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 January 14, 2020

Hospital-wide Policies and Procedures

Revised Policies (page 5)

Policies	Comments
01-13 Fraud, Waste and Abuse	Revised to clarify that this policy applies to all Department of Public Health (DPH) workforce members including employees, residents, contracted staff, students, volunteers, medical staff and individuals representing or working at LHH.
22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response	Revised to clarify the role of the mandated reporter and notification requirements; and updated Appendix A Investigation of Alleged Abuse Form.
22-07 Physical Restraints	Revised to add definition for chemical restraint.
24-06 Resident and Visitor Complaints/Grievances (re-titled)	Revised to include visitors in the policy; the Grievance Official was changed from Risk Management Nurses to the Assistant Hospital Administrator; contents from Suggestion boxes shall be picked up by a designee from Administration and routed to the Grievance Official; and complaints/grievances shall have a final resolution in 30 business days. Attachments C and D have been updated with new templates for Grievance Acknowledgement and Response.
24-08 Off Campus Appointments or Activities	Revised to add new procedure for patients eligible for Veterans Affairs transportation services.
25-05 Hazardous Drugs Management	Revised to be consistent with ZSFG practice and personal protective equipment recommendations that are built into the electronic health record (EHR) Medication Administration Record (MAR) – only one pair of chemotherapy gloves is required to handle solid tablet and capsule dosage forms.
45-02 Employee Development Fund	Revised to reflect Epic implementation with updated Fund codes; and for funding requests to be submitted to the Learning and Development Manager.
50-11 Procurement Card	Revised to require pre-approval prior to expenditures made with procurement cards (P-Card), except for Disaster Response and Fastrak replenishment; included examples of allowable purchases; updated Attachment A and added Attachment B and C.
55-01 Payor Eligibility, Certification and Coverage	Revised for Epic workflow and documentation including completing the Pre-Admission Screening Resident Review (PASRR) in the EHR; and to reflect use of InterQual Adult Acute Rehab Level of Care Criteria for admissions
55-02 Processing of Long Term Care Treatment Authorization Requests (TAR)	Revised to add procedure for TAR Clerk to update the Bed Days Table in the EHR when the TAR is approved/modified.

55-04 Triple Check Process	Revised for Epic workflow and documentation.
60-04 Unusual Occurrences (UO)	Revised to align with procedures in LHHPP 22-01; and revised policy statement to state that any LHH employee may complete a UO report.
70-01 C9 Heat Emergency Plan	Revised to align with Public Health Emergency Preparedness and Response (PHEPR); and establish procedures for alerting the Nursing Office and monitoring high risk residents when the interior temperature in a care area reaches 80°F or higher.
72-01 C22 Influenza Immunization	Revised to align with Epic workflow in which education documentation may only occur after vaccine has been ordered; and clarified standard procedure used by the registered nurse (RN) for the flu vaccine screen.
72-01 C26 Guidelines for Prevention and Control of Tuberculosis	Revised to align with Epic workflow for only one documentation of Tuberculosis Skin Test (TST) reading time; TST shall be read at 48 hours from placement.
76-01 Secured Neighborhood Safety Standard	Revised to add that inspection of outer egress doors in each household shall be conducted during environmental care rounds; and clarified staff response to household exit doors.
90-04 Parking on the Laguna Honda Campus	Revised to reflect current procedures for parking at LHH.

Deleted Policies (page 175)

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

Department: Clinical Nutrition Services

New Policies (page 179)

Policies	Comments
1.2 Nutrition Screening and Assessment Documentation for Acute Hospital Admissions	Created to provide medical nutrition therapy for patients admitted to the LHH Acute unit and communication the nutrition plan of care to the Resident Care Team.

Department: Medical Staff

Revised Policies (page 183)

Policies	Comments
001-03 Laguna Honda Acute Medical Unit Admission Guidelines	Revised policy to state that LHH residents who meet criteria for intensity of care and severity of illness shall be transferred to the Acute Medical Unit; and removed procedures that are no longer relevant.

Department: Nursing Services

Revised Policies (page 187)

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

Department: Pharmacy Services

Revised Policies (page 203)

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

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

San Francisco Department of Public Health (SFDPH)

Revised Policies

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

Revised Hospital-wide Policies and Procedures

FRAUD, WASTE, AND ABUSE

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to prevent and detect fraud, waste, and abuse. LHH endeavors to train and educate staffemployees to recognize potential problem areas and to use the internal mechanisms available to report suspected problems. This policy describes ways in which LHH can detect and prevent fraud, waste, and abuse, and the avenues through which to report a suspected violation.

1.

1.2. LHH staffemployees, volunteers, contractors, and agents shall not engage in any activity that constitutes fraud, waste, and/or abuse. LHH staff employees, volunteers, contractors, and agents shall comply with state and federal laws, including the False Claims Act and the California False Claims Act related to the prevention of fraud, waste, and abuse. In addition, LHH employeesstaff, volunteers, contractors, and agents shall comply with the San Francisco Department of Public Health's (DPH) Code of Conduct and DPH wide and LHH specific compliance policies.

PURPOSE:

To provide employees, volunteers, contractors, and agents of LHH staff with information regarding federal and state laws relating to false claims, including the prevention of retaliation against whistleblowers. This policy applies to LHH employees, volunteers, contractors, and agents who, on behalf of LHH, furnish or authorize the furnishing of Medicare or Medi-Cal services, perform billing or coding functions, deliver or monitor health care provided by LHH.
This policy applies to all DPH workforce members including employees, medical residents in training, contracted staff, students, volunteers, medical staff and individuals representing or working at LHH, who, on behalf of LHH, furnish or authorize the furnishing of Medicare or Medi-Cal services, perform billing or coding functions, deliver or monitor health care provided by LHH. These individuals are referred to as LHH staff in this document.

DEFINITIONS:

1. **"Abuse"** is any practice that is inconsistent with accepted medical or business practice that results in an unnecessary cost to the Medicare or Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. (42 CFR § 455.2)

2. **"Claim"** includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee,

or other recipient for any portion of the money or property which is requested or demanded. (31 U.S. Code § 3729)

3. **"The California False Claims Act (CFCA)"** is the state law that prohibits any person or entity from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or use a false record or statement material to a false or fraudulent claim. (Cal. Govt. Code §12650 et seq.)

4. **"The False Claims Act (FCA)"** is a federal law that that imposes liability on persons and entities who defraud governmental programs, and is the federal Government's primary litigation tool in combating fraud against the Government. (31 U.S.C. §§ 3729 – 3733)

5. **"Fraud"** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. (42 CFR § 455.2)

6. **"Waste"** is the intentional or unintentional over-utilization of services, careless or thoughtless expenditure, consumption, mismanagement, squandering of government resources; or engaging in practices that result in unnecessary costs.

PROCEDURE:

1. Preventing and Detecting Fraud, Waste, and Abuse

   a. LHH documentation and coding policies support accurate billing for services provided to our patients and clients. LHH staffemployees are required to understand and abide by the laws, regulations, policies, and procedures that apply to them in the performance of their job duties.

   b. The DPH Office of Compliance and Privacy Affairs (OCPA) through its onsite LHH Compliance Officer conducts both scheduled and unscheduled reviews of programs and services with particular emphasis on risk areas identified by the federal government or LHH staffemployees, volunteers, contractors, or agents. OCPA provides continuing education and guidance, and remains current on regulatory changes that impact the submission of claims.

   c. Mistakes or errors on bills that result in overpayments are returned in accordance with applicable laws and corrective action plans are enacted when problems are identified. LHH's Compliance Officer monitors the implementation of corrective action plans.

   d. Corrective action plans may include findings and recommended process improvements, including monitoring, training on the FCA, CFCA, any other relevant law or policy, or coding and documentation practices.

2. Reporting Fraud, Waste, and Abuse

   a. Any illegal, unethical, or improper activities shall be reported, investigated and rectified. LHH employeesstaff, volunteers, contractors, and agents shall report any known or suspected violations of the FCA, CFCA, state and local laws, and LHH and DPH policies.

   b. LHH staffemployees, volunteers, contractors, and agents have a variety of internal reporting options to resolve concerns related to fraud, waste or abuse. Any concern may be reported to an immediate supervisor, manager, and LHH's Compliance Officer. Individuals may alternatively contact the OCPA Compliance and Privacy Hotline by telephone at 855-729-6040, or by email at compliance.privacy@sfdph.org. All employees, volunteers, contractors, and agentsstaff may anonymously report known or suspected violations.

   c. In addition to internal reporting, any individual may report any known or suspected violation to the United States Office of Inspector General (OIG). Information on reporting to the OIG is available at https://oig.hhs.gov.

3. Investigation of Fraud, Waste, and Abuse

   a. Reports alleging fraud, waste, and abuse shall be immediately investigated according to the "DPH Compliance Policy – Investigations Conducted by the Compliance Office."

4. Prohibition on Retaliation against Whistleblowers

   a. DPH has a strict non-retaliation policy and will not tolerate or condone any form of retaliation against any employee staff who reports a known or suspected violation in good faith. Any DPH employee who commits or condones any form of retaliation shall be subject to discipline, including and up to termination. The FCA and CFCA protect whistleblowers from retaliation for reporting known or suspected violations pursuant to those Acts. In addition, the San Francisco Campaign and Governmental Conduct Code also protects City employeesstaff for reporting improper governmental activity.

5. Enforcement of Policy

   a. A DPH staffemployee who violates any provision of this policy may be subject to disciplinary action up to and including termination of employment.

ATTACHMENT:
None.

REFERENCE:

LHHPP 01-12 Compliance Program
DPH Compliance Policy – Investigations Conducted by the Compliance Office
DPH Compliance Program – Employee Non-Retaliation Policy

Revised: 18/11/13, 20/01/14 (Year/Month/Day)
Original adoption: 17/09/12

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

PHILOSOPHY:

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

POLICY:

1. LHH employees, contractors, and volunteers shall provide a safe environment and protect residents from abuse, neglect, misappropriation of property, exploitation, and use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's condition.

2. All LHH employees, contractors, and volunteers are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

3. LHH employees, contractors, and volunteers shall immediately respond to and report observed or suspected incidents of abuse to the California Department of Public Health (CDPH), the Ombudsman, and Nursing Operations.

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

5. LHH Department Managers are responsible for monitoring staff compliance with this policy and LHH Quality Management (QM) and Human Resources (HR) departments shall be responsible for the process oversight.

6. LHH shall not employ or otherwise engage individuals who:

    a. have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

    b. have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and/or

    c. have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

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

PURPOSE:

1. To protect the resident from abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

2. To report incidents or alleged violations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms without fear of retaliation and in a timely manner.

3. To promptly investigate allegations of abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

4. To provide clinical intervention to prevent and minimize abuse or neglect, exploitation of residents, misappropriation of resident property, use of involuntary seclusion or any physical or chemical restraint not required to treat the resident's medical symptoms.

5. To meet reporting requirements as mandated by federal and state laws and regulations.

DEFINITION:

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

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

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

saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

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

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

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

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

2. "Neglect" as defined at 42 CFR §483.5 means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

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

4. Misappropriation of resident property means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

5. Mistreatment means inappropriate treatment or exploitation of a resident.

6. Involuntary seclusion is defined as separation of a resident from other residents or from her/his room or confinement to her/ his room (with or without roommates) against the resident's will, or the will of resident representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet resident's needs.

7. Injury of unknown source/origin is an injury when the source of the injury was not observed by any person, or the source of injury could not be explained by a resident, and when the extent of the injury, location of the injury or the number of injuries observed at one particular point in time or the incidents of injuries over time are suspicious in nature.

8. Serious bodily injury [as defined in Section 6703 (b) (3) of the Affordable Care Act] is defined as an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

9. Criminal sexual abuse is defined in section 2011(19)(B) of the Act (as added by section 6703(a)(1)(C) of the Affordable Care Act), serious bodily injury/harm shall be considered to have occurred is the conduct causing the injury is conduct described in section 2241(related to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or ay similar offense under State law. In other words, serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident or others or any sexual act involving a child. Serious bodily injury also includes intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act.

10. "Immediately" means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

PROCEDURE:

1. Screening of Potential Employees

a. Criminal Background Checks

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

b. Experience and References

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

2. Education

a. Employee and Volunteer Education

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

ii. New employees/volunteers, including transfers or inter- facility reassignments to LHH, shall, as a condition of employment, participate in "The Abuse Prohibition/Prevention Program", which includes the following:

- Facility orientation program on residents' rights, including confidentiality, preservation of dignity, identifying what constitutes abuse, and recognizing and reporting abuse without fear of retaliation;
- Nonviolent safety management and prevention of challenging behaviors**;**
- Review of the following policies and procedures that support the overall program:
  - LHHPP 22-03 Resident Rights
  - LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
  - LHHPP 22-07 Physical Restraints Including Bed Rails
  - LHHPP 22-08 Threats of Physical Violence to Residents
  - LHHPP 24-06 Resident Complaints/Grievances
  - LHHPP 22-10 Management of Resident Aggression
  - LHHPP 73-05 Workplace Violence Prevention Program
- Annual in-service education provided by the Nurse Educators to all employees, which includes a review of residents' rights, abuse and neglect prohibition/prevention, mandated reporting, and resident and employee freedom from retaliation when reporting abuse allegations.
- Nurse Educators provide additional abuse and neglect prevention training to nursing and other staff annually, including recognition of psychological, behavioral, or psychosocial indicators of abuse, recognition of environmental factors that could potentially lead to abuse, and other pertinent abuse and neglect prevention and response educational topics.

iii. Employees shall be notified of their reporting obligations to report any reasonable suspicion of a crime against a resident during the New Employee Orientation (NEO) and annually during residents' rights, abuse and neglect prevention in-services. Annual notification shall also include a description of the fines and Federal health care program sanctions associated with the

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

b. Employees shall be informed of their rights during NEO and through posted information in the Human Resources Department. This shall include the right to file a complaint with the State Survey Agency if anyone at LHH retaliates against an employee who files a report of a reasonable suspicion of a crime committed against a resident to a law enforcement agency (such as the San Francisco Sheriff's Department (SFSD) at 4-2319).

   i. Information on employee rights related to reporting a crime or retaliation shall be posted in HR.

c. Resident Education

   i. Residents are presented on admission with a Residents' Handbook that contains information on residents' rights and responsibilities, contacting advocates, and the abuse reporting process. Residents are informed to whom they may report concerns, incidents and complaints.

   ii. A listing of Residents' rights shall be posted on each unit.

   iii. Resident education topics such as reporting abuse, neglect, exploitation and/or mistreatment shall be reviewed at the neighborhood/unit community meetings at least twice a year or more frequently as determined by the Resident Care Team (RCT).

3. Prevention

a. Staff shall be trained in nonviolent safety management and prevention of challenging behaviors, which includes assessment, response techniques, and tools to prevent and identify potential crisis and/or de-escalate challenging behaviors. Training includes:

   i. Nonverbal communication

   ii. Para verbal communication

   iii. Verbal communication

   iv. Precipitating factors, rational detachment and the integrated experience

   v. Staff fear and anxiety

   vi. Decision making

   vii. Physical interventions (disengagement skills) as a last resort

viii. Debriefing

b. Staff and families shall be provided with information on how and whom they may report concerns, incidents and grievances, as well as feedback regarding their expressed concerns (see procedure 2.a. Employee and Volunteer Education).

c. RCT members and clinical staff shall conduct ongoing resident assessments, revise care plans as needed, and monitor resident's needs and behaviors that may lead to conflict or neglect (see procedure 9 Resident Assessment and Care Planning).

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

a. Abuse may result in psychological, behavioral, or psychosocial outcomes. The following signs may alert LHH staff to possible resident abuse and indicate the need for immediate reporting, response, and investigation:

i. Statements from a resident alleging abuse, neglect, misappropriation of resident property, or exploitation (including involuntary seclusion and unreasonable confinement) by staff, another resident, or visitor;

ii. Sounds and/or utterances that suggest physical or verbal abuse, neglect, misappropriation of resident property, or exploitation, chemical or physical restraints;

iii. Injuries, abrasions, falls, or bruises of unknown or suspicious origin and/or location;

iv. Illogical accounts given by resident or staff member of how an injury occurred;

v. Sudden or unexplained changes in resident's personality or behavior(s) such as aggressive or disruptive behavior, running away, fear of being around a certain person or being in a particular context, withdrawal, isolating oneself, expressions of guilt and/or shame, depression, crying, talk of suicide and/or attempts, disturbed sleep;

vi. Resident asks to be separated from caregiver or accuses caregiver of mistreatment;

vii. Resident-to-resident altercations;

viii. Visitor-to-resident altercations;

ix. Discovery or observation of illicit photographs and/or recordings of residents being taken;

x. Unexplained contraction of sexually transmitted diseases, vaginal or anal bleeding, or torn and/or bloodied underclothing.

b. These signs may indicate that mental and/or verbal, sexual, or physical abuse, and/or the deprivation of goods and services has occurred; in the event that an indicator becomes apparent, LHH staff should immediately respond to and report the potential abuse.

