respecto a los beneficios, riesgos y alternativas de la transfusión de productos sanguíneos (entre ellos glóbulos rojos, plasma, plaquetas y otros) obtenidos del paciente (autólogos) o de otra persona. Este material sirve como complemento de la plática que tuvo con su médico. Es importante que entienda perfectamente esta información, por lo que le pedimos leer este documento detenidamente. Si tiene preguntas respecto al procedimiento, pregunte a su médico antes de dar su consentimiento para recibir una transfusión.

Información sobre el tratamiento

Las transfusiones de productos sanguíneos se realizan para aumentar la cantidad de componentes sanguíneos en su cuerpo cuando estos están por debajo del nivel razonable para su salud. La transfusión puede estar compuesta por glóbulos rojos, plasma, plaquetas u otros productos especializados derivados de la sangre. Su médico decidirá la cantidad exacta y el tipo de producto sanguíneo según su condición médica o diagnóstico.

Beneficios potenciales del tratamiento

La transfusión de productos sanguíneos puede ser necesaria para corregir los bajos niveles de componentes sanguíneos en su cuerpo, y también pueden hacerle sentir mejor. En algunos casos, no recibir la o las transfusiones puede causar la muerte.

Riesgos del tratamiento

Los riesgos conocidos de este tratamiento son los siguientes, entre otros:

- Irritación, dolor o infección en el lugar donde se coloca la aguja
- Reacción temporal, como fiebre, escalofríos o erupcionees en la piel.

Otras complicaciones poco frecuentes aunque más graves incluyen reacciones alérgicas severas, insuficiencia cardiaca debido al exceso de líquido circulante, edema pulmonar agudo (líquido que se filtra a los pulmones), hemólisis (destrucción de los glóbulos rojos), choque o muerte.

La transfusión de productos sanguíneos implica un riesgo muy bajo de transmisión de enfermedades infecciosas como el VIH (cerca de 1 en 1.5 millones), hepatitis C (cerca de 1 en 1.2 millones) y hepatitis C (cerca de 1 en 1 millón). Se pueden transmitir también otras infecciones importantes a través de la transfusión, pero en general el riesgo es bajo.

Opciones y alternativas de tratamiento

Si usted requiere sangre, tiene varias opciones. La mayoría de los pacientes que requieren transfusión reciben los productos sanguíneos de donadores voluntarios de la comunidad. Estos donadores se someten a una amplia investigación de sus antecedentes de salud y a múltiples análisis de sangre conforme a lo dispuesto por los reglamentos estatales y federales, con el fin de asegurar que la sangre proviene de la fuente más segura posible. Entre las alternativas a la transfusión con productos sanguíneos provenientes de donadores voluntarios de la comunidad están:

- Donación autóloga preoperatoria (usar su propia sangre donada previamente). Ver más información a continuación
- Donación dirigida (sangre donada por personas a las que usted les ha pedido donar para usted). Ver más información a continuación
- Transfusión autóloga intraoperativa/ hemodilución (recuperación de su propia sangre durante la cirugía para volver a administrársela)
- Medicamentos ciertos medicamentos pueden incrementar el volumen de sangre antes de la cirugía o reducir el sangrado activo para disminuir la necesidad de una transfusión)

Estas opciones pueden ser posibles solo si su salud, tiempo y procedimiento lo permiten. Es posible que no se realicen en todos los hospitales o para todos los pacientes. También puede elegir no recibir una transfusión de sangre. Sin embargo, esta decisión puede tener consecuencias que pueden poner en riesgo su vida.

La donación autóloga preoperatoria no es pertinente para todos los pacientes. La donación autóloga implica obtener su propia sangre antes de una cirugía planeada para almacenarla en el banco de sangre del hospital. Es importante hablar con su médico sobre si es seguro que usted done sangre y sobre la posibilidad de necesitar una transfusión según su cirugía y las normas vigentes sobre la transfusión. Recibir su propia sangre puede reducir, aunque no eliminar, el riesgo de presentar complicaciones relacionadas con la transfusión. Las pólizas de las compañías de seguros pueden variar respecto al reembolso por este servicio. En general, aunque la donación autóloga es una opción que debe considerarse en aquellas personas que reúnan los requisitos, el número de donaciones autólogas en Estados Unidos ha disminuido considerablemente en las últimas décadas, principalmente debido a los grandes avances en la seguridad de la sangre y a los esfuerzos por reducir las transfusiones innecesarias.