5. Protection: Staff/Volunteer Intervention

a. In the event that an employee/volunteer

i. Observes abuse,

ii. Suspects that abuse has occurred,

iii. Observes resident–to-resident or visitor-to-resident altercation,

iv. Identifies an injury of unknown source/ origin,

v. Learns about an allegation of abuse, neglect or exploitation of any LHH resident, and/or is the first person to learn of a resident-to-resident or visitor-to-resident altercation, that employee/volunteer shall immediately attempt to identify the involved resident(s) and notify the responsible manager and the nurse manager or nursing supervisor.

b. The employee and/or responsible managers shall take immediate measures to assure resident safety as follows:

i. In the event of alleged employee to resident abuse, neglect or exploitation, the responsible manager shall reassign the employee who is being investigated to non-patient care duties or place the employee on administrative leave if non-patient care duties are not available at the point the manager was notified of the allegation. These measures shall be in place until the investigation is completed.

ii. In the event of alleged resident-to-resident abuse or resident-to-resident altercation, the employee shall immediately separate the residents and move each resident to a safe area apart from one another until the incident is addressed by the responsible manager/supervisor.

c. The responsible manager shall document the incident in each respective involved resident's medical record and develop or revise care plan as necessary.

d. Upon receiving a report of alleged abuse, neglect or exploitation, the attending or on-call physician shall promptly perform a physical exam. The physician shall record in the progress notes of the resident's medical record the history of abuse as relayed, any findings of physical examination and psychological evaluation, and any treatment initiated. The physician shall, in the event of a resident-to-resident altercation, perform a physical exam on both residents and record in the progress notes of both residents' medical records the history, examination findings, psychological evaluation and any treatment initiated.

e. The Medical Social Services Worker shall follow-up with the resident within 72 hours to assess and to provide psychosocial support.

f. The employee and/or responsible managers, supervisors, physicians and others shall complete all required forms. See "Reporting Protocol".

6. Reporting Protocol

a. All LHH employees, volunteers, and contractors are mandated reporters of alleged incidents of abuse and/or suspicion of incidents of abuse.

   i. ~~Employees~~ The mandated reporter shall immediately respond to and report observed or suspected incidents of abuse by contacting the following within 2-hours:

      - CDPH (415) 330-6353
      - Ombudsman (415) 751-9788
      - Nursing Operations (415) 327-1902

   ii. The mandated reporter ~~Employees~~ may report anonymously to each internal and/or external agency.

b. LHH mandates ~~staff to report~~ suspected abuse to be reported to the local Ombudsman office as required by State law.

c. LHH also requires ~~the employee, manager/supervisor, agent or contractor of the facility to report to SFSD~~ any reasonable suspicion of a crime committed against a resident of LHH be reported to SFSD.

   i. Examples of crimes that are reportable include but are not limited to the following:

      - Murder;
      - Manslaughter;

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

d. Notification requirements:

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

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

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

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

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

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

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

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

ii. Immediately inform the resident and/or surrogate decision-maker that the abuse allegation is being taken seriously; identify for the resident and/or the surrogate decision-maker the steps being taken to provide for the resident's safety; and assure the resident and/or the surrogate decision-maker that an investigation is being conducted, the outcome of which will be reported to the resident and/or surrogate decision-maker. ~~Notify within 2 hours to the CEO or designee, CDPH, Ombudsman, SFSD, and QM staff of events involving alleged violations of abuse (physical, verbal, mental and sexual), neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property and involuntary seclusion.~~

~~iii. Notify within 24 hours to the CEO or designee, Medical Social Services Worker, Ombudsman, SFSD, QM staff and CDPH of events involving allegations of abuse that are not substantiated and do not result in serious bodily injury.~~

f. If given permission by a resident with decision-making capacity, the physician or nurse manager shall contact the resident's family or representative regarding the alleged abuse. If the resident does not have decision-making capacity, the physician shall notify the resident's surrogate decision-maker.

g. If an abuse allegation involves a LHH staff person, the nursing supervisor shall notify HR and the staff person's immediate supervisor within 24 hours.

h. The nurse manager or nursing supervisor shall also assess and determine if the incident warrants contacting other resources, such as the psychiatric on-call physician.

i. The nurse manager or nursing supervisor shall assess on a case-specific basis allegations of, resident to resident altercations, including altercations that occur between two residents with dementia that do not result in bodily injury, or rise to a reasonable suspicion of a crime, and determine, if an incident is reportable to ~~the Sheriff's Department~~SFSD. The Deputy Sheriff may be consulted as necessary if the allegation warrants official notification to the Sheriff's Department.

j. In cases of alleged or factual rape the following steps must be taken:

i. ~~Facility~~ LHH staff must immediately notify ~~the San Francisco Sheriff's Department~~SFSD (Ext. 4-2319~~; 4-2301~~).

ii. The attending physician shall make a direct referral to the San Francisco Rape Treatment Center located at 2801A – 25th Street, San Francisco (Ph: 415-821-3222) and shall direct the staff to preserve physical evidence to include the resident's physical condition and related personal effects.

iii. At the San Francisco Rape Treatment Center, the resident ~~will~~ shall be interviewed, specimens ~~will~~ shall be taken, and treatment for possible sexually transmitted diseases as well as HIV prophylaxis shall be prescribed as deemed appropriate.

iv. In all cases of rape the attending physician shall request a psychiatric consultation for the resident.

v. If a non-employee is identified as a suspect of rape, the nursing supervisor or nurse manager shall contact the Sheriff's Department.

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

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

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

7. Investigation

a. Any nurse or RCT member involved in the investigation of a resident-to-resident altercation, or allegation of abuse, neglect or exploitation shall document in the progress notes the details surrounding the incident (e.g., the times of physician notification and visits, the time of notification of the nursing supervisor, pertinent orders and actions, relevant resident remarks and assessment of resident condition related to the situation).

b. If an abuse, neglect or exploitation allegation involves a LHH employee, the investigating supervisor/manager shall immediately give the involved employee an interim reassignment in non-patient care areas or place the employee on administrative leave, pending completion of the investigation. The interim reassignment or administrative leave will be in place until the Nursing and HR Departments complete their investigations and confer on their findings. The employee shall be formally notified of the outcome of the investigation and future employee assignment.

c. If an abuse allegation, neglect or exploitation involves a LHH employee and the conclusion to the investigation does support the allegation, the manager shall continue the administrative leave measure pending completion of the full investigation by HR. The investigating supervisor/manager may consider the following factors in determining whether the alleged employee shall be placed on leave or reassigned to non-patient care duties:

   i. Severity of the allegation,

   ii. Circumstances of the case per the investigation, and

   iii. Prior disciplinary and employment history.

d. QM staff shall forward investigation documents related to the abuse, neglect or exploitation allegation involving LHH staff to the LHH HR. The LHH HR shall conduct an independent investigation of any abuse allegation involving LHH staff whenever the investigating party determines that the alleged abuse is substantiated.

e. LHH HR shall confer with the involved staff's immediate supervisor about the findings of the investigation to determine the appropriate administrative course of action.

f. If an employee or non-employee is identified as a suspect of a crime, the nursing supervisor or nurse manager shall contact SFSD~~the Sheriff's Department~~. The nursing supervisor or manager shall initiate action to protect the resident and the ~~Sheriff's Department~~SFSD and or San Francisco Police Department shall carry out the investigation.

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

8. Forms Completion and Submission

a. The Charge Nurse or ~~reporting employee~~designee shall complete the Unusual Occurrence report related to the suspected criminal incident or allegation of abuse and submit to QM electronically.

b. The "Report of Suspected Dependent Adult/Elder Abuse" form (SOC 341), shall be completed by the designation of Nursing Operations. The staff person may be the Nurse Manager, Charge Nurse, Medical Social Worker or Nursing Operations Nurse Manager. The completed SOC 341 shall be submitted to QM. ~~/designee or Operations Nurse Manager or be designated to the Medical Social Worker to complete form SOC 341 during regular business hours and submitted to QM.~~ (Refer to LHH SharePoint Forms page for an electronic form).

c. The investigating supervisor/manager conducting the investigation into resident abuse, neglect or exploitation shall verify that the Unusual Occurrence and ~~Report of Suspected Dependent Adult/Elder Abuse~~the SOC 341 forms have been completed and submitted to QM.

d. The SOC 341 shall be faxed to 415-751-9789 by Nursing Operations or designee and the fax verification submitted to QM.

e. The investigating supervisor/manager shall complete the Investigation of Alleged Abuse form and submitted to QM with attachments in cases of:

i. Resident-to-resident
ii. Visitor-to-resident
iii. Staff-to-resident
iv. Injury of unknow origin
v. Neglect
vi. Misappropriate of resident's property

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

f. In cases of alleged resident abuse, neglect or exploitation by staff or visitor, the ~~investigating director/manager conducting the inquiry shall complete the Investigation of Alleged Abuse form and submit the form, along with any attachments to QM. F~~final conclusion shall be determined by the Nursing Director, after conferring with the Chief Nursing Officer.

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

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

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

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

9. Resident Assessment and Care Planning

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

   i. Short-term and long-term measures to provide the resident with a safe and secure environment.

   ii. Measures to mitigate the psychological impact of the incident.

   iii. Characteristics, behaviors or habits that make the resident vulnerable at risk for aggression or altercations.

   iv. Physiologic factor(s) involved in this incident. (Was the resident hungry, thirsty, constipated, in need of going to the bathroom, sleep deprived? Was the resident in pain? Did the resident have signs of an infection or delirium?)

   v. Treatment that may have contributed to or induced the resident's behavior.

   vi. Need for psychiatric evaluation.

   vii. Environmental stimulus/factor(s) contributing to this incident (excessive noise, crowded room).

   viii. Staff action and/or inaction that may have contributed to the resident's behavior

   ix. Ability to modify environment.

x. Likelihood of a repeat incident.

xi. Interventions to minimize the risk of recurrence.

xii. Need for frequent check-ins

xiii. Need for relocation or transfer to another level of care.

ATTACHMENT:
Appendix A: Investigation of Alleged Abuse Form

REFERENCE:
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-07 Physical Restraints Including Bed Rails
LHHPP 22-08 Threats of Violence to Residents by an External Party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-06 Resident Complaints/Grievances
LHHPP 73-05 Workplace Violence Prevention Program
SOC 341 Form

Revised: 07/15/96, 12/27/99, 05/18/00, 01/03/01, 04/18/05, 04/28/05, 06/28/05, 07/29/05, 04/05/06, 01/08/08, 12/03/27, 16/01/12, 17/09/12, 18/05/08, 18/09/11, 19/05/14, 19/07/09, 19/09/10, 19/11/12 (Year/Month/Day)
Original adoption: 05/20/92

Appendix A: Investigation of Alleged Abuse Form

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

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

Occurrence of Incident

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

Brief Description of Incident
PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

☐ No witnesses were identified.

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

PART II: REPORTER INFO

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

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

Reported to: _____ Job Class/Title:

Page 1 of 6

Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

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

Resident B (Suspected Abuser) ☐ N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

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

Staff/Other ☐ N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident ☐ N/A

☐ Reassignment of alleged staff to a non-patient area.

☐ Staff sent home or on administrative leave.

Resident to Resident / Other to Resident ☐ N/A

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

☐ One of more residents moved or relocated.

☐ Other. Please explain:

Other Types of Alleged Abuse ☐ N/A

☐ Please describe action taken:

Page 2 of 6

Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

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

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

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

Notification of Resident's Responsible Party ☐ N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist *(Check appropriate boxes)*

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

External Notification Checklist *(Check appropriate boxes)*

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

Sample call to CDPH:

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

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

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

Page 3 of 6

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Medical Assessment of Resident B ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Resident to Resident Incident Assessment(s) ☐ N/A

Please complete ONLY if incident is Resident to Resident.

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

Resident Interview

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

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

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

Analysis

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

If yes, did the deliberate act result in:

Physical Harm ☐ Yes ☐ No Pain ☐ Yes ☐ No Mental Anguish ☐ Yes ☐ No

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

Page 4 of 6

Investigation of Alleged Abuse

PART VII: CONCLUSION

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

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

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

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

Additional Required Documents

(Check appropriate boxes)

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

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

Page 5 of 6

Investigation of Alleged Abuse

ADDITIONAL SPACE

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

Page 6 of 6

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

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

Occurrence of Incident

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

Brief Description of Incident
PLEASE INCLUDE WHO, WHEN, WHERE, WHAT AND WHY.

List of Witnesses

☐ No witnesses were identified.

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached
Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

PART II: REPORTER INFO

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

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

Reported to: _____ Job Class/Title: _____

Page 1 of 6

Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

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

Resident B (Suspected Abuser) ☐ N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

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

Staff/Other ☐ N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident ☐ N/A

☐ Reassignment of alleged staff to a non-patient area.

☐ Staff sent home or on administrative leave.

Resident to Resident / Other to Resident ☐ N/A

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

☐ One of more residents moved or relocated.

☐ Other. Please explain:

Other Types of Alleged Abuse ☐ N/A

☐ Please describe action taken:

Page 2 of 6

Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

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

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

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

Notification of Resident's Responsible Party ☐ N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist *(Check appropriate boxes)*

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

External Notification Checklist *(Check appropriate boxes)*

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

  Name _____ ☐ Answering Machine

  Date _____ Time _____

Quality Management Business Hours*

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

Sample call to CDPH:

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

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

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

Page 3 of 6

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Medical Assessment of Resident B ☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Resident to Resident Incident Assessment(s) ☐ N/A

Please complete ONLY if incident is Resident to Resident.

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

Resident Interview

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

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

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

Analysis

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

If yes, did the deliberate act result in:

Physical Harm ☐ Yes ☐ No Pain ☐ Yes ☐ No Mental Anguish ☐ Yes ☐ No

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

Page 4 of 6

Investigation of Alleged Abuse

PART VII: CONCLUSION

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

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

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

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

Additional Required Documents

(Check appropriate boxes)

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

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

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Investigation of Alleged Abuse

ADDITIONAL SPACE

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

Page 6 of 6

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Investigation of Alleged Abuse

PART I: INCIDENT INFO

TODAY'S DATE _____

Type of Alleged Abuse

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

☐ Resident to Resident ☐ Staff to Resident ☐ Other _____

Occurrence of Incident

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

Brief Description of Incident

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

List of Witnesses

☐ No witnesses were identified.

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

Name: _____ Contact Number: _____ ☐ Interviewed ☐ Summary Attached

PART II: REPORTER INFO

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

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

Reported to: _____ Job Class/Title: _____

Investigation of Alleged Abuse

PART III: PERSONS INVOLVED

Resident A (Alleged Victim)

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

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

Resident B (Suspected Abuser) ☐ N/A

First Name _____ Last Name _____ Medical Record # _____

Date of Birth _____ Unit _____ Bed _____ Contact Number _____

Relevant Diagnosis _____

Resident is determined by physician to be:

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

Staff/Other ☐ N/A

First Name _____ Last Name _____ Contact Number _____

Job Class/Title _____ Relationship to Resident _____

PART IV: PROTECTIONS TAKEN

Staff to Resident ☐ N/A

☐ Reassignment of alleged staff to a non-patient area.

☐ Staff sent home or on administrative leave.

Resident to Resident / Other to Resident ☐ N/A

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

☐ One of more residents moved or relocated.

☐ Other. Please explain:

Other Types of Alleged Abuse ☐ N/A

☐ Please describe action taken:

Investigation of Alleged Abuse

PART V: NOTIFICATION TO BE COMPLETED

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

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

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

Notification of Resident's Responsible Party ☐ N/A

Resident A: Name _____ Date _____ Time _____

Resident B: Name _____ Date _____ Time _____

LHH Staff Notification Checklist *(Check appropriate boxes)*

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

External Notification Checklist *(Check appropriate boxes)*

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

Sample call to CDPH:

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

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

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

Investigation of Alleged Abuse

PART VI: ASSESSMENT

Medical Assessment of Resident A

☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Medical Assessment of Resident B

☐ N/A

Name of Physician _____ Date _____ Time _____

Brief Statement of Findings:

Resident to Resident Incident Assessment(s)

☐ N/A

Please complete ONLY if incident is Resident to Resident.

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

Resident Interview

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

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

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

Analysis

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

If yes, did the deliberate act result in:

Physical Harm ☐ Yes ☐ No Pain ☐ Yes ☐ No Mental Anguish ☐ Yes ☐ No

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

Investigation of Alleged Abuse

PART VII: CONCLUSION

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

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

Please explain the reason for your conclusion below.

Reason(s) for my conclusion:

PART VIII: SUPPORTING DOCUMENTS

Additional Required Notifications

(Check appropriate boxes)

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

Additional Required Documents

(Check appropriate boxes)

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

Name / Title: _____ Date Completed: _____

Signature: _____

Name / Title: _____ Date Completed: _____

Signature: _____

Investigation of Alleged Abuse

ADDITIONAL SPACE

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

PHYSICAL RESTRAINTS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) affirms the right of each resident to be free from any ~~physical~~ restraint imposed for purposes of discipline or staff convenience, and when not required to treat the resident's medical symptoms.

2. LHH supports preventing, reducing, and eliminating the use of restraints and restraint-associated risk through ~~the use of~~ preventive strategies, alternatives, and process improvements.

3. The least restrictive interventions shall be discontinued as soon as it is safe for the resident and staff regardless of the scheduled expiration of the restraint order.

4. A ~~R~~restraint order shall not be written as a standing or PRN order.

5. The ~~R~~restraint consent form shall be updated annually.

PURPOSE:

To assure resident freedom from physical restraints whenever possible, and to utilize the least restrictive restraints only when other less restrictive means to provide safety have been ineffective.

DEFINITIONS:

1. Physical restraint: Any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that he or she cannot easily remove which restricts freedom of movement or normal access to one's body.

   a. Freedom of movement: any change in place or position for the body or any part of the body that the person is **physically** able to control or access.

2. Bed rail(s) are considered restraints when:

   a. The purpose is to keep a resident from getting out of bed when he/she wants to get out of bed.

   b. The use of the bed rail restricts freedom of movement.

3. Chemical restraints are defined as any drug that is used for discipline or convenience and not required to treat medical symptoms

~~3.~~4. Convenience: as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care

and is not in the resident's best interest.

~~4.~~5. Discipline: any action taken by the facility for the purpose of punishing or penalizing residents.

~~5.~~6. Manual Method: to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint

~~6.~~7. Medical symptom: is defined as an indication or characteristic of a physical or psychological condition.

~~7.~~8. Position Change Alarms: alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in criteria ways.

a. Alarms are considered restraints when the resident is afraid to move to avoid setting off the alarm.

EXCLUSIONS:

Mechanical/postural Support:

Mechanical/postural support is not considered a restraint. It is used to achieve proper body position, balance, or alignment to allow greater freedom of mobility that would not be possible without the use of the mechanical support (refer to NPP D6 4.0 Positioning and Alignment in Bed and Chair).

STANDARDS / GUIDELINES FOR RESTRAINT USE:

1. A physical restraint can only be used to provide safety if less-restrictive interventions have been ineffective. A physician order must be completed via EHR.

2. If the covering physician writes a restraint order, this shall be communicated to the attending physician during endorsement.

3. The physician must conduct a face-to-face assessment within one calendar day of initiation when initial restraint order is verbal.

4. Only restraints approved by LHH may be used (hand mittens, abdomen binder, and ultimate walker, bed rails in certain circumstances). The appropriate size and type of restraint for the resident is to be applied following manufacturer's directions. Restraints are to be applied ~~so as~~ to permit easy removal in emergency situations (e.g., in the event of a fire or disaster).

PROCEDURE:

1. **Procedure for Using Restraints:**

   a. Before applying a new restraint:

      i. Consult with the Resident Care Team (RCT), consisting of at least the nurse and physician, to discuss and document:

         - Circumstances leading to the use of restraints and what less-restrictive interventions were tried first;

      ii. The degree of effectiveness of the less-restrictive alternatives and how it was decided what type of restraint to use.

   b. When a decision is made to order a new physical restraint:

      i. Orders are to be completed via EHR.

      ii. Complete Consent for Physical Restraint. Consents must include discussion with the resident or resident representative regarding:

         - Educate family/resident representative on risk of removing, repositioning, or retying restraint.

         - Type of restraint and duration of use.

         - Possible benefits and risks of using, or not using, restraints.

         - Rights of resident or resident representative to accept or refuse the use of restraints at any time.

      iii. Update the resident's Care Plan:

         - The type of restraint and whether the restraint used is the least restrictive device.

         - The reason for the restraint (medical symptom) and restraint use duration

         - Document ongoing efforts to evaluate/eliminate use of the restraint.

         - Interventions (restorative) to address potential functional decline.

         - A plan for reduction or eventual discontinuation of the restraint.

iv. For a new order, RN's will monitor the resident within one hour after initiating the restraint and release and document every 2 hours or sooner according to resident need – a continuous face-to-face monitoring may be required when the restraint leaves a resident vulnerable.

v. The RCT will meet in a timely manner to discuss alternatives and plan for least-restrictive restraint(s).

c. For continued restraint use:

i. Ongoing use of restraints shall be discussed with the RCT quarterly, or during "Special Review" which can be conducted at any time.

ii. Discussion shall include:

- Resident's response to restraint being used.
- Possible alternatives/least-restrictive restraint to be used.
- Referrals to ancillary departments, as appropriate.
- Continuation of restraint use must be renewed via EHR.

2. **Procedures for Using Restraints: Treatment**

Treatment restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.

3. **Procedures for Using Restraints: Acute Patients (Medical or Rehabilitation)**

Physician orders for the use of physical restraints in an acute care setting follow the same procedures as outlined above with the exception of every 24-hour renewal time.

DOCUMENTATION

1. The condition of the resident utilizing a restraint shall be monitored every 2 hours.

a. Assessments are to be documented by RNs via EHR and shall include, but are not limited to:

i. Circulation (including vascular checks such as capillary refill, temperature, edema and color of skin)

ii. Skin integrity of the restrained extremity(ies)

iii. Signs of injury associated with a restraint

b. Clinical justification and resident response that warrants the use of the restraint are to be reflected in the weekly/monthly nursing summary by the Licensed Nurse.

2. Certified nursing assistants or patient care assistants are to document via EHR on the following:

a. Proper placement of restraint as ordered

b. Release of restraint every 2 hours for:

i. ROM to the restrained extremity(ies) while awake

ii. Turning and repositioning

iii. Hygiene/elimination

(Note: a temporary release that occurs for the purpose of caring for a resident's needs, i.e., toileting, feeding, repositioning and ROM, is not considered a discontinuation of the intervention.)

3. Staff Training

a. Nursing Staff who have direct patient contact shall receive new employee orientation training and subsequent annual education and training in the proper and safe use of restraints, including, but not limited to the following:

i. Methods to reduce and eliminate restraint use;

ii. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger physical restraint use;

iii. Use of non-physical intervention skills;

iv. Choosing the least-restrictive intervention based on individualized assessment;

v. Safe application of physical restraints;

vi. Clinical identification of behavioral changes that indicate that restraint is no longer necessary; and

vii. Monitoring physical and emotional well-being of patients (e.g., respiratory and circulatory status, skin integrity, vital signs, etc.).

ATTACHMENT:
Appendix A: Alternatives to Restraint Suggestions
Appendix B: Seatbelt table

REFERENCE:
Barclays Official California Code of Regulations: §72319, Nursing Service - Restraints and Postural Supports
State Operations Manual Appendix PP - Survey Protocol, Regulations and Interpretive Guidelines for Long Term Care (Rev. 168, 03-08-2017)
Title 22

CROSS-REFERENCE:
LHHPP 22-13 ~~Siderail~~ Bed Rail Use
LHHPP 24-13 Falls
NPP D6 4.0 Positioning and Alignment in Bed and Chair

Revised: 97/04/15, 00/01/27, 02/09/06, 08/08/08, 09/01/13, 09/08/21, 10/09/24, 10/11/10, 16/01/12, 17/09/12, 19/03/12, 19/11/12 (Year/Month/Day)
Original adoption: 96/07/15

RESIDENT AND VISITOR COMPLAINTS/GRIEVANCES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) strives to create an environment that is responsive to residents/visitors' ~~–~~complaints/grievances and addresses residents/visitors' concerns.

2. LHH encourages residents to raise concerns for resolution with their care team (RCT), at Community meetings, or at Residents Council without discrimination or fear of reprisal.

3. LHH shall make prompt efforts to resolve grievances ~~the~~ residents/visitors may have by actively working toward a resolution.

4. Individual resident concerns that are addressed by the RCT shall be documented in the medical record. Concerns raised during Residents Council and Community meetings shall be reflected in meeting minutes and or notes of those meetings respectively.

5. When methods for resolving concerns have not been successful and ~~the~~ residents/visitors chooses not to use any of the above methods, LHH has a ~~Resident~~ Complaint/Grievance form that can be submitted to the ~~Quality Management (QM)~~Administration Department (Administration) to address unresolved complaints/grievances in a culturally sensitive manner.

6. The neighborhood bulletin board shall display necessary information, consistent with federal requirements, on the resident~~'~~s/visitors right to file complaints/grievances orally and in writing, including anonymously, and the process for submitting complaints/grievances.

PURPOSE:

1. To ensure that significant complaints are addressed and appropriate follow-up actions are taken to resolve the issue to the fullest extent possible.

2. To optimize the ~~quality of life~~experience and satisfaction of the residents/visitors ~~and satisfaction~~ with the care and services in a timely manner.

DEFINITION:

Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction surveys, or given directly to staff. Examples of complaints/grievances may include those about treatment, care, management of funds, lost clothing, or violation of rights.

PROCEDURE:

1. On admission, each resident receives the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy.

2. The Resident/Visitor Complaint/Grievance policy will be reviewed in Hospital-wide orientation for new employees and will be included in Resident's Rights annual in-services when policy changes occur.

3. Resident/Visitor Complaint/Grievance forms shall be kept on each unit, in the Social Services Office, in the Nursing Office, and in the Administration Office to be available for residents or families as requested.

4. The Resident Care Team shall encourage a resident to complete the Resident/Visitor Complaint/Grievance form when methods for resolving concerns are not successful despite interventions by the Team and the resident's concerns continue to be unresolved.

5. If the resident/visitor is unable to or does not wish to complete the complaint form, staff may document the resident's complaint/grievance on behalf of the resident/visitor. The Resident Complaint/Grievance form shall be submitted to staff in Nursing, Social Service, or Administration. Any staff that receives a complaint/grievance form is responsible for submitting the completed form to ~~the QM department~~Administration.

6. Residents/Visitors who wish to file their grievances anonymously may submit their Complaint/Grievance form into drop boxes labelled "Suggestion box" located at the Pavilion lobby entrance (ground floor), Out-patient clinic lobby (first floor Pavilion) and the Administration lobby.

7. Contents from Suggestion boxes shall be picked up Monday through Friday, excluding holidays by a designee from ~~the QM department~~Administration. ~~Resident~~ Complaint/Grievance forms and Suggestion forms shall be routed to ~~Risk Management Nurses~~Assistant Hospital Administrator ~~and Suggestion forms shall be routed to Administration~~.

8. ~~Risk Management Nurses~~The Assistant Hospital Administrator shall triage the complaint/grievance~~,~~ and create an Unusual Occurrence (UO) report.~~, and conduct follow up through the established UO process.~~

9. ~~Risk Management Nurses~~The Assistant Hospital Admin~~sitrator~~istrator shall act as the Grievance Official~~s~~ and ~~are~~ is responsible for managing the grievance process; receiving and tracking grievances through to their conclusions; leading/directing any necessary investigations; maintaining confidentiality of information compiled; issuing written grievance decisions on behalf of department/unit managers; and coordinating

with state and federal agencies as necessary. ~~The QM Director or designee shall provide oversight for the overall Resident Complaint/Grievance process.~~

~~8.~~10. The appropriate department/unit manager shall acknowledge the complaint/grievance and or make contact the resident in ~~a timely manner (1 to 2~~5 ~~business~~ business days~~)~~. The resident's right to confidentiality and privacy will be respected at all times.

11. If the complaint/grievance is anonymous, follow up with the complaintant is not possible. However, the appropriate department head is still responsible for acknowledging ~~—~~receipt of the complaint/grievance, investigate the complaint/grievance, and address the general concerns of the complaint if the matter can be confirmed to the Grievance Official. ~~.~~

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

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

~~11.~~14. Documentation consistent with federal requirements related to resident grievances shall be maintained for a period of 3 years from the issuance of the grievance decision.

~~12.~~15. Data on ~~R~~resident complaints/grievances shall be aggregated quarterly and presented bi-annually at the Performance Improvement and Patient Safety (PIPS) meeting. Complaints/grivances shall be evaluated and analyzed with respect to type, timely follow-up, trends, identification of problems/process gaps and the prevention of similar future problems.

ATTACHMENT:
Attachment A: ~~Resident~~ Grievance Information Flyer
Attachment B: ~~Resident~~ Grievance Form
Attachment C: ~~Resident~~ Grievance Acknowledgment
Attachment D: ~~Resident~~ Grievance Response Form

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 22-03 Residents' Rights
Appendix PP/Guidance to Surveyors for Long Term Care Facilities F165 -F166/Sections 483.10(j) (1) – (4)

Revised: 09/10/01, 10/04/27, 16/01/12, 17/09/12, 19/03/12, 19/11/12 (Year/Month/Day)
Original adoption: 92/03/01

San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC

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

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

Click here to insert Month Day, Year

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

Dear Patient/Resident/Family/Visitor,

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

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

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

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

Sincerely,

Laguna Honda Grievance Officer

San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC

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

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

Click here to insert date

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

Dear Patient/Resident/Family/Visitor,

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

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

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

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

Sincerely,

Name, Credentials
Working Title

OFF CAMPUS APPOINTMENTS OR ACTIVITIES

POLICY:

1. Escorts shall be provided with the necessary training and or information for resident safety.

2. Staff, volunteers, peer mentors, resident family members/surrogate decision-makers and their approved friends may escort a resident to an off campus appointment or activity, if deemed appropriate through an assessment by the Resident Care Team (RCT).

PURPOSE:

To provide resident safety and supervision during off campus appointments or activities.

PROCEDURE:

1. Assessment and Documentation

a. The Resident Care Team (RCT); comprising at a minimum, a physician and the licensed nurse; shall determine

   i. if a resident needs to be accompanied by an escort, and

   ii. the escort must be deemed appropriate to accompany the resident.

b. A physician's order shall be written for resident activities.

c. A physician shall be responsible for completing referrals for off-campus medical appointments.

2. Transportation

a. The Transportation Prescription Form shall be completed for any off-site appointments needing transportation. A physician shall review and sign the form and certify that the information is correct. The details of the appointment and patient information on the form shall be completed by a Licensed Nurse or Unit Clerk.

b. The Unit Clerk or designee shall:

   i. fax the Transportation Prescription Form to A&E to arrange transportation ~~services~~ with a contracted transportation service.

   ii. write the appointment on the Neighborhood's calendar.

iii. complete the Transportation and Appointment Ticket and attach it to the specially designated envelope for off-site appointments.

c. Nursing and non-nursing staff may escort the resident using a hospital vehicle or contracted transportation service.

d. If the contracted transportation service is unable to fulfill the transportation arrangement, the Nurse Manager or designee may arrange alternative transportation, including use of hospital vehicle or taxi service, to transport the resident to the appointment and or back from the appointment.

~~d.~~e. For patients who are eligible for Veterans Affairs (VA) transportation services, ~~all~~ the arrangements are made by the VA. The unit clerk or designee notifies the transportation coordinator at the VA about the resident's dialysis and other medical appointment times and locations. The transportation coordinator at the VA schedules the rides with the VA's contracted vendor. The Unit Clerk or designee and the transportation coordinator at the VA ~~will~~shall communicate changes in the appointment schedule or VA transportation vendor.

~~e.~~f. Use of Taxi Service:

i. Taxi service is used when the contracted transportation is unable to pick up or drop off resident to appointments. When the resident ends up to be admitted to acute hospital and escort needs to return to hospital use public transportation unless considered as over time.

ii. The Nursing Office Supervisor is the designated safe keeper of the taxi voucher, and shall provide oversight of the process, including the reconciliation of the used of vouchers to ensure accurate accounting of the funds used.

iii. Taxi Vouchers are available in the Nursing Office. (A receipt is submitted to Nursing Office whenever a Taxi Voucher is used, including completion of the log to reflect date, amount used and staff who voucher was issued to.)

iv. Vouchers are in triplicate form: the original copy shall be given to the taxi driver; the second copy (yellow) for Finance Department; and the third copy (pink) shall be filed in the Nursing Office.

v. Nursing Office submits the receipt and log to Accounting on a monthly basis for invoice payments to replenish the Taxi Vouchers when the remaining amount number of voucher is less than $5.00.

vi. In the absence of an approved taxi voucher, a staff member may provide personal funds as necessary in the event of a transportation need for patients/residents. The staff member shall be entitled to be reimbursed of all funds used by completing properly the "Employee Expense Authorization and Reimbursement Form", which is being kept in the Nursing Office.

3. Request for Nursing Staff Escort

a. When a nursing staff escort is needed to accompany the resident to an off-site appointment or activity, the nursing staff shall carry out the following steps according to the timeline established below:

i. The Day the Transportation Prescription is signed by the Physician:

- Fax the completed Transportation Prescription form to Nursing Office.
- Write a reminder on the calendar to call nursing office the day before the scheduled appointment to confirm an escort.

ii. The Weekend prior to the appointment:

- In order to assign an escort, Nursing Office Staff will call the neighborhood the weekend prior to the appointment. Once confirmed, they shall assign an escort for the scheduled date.

iii. The Day before the appointment:

- The Neighborhood will call the Nursing Office to confirm the escort requested.

iv. The Day of the appointment:

The Charge Nurse or designee will:

- give hand off report to the escort, and
- provide the escort with the completed Transportation and Appointment Ticket enclosed in a specifically designated envelope for off-site appointment.

The Escort shall:

- obtain hand off report from the Charge Nurse or designee.
- upon return to Laguna Honda:

- hand the Transportation and Appointment Ticket back and give a verbal report to the charge nurse.

- report back to the Nursing Office once resident has been returned to the neighborhood.

4. Medical Record Information Needed for Off Campus Appointment

a. Information shared for off campus appointments shall be the minimum necessary for treatment or billing purposes during the appointment.

~~b. For SFGH clinic visits, only the clinic addressograph card (currently a gold card) and the transport ticket shall accompany the resident.~~

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

~~d.~~c. When needed information is not in an electronic health record or the clinic does not have access to the SFDPH electronic health records, the medical record information may be processed through the medical records department or faxed securely to the clinic according to the facility's facsimile transmission process (as described in LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile).

5. Non-staff Escort

a. Family or Surrogate Decision-Makers and Approved Friends as Escorts

i. The RCT designee shall contact and make arrangements for the resident's family or surrogate decision-makers or approved friend to accompany the resident to an off campus appointment or activity.

ii. Resident families or surrogate decision-makers or their approved friend shall be trained by the Charge Nurse or designee.

iii. Resident families or surrogate decision-makers and their approved friends may transport the resident using their personal vehicles or contracted transportation service.

b. Volunteer Escorts (when available)

i. When the RCT determines that a volunteer escort is appropriate to accompany the resident to an off campus activity, the RCT designee shall submit a request to the Volunteer Services Department for a volunteer to escort the resident.

ii. The Volunteer Services Department shall recruit for a volunteer to escort the resident and notify the Charge Nurse or designee.

iii. The Charge Nurse or designee shall introduce the volunteer to the resident and provide pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Volunteers shall escort the resident using contracted transportation service or public transportation.

c. Peer Mentor Escorts (when available)

i. When the RCT determines that a peer mentor is appropriate to accompany the resident to an off campus activity, Social Services shall submit a referral request to the Peer Mentor coordinator.

ii. The Peer Mentor Program Coordinator shall recruit a peer mentor to match with the resident and notify the Social Worker.

iii. The social worker shall introduce the peer mentor to the resident and the peer mentor shall check in with the Charge Nurse or designee prior to outings for any pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Peer mentors shall escort the resident using contracted transportation service or public transportation.