La donación dirigida se refiere a la sangre obtenida de "donadores dirigidos" que donan sangre para un paciente específico a petición del paciente. Con frecuencia, los donadores dirigidos son familiares o amigos del paciente. Los donadores dirigidos pasan por el mismo proceso de selección que los donadores voluntarios. Las donaciones dirigidas no se consideran más seguras que la obtención general de sangre.

DATE, TIME RECEIVED ACC #

LAB USE ONLY

BLOOD BANK REQUISITION

SAN FRANCISCO GENERAL HOSPITAL
CLINICAL LABORATORY

PHYSICIAN NAME (Print), I.D. #, PAGER/EXT

BLOOD DRAWER'S SIGNATURE (REQUIRED)

LOCATION DATE TIME

DRAW PINK TOP TUBE ONLY
REQUISITION MUST BE SIGNED AND DATED BY PERSON DRAWING/LABELING BLOOD.

PATIENT I.D. & HOSPITAL NO.

DIAGNOSIS / ICD9 CODE:

TRANSFUSION REQUESTS

TRANSFUSION/SURGERY DATE:

☐ TYPE AND CROSSMATCH
- INCLUDES ANTIBODY SCREEN

☐ NEONATAL TRANSFUSION
- SPECIMEN MAY BE REQUIRED

PATIENT HAS ARRANGED FOR:
☐ AUTOLOGOUS BLOOD
☐ DESIGNATED DONOR BLOOD

COMPONENT	NO. OF UNITS
RED BLOOD CELLS	
QUAD PACK	
FRESH FROZEN PLASMA	
PLATELETPHERESIS	
CRYOPRECIPITATE	
RH IMMUNE GLOBULIN	
POST PARTUM RH IMMUNE GLOBULIN	

SPECIAL REQUESTS

TEST REQUESTS

☐ TYPE (ABO/RH) AND HOLD

☐ TYPE AND ANTIBODY SCREEN
- RED CELLS MAY BE ADDED IF NEEDED

☐ DIRECT COOMBS (DAT)

☐ PRENATAL ABO/RH, ANTIBODY SCREEN

☐ PRENATAL ANTIBODY TITER

☐ CORD BLOOD TEST

☐ OTHER TESTS

BLOOD BANK USE ONLY

ABO/RH HISTORICAL CHECK ____________

ANTIBODIES ____________

ADDITIONAL INFO ____________

TEST CODE ________ ACC # ________

TEST CODE ________ ACC # ________

TEST CODE ________ ACC # ________

EMERGENCY REQUESTS

RESPONSIBILITY FOR RELEASE OF EMERGENCY/TYPE SPECIFIC BLOOD ASSUMED BY:

____________ M.D.

☐ EMERGENCY GROUP O RED CELLS
- UNCROSSMATCHED/AVAILABLE IMMEDIATELY
- SPECIMEN NOT REQUIRED

NO. OF RED CELL UNITS REQUESTED: ________

☐ TYPE SPECIFIC RED CELLS
- AVAILABLE BEFORE CROSSMATCH COMPLETED
- SPECIMEN REQUIRED

NO. OF RED CELL UNITS REQUESTED: ________

5788120 (Rev. 6/10)

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

Name

DOB

MRN#

PM Acute Nursing Blood Transfusion Administration Record

Pt/ID Addressograph

Date: __________ **Allergies:** Yes (describe below) No
Admit Time: __________

Primary language: ______________________ Need Interpreter: Yes No
Past Medical History: ______________________

Treatment: PRBC (packed red blood cells) # units to be given: ________

Blood Type: ______________

Interventions: **IV started: Date:** ________ **Time:** ________ Gauge: ________
Location: ______________________