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

a. Generally, transportation for discharging patients within the Bay Area involving a City vehicle will be handled by the Social Services Department. A Nursing staff member may accompany the Social Worker, but it is the responsibility of the Social Worker to reserve and drive a City vehicle to the discharge location.

b. If travel outside of the Bay Area is required, the Nursing office is contacted to solicit a Patient Care Assistant (PCA) to voluntarily escort the resident out of CCSF. Such an escort arrangement would involve transportation via airline or bus. If no PCA staff is willing to escort the resident, plans for the trip as arranged by Laguna Honda will be abandoned.

c. The need for escort shall be based on supervision only. No treatments or other medical intervention shall be administered by the PCA during escort.

d. Travel airline or bus tickets for the resident and the staff person shall be made in advance though City-approved travel agencies.

e. If accommodation is required during the trip, The Accounting Department shall attempt to book lodging for the staff and resident using a P-Card. If attempts to book the lodging are unsuccessful, the staff person shall be asked to pay for the lodging and be reimbursed though the Business Travel Reimbursement process.

    i. Separate accommodations shall be provided for the resident and the staff member.
    ii. Social Services and/or Accounting shall assist the employee in completing forms and other requirements for travel reimbursement. The applicable form is Travel/Training Authorization Form.

f. Staff members shall be paid the applicable premium rates during the duration of the trip. Preapproval is required by the Chief Nursing Officer.

g. Expenses related to employee travel will be charged to the Nursing operating fund. Expenses related to resident travel will be charged to the Gift Fund.

ATTACHMENT:
Attachment A: Transportation and Appointment Ticket

REFERENCE:
LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile
LHHPP 21-06 Transporting the Resident's Filed Medical Records on Campus
LHHPP 24-10 Coach Use for Close Observation
MR908 Transportation Prescription

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

HAZARDOUS DRUGS MANAGEMENT

POLICY:

1. Hazardous Drugs (HDs) shall be managed according to established safe procedures to mitigate the risk to resident, employee and environmental safety.

2. Intravenous cytotoxic/chemotherapy drugs shall not be initiated or administered at Laguna Honda Hospital and Rehabilitation Center (LHH).

3. The management of intravenous cytotoxic/chemotherapy drugs initiated elsewhere via an ambulatory computerized drug delivery (CADD) pump shall be restricted to the Pavilion Mezzanine Acute (PMA).

4. Staff who are trying to conceive (male or female), or are pregnant or breast-feeding, shall not administer cytotoxic or Hazardous Drugs or handle excreta of residents on chemo precautions. Staff who fit into these categories should inform their immediate supervisor for work reassignment.

5. Nurses preparing medications shall never crush or cut tablets, or open capsules labeled as “hazardous” by the Pharmacy.

6. Clinical staff responsible for the ordering, dispensing, administering and monitoring of hazardous drugs shall be provided with training on hazardous drugs.

PURPOSE:

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

1. Prescribing Cytotoxic Drugs

2. Preparing, Administering and Disposing of Hazardous Drugs

3. Exposure and Spill Management of Hazardous Drugs

DEFINITION:

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

2. Cytotoxic Drug: A type of hazardous drug that destroys cells or inhibits or prevents their function. Cytotoxic drugs include drugs used for cancer (chemotherapy) and in some cases those drugs are used to treat other conditions (e.g., psoriasis, arthritis, transplant rejection). Not all drugs used to treat cancer are cytotoxic.

3. Chemo Precautions for cytotoxic medications: Precautions required when handling and disposing of excreta from residents who are currently receiving or have recently received cytotoxic drugs or cytotoxic chemotherapy. The duration of chemo precautions after the administration of any cytotoxic drug is 7 days unless otherwise identified and documented on the medication administration record by pharmacist that verified the original order.

PROCEDURE:

1. Procedure for Prescribing Cytotoxic Drugs

a. Consulting medical specialists (oncologist, rheumatologist, and dermatologist) may prescribe cytotoxic drugs, in consultation with a LHH physician responsible for the resident's care.

i. A LHH physician may order cytotoxic drugs in consultation with a clinical pharmacist.

ii. Cytotoxic/Chemotherapy IV infusions initiated at another healthcare facility and continued at LHH (for example, CADD pump continuous infusion of fluorouracil) shall be ordered by a LHH physician. The ordering healthcare facility that originally ordered the continuous cytotoxic/chemotherapy infusion shall furnish and dispense these medications.

iii. "Off-label" prescribing of cytotoxic drugs is prohibited, unless the provider documents the rationale for use and supporting evidence

2. Preparing and Administering Hazardous Drugs (HDs)

a. General Principles for HD Medication Administration

i. Hazardous Drugs shall be identified by a label on the medication from the pharmacy and will also be identified as hazardous on the medication administration record in the electronic health record. A list of common hazardous drugs prescribed at the hospital is located on the nursing and pharmacy intranet.

ii. Procedures for oral, enteral, subcutaneous and topical routes of administration shall comply with Nursing policies and procedures.

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

- Wear two pairs ofchemotherapy gloves when handling HDs and medication administration equipment or supplies. The standard hospital supply of exam gloves are rated for chermotherapychemotherapy. Wear one or two pairs of chemotherapy gloves depending on the dosage form being handeledhandled:
  - Solid intact tablet/capsule – 1 pair of gloves
  - Parenteral – 2 pairs of gloves
  - Liquid oral solution – 2 pairs of gloves
  - Transdermal patch – 2 pairs of gloves
  - Suppository – 2 pairs of gloves
  - Topical – 2 pairs of gloves

- When wearing 2 pairs of gloves the oOuter glovess shall be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated

- Wear a splash-resistant chemo gown and eye protection if risk of spillage or splashing is possible. Yellow gowns used for contact precautions do not provide adequate protection.

- Before leaving the immediate area where a cytotoxic drug was administered or prepared, remove PPE and dispose in a yellow cytotoxic waste container.

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

i. Never crush or cut tablets, or open capsules labeled as “hazardous” by the Pharmacy.

ii. If a resident is unable to swallow intact tablets or capsules, contact Pharmacy to provide an alternative dosage form. Contact Pharmacy for liquid dosage form immediately if tablets/capsules are dispensed for an enteral feeding resident.

iii. If a HD is to be administered enterally via GT/JT, a liquid preparation must be obtained from pharmacy.

iv. After a hazardous drug has been administered, discard administration equipment such as medication cups, PPE, and enteral feeding syringes, into the yellow cytotoxic waste container.

c. Intravenous Administration of Hazardous Drugs (HDs)

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

- Prior to administration of intravenous HDs nursing shall obtain a yellow cytotoxic waste container from EVS. In addition, an intravenous medication infusion pump shell be obtained.

- Wear a splash resistant chemotherapy gown and two pairs of gloves when starting or discontinuing intravenous HDs or changing I.V. tubing.

- Face shields or goggles shall be used when there is a splash hazard.

- Place an absorbent pad with impermeable plastic backing underneath the infusion site to contain any leakage of solution which may occur during handling of I.V.

- All PPE and equipment used for administration of intravenous HDs shall be disposed of in a yellow cytotoxic waste container.

d. Subcutaneous or intramuscular hazardous drugs including cytotoxic chemotherapy may be administered at LHH and shall be administered using the same processes described in Nursing Medication Administration Policy. The Pharmacy shall dispense the medication in a pre-filled syringe for administration.

e. Topical HDs including cytotoxic chemotherapy may be administered at LHH according to Nursing Medication Administration Policy using two pairs of gloves and a chemo gown. Chemo precautions for handling patient excreta are not required for residents receiving only topical HDs.

f. Disposal of Hazardous Drug Waste from Medication Administration

   i. Unused, unopened or expired drugs shall be returned to the pharmacy for disposal.

   ii. Any contaminated containers or materials used in the preparation or administration of HDs including cytotoxic/chemotherapy, shall be disposed of in a yellow, cytotoxic waste container.

   iii. Do not pour hazardous drugs/solutions down drains or into toilets.

g. Chemo Precautions for cytotoxic drugs

   i. Residents may excrete active drug and/or hazardous metabolites for a limited time after administration of a cytotoxic drug. The duration of chemo precautions after the administration of any cytotoxic drug is 7 days unless otherwise identified and documented on the medication administration record by the pharmacist that verified the original order.

Note: Follow standard infection control precautions whenever contact with body fluids is possible (regardless of medication regimen).

ii. A chemo precautions cart shall be ordered from Central Processing Department and a yellow, cytotoxic waste bin shall be ordered from EVS. The chemo precautions cart contains appropriate PPE, a spill kit, and a yellow sign for the door.

iii. Place yellow sign on resident room door to inform all staff that all waste generated in the room must be disposed of in the yellow, cytotoxic waste bin.

iv. Use double gloves and splash-resistant chemo gown available on the cart when handling blood or excreta. A face shield shall be worn if splashing is possible.

v. Linen that is contaminated with cytotoxic drugs or excreta from patients who are on chemo precautions shall be separated from regular dirty linen and placed in a yellow laundry bag from the cytotoxic medication cart.

vi. Linens used by patients who have received cytotoxic drugs, which are not contaminated with body fluids shall be handled as other linen.

vii. Staff Laundering Practices for residents on Chemo precautions:

- Staff laundering residents' personal clothing soiled with urine or feces shall wear double gloves and a splash-resistant chemo gown. If splashing is possible, face shield shall be used.

- Personal clothing soiled with urine or feces for a patient on chemo precautions shall be:

- Washed separately from other residents' clothing if resident is incontinent.

- Placed in a yellow laundry bag for transport to washing machine.

- Sent through two cycles of washing (first a pre-wash, followed by a second wash) with regular detergent.

- Personal clothing that is not soiled with urine or feces shall be handled according to standard laundry procedure.

3. Hazardous Drug Exposure Response

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

b. Provide first aid as outlined below:

   i. If there is skin or mucous membrane contact: wash contact area thoroughly with soap and water. Avoid iodine preparations or chlorhexidine.

   ii. If there is eye exposure, immediately flood affected eye with a gentle stream of water for at least 15 minutes using the emergency eye wash. Make sure the eye is open and the individual blinks and rotates eye in all directions.

   iii. If there is a needle stick injury or sharp exposure, immediately rinse any sharps injury with soap and water. Report the exposure to the Needle stick hotline for expert assessment and advice regarding immediate treatment.

c. Report the exposure to your supervisor, who shall complete an injury report according to the LHH 73-01 IIPP.

d. Complete an Unusual Occurrence report for residents or other exposed individuals.

e. If exposure involves a resident, provide immediate first aid as outlined above and immediately notify the physician and nursing supervisor.

4. Hazardous Drug Spill Management

a. Spills of hazardous drugs or body fluids contaminated with cytotoxic/chemotherapy drugs shall be contained by the person who caused the spill with help from another staff person on the scene using a Chemo Spill Kit.

b. Chemo Spill Kits are available on PMA, and on Chemo carts that are provided to resident rooms where there are chemo precautions in effect.

c. Procedures for cleanup are provided in the Spill Kit and in Appendix B.

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

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

http://www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/MedicalWasteManagementAct.pdf
CDC NIOSH (National Institute for Occupational Safety and Health). 2004- 165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings
U.S. Department of Labor Occupational Safety & Health Administration. 2008. Controlling Occupational Exposure to Hazardous Drugs; Section VI: Chapter 2; www.osha.gov
American Society of Health System Pharmacists. 1/12/2006. ASHP Guidelines on Handling Hazardous Drugs.

Revised: 13/11/21, 17/07/11, 17/09/12, 19/07/09, 19/11/12 (Year/Month/Day)
Original Adoption: 08/09/30
Replaces LHHPP 70-02 Cytotoxic Agents (Chemotherapy) (rev. 03/05/08)
Replaces NPP J10.0 Antineoplastic/Cytotoxic Medications (rev. 00/08/03)

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

Procedure for Cleanup of Chemotherapy and Hazardous Drug Spills

Laguna Honda Hospital and Rehabilitation Center
July 29, 2016

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

Cleanup Requires 2 Persons

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

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

Personal Protection Needed

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

Procedures

1. Block off spill area using "Do Not Enter" signs in the spill kit (Use the tape provided in the box). Notify area supervisor of the spill.
   R2 shall read off and use the checklist on the back of the "OK to Enter" sign to keep track of the cleanup progress, initialing steps as they are completed.

2. R1 dons all PPE in the following sequence
   - Safety Glasses
   - Chemo Gown
   - Shoe covers
   - Fitted N95 Respirator
   - Face shield

- Long cuff inner gloves
- Short cuff outer gloves

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

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

   For liquid spills:

   Taking care not to step or come in contact with spilled materials, R1 uses sorbent supplies in the spill kit to soak up the spilled materials. Use:
   - Spill pads if there are puddles
   - "Green Z" sorbent powder if there is spattered liquid or lots of droplets

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

   For dry material spills:

   Avoiding contact with dry material, R1 uses the dampened sponge to push spilled material into the scoop.
   - Avoid using scraper from orange scoop/scraper; use the sponge
   - Do NOT over wet the sponge
   - Do NOT use sponge to clean surfaces.

4. After all the spilled materials are collected, R1 removes outer pair of gloves and dons a fresh set.

5. R1 uses detergent solution in a wash bottle to gently wet down the area (try to go 1 foot beyond known spill area). Gently agitate/wipe detergent on surfaces with paper towels. Use spill pads or clean sponge if lots of detergent solution is left over. Repeat detergent wipe down a second time.

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

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

7. When area has dried, R1 uses step 1 - (Blue Label) of Surface Safe Wipes to wipe the spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag.Wait for two minutes.

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

9. R1 uses step 2 - (Red Label) of surface safe wipes to re-wipe the entire spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag.

10. R1 removes all PPE in following sequence:

    - Shoe Covers
    - Outer Gloves
    - Chemo gown
    - Face shields
    - Inner Gloves
    - Safety glasses

    Place the used PPE in a chemotherapy waste bag for disposal.

11. R2 places the chemotherapy waste bags in a chemotherapy waste bin, and removes and disposes off their gloves as conventional trash.

12. R1 and R2 immediately wash their hands and arms with soap and water.

13. Post green “OK TO Enter” sign showing cleanup has been completed.

14. Contact EVS and request a “disinfection” (i.e. wet-cleaning) of the area. Ask EVS to check the floor and spot wax as necessary.

Complete and submit the Unusual Occurrence (UO) report.

EMPLOYEE DEVELOPMENT FUND

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) may accept and will manage monetary donations that are earmarked for employee development according to the intentions of donor(s).

2. Only donations that are specified for use towards employee development, education and training can be accepted into this fund.

3. Whenever possible, donors shall be encouraged to specify the focus of employee development for which donated funds are to be used (e.g. quality improvement, skill building, employee wellness, etc.).

4. Items that are paid by monies from the Employee Development fund are limited to training resources used to educate employees to improve themselves (e.g. trainer/training fees, books, CDs, DVDs, and other materials used for training purposes).

5. Acceptance and expenditure of donations shall be documented according to the Administrative Code of San Francisco.~~City procedures.~~

6. Oversight of the fund is the responsibility of the Executive Committee.
~~5.~~

~~6.~~7. ~~An Employee Development Fund Management (EDFM) Committee shall be established to~~ The Department of Education and Training (DET) shall review requests for funding and provide recommendations to the Executive Committee to approve or not approve expenditure requests for employee development activities.

~~7.~~8. Individual staff members or a group of staff benefitting from training opportunities paid for from the fund are required to share the benefits of the training though in-service presentations and/or making training materials available to other staff.

PURPOSE:

1. To honor the intentions of donors and to provide education and training opportunities for staff.

2. To assure that the acceptance and expenditure of donations earmarked for staff development meet the specific requirements of the DPH Grants Office as well as the specific requirements of the Health Commission, Board of Supervisors, Controller, and City Attorney.

3. To optimize the use of the funds to benefit as many employees who are interested in enhancing their knowledge, skills and self-development.

PROCEDURE:

1. Donations equal or greater to ten thousand dollars ($10,000.00) require an Accept and Expend Resolution from both the Health Commission and the Board of Supervisors.

2. The Employee Development Fund is maintained as a project within the City's financial accounting systems.

   a. Fund - 21650
   ~~a. Sub Fund – 5LAGTEDF~~

   b. Project Code - 10023362
   ~~b. Index Code – HLHAGTEDF~~

   c. Authority – 10000
   ~~c. Project Code – PHLEDF~~

   d. Activity - 0001

3. Requests for funding of employee development activities shall be submitted to the Learning and Development Manager.
~~3. The EDFM Committee shall consist of representatives from the following Divisions/Departments: Administration, Finance, Human Resources, Medicine, Nursing, Operations and Quality Management.~~

~~4. Requests for funding of employee development activities shall be submitted to the Chair of the EDFM Committee.~~

~~5.~~4. Proposals and recommendations for use of the fund shall be reviewed by DET ~~the EDFM Committee~~ and submitted to the Executive Committee by the ~~Chair of the EDFM Committee~~ Learning and Development Manager.

~~6.~~5. Expenditures of the fund are subject to the hospital's budgetary processes and purchasing requirements.