MEDICATION RECORD

TIME	MEDICATIONS	DOSE	ROUTE	INITIALS

Assessment Temp (F): ________ B/P: ________ Pulse: ________ RR: ________

Neuro/mental status: ______________________

Respiratory: ______________________

Cardiovascular: ______________________

GI: ______________________ GU: ______________________

Musculoskeletal: ______________________

Safety Precautions: ______________________ Psychosocial: ______________________

				INTAKE		OUTPUT	
Start time	Initials	Blood donor #	IV Solution	IV	Oral	Urine	Other
			Subtotal				
			Totals:				

MR# 354
8/1/11 Rev

Page 1 of 2

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

Name

DOB

MRN#

PM Acute Nursing Blood Transfusion Administration Record

Pt ID/Addressograph

Date														
Time														
Temp F														
	104													
Rectal °	103													
	102													
Tympanic ●	101													
	100													
	99													
	98													
	97													
	96													
Pulse	140													
	130													
Apical ◆	120													
	110													
Radial ■	100													
	90													
	80													
	70													
	60													
	50													
Respirations														
Blood Pressure														
O2 saturation														
Oxygen L/min														
Pain Scale														
RN initials														

Transfusion Nursing Progress Notes

PM Acute "Come & Go " Summary

Post transfusion education ☐ Resident ☐ Unit:________

Discharge time:______________ To Unit:____________

Initials: Signature:

Initials: Signature:

MR# 354
8/1/2011

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

Consent to Blood Transfusion

(Paul Gann Blood Safety Act, Health & Safety Code 1645)

ADDRESSOGRAPH

I have explained to the patient/resident, the risks and benefits of blood transfusion options. I have given the patient/resident a copy of ***A Patient's Guide to Blood Transfusion,*** the standardized written blood transfusion summary from the State Department of Public Health, concerning the advantages and disadvantages of autologous blood, designated donor blood, and homologous blood from volunteers. Also, I have allowed adequate time for the patient/resident or other person(s) to predonate blood.

Autologous or designated blood donation was not done due to one or more of the following reasons:

- Life-threatening emergency*
- Medical contraindication for autologous blood donation
- The patient/resident chose not to delay medical treatment and waived the right to predonate blood

* The patient/resident or legally responsible adult has been advised that there may be circumstances in which emergent need for blood or certain blood products may preclude the use of directed or autologous blood donations.

☐ Resident lacks capacity to make decisions concerning his/her health care and cannot give consent to the medical intervention sought by the physician, and there is no person with legal authority to make those decisions on behalf of the resident. The physician and Resident Care Team have complied with the requirements under LHHPP-29-08 to administer this medical intervention.

Physician: ____________________ / ____________________ ____________ ____________

Signature / Print Name / Date / Time

SUMMARY

The risks and benefits of blood transfusion have been explained to me. I understand my options regarding the source of blood or blood products. I have been given a copy of ***A Patient's Guide to Blood Transfusion*** concerning the advantages and disadvantages of autologous blood, designated donor blood, and blood from the blood bank.

I ______________________________ have read/had read to me the above. My questions have been answered to my full satisfaction. I hereby consent to transfusion of blood or blood products as my physician may deem necessary or advisable in the course of my treatment.

Date: ________________ ______________________________

(indicate relationship) Patient / Resident / Parent / Conservator / Guardian Signature

Date: ________________ ______________________________

Witness(es) / Title or relationship to patient

Nursing

Policies and Procedures

For Deletion

Daily Nursing Care Record

Interventions

Record initials in the date column corresponding to the shift that treatment was administered.

Legend X = Not Performed, R = Refused (Response of X or R requires nurse notification and supplemental note).

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Test the Resident's call light devices daily	N																															
	D																															
	E																															
On weekly bed strip days, test ALL the Resident's call lights (bathroom, shower & routine)	N																															
	D																															
	E																															
On bath days, check if the resident's nails need trimming: C=check T=trimmed R=refused																																
	D																															
	CTR																															
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

MR 343A (REV 6/11)

UNIT: BED: MONTH/YEAR: **October 2015**

MR 343A i (REV 6/11)

ADDRESSOGRAPH LHH 1760

Revised Pharmacy Policies and Procedures

LAGUNA HONDA HOSPITAL 07.02.00
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PREPARATION, HANDLING, AND DISPOSAL OF HAZARDOUS DRUG

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.