~~7.~~ The ~~Chief Financial Officer~~Finance Director~~,~~ ~~on behalf of the EDFM Committee,~~ shall provide quarterly financial reports to the Executive Committee.
6.
~~8.~~1. ~~Oversight of the fund is the responsibility of the Executive Committee.~~

~~9.~~7. Staff training sponsored by the fund requires a course certificate or proof of

completion of the training classes to be eligible for the reimbursement of the training costs.

~~10.~~8. Staff from the Department of Education and Training ~~and Nursing Education~~ shall be responsible for coordinating employee in-service presentations and/or the dissemination of training materials (described in Policy statement # 7) for the benefit of the larger ~~Laguna Honda~~LHH employee community.

ATTACHMENT:
None

REFERENCE:
LHHPP 45-03 Donations
LHHPP 65-01 Procedures for Grant Application, Acceptance and Expenditure
~~Financial Administration of Grants and Gifts:~~
~~http://sfcontroller.org/Modules/ShowDocument.aspx?documentid+~~
~~City and County of San Francisco Budget and Appropriation Ordinance, Administrative Provisions Section 11.23, Fiscal Years 2012-2013 and 2013-2014~~

Revised: 20/01/14 (Year/Month/Day)
Original adoption: 15/11/09

PROCUREMENT CARD

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) utilizes procurement cards (P-Card) for the acquisition of materials, supplies, and services that are not readily available through the normal purchasing ~~mechanism~~mechanisms due to the unique needs of resident programing, disaster response, and on-line business transactions.

PURPOSE:

To ensure a process for the procurement of materials, supplies, and services that is efficient and maintains appropriate internal controls in compliance with City Controller's policy.

CHARACTERISTICS:

1. P-Cards are used to procure non-medical resident related materials, supplies and services within the Activity Therapy, and Substance Treatment and Recovery Services (STARS) programs. The LHH Gift Fund is the funding source for these programs.

   a. Allowable purchases for the Activity Therapy program include:
      i. Game prizes purchased from a discount variety dollar store.
      ii. Tickets to community events including concerts, lectures, and other cultural events.

   b. Allowable purchases for the STARS program are limited to incentive prizes purchased from a discount variety dollar store.

2. P-Cards are used for physician credentialing, hospital certifications, and emergency and disaster response. P-Cards are also used to maintain appropriate balances for the hospital's Fastrak accounts.

~~3. Use of P-Cards is appropriate only when normal purchasing mechanisms are prohibitive.~~

~~**PROCEDURE:**~~

ROLES

1. The ~~Chief Financial Officer (CFO)~~Finance Director or designee maintains the role of **Department Coordinator** for the P-Card program. Responsibilities include:

   a. Oversight of the P-Card program for the hospital.

   b. ~~Approves~~Approve requests for P-Cards from Approving Officials.

c. ~~Reviews~~Pre-approve cardholder expenditures over $200.

~~c.~~d. Review and approves reports for P-Card use and performance.

~~d.~~e. ~~Approves~~Approve payments to US Bank for P-Card transactions.

~~e.~~f. Liaison with the P-Card Coordinator in the Controller's Office.

2. The Director of Wellness and Therapeutic Activities and the Director of Psychology, or designees maintain the role of **Approving Officials** for the P-Card program within their respective departments. ~~Responsibilities include:~~The Director of Environmental Services maintains the role of Approving Officer for Fastrak expenditures. The Chief Medical Officer is the Approving Official for physician credentialing expenditures. Responsibilities include:

   a. Oversight of proper P-Card use within their departments and programs.

   b. Make requests to Department Coordinator for P-Cards for employees under their supervision. Notify Department Coordinator of change of employment status of cardholders within their departments.

   c. ~~Approve~~Pre-approve cardholder ~~purchases,~~expenditures and verify that ~~purchases~~Expenditures are made for official hospital business.

   d. Review and certify the reconciled Cardholder Statements of Account and ensure that original receipts and documents are in order.

   e. Ensure that each cardholder statement of account is accounted for and forward them to the Billing Official.

3. The ~~Accounting Cashier~~Accounts Receivable Supervisor or designee maintains the role of **Billing Official**. Responsibilities include:

   a. ~~Receives, reviews~~Receive, review, and ~~ensures~~ensure accuracy of account statements, receipts, and reconciliation reports.

   b. ~~Facilitates~~Facilitate monthly P-Card payments to U. S. Bank and charges expenses to proper accounts.

   c. ~~Determines~~Determine whether proper sales tax has been paid and accrue any use tax.

   d. ~~Prepares~~Prepare reports for the Department Coordinator.

   e. ~~Executes~~Execute payments to US Bank within the City's Financial System.

4. Assigned staff of the above ~~mentioned~~referenced programs are **Cardholders**. Responsibilities include:

   a. Review and consent the CCSF P-Card Cardholder Guide.

   b. Maintain security of the account number and P-Card.

   c. Secure pre-approval of all expenditures to be made by P-Card.

   ~~c.~~d. Make appropriate purchases while securing the value for the hospital.

   ~~d.~~e. Secure itemized original receipt at the point of purchase and verify for accuracy.

   ~~e.~~f. Complete expense form.

   ~~f.~~g. Reconcile all transactions and forward original receipts and expense forms to Approving Official.

   ~~g.~~h. Cardholders shall return P-Card to Department Coordinator if position duties change.

PROCEDURE:

1. Procurement Card Management.

   ~~5.~~a. All staff involved with P-Card, shall complete training developed by the Controller's Office and comply with the standards established in the City and County of San Francisco's policy on Procurement Card.

   ~~6.~~b. All P-Cards issued to cardholders will have a default credit limit of $1,000.

   ~~7.~~c. The expenses in support of Activity Therapy, and STARS programs may not exceed Gift Fund budget limits established by the Gift Fund Committee and approved by the Health Commission.

   ~~8.~~d. Potential cardholders/requesters shall complete a Procurement Card Request Form with approval from their department head and the ~~LHH CFO.~~Department Coordinator. The requesters shall indicate and sign the request form acknowledging that they have read and understand the Controller's and LHH P-Card policy.

   e. P-Cards are surrendered to the Accounting Department and cancelled promptly when the position, responsibilities, or employment status of a Cardholder changes.

f. The Accounting Department maintains a spreadsheet of P-Cards/Cardholder accounts.

~~9.~~2. Prior to any expenditures made with a P-Card, Cardholders shall ~~make purchases~~ obtain prior written approval from the Approving Officials related to the programs for which expenditures are made in support of department programs documented on the Procurement Card Pre-Expenditure Authorization Form.

a. Expenditures exceeding $200 require Department Coordinator approval in addition pre-approval by Approving Official

b. Expenditures for Disaster Response expenditures and Fastrak account replenishment do not require written pre-authorization.

3. The Cardholder shall make the purchases within the limits of the pre-authorization.

~~10.~~4. Cardholders shall download and print monthly statements, reconcile all transactions, and forward all documentation including original receipts and ~~expense forms~~The Direct Payment Request Form to their respective Approving Officials prior to the 28th of each month. If the 28th falls on a weekend, the original receipts are forwarded to the Approving Official on the previous business day.

~~11.~~5. Approving Officials shall review P-Card documentation and approve Cardholder transactions, then forward P-Card documentation to the Billing Official by the 2nd of the following month unless it falls on the weekend, then the previous business day.

~~12.~~6. The Billing Official shall review and reconcile P-Card documentation and direct Accounting staff to set up payment to U.S. Bank in the City's Financial System by the 4th of each month or prior if that date falls on the weekend.

~~13.~~7. The Billing Official forwards P-Card documentation to the Department Coordinator for review and approval by the 6th of the month or prior if that date falls on the weekend.

~~14.~~8. Upon approval by the Department Coordinator, the Billing Official will approve payment to U.S. Bank in the City's Financial System by the 8th of each month or prior if that date falls on the weekend.

P-Card statements generated on the ***25th*** of each month or previous business day if the 25th falls on a weekend. Card payment due ***14 days*** from the statement date		
Staff/Role	**Description**	**Monthly Due Date**
Cardholder	Downloads statement, reconciles transactions and submits original receipts with expense form to Approving Officer	28th or prior if weekend

Approving Official or Designee	Reviews & approves Cardholder documents and submits them to Billing Officer/Accounting Department	2nd or prior if weekend
Billing Official/Accounting	Reviews and reconciles all documents including on-line bank statements, sets up payment in City's Financial System, and submits to the Department Coordinator	4th or prior if weekend
Department Coordinator or Designee	Reviews all documentation and approves payment.	6th or prior if weekend
Billing Official/Accounting	Approves payment in the City's Financial System	8th or prior if weekend

~~15.~~9. A P-Card is issued to the Medical Staff Secretary to transact on-line physician credentialing charges. The Medical Staff Secretary assumes the role and responsibilities of the card holder. The Medical Director assumes the role of Approving Official.

~~16.~~10. Medicare/Medi-Cal certification and Fastrak account payments are transactions for which an Accounting staff member is assigned the role of Cardholder.

a. Hospital staff responsible for Medicare/Medi-Cal Certification ~~contact~~contacts the Accounting staff member to facilitate on-line payment and assumes the role of Approving Officials for the transactions. The Procurement Card Pre-Expenditure Authorization Form is presented at the time of contact.

b. ~~The Program Manager, Gift Fund~~The designated Accounting Department staff person monitors the hospital's Fastrak account in which automatic payments are set up using the purchase card issued to the Accounting Staff member. ~~When the automatic payments are generated, The Program Manager, Gift Fund contacts the Accounting Department staff member to facilitate payment on the account. The Director of Environmental Services assumes the role and responsibility or the Approving Official for Fastrak payments.~~

i. ~~Departments having been issued~~ Two Fastrak transponders ~~maintain Fastrak~~ each are provided to the Activity Therapy Department and Administration.

ii. Staff checking out transponders document usage of the transponders on the Fastrak transponder logs ~~which~~.

~~i.~~iii. The logs are ~~check against~~reconciled with monthly Fastrak statements~~.~~ to ensure appropriate use of the transponders for hospital business

c. When the automatic Fastrak charges are generated, Accounting Department staff persons collaborate to facilitate payment on the account. The Director of Environmental Services executes the role and responsibility or the Approving Official for Fastrak payments.

~~c.~~d. The Accounting staff member fulfils the responsibilities of the Cardholder and forwards all documentation to the Approving Official who in turns submits approved documents to the Billing Official, all within the established timelines.

~~17.~~11. Declared Emergency and Natural Disasters

a. Emergency purchases during Declared Emergencies and Natural Disaster. Refer to San Francisco Administrative Code Section 21.15 and Section 6.60 for emergency procurement procedures and who can declare emergency. Disaster P-Cards do NOT replace the City's existing Emergency Purchasing Procedures, but will supplement the procedures.

b. A P-Card is issued to the Director of Emergency Response and Workplace Safety. The default credit limit for that card is $~~5000.~~1000. When an emergency is declared, the department will take the following steps to increase P-Card credit limit should the need of credit limit increase arise:

   i. The ~~CFO~~Finance Director or designee will contact the Citywide P-Card Administrator to request an emergency increase to the P-Card credit limit.

   ii. The City Controller's Office will contact U.S. Bank to increase the credit limit.

c. The Director of Emergency Response and Workplace Safety will coordinate all purchases in response to an emergency or disaster.

d. The Director of Emergency Response and Workplace Safety is responsible for reconciling all transactions and forwarding original receipts and expense forms to the ~~CFO~~Finance Director for verification.

e. All Documentation related to emergency and disaster purchases are forwarded to the Office of the Controller for financial processing.

ATTACHMENT:
Attachment A: Procurement Card Request Form
Attachment B: Procurement Card Pre-Expenditure Authorization Form
Attachment C: Direct Payment Request Form

REFERENCE:
LHHPP 45-01 Gift Fund Management
CCSF Procurement Card Policy and Procedures
CCSF Purchasing Cardholder Guide
San Francisco Administrative Code Section 21.15 and Section 6.60

Revised: 18/05/08, 20/01/14 (Year/Month/Day)
Original adoption: 16/11/08

~~Attachment A: Procurement Card Request Form~~

Procurement Card Request Form

Name		DSW #	
Department	Department of Public Health	Department Code	DPH
Division	Laguna Honda Hospital	Division Code	HLH
Program			
Job Title		Job Class #	
Address	375 Laguna Honda Boulevard	Room #	
City	San Francisco	State/Zip Code	California, 9411
Work E-mail		Work Phone	
Approving Officer of Designee			

☐ I have read and understand the hospital policy and procedure of the use of Procurement Cards

Name	Signature		
Department Head	Signature	Chia Yu Ma, Chief Financial Officer	Signature

Procurement Card Request Form

Name		DSW #	
Department Level 1	Department of Public Health	Department Code	DPH
Department Level 2	Laguna Honda Hospital	Division Code	HLH
Program			
Job Title		Job Class #	
Address	375 Laguna Honda Boulevard	Room #	
City	San Francisco	State/Zip Code	California, 94116
Work E-mail		Work Phone	
Approving Officer of Designee			

☐ I have read and understand the hospital policy and procedure of the use of Procurement Cards and the CCSF P-Card Cardholder Guide

Name	Signature		
		Denise Payton, Finance Director	
Department Head	Signature		Signature

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Laguna Honda Hospital and Rehabilitation Center
Procurement Card Pre-Expenditure Authorization

☐ Physician Credentialing ☐ Hospital Certification ☐ Activity Therapy Programs

☐ STARS Programs

Purpose of Expenditure: _____

_____

_____

Amount of Expenditure, not to Exceed $_____

Date of Expenditure, on or Before _____

Requester/Cardholder _____
Print Name

_____ Date _____
Signature

Approving Official _____
Print Name

_____ Date _____
Signature

Department Coordinator _____
For expenditures exceeding $200 Denise Payton, Finance Director, or
Authorized Designee: Print Name

_____ Date _____
Signature

Department Coordinator Notes _____

_____

_____

_____

PEOPLESOFT **FY:** _____

CITY/COUNTY OF SAN FRANCISCO

DIRECT PAYMENT REQUEST FORM

Document Number

Supplier Number

DEPARTMENT	DPH
DEPARTMENT CONTROL NO.	
DATE	

To: _____

Address:

_____

_____

_____

_____

invoice# _____

Invoice Date

Date Received

Due Date

Multiple Payees ☐

Scheduled Payment ☐

One-Time Vendor ☐

COMMODITY OR SERVICE CODE #	**Description:**

PREPARED BY (Print Name and Sign)	APPROVALS (IF REQUIRED, SEE INSTRUCTIONS)		
APPROVED BY (Print Name & Sign)	MATERIALS, SUPPLIES & SERVICES PURCHASER	CHIEF ADMINISTRATION OFFICER	CONTROLLER
DEPT. HEAD/BOARD OR COMMISSION			

Amount	Account Code(s)	Fund ID	Dept ID	Authority ID	PC Bus Unit	Project ID	Activity ID	Addendum Attached
					SFGOV			
								Nos. of Pages ____

Revised August 2017

DIRECT PAYMENT REQUEST (DPR) CHECKLIST - SUPPLIER PAYMENT

DPR is used for requesting payment of the following: conference registration fees, training fees, non-recurring advertisements, legal advertisements, interim assistance reimbursement program (SSI) payments, subscription renewal, and membership fees approved by the Board of Supervisor, payment to government agencies, revolving fund replenishments and all other payments that do not normally go through the procurement procedures.

Submit original and completed DPR form duly approved by an authorized signatory with appropriate attachments.

☐ **1. CHECK SUPPLIER COMPLIANCE (Refer to Supplier Compliance Checklist)**

Attachments for conference registration fees and training fees:

☐ **2. COPY OF TRAVEL/TRAINING AUTHORIZATION FORM** (pre-approved and completed prior to the travel date)

☐ **3. ORIGINAL INVOICE or COPY OF FULLY ACCOMPLISHED REGISTRATION FORM**

☐ **4. CONFERENCE/TRAINING INFORMATION** (such as invites, announcements, email confirmation, etc.)

Attachments for non-recurring advertisements and legal advertisements:

☐ **1. ORIGINAL INVOICE** (A copy is acceptable only if it is certified by the Department Head)

☐ **2. PROOF OF PUBLICATION**

Attachments for other payment requests (subscription, membership, SSI payments, RF, remittances, etc)**:**

☐ **1. ORIGINAL INVOICE, BILLING OR RECEIPTS** (A copy is acceptable only if it is certified by the Department Head)

- A monthly statement is not acceptable as a substitute for original invoice

☐ **2. OTHER SUPPLIER REQUIRED ATTACHMENTS**

IMPORTANT REMINDER

For revolving fund, please check program's protocol.

CHECKLIST - EMPLOYEE REIMBURSEMENT

DPR is NO LONGER required for employee reimbursement requests for certification, professional license fees and parking tickets if specifically provided in the MOU.

Upload scanned copies of the following to PeopleSoft - Expense Report module.

Attachments for employee reimbursement for certification, professional license renewal (with MOU provision)**:**

☐ **1. PROFESSIONAL LICENSE REIMBURSEMENT REQUEST FORM** (duly Approved by HR Manager)
The form is available in DPHNET:
http://dphnet/node/773

☐ **2. COPY OF LICENSE RENEWAL FORM INDICATING AMOUNT OF FEES AND AGENCY**

☐ **3. COPY OF NEWLY ISSUED LICENSE/CERTIFICATE**

☐ **4. PROOF OF PAYMENT** (official receipt, front and back copy of cleared check, or copy of credit card statement)

☐ **5. COPY OF THE CURRENT MOU PROVISION stating that the City shall reimburse employee for such payment**
(Please attach only the page that states the provision.)

Attachments for employee reimbursement request for parking tickets (with MOU provision)**:**

☐ **1. REQUEST FOR PARKING TICKETS REIMBURSEMENT FORM** (approved by supervisor)
The form is available in DPHNET:
http://dphnet/node/108

☐ **2. ORIGINAL NOTICE OF PARKING CITATION**

☐ **3. PROOF OF PAYMENT** (official receipt, front and back copy of cleared check, or copy of credit card statement)

☐ **4. COPY OF THE CURRENT MOU PROVISION stating that the City shall reimburse employee for such payment** (Please attach only the page that states the provision.)

PAYOR ELIGIBILITY, CERTIFICATION AND COVERAGE

POLICY:

Utilization Management (UM) Nurse shall conduct admission/readmission review for patients/residents who are admitted to the Acute Medical Unit, Acute Rehab Unit, or a SNF Unit based on primary payor sources.

PURPOSE:

Admission/readmission reviews shall be conducted by the UM Nurse following the criteria set by the primary payor sources. Patients/residents who meet the eligibility requirements of Medicare Part A care shall be covered under Medicare Part A benefits.

PROCEDURE:

1. Provision of Medicare Rights Form

a. All Medicare recipients upon admission or re-admission to SNF or Acute Rehab or Acute Medical must sign the Medicare Rights form. The financial counselor shall meet with the patient/resident and review the Medicare Rights form and secure a signature from the patient/resident or responsible party. All Medicare recipients upon final discharge must receive a copy of their original signed Medicare Rights form. If a patient/resident from SNF or Acute Rehab or Acute Medical discharges before a copy can be given, a copy shall be mailed to patient/resident.

2. Determination of Primary Payor, Level of Care, Certification and Coverage

a. The UM Nurse shall review the patient's/resident's face sheet.

i. If the patient's/resident's face sheet indicates that the patient/resident has ~~a.~~ Medicare Part A, go to Procedure A.

~~i.~~ii. If the patient's/resident's face sheet indicates Medi-Cal fee-for-service (FFS), go to Procedure B.

~~ii.~~iii. If the patient's/resident's face sheet indicates SFHP-CHN, go to Procedure C.

~~iii.~~iv. If the patient's/resident's face sheet indicates SFHP-UCSF, go to Procedure D.

~~iv.~~v. If the patient's/resident's face sheet indicates Anthem Blue Cross Medi-Cal Managed Care, go to Procedure E.

~~v.~~vi. For other payor sources, go to Procedure F.

b. UM Nurse completes the Utilization Review (UR) Daily Analysis form to identify sequence of payor sources (refer to Appendix L8).
~~b.~~

3. Procedure A – Medicare Part A Coverage

a. The UM Nurse confirms from the Medicare contracted vendor that the patient/resident:

i. has Part A Medicare eligibility,

ii. is not currently enrolled in a Medicare Advantage Plan, or HMO Plan, and

iii. has not exhausted his/her Medicare Acute Care or SNF benefits.

b. Acute Medical Unit

i. The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification. ~~signs the Acute Care Unit Physician Certification (refer to Appendix A1), for initial certification which is placed in the front of the medical record. Subsequent signatures may be made by the attending/covering physician for continued certification according to the required time frames. Completed Certification form shall be filed in the closed medical record under "Other Tab"~~

ii. The UM Nurse enters the patient information in the log of PMA Admission and updates log as needed (refer to Appendix L4). The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria.

iii. If the patient's admission~~stay~~ does not meet the InterQual Adult Acute Level of Care C~~c~~riteria ~~for admission~~, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. ~~UM Nurse Manager for secondary review. The UM Nurse Manager shall either approve or shall ask UM Nurse to speak with the attending Physician.~~ If the ~~Attending~~ Physician concurs the patient's admission was not medically necessary, the UM Nurse issues the Preadmission or Admission Hospital-Issued Notice of Noncoverage on the day of admission (refer to Appendix A2). ~~If the attending Physician does not agree,~~ T~~t~~he UM Nurse ~~Manager~~ shall refer the case to the UM Committee Chair or Physician Advisor as needed.

iv. If the patient's stay meets criteria, the UM Nurse shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay) ~~—~~using InterQual Adult Acute Level of Care Criteria in EHR.~~via Care Enhanced Review Manager Enterprise (CERMe) which is accessible in the website. Enter the level of care assigned in the UM Module in the LCR.~~

- Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

v. When the patient does not ~~no longer~~ meet~~s~~ InterQual Adult Acute Level of Care C~~c~~riteria for continued stay, ~~and there is no discharge plan,~~ the UM Nurse shall refer the case to the Physician for Secondary Medical Review.~~UM Nurse Manager. The UM Nurse Manager shall either approve the case or shall ask the UM Nurse to speak with the attending physician to determine discharge plan.~~

vi. ~~When there is no discharge plan, T~~the UM Nurse ~~Manager~~ shall refer the case to the UM Committee Chair or Physician advisor as needed. If the UM Chair or Physician advisor concurs the patient needs to be discharged, the UM Nurse shall issue the Hospital-Issued Notice of Noncoverage Noncovered Continued Stay (refer to Appendix A3).

c. Acute Rehab Unit

i. The UM Nurse sends a notification ~~via email~~ on the day of admission or as soon as possible and after patient discharge to RAI, A & E, Billing, Pharmacy, Rehabilitation, PM Acute Rehab Team, MSW, staff responsible for completing Hudman Bed Call list, and other staff involved to complete the Patient Assessment Instrument (PAI).

The Charge Nurse (CN)/designee completes the PAI with input from other staff and notifies RAI Specialist/designee when PAI is ready for transmission. RAI Specialist or designee notifies UM, Billing, CN/NM/designee when PAI was transmitted. Status of PAI is reviewed during Triple Check meeting.

During an Interrupted Stay (patient was discharged for an acute medical intervention for less than or equal to 3 days and is readmitted to the Acute Rehab Unit), the previous PAI prior to the discharge shall be continued.

ii. The UM Nurse enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5). The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab level of Care Criteria, the UM Nurse shall refer the case to ~~the~~a Physician for Secondary Medical Review.

~~ii.~~ The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the ~~C~~calls. ~~The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.~~

iii. The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, and Physiatrists.

~~iv. When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons, and/or there is no discharge plan, the UM Nurse shall speak with the attending Physician to determine discharge plans.~~

d. SNF

i. The UM Nurse shall ensure completion of Pre-Admission Screening Resident Review (PASRR). Refer to File 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.
~~i.~~

ii. The UM Nurse reviews the resident's medical record and determines if the resident's care meets the criteria for coverage under Medicare Part A SNF benefits.

iii. If the resident's stay does not meet criteria for Medicare Part A SNF coverage, the UM Nurse issues the appropriate Medicare Denial letter (refer to Appendix M1, ~~-~~ M2a, M2b).

iv. If the resident's stay meets criteria for Medicare Part A SNF coverage, the UM Nurse shall conduct the following procedures

- Completes and submits the SNF Physician Certification to the admitting physician for his/her signature of initial certification. Subsequent signatures shall be submitted to the attending/covering physician for continued certification according to the required time frames (see Appendix M3). When ~~medicare~~ Medicare coverage is discontinued, the completed Certification form shall be filed in the EHR.~~medical record under "Other Tab".~~ If the form was signed after the due date, the Delayed Physician

Medicare Certification needs to be filled out/completed by the Physician (see Appendix M8).

- Notifies the appropriate administrative and clinical team members that the resident's stay shall be covered under Medicare Part A SNF benefits. The administrative team consists of a designee from Admissions and Eligibility, pharmacy and staff responsible for entering Hudman Calls. The clinical team consists of the RAI Coordinator, Unit Nurse Manager, Physician and designated members of the Rehabilitation Department. ~~Medicare sticker shall be placed on the spine of the chart on the front cover to alert staff regarding Medicare coverage and what the focus of documentation should address.~~ During Medicare coverage, Licensed staff are to have at least daily nurses' notes to document the focus of skilled nursing care. The UM Nurse shall enter an order for Medicare Charting in EHR and discontinue the order after medicare coverage.

- Conducts and documents periodic reviews to determine that the resident continues to meet Medicare Part A SNF coverage and benefits. Reviews shall be conducted on a weekly basis and no more than ten days shall lapse between reviews.

- Documents all pertinent reviews on the Medicare Information Summary (refer to Appendix M5). The reviews shall document the resident's qualifying stay, diagnosis, qualifying criteria for Medicare coverage and MDS ~~Prospective Payment System (PPS) RUG scores according to the required schedule.~~Payment Categories which started under Payment Driven Payment Model (PDPM).

- Maintains a monthly log of all residents covered on Medicare Part A SNF coverage (refer to Appendix M6).

v. Completion of the Minimum Data Set (this is applicable only for SNF stays)

- The MDS is a clinical assessment tool that is completed by the resident care team and are used to classify resident into payment categories~~is the basis for the RUG IV Classification System~~. ~~The MDS is completed according to the specified required intervals established by the Medicare PPS.~~ The two required SNF PPS Assessments are: 5-Day Assessment and the PPS Discharge Assessment~~Unless modified by the MDS Coordinators, UM Nurses or member(s) of the resident care team, the MDS shall be completed with Assessment Reference Dates (ARD) of Days 5, 14, 29, 59, and 89 while the resident is covered on Medicare Part A benefits. Other Medicare Required Assessments (OMRA) such as End of Therapy and Change of Therapy shall be completed if indicated for a resident who is receiving rehabilitation therapy~~. The Interim Payment Assessment (IPA) shall

be completed when providers determine the resident has undergone a significant change in condition.

- During an Interrupted Stay (patient was discharged from Part A covered SNF care due to an acute hospitalization and subsequently readmitted to Part A covered SNF care in the same SNF during the interruption window of <3 or 3-day period), the previous MDS prior to the discharge shall be continued
-

~~2.~~

~~i.~~vi. Medicare Denial Determination

- When the resident no longer meets Medicare criteria for coverage under Part A benefits; the UM Nurse, as the designated Administrative Officer shall issue the appropriate Notice of Medicare Provider Non-Coverage letter, also known as the Generic Notice, no later than 2 days before covered services shall end. The UM Nurse shall notify all appropriate administrative and clinical team members of the resident's non-coverage determination. The UM Nurse must also provide a Detailed Explanation of Skilled Nursing Non-Coverage letter, also known as the Detailed Notice, to the resident or the responsible party, if the resident or responsible party chooses to appeal the Medicare denial determination with the Quality Improvement Organization (QIO). If the patient shall remain in the SNF after Medicare coverage, the SNF Advance Beneficiary Notice of Non-coverage (SNFABN) shall be issued ~~SNF Determination on Continued Stay shall be issued by the UM Nurse~~ (refer to Appendix M4A, M4B and M14~~C~~ for the Generic, Detailed Notice, and SNFABN~~ Determination on Continued Stay~~). The Admission~~tting~~ and Eligibility Manager/designee shall sign as verification of the receipt of the Generic notice. If a patient has no Medi-Cal Eligibility, the UM Nurse obtains the patient's/resident's or responsible party's signature.

vii. If the resident is not discharged from the skilled nursing facility and the resident or responsible party disagrees with the Medicare denial determination, the resident or responsible party can request for an intermediary review. The UM Nurse shall notify the Billing department regarding the beneficiary's request for a Demand Bill on a monthly basis.

viii. The MDS Coordinators shall also be notified regarding the Demand Bill ~~and shall be asked to complete a Demand Bill MDS~~. The payment category for 5-day PPS Assessment shall be used if the patient/resident request for the demand bill.

ix. The Utilization Management department shall be notified by the Billing department regarding the outcome of the Intermediary's decision. Any decisions made by the Intermediary that is contrary to the facility's Medicare

coverage determination shall be reported and reviewed at the monthly Utilization Management Committee.

~~ix.~~

x. Medicare Reinstatement (applicable only for SNF stays)

- When a resident who has been issued a Medicare Denial letter experiences a change in condition that requires daily skilled services, and is within 30 days of the last Medicare covered day, s/he may be reinstated Medicare Part A benefits if s/he meets Medicare coverage criteria. The UM Nurse shall complete the Skilled Nursing Facility Reinstatement letter (see Appendix M7) to reinstate the resident's Medicare coverage and notify the appropriate administrative and clinical team members, resident care team and the Billing department of the change in coverage.

xi. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

xii. The UM Nurse shall enter a Utilization Review note.

4. Procedure B - Medi-Cal Fee for Service

a. Acute Medical Unit

~~i.~~ The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR.~~signs the Acute Care Unit Physician~~

i. ~~Certification (refer to Appendix A1), for initial certification which is placed in the front of the medical record.~~ After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification. ~~Subsequent signatures may be made by the attending/covering physician for continued certification according to the required time frames. Completed Certification form shall be filed in the closed medical record under "Other Tab"~~

ii. The UM Nurse enters the patient information in the log of PMA Admission and updates log as needed (refer to Appendix L4). The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria.

iii. If the patient's admission ~~stay~~ does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.~~, the UM Nurse shall refer the case to the UM Nurse Manager for secondary review. The UM Nurse Manager shall either approve the case or ask the UM Nurse to speak with the attending Physician. If the attending Physician does not agree,~~ Tthe UM Nurse ~~Manager~~ shall refer the case to the UM Committee Chair or Physician Advisor as needed.

iv. If the patient's stay meets criteria, the UM Nurse shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay) ~~in~~ using InterQual Adult Acute Level of Care Criteria in EHR. ~~via Care Enhanced Review Manager Enterprise (CERMe) which is accessible in the website. Enter the level of care assigned in the UM Module in the LCR.~~

- Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

- When the patient does not meet InterQual Adult Acute Level of Care Criteria for continued stay, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

- ~~v. When the patient no longer meets InterQual Adult Acute Level of Care criteria and there is no discharge plan, the UM Nurse shall refer the case to the UM Nurse Manager. The UM Nurse Manager shall either approve the case or shall ask the UM Nurse to speak with the attending physician to determine discharge plan.~~

~~vi. When there is no discharge plan, the UM Nurse Manager shall refer the case to the UM Committee Chair or Physician advisor.~~

b. Acute Rehab Unit

i. The UM Nurse enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5). The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

~~i. The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.~~

ii. ~~The UM Nurse enters patient information in the log of PMR Admission and updates as needed (refer to Appendix L5).~~ The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, and Physiatrists.

~~iii. When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons, and/or there is no discharge plan, the UM Nurse shall speak with the attending Physician to determine discharge plans.~~

~~iv. If the patient is going to be discharged to a SNF and there is no available SNF bed the attending Physician shall document in the progress notes that the patient is awaiting for SNF bed availability. The UM Nurse shall request to staff responsible for entering Hudman Bed Call list to start the calls.~~

c. SNF

i. The UM Nurse reviews the resident's medical record and determines the resident's care needs and the reason for admission.

ii. The UM Nurse enters/updates the Medi-Cal SNF Log (refer to Appendix L9)

iii. The UM Nurse ensures the completion of PASRR. Refer to File: 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

iv. The UM Nurse ensures the completion of Treatment Authorization Request (TAR). Refer to File: 55-02 Processing of Long Term Care Treatment Authorization Requests Policy.

v. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

vi. The UM Nuse shall complete a Utilization Review note in EHR.

~~iv.~~

5. Procedure C - SFHP CHN Coverage

a. Acute Medical Unit

i. The UM Nurse ~~obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to~~ verifiesy patient's membership with SFHP via SFHP website.

ii. The UM Nurse notifies SFHP ~~via telephone~~ of patient's admission. The UM Nurse enters the patient information in the log of PMA Admission and SFHP Patient List and update~~s~~ as needed (refer to Appendix L4 and L2).

~~iii. The UM Nurse affixes a sticker (neon) on the spine of the chart for RCT to identify that the patient has private insurance.~~

~~iv.~~iii. The UM Nurse sends a notification ~~via email~~ on the day of admission or soon thereafter to A & E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.

~~v.~~ The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR. ~~signs the Acute Care Unit Physician Certification (refer to Appendix A1), for initial certification which is placed in the front of the medical record.~~After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification ~~Subsequent signatures may be made by the attending/covering physician for continued certification.~~ ~~according to the required time frames. Completed Certification form shall be filed in the closed medical record under "Other Tab"~~

~~vi.~~iv. ~~The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria for admission.~~

~~—~~The UM Nurse reviews the patient's medical record and determines if the patient's medical condition meets InterQual Adult Acute Level of Care Criteria. If the patient's admission does not meet criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

~~vii.~~v. ~~If the patient's stay does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse shall refer the case to the UM Nurse Manager for secondary review. The UM Nurse Manager shall either approve the case or ask the UM Nurse to speak with the attending Physician. If the attending Physician does not agree, the UM Nurse Manager shall refer the case to the UM Committee Chair or Physician Advisor.~~

~~viii.~~vi. If the patient's stay meets criteria, the UM Nurse shall conduct the following procedures:

- Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.~~via Care Enhanced Review Manager Enterprise (CERMe) which is accessible in the website. Enter the level of care assigned in the UM Module in the LCR.~~

- Review the medical record at least daily (except on weekends and/or holidays) and determine if the patient continues to meet the criteria for continued stay.

~~ix.~~vii. When the patient does not ~~no longer~~ meet~~s~~ InterQual Adult Acute Level of Care Ceriteria for continued stay, ~~and there is no discharge plan,~~ the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician advisor as needed.~~Nurse Manager. The UM Nurse Manager shall either approve the case or shall ask the UM Nurse to speak with the attending physician to determine discharge plan.~~

~~x. When there is no discharge plan, the UM Nurse Manager shall refer the case to the UM Committee Chair or Physician advisor.~~

b. Acute Rehab Unit

i. The UM Nurse ~~obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to~~ verifiesy patient's membership with SFHP via SFHP website.