Qualified personnel – Pharmacists and pharmacy technicians that have completed required training, successfully passed all of the required competency assessments for non-sterile compounding of hazardous drugs, and signed the hazardous drug acknowledgement form

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 or compounding) shall be performed in a C-PEC in the hazardous rug room.
2. Compounding of non-sterile hazardous drugs shall occur in 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 containment ventilation enclosure (CVE)~~CACI, but~~ and it is only used for non-sterile compounding and manipulation of hazardous drugs by qualified personnel
   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. Perform hand hygiene for 30 seconds using soap and water up to the elbows and dry hands

7. Don a non-shedding splash resistant gown
5.8. Don 2 pairs of chemotherapy gloves
6. Disinfect hands again using waterless surgical scrub and allows hands to dry before placing hands in isolator gauntlets.
7. 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.
8. 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.
9. 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 C-PEC~~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~~C-PEC shall occur before and after compounding.
c. Pharmacy personnel shall clean the carts, bins, and shelves once a week

2. ~~CACI~~C-PEC
   ~~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.~~a. Deactivate all the surfaces of the ~~CACI~~ C-PEC 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.~~b. 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~~ C-PEC for compounding non-sterile hazardous drugs

1. The C-PEC is run continuously, but if it is turned off then turn on the C-PEC and wait one minute before raising the sash to deactivate, decontaminate, and sanitize all of the surfaces inside the C-PEC
~~1.~~2. All of the surfaces in the C-PEC~~CACI~~ ~~work area and antechamber~~ must be deactivated, decontaminated, and sanitized before and after compounding.
~~2.~~3. Place compounding equipment and ingredients in the ~~CACI~~ C-PEC and lower the sash before starting to compound. ~~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 plastic~~chemotherapy~~ bag to decrease the risk of spilling.~~ in the antechamber~~.
5. Deactivate and decontaminate any reusable compounding equipment with diluted bleach and a germicidal detergent and then place in a plastic~~chemotherapy~~ bag for storage in the hazardous drug room~~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.~~6. ~~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~~.

7. A beyond use date shall be assigned based on the master formula and USP795 (See policy 07.01.00 "Beyond use dating")
8. Discard any waste in the yellow hazardous drug waste bin

~~8.~~

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 ¾ 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 ¾ 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:
Attachment 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

Revision History: 10/15, 7/19, 2/20

Revised Rehabilitation Services Policies and Procedures

PROCEDURE FOR OUTPATIENT REFERRAL, REGISTRATION, AND TREATMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Services (LHH) has an established method for the referral, registration, and treatment of outpatients.

PURPOSE:

1. To ensure that this facility provides continuity of care for patient's discharged to the community following inpatient treatment as well as rehabilitation services to outpatients from the community.

PROCEDURE:

1. Outside Referrals

Referrals for outpatient rehabilitation services are made by the patient's provider. Outpatient referrals are accommodated as staffing permits, with priority given to those patients requiring outpatient rehabilitation services immediately following discharge from LHH. Outpatients ~~referrals that~~ who cannot be accommodated at LHH are referred to the Department of Rehabilitation Services at Zuckerberg San Francisco General Hospital and Trauma Program for outpatient services.

2. Referrals for Outpatient Therapy for Patients being discharged from LHH

a. Follow-up Physiatry appointments for patients being discharged from LHH are scheduled by the treating physiatrist through the LHH outpatient clinic.

b. ~~The referring MD will order outpatient PT, OT, audiology and/or ST therapies via MR Form 505 (*Rehabilitation Services Physician Order Form/Consultation Request*).~~ The referring provider will order outpatient PT, OT, and/or ST~~, and/or audiology~~ via the electronic health record (EHR).