~~ii. The UM Nurse affixes a sticker (neon) on the spine of the chart for RCT to identify that the patient has private insurance.~~

~~iii.~~ii. The UM Nurse sends a notification via email on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.

~~iv.~~iii. The UM Nurse notifies SFHP of patient's admission. The UM Nurse enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2). ~~The UM Nurse reviews the medical records and progress notes from the therapists and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.~~

iv. The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

~~v.~~ The UM Nurse updates and sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, Physiatrists.

~~vi.~~v. ~~When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons, and/or there is no discharge plan, the UM Nurse shall speak with the attending Physician to determine discharge plans.~~

~~vii. If the patient is going to be discharged to a SNF and there is no available SNF bed, the attending Physician shall document in the progress notes that the patient is awaiting for SNF bed availability. The UM Nurse shall request to staff responsible to entering Hudman Bed Call list to start the calls.~~

c. SNF

i. The UM Nurse ensures the completion of PASRR. Refer to File: 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

ii. The UM Nurse ~~obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to~~ verifiesy patient's membership with SFHP via SFHP website.

~~iii. The UM Nurse affixes a sticker (neon) on the spine of the chart for the RCT to identify that the patient has a private insurance~~.

~~iv.~~iii. The UM Nurse sends a notification ~~via email~~ on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-CHN.

~~v.~~iv. The UM Nurse enters the patient information in the SFHP List and updates as needed (refer to Appendix L2). The UM Nurse reviews the medical record for skilled nursing/rehab needs.

~~vi.~~v. The UM Nurse obtains information from review of medical record or from RCT re discharge plan. Communicates with A & E as needed.

~~vii.~~vi. The UM Nurse sends to SFHP on the 1st working day of the month via fax the list of patients who are due for disenrollment which includes patient name, admit date, discharge location/date, SFHP ID, date of service, term date (refer to Appendix L2~~1~~). Facesheets are also sent as needed.

~~viii. UM Nurse/designee sends monthly list of SFHP-CHN patients to Billing Department, A & E, Rehab, RAI, Pharmacy, Staff responsible for entering Hudman Bed~~

~~Call list every 1st week of the month which includes patient name, unit, admit date, SFHP ID, date of service, discharge location/date, term date (refer to Appendix L2).~~

vii. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

viii. The UM Nurse shall complete a Utilization Review note in EHR.

6. Procedure D – SFHP-UCSF Coverage

a. Acute Rehab Unit

i. The UM Nurse ensures that pre-authorization is received from A & E.

ii. The UM Nurse ~~obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to~~ verifiesy patient's membership with SFHP via SFHP website.

iii. The UM Nurse notifies SFHP-UCSF of patient's admission on the day of admission or soon thereafter by sending via fax the facesheet and admission orders.

~~iv. The UM Nurse affixes a sticker (neon) on the spine of the chart for RCT to identify that the patient has private insurance.~~

~~v.~~iv. The UM Nurse sends a notification ~~via email~~ on the day of admission or soon theraftер to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF. Sends updates to the group as needed.

v. The UM Nurse enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2).

vi. The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission is not meeting the criteria, the case shall be referred to the Physician for Secondary Medical Review.

~~vi.~~The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls. ~~The UM Nurse reviews the medical records and progress notes from the therapists~~

~~and determines if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.~~

vii. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

viii. The UM Nurse sends copies of medical records to SFHP-UCSF weekly via fax to obtain authorization for continued stay.

ix. The UM Nurse sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Nurses, Physiatrists.

~~x. When the patient no longer meets the required acute inpatient intensive rehabilitation therapy minutes, the UM Nurse shall speak with the attending Physician to determine discharge plans if there are no documented discharge plan.~~

~~xi.~~ If the patient is still meeting the ~~acute~~ InterQual Adult Acute Rehab Level of Care Criteria ~~inpatient intensive rehabilitation therapy~~ and denial received from SFHP-UCSF, the UM Nurse shall discuss case with SFHP-UCSF contact person. If no resolution obtained, follow the next step as recommended by SFHP-UCSF such as peer-to-peer review or appeal the denial.

~~xii.~~x. ~~Sends a notification via email to A& E, Billing, and Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF.~~

~~xiii.~~xi. When the patient is discharged either to the acute hospital or to home, the UM Nurse notifies SFHP-UCSF.

b. SNF

i. The UM Nurse shall ensure the completion of PASRR. Refer to LHHPP 55-03 PASRR Policy. The UM Nurse shall complete the PASRR flowsheet in EHR.

ii. The UM Nurse shall ensure that pre-authorization is received from A & E.

iii. The UM Nurse ~~obtains CIN from LCR to use when accessing SFHP website. Access the SFHP website to~~ verifies~~y~~ patient's membership with SFHP via SFHP website.

iv. The UM Nurse notifies SFHP-UCSF of patient's admission on the day of admission or soon thereafter by sending via fax the facesheet and admission orders.

~~v. The UM Nurse affixes a sticker (neon) on the spine of the chart for RCT to identify that the patient has private insurance.~~

~~vi.~~v. The UM Nurse sends a notification ~~via email~~ on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF. Sends updates to the group as needed.

~~vii.~~vi. The UM Nurse enters the patient information in the SFHP Patient List and updates as needed (refer to Appendix L2). The UM Nurse reviews the medical records and progress notes for determination of skilled needs.

~~viii.~~vii. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

~~ix.~~viii. The UM Nurse sends copies of medical records weekly to SFHP-UCSF via fax to obtain authorization for continued stay.

~~x.~~ If denial for continued stay received from SFHP-UCSF, the UM Nurse shall discuss case with SFHP-UCSF contact person. If no resolution obtained, follow the next step as recommended by SFHP-UCSF such as peer-to-peer review or appeal the denial.

~~xi.~~ix. ~~Sends a notification via email to A& E, Billing, and Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under SFHP-UCSF.~~

~~xii.~~x. When the patient is discharged either to the acute hospital or to home, the UM Nurse notifies SFHP-UCSF contact person.

xi. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

xii. The UM Nurse shall complete a Utilization Review note.

7. Procedure E – Anthem Blue Cross Medi-Cal Managed Care Coverage

a. Acute Rehab Unit

i. The UM Nurse ensures that pre-authorization is received from A & E.

~~ii.~~ The UM Nurse notifies Anthem Blue Cross UM RN of patient's admission on the day of admission or soon thereafter by sending via fax the Facesheet and admission orders.

~~iii.~~ii. ~~The UM Nurse affixes a sticker (neon) on the spine of the chart for RCT to identify that the patient has private insurance.~~

~~iv.~~iii. The UM Nurse sends a notification ~~via email~~ on the day of admission or soon thereafter to A & E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross Medi-Cal Managed Care. Sends updates to the group as needed.

iv. The UM Nurse enters the patient information in the Log of PMR Admission and Anthem Blue Cross Medi-Cal Managed Care Patient List (refer to Appendix L5 and Appendix L6). ~~The UM Nurse reviews the medical records and progress notes from the therapists and determine if patient is meeting the required therapy minutes for acute inpatient intensive rehabilitation.~~

v. The use of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission review is not meeting the criteria, the case shall be referred to the Physician for Secondary Medical Review.

The continued stay reviews shall be done weekly. If the patient no longer meets acute inpatient rehab level of care and is placed on administrative days, the continued stay reviews shall be done on a daily basis. The Attending Physician shall document in the progress notes "patient is on administrative day pending availability of SNF bed". The UM Nurse shall notify the staff responsible for completing Hudman Bed Call list to start the Calls.

~~v.~~vi. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

~~vi.~~vii. The UM Nurse sends copies of medical records to Anthem Blue Cross UM RN weekly via fax to obtain authorization for continued stay. The ~~When approved the~~ UM Nurse shall receive the authorization for continued stay via fax.

~~vii.~~ The UM Nurse sends the Acute Rehab Patient List (which includes patient name, admit date, diagnosis, primary payor, rehabilitation treatment order and the rehabilitation treatment dates and minutes; refer to Appendix L3) weekly to RAI, Rehabilitation, UM Coordinators, Physiatrists.

viii. ~~When the patient no longer meets the required intensive rehabilitation therapy minutes and there are no supporting documentation by the Physiatrist or attending Physician and therapist to indicate reasons and/or there is no discharge plan, the UM Nurse shall speak with the attending Physician to determine discharge plans.~~

~~ix.~~ If the patient is still meeting the InterQual Adult Acute Rehab Level of Care Criteria ~~acute inpatient intensive rehabilitation therapy~~ and denial received from Anthem, the UM Nurse shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next step as recommended by Anthem Blue

Cross such as peer-to-peer review within 30 days of receiving the denial or appeal the denial.

~~x.~~ix. ~~The UM Nurse sends a notification via email to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurse notifying them of patient's coverage under Anthem Blue Cross.~~

~~xi.~~x. When the patient is discharged either to the acute hospital or to the community, the UM Nurse notifies Anthem Blue Cross ~~to obtain authorization for bedhold if discharge is to the acute hospital~~.

b. SNF

i. The UM Nurse shall ensure that pre-authorization is received from A & E.

~~ii.~~ The UM Nurse notifies Anthem Blue Cross UM RN of patient's admission on the day of admission or soon thereafter by sending via fax the Facesheet and admission orders.

~~iii.~~ii. ~~The UM Nurse affixes a sticker (neon) on the spine of the chart for to RCT to identify that the patient has private insurance~~.

~~iv.~~iii. The UM Nurse sends a notification ~~via email~~ on the day of admission or soon thereafter to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross Medi-Cal Managed Care. Sends updates to the group as needed.

~~v.~~iv. The UM Nurse enters the patient information in the Anthem Blue Cross Medi-Cal Managed Care Patient List and updates as needed (refer to Appendix L6). The UM Nurse reviews the medical records if patient meets the levels of care by Anthem Blue Cross.

~~vi.~~v. The UM Nurse obtains information from review of medical records or from RCT re discharge plan. Communicates with A & E as needed.

~~vii.~~vi. The UM Nurse sends copies of medical records to Anthem Blue Cross UM weekly via fax to obtain authorization for continued stay. When approved the UM Nurse shall receive the authorization for continued stay via fax and~~. The UM Nurse shall~~ make sure the approved level of care is appropriate. If not, the UM Nurse shall discuss the case~~is~~ with Anthem Blue Cross UM RN.

~~viii.~~ If the patient is still meeting the levels of care by Anthem Blue Cross and denial for continued stay was received, the UM Nurse shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next steps recommended by Anthem Blue Cross such peer-to-peer within 30 days of receiving the denial or appeal the denial according to required time frames.

~~ix.~~vii. ~~The UM Nurse sends a notification via email to A& E, Billing, Staff responsible for entering Hudman Bed Call list, UM TAR Clerk, RCT, Rehabilitation, Pharmacy, UM Nurses notifying them of patient's coverage under Anthem Blue Cross.~~

viii. The UM Nurse notifies Anthem Blue Cross about patient's disposition. When the patient is discharged to the Acute Hospital, UM Nurse obtains authorization for bedhold.

~~x.~~

ix. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

x. The UM Nurse shall complete a Utilization Review note in EHR.

8. Procedure F – Other Payor Coverage

a. A & E sends Letter of Agreement (LOE) and any other information related to ~~–~~this case to UM Department.

b. The UM Nurse notifies payor/insurance of this admission on the day of admission or soon thereafter and obtain information from the payor of the requirements to obtain coverage for this admission.

c. The UM Nurse enters patient information in the Other Payor List and updates the list as needed (refer to Appendix L7).

d. For any issues, obtain assistance from OMC as necessary.

e. The UM Nurse shall complete the LHH UM Triple Check Flowsheet in EHR.

f. The UM Nurse shall complete a Utilization Review note in EHR.

ATTACHMENT:

~~Appendix A1: Acute Care Unit Physician Certification~~
Appendix A2: Preadmission or Admission Hospital-Issued Notice of Noncoverage
Appendix A3: HINN Noncovered Continued Stay
~~Appendix L1: SFHP Patient List (for SFHP)~~
Appendix L2: SFHP Patient List
Appendix L3: Acute Rehab Patient List
Appendix L4: Log of PMA Admission
Appendix L5: Log of PMR Admission
Appendix L6: Anthem Blue Cross Medi-Cal Managed Care
Appendix L7: Other Payor List
Appendix L8: Utilization Review Daily Analysis
Appendix L9: Medi-Cal SNF Log
Appendix M1: SNF Advance Beneficiary Notice of Non-coverage~~Determination on Admission~~

Appendix M2a: Benefit Exhaust Letter
Appendix M2b: No Qualifying 3-day Inpatient Hospital Stay~~Notice of Exclusions from Medicare Benefits - SNF~~
Appendix M3: SNF Physician Certification
Appendix M4A: The Generic Notice (Notice of Medicare Provider Non-Coverage)
Appendix M4B: The Detailed Notice (Detailed Explanation of Non-Coverage)
~~Appendix M4C: SNF Determination on Continued Stay~~
Appendix M5: Medicare Information Summary
Appendix M6: Medicare Part A SNF List
Appendix M7: Skilled Nursing Facility Reinstatement
Appendix M8: Delayed Physician Certification

REFERENCE:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
LHHPP 55-02 Processing of Long Term Care TARs
LHHPP 55-03 PASRR

Revised: 04/08/19, 05/08/18, 08/04/17, 10/08/19, 11/09/27, 14/01/28, 14/03/25, 14/07/29, 16/11/08, 20/01/14 (Year/Month/Day)
Original Adoption: Est. 1993

Laguna Honda Hospital & Rehabilitation Center
375 Laguna Honda Boulevard, San Francisco, CA 94116
Telephone Number (415) 759-2300

Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN)

Name of Patient: _____ *Name of Physician:* _____
Patient ID Number: _____ *Date Issued:* _____

We believe that Medicare is not likely to pay for your admission for
_____ *because:*

____*it is not considered to be medically necessary*
____*it could be furnished safely in another setting*
____*other*_____.

However, this notice is not an official Medicare decision.

If you disagree with our finding:

☐ *You should talk to your doctor about this notice and any further health care you may need.*

☐ *You also have the right to an appeal, that is, an immediate review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to make a formal decision about whether your admission is covered by Medicare.* ***See page 2 for instructions on how to request a review and contact the QIO.***

☐ ***If you decide to go ahead with the hospitalization, you will have to pay for:***
_____[1]

[1] *For preadmission notices, insert: "customary charges for all services furnished during the stay, except for those services for which you are eligible under Part B."*

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

CONTINUED ON PAGE 2

Appendix A2

PAGE 2 – PREADMISSION/ADMISSION HOSPITAL-ISSUED NOTICE OF NONCOVERAGE

If you want an immediate review of your case:

Preadmission:

- ☐ *Call the QIO immediately at the number listed below, but no later than 3 calendar days after you receive this notice. If you are admitted, you may call the QIO at any point in the stay.*

Admission:

- ☐ *Call the QIO immediately at the number listed below or you may call the QIO at any point during your stay.*
- ☐ *You may also call the QIO for quality of care issues.*

QIO Contact Information: ***Health Services Advisory Group (HSAG).***
1-800-841-1602 (TDD: 1-800-881-5980)

If you do not want an immediate review:

- ☐ *You may still request a review within 30 calendar days from the date of receipt of this notice by calling the QIO at the number below.*

Results of the QIO Review:

- ☐ *The QIO will send you a formal decision about whether your hospitalization is appropriate according to Medicare's rules, and will tell you about your reconsideration and appeal rights.*
  - ° *IF THE QIO FINDS YOUR HOSPITAL CARE IS COVERED, you will be refunded any money you may have paid the hospital except for any applicable copays, deductibles, and convenience items or services normally not covered by Medicare.*
  - ° *IF THE QIO FINDS THAT YOUR HOSPITAL CARE IS NOT COVERED, you are responsible for payment for all services beginning on _____.*

For more information, call 1-800-MEDICARE (1-800-633-4227),or TTY:1-877-486-2048.

Please sign your name, the date and time. Your signature does not mean that you agree with this notice, just that you received the notice and understand it.

_____	_____	_____
Signature of Patient or Representative	*Date*	*Time*

HINN 12 - Noncovered Continued Stay

Laguna Honda Hospital & Rehabilitation Center

375 Laguna Honda Boulevard, San Francisco, CA 94116

Telephone Number (415) 759-2300

Name of Patient or Representative	Identification Number

The purpose of this notice is to inform you that we believe your continued hospital stay will not be paid for by Medicare because:

Based on our understanding of Medicare policy, we believe that beginning on _____ you will be responsible for payment of your continued stay. **Beginning on this date, you or your other insurance may have to pay for your continued stay. We estimate the cost of your continued stay to be:**

You should talk with your physician about your health care needs, including your continued stay.

You can ask us to file a Medicare claim for your continued stay. You will receive a Medicare Summary Notice (MSN) telling you Medicare's payment decision on this claim, and how to ask for an appeal of that decision if Medicare does not pay. If you appeal and Medicare decides to pay despite our opinion, any charges we collected (minus co-pays and deductibles) will be refunded to you. If you have questions you can call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

This notice is not an official Medicare decision. Your signature below only shows that you have received this notice and understand what you may have to pay for. You will receive a copy of this notice.