~~2.~~ 3. Referrals for Outpatient for Outpatient Aquatic PT, PT (non-aquatic), OT and/or Speech Therapy:

Referring provider will order outpatient therapy via ~~e-Consult~~the electronic ~~referral system..~~health record. With the exception of Aquatic PT, all therapy referrals are triaged by the appropriate therapy disciplines for scheduling. The referrals are then routed to the appropriate scheduler (at ZSFG or LHH) via the EHR.

4. Pre-appointment Process and Scheduling:

At LHH, evaluations are scheduled by Admitting and Eligibility Department (A&E) staff. A&E must determine eligibility for outpatient services prior to initiation of care. Please refer to Admissions and Eligibility Policy and Procedure 3.01 Outpatient Rehabilitation Services for procedure related to eligibility and outpatient scheduling.

~~a. Physical referral for outpatient services will be forwarded to A&E~~

~~b. Once eligibility is established A&E will return the approved referral to rehabilitation services.~~

~~c. Patients eligible for outpatient services will be registered by A&E prior to or on the first day of their outpatient appointments.~~

~~d. Rehabilitation staff assigned to the patient will contact the patient with their appointment date and time~~

~~e.~~ Schedigstration.

~~5~~5. Outpatient Appointments

a. All outpatients shall check-in with the Department of Admissions and Eligibility (A and E) prior to their appointment, per A and E Policy and Procedure 3.01 .

- Appropriate billing and documentation are completed in the EHR by the treating therapist.
- Subsequent treatment times are scheduled at the end of the appointment per plan of care. ~~as needed.~~

ATTACHMENT:
None

REFERENCES:

Admissions and Eligibility Department Policies and Procedures: Section Number 3.01. Outpatient Rehab Services

Most Recent Review: 16/08/05, 17/08/01
Original Adoption: 99/08/23

Revised: 06/09/22, 10/12/07, 11/08/30, 13/08/22, 14/08/22, 16/08/05, 18/08/14, 19/03/15, 19/06/22, 2020/01/16, 2020/01/27

Rehabilitation Services Policies and Procedures For Deletion

FOR DELETION

VERBAL ORDERS

POLICY:

Physical therapists (PT), occupational therapists (OT), and speech/language pathologists (SLP) may accept verbal orders from physicians within their scope of practice.

PROCEDURE:

1. The physician must give the verbal order directly to the desired service.

2. The therapist may accept the verbal order if it falls within the scope of his practice and does not involve other disciplines in its implementation.

   Acceptable verbal orders include, but are not limited to:

   a. Initiation of therapy (PT, OT, ST)
   b. Discontinuation of therapy (PT, OT, ST)
   c. Splint fabrication (PT, OT)
   d. Swallow evaluation (ST)
   e. Ultrasound treatment (PT)
   f. Functional electrical stimulation (PT)
   g. Wheelchair evaluation (OT)
   h. Community evaluation (PT, OT)
   i. Augmentative Communication Evaluation (ST)
   j. Restorative Care

   Unacceptable verbal orders include, but are not limited to:

   a. Use of a splint or other equipment on the Unit
   b. Beginning a Unit-based ambulation program
   c. Positioning of a patient
   d. Changing the texture of a patient's diet

   e. Changing a patient's weight-bearing status

3. For verbal orders to initiate treatment, the therapist must fill out form *MR 505 (Rehabilitation Services Physician Order Form/Consultation Request*) per guidelines in Appendix A. For other orders, the therapist must write, date, time, and sign the order on the Physician's Order sheet at the front of the patient's chart.

4. The verbal order is valid at the time that it is written; it does not need an accompanying physician's signature to be implemented; however, it must be signed within by the physician within 24 hours, per Laguna Honda Hospital and Rehabilitation Services policy.

5. The verbal order does not need to be noted or initiated by Nursing staff or the Unit clerk.

ATTACHMENT:
None

REFERENCE:
Medical Staff P&P: 01-01 Daytime Physicians' General Information (Orders — ¶ 1)

Most Recent Review: 18/08/24, 16/08/14, 17/07/31
Revised: 18/08/24, 06/09/22
Original Adoption: 99/08/23