Signature of Beneficiary or Representative	Date

SFHP Patient List

APPENDIX L2

Date	Time	By (Initial)

Name MRN	Unit	Admit Date	SFHP Group ID#	Date of Service	Dis-enrollment Date	Discharge Location/ Date	Authorization	Comments

Acute Rehab Patients

APPENDIX L3

Name, Admit Date, Dx	Insurance	Rehab Tx Ordered	Rehab Tx Dates and Minutes ***Comprehensive rehabilitation program with @ least 2 disciplines and > or = 3h/day, > or = 5 d/week**

ACUTE REHAB TREATMENT MINUTES GUIDELINE:

1 day = 180 minutes 2 days = 360 minutes 3 days = 540 minutes 4 days = 720 minutes 5 days = 900 minutes

Log of PMA Admissions:

APPENDIX L4

Revised on	*Time*	*By (Initial)*

Name	MRN (indicates patients w/ DM) (UM Initial)	Admit Date	Discharge Date	LOS	Admitting Dx	Payor Source(s) Check All Payors				Acute Stay Payor Check #1 Payor				Comments
						Medicare		Medi-Cal	Private	Medi-care	Medi-cal	PP	PI	
						A	B							

Log of PMR Admissions:

APPENDIX L5

Revised on	Time	By (Initial)

Name	MRN (indicates patients w/ DM) (UM Initial)	Admit Date	Discharge Date	LOS	Admitting Dx	Payor Source(s) Check All Payors				Acute Stay Payor Check #1 Payor				Comments
						Medicare		Medi-Cal	Private	Medi-care	Medi-cal	PP	PI	
						A	B							

APPENDIX L6 - ANTHEM BLUE CROSS MEDI-CAL MANAGED CARE PATIENT LIST

Revised on	*Time*	*By (Initial)*

Name	Unit	Admit Date	Authorization Ref No.	Dis-enrollment Date	Discharge Date/ Location	Comments/ Appeal Status

Other Payor Patient List									
APPENDIX L7									
Revised on	*Time*	*By (Initial)*							
Name	Unit	Admit Date	ID#	Date of Service	Dis-enrollment Date	Discharge Location/ Date	Authorization	DOS paid	Comments

Utilization Review Daily Analysis - Laguna Honda Hospital

APPENDIX L8

	DATE	RESIDENT NAME (DPNA - denial of payment for new admissions) (Note Respite Residents)	UNIT	FROM	ADMIT Code	AGE	PAYOR SOURCE(S)				ACUTE STAY PAYOR				SEQUENCE OF SNF STAY				TAR MDS	TYPE OF MCARE DENIAL		
							MEDI CARE		MEDI CAL	PRIVATE (Specify name of private insurance if known)	CARE	CAL	OTHER		CARE & 5 DAY MDS	CAL & TAR MDS	OTHER		x = yes	AD	NQS	BE
							A	B	P = Pending				PP	PI			PP	PI				
1																						
2																						
3																						
4																						
5																						
6																						
7																						
8																						
9																						
10																						
11																						
12																						
14																						
15																						

Admit Codes:	Private Payor Codes:	Medi-Cal Code	Medicare Denial Codes
1 = New Admission	PP = Private Pay	NTN = No TAR Needed	AD=Admit Denial (Readmit #2 TAR MDS)
2 = Re-Admission Continued Stay	PI = Private Insurance	< 8 Days Acute Stay	BE = Benefit Exhaust
3 = Re-Admission New Stay			NQS = No Qualifying Stay

APPENDIX L9

Revised on	*Time*	*By (Initial)*

Medi-Cal SNF Log

Resident Name (UM Nurse Initials)	MRN	Svc/ Unit	Admit Date	TAR#/ Date Submitted	Comments

Appendix M1

Skilled Nursing Facility: **LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER**
375 LAGUNA HONDA BOULEVARD, SAN FRANCISCO, CALIFORNIA 94116
(415) 759-2300

Beneficiary's Name: **Identification Number:**

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on_____, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

Care:	Reason Medicare May Not Pay:	Estimated Cost:

WHAT TO DO NOW:

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can't require us to do this.

OPTIONS: **Check only one box. We can't choose a box for you.**

☐ **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but **I can appeal to Medicare** by following the directions on the MSN.

☐ **Option 2.** I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. **I cannot appeal because Medicare won't be billed.**

☐ **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and **I can't appeal to see if Medicare would pay**.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call **1-800-MEDICARE** (1-800-633-4227) /**TTY:** 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signing below means that you've received and understand this notice. You'll also get a copy for your records.

Signature of Patient or Authorized Representative*	Date

* If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

Form CMS-10055 (2018)

Appendix M2a

Department of Public Health
Grant Colfax, MD, Director of Health

San Francisco Health Network
Roland Pickens, MHA, FACHE, Director

City and County of San Francisco
London Breed
Mayor

Laguna Honda Hospital and Rehabilitation Center
Maggie Rykowski, RN, MS, Acting Executive Administrato

SKILLED NURSING FACILITY
DENIAL DETERMINATION
BENEFITS EXHAUSTED

DATE: _____ RE: _____

TO: _____ MRN.: _____

_____ ADMIT DATE: _____

_____

Under the Medicare Law, payment for Skilled Nursing Facility care is limited, and designed to pay only part of the costs. When you are eligible for such care, Medicare insurance will pay for services up to a maximum of 100 days in each benefit period.

According to our records, Part A SNF days in the current benefit period:

☐ were exhausted on _____.

☐ will be exhausted on _____.

Therefore, Medicare will not cover your stay from _____.

This does not mean that you must be discharged from Laguna Honda Hospital at this time, but that payment for further care will have to come from other sources. If you have further concerns, you may discuss this matter with your Eligibility Worker or Social Worker.

Sincerely,

_____

Signature of Administrative Officer

(415) 759-2300 **375 Laguna Honda Blvd.** **San Francisco, CA 94116**

Appendix M26

San Francisco Department of Public Health
Grant Colfax, MD, Director of Health

San Francisco Health Network
Roland Pickens, MHA, FACHE, Director

City and County of San Francisco
London N. Breed
Mayor

Laguna Honda Hospital and Rehabilitation Center
Maggie Rykowski, RN, MS, Acting Executive Administrator

SKILLED NURSING FACILITY
DENIAL DETERMINATION ON ADMISSION
NO QUALIFYING 3-DAY INPATIENT HOSPITAL STAY

DATE: _____ RE: _____

TO: _____ MRN.: _____

_____ ADMIT DATE: _____

_____

Under the Medicare Law, you need Medicare Part A Insurance and a three-day inpatient hospital stay to qualify for Medicare coverage for your skilled nursing facility stay.

We have carefully examined your case, and Medicare will not cover your stay because you do not have a three-day prior inpatient hospital stay.

This does not mean that you must be discharged from Laguna Honda Hospital at this time, but that payment for further care will have to come from other sources. You may discuss this problem with your Eligibility Worker or Social Worker.

Sincerely,

_____

Signature of Administrative Officer

(415) 759-2300 **375 Laguna Honda Blvd.** **San Francisco, CA 94116**

Appendix M3

LAGUNA HONDA HOSPITAL & REHABILITATION CENTER SKILLED NURSING FACILITY MEDICARE PART-A PHYSICIAN CERTIFICATION & RECERTIFICATION

(Addressograph) / Name:

INPATIENT ADMISSION CERTIFICATION – Required at time of admission	I certify that post-hospital SNF services are required to be given on an inpatient basis because the above named patient's need for skilled nursing care on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services prior to transfer to SNF. _____ Physician's Signature	_____ Date
RECERTIFICATION on or before the 14th day of post hospital SNF care	I certify that continued SNF care is necessary for the following reason(s)_____ _____ I estimate that additional period of SNF inpatient care will be: _____days or _____ weeks. Plan(s) for post-SNF care is(are):_____ _____ Physician's Signature	_____ Date
2nd RECERTIFICATION on or before the 30th day following the 1st recertification	I certify that continued SNF care is necessary for the following reason(s) _____ _____ I estimate that additional period of SNF inpatient care will be: _____days or _____ weeks. Plan(s) for post-SNF care is(are) :_____ _____ Physician's Signature	_____ Date
3rd RECERTIFICATION on or before the 30th day following the 2nd recertification	I certify that continued SNF care is necessary for the following reason(s) _____ _____ I estimate that additional period of SNF inpatient care will be: _____days or _____ weeks. Plan(s)for post-SNF care is(are):_____ _____ Physician's Signature	_____ Date
4th RECERTIFICATION on or before the 30th day following the 3rd recertification	I certify that continued SNF care is necessary for the following reason(s) _____ _____ I estimate that additional period of SNF inpatient care will be: _____days or _____ weeks. Plan(s) for post-SNF care is(are): _____ _____	_____

Appendix M4A

Laguna Honda Hospital & Rehabilitation Center
375 Laguna Honda Boulevard, San Francisco, CA 94116
Telephone Number (415)759-2300

Notice of Medicare Non-Coverage

Patient name: _____ **Patient number:** _____

The Effective Date Coverage of Your Current Skilled Nursing Services Will End: _____

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Health Services Advisory Group (HSAG) at 1-800-841-1602 (TDD: 1-800-881-5980) to appeal, or if you have questions.

See page 2 of this notice for more information

Appendix M4A

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

  Plan contact information _____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

Laguna Honda Hospital & Rehabilitation Center

375 Laguna Honda Boulevard, San Francisco, CA 94116
Telephone Number (415) 759-2300

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current Skilled Nursing services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at:

Appendix M5

NAME:
MRN:
DOB:
ADMIT DATE:
UNIT/RM #:
ADMIT CODE:

LAGUNA HONDA HOSPITAL
SKILLED NURSING FACILITY
MEDICARE INFORMATION SUMMARY

Unit	Dates of Acute Care Stay:	Hospital:

Diagnosis/Procedures with Dates:	Number of Days Covered	
	PTA	
Physician Certification Dates (Write in certification due dates and ☒ when signed.)		
Admit ☐ / **1st Recertification** ☐ / **2nd Recertification** _____ ☐ / **3rd Recertification** _____ ☐ / **4th Recertification** _____ ☐		

PPS Period	5 day MDS	IPA	IPA			
Payment Categories						**Total Days Used:**
ARD						**LCD:** ☐ Continued Stay Denial ☐ Benefit Exhaust ☐ Discharged _____ ☐ Expired _____
☐ Epic LHH UM Triple Check start of coverage ☐ Epic LHH UM Triple Check end of coverage		☐ Epic Case Mgmt bed days (off Medicare) ☐ Enter Green Sticky ☐ Remove Green Sticky		☐ Medicare Charting Order ☐ Remove Charting Order		
☐ LCD Email ☐ LCD Review ☐ Update LCD on Logs		☐ MD Cert to HIS ☐ Denial to A&E ☐ Denial from A&E				

Basis of Medicare Skilled Nursing Level of Care Coverage

Current Skilled Rehabilitation Services (Indicate frequency, start and stop dates of services provided.)			
Physical Therapy:			
Occupational Therapy:			
Speech Therapy:			
Current Skilled Nursing Services (Indicate frequency, start and stop dates of services provided.)			
Trach Care/Suctioning:	**Naso/Pharyngeal Suctioning:**	**IV Medication:**	**IV Fluids** (includes look-back for nutrition/hydration)
Ulcer Care:	**Surgical Wound Care:**	**Tube Feeding** (includes look-back for nutrition/hydration)	**Isolation for active infectious disease:**
☐**Skilled Observation and Assessment** ☐**Presumption of Coverage** ☐**Management and Evaluation of Care Plan (x one):**			

Epic Utilization Review (Indicate the date of review and your initials.)	
Date of Review/ Initials	NOTES:
CARE PLAN	
	☐ ☐
	☐ Epic Utilization Review ☐ Nsg notes:

U.M. Coordinator Signature and Initials			

*LHH Medicare Provider Number: 555020 ** Intermediary: Noridian (Telephone No: 1-877-908-8431) Revised 12/17/14

APPENDIX M6 - Medicare Part A SNF List

Revised on	Time	By (Initial)

*If not signed, enter the date checked by HIS.

Name	Unit	Admit Date	Reinstatement Date	Dates of Acute Care Stay and Name of Acute Hospital	Reason for Coverage	5-DAY ARD, PAYMENT CATEGORY, REHAB MINUTES/ DAYS	IPA ARD, PAYMENT CATEGRY	IPA ARD, PAYMENT CATEGORY	LCD REASON D/C Date D/C LOCATION	SNF Days Used	Total SNF Days Used	Demand Bill (ARD and RUGS)	ICD Code of B20 (Y/N)	H&P Signed by MD*	PT Eval Signed by MD*	OT Eval Signed by MD*	ST Eval Signed by MD*

Tip: ***Paper Size is set to 8.5 x 14 (Legal)***

Appendix M7

San Francisco Department of Public Health
Grant Colfax, MD, Director of Health

San Francisco Health Network
Roland Pickens, MHA, FACHE, Director

City and County of San Francisco
London N. Breed
Mayor

Laguna Honda Hospital and Rehabilitation Center
Maggie Rykowski, RN, MS, Acting Executive Administrator

SKILLED NURSING FACILITY REINSTATEMENT

DATE: _____ RE: _____

TO: _____ MEDICARE NO.: _____

_____

_____ ADMIT DATE: _____

By letter dated _____, you were notified of the termination of Medicare benefits for the above named resident effective _____.

Due to a change in the level of care required, Medicare benefits have been reinstated effective _____, and will continue as long as a covered level of care is required.

You will be notified regarding any change in Medicare status.

Sincerely,

_____

Signature of Administrative Officer

Appendix M8

Laguna Honda Hospital &
Rehabilitation Center Skilled
Nursing Facility Medicare Part-A DELAYED
Physician Certification & Recertification

(Addressograph) / Name:

Date the Certification/Recertification was Due: _____

Date(s) covered by this Delayed Certification/Recertification: _____

I certify that SNF services were required to be given on an inpatient basis because of the above named patient's need for skilled nursing care on a continuing basis for the condition(s) for which he/she was receiving inpatient hospital services or prior to his/her transfer to the SNF. This certification is based upon thorough review of the patient's medical record and my knowledge of the patient.

This Certification/Recertification has been inadvertently delayed due to the following reason(s):

_____

_____

_____

I certify that continued SNF inpatient care is necessary for the following reason(s):

_____

_____

_____

_____

_____

_____

I estimate that the additional period of SNF inpatient care will be _____ days or ____ weeks

Plan(s) for post SNF care is(are): _____

_____ _____

(Physician's Signature) **(Date)**

PROCESSING OF LONG TERM CARE TREATMENT AUTHORIZATION REQUESTS

POLICY:

1. The Utilization Management (UM) Department is responsible for submitting Long Term Care (LTC) Treatment Authorization Requests (TARs) for all residents who are admitted to the facility and whose LTC stays are eligible for Medi-Cal reimbursement.

2. Effective July 1, 2016, TARs shall be electronically submitted to the Medi-Cal office according to procedures established by the Department of Health Care Services (DHCS) eTAR Medi-Cal User Guide.

PURPOSE:

LTC TARs shall be submitted via the Medi-Cal Website so that the facility can receive the maximum allowable reimbursement dollars from Medi-Cal, in order to meet or exceed the annual fiscal budget for the facility.

PROCEDURE:

1. Submission

a. The submission of Initial LTC TARs is based on the monthly log of Utilization Review Daily Analysis created by the TAR Clerk.

b. The submission of LTC Re-Authorization TARS is based on the monthly log of Re-Authorization TARs created by the TAR Clerk.

2. Tracking

a. The TAR Clerk is responsible for tracking the status of the submitted TARs via the Medi-Cal website at least once a week.

b. The TAR Clerk shall update the Bed Days Table in the electronic health record (EHR) when the TAR is approved or modified.

c. Refer to Procedures 3 through 7, for continued tracking procedures related to Modified, Deferred and Short Stay TARs, TARs approved for 2 years and Denied TARs, respectively.

3. Deferrals

a. The TAR Clerk enters the TAR information in the Deferred TAR Log and provides copy to the UM Nurse.

b. The UM Nurse shall respond to the deferred TAR within 30 days of the adjudication date via the Medi-Cal website with additional documentation, correction, and or clarification to the TAR information as requested by the Medi-Cal Field Office. After responding to the deferred TAR, the TAR Clerk updates the Deferred TAR log and tracks the TAR status; go to Procedure 2.

c. If TAR is deferred because the Medi-Cal Consultant has determined that the resident is at lower level of care (LLOC), the UM Nurse notifies Unit Nurse Manager, attending Physician, Social Worker, UM Nurse Manager, Director of Social Services and Patient Flow Coordinator.

4. Modified TARs

a. The TAR Clerk enters the TAR information in the Modified TAR log and provides copy to the UM Nurse.

b. The UM Nurse reviews the approved period of service (POS) and TAR comments and determines the next action.

c. If the TAR is modified due to a LLOC determination, the UM Nurse notifies Unit Nurse Manager, attending Physician, Social Worker, UM Nurse Manager, Director of Social Services and Patient Flow Coordinator.

d. The TAR Clerk prepares/updates the Re-Authorization TAR List and informs the UM Nurse of the updated list.

e. The UM Nurse shall submit a new TAR with additional documentation, correction, and clarification to the TAR information as requested by the Medi-Cal Field Office.

5. Approved TARs for Short Stay

a. The TAR Clerk enters the TAR in the Modified TAR log and provides copy to the UM Nurse.

b. If the TAR is approved for period of service of <2 years (either due to the requested period of service by the UM Nurse secondary to potential LLOC or due to approved period of service by Medi-Cal Field Office for potential LLOC), the process is the same as a modified TAR; go to Procedure 4.

6. TARs Approved for 2 Years

a. The TAR Clerk updates the monthly log of Utilization Review Daily Analysis. Logs and distributes the TAR copy for the UM Nurse to review, initial the TAR copy and return to the TAR Clerk.

b. The TAR Clerk prepares/updates the Re-Authorization TAR List and informs the UM Nurse as needed of the updated list.

7. TAR Denials

a. The TAR Clerk enters the TAR information in the denied TAR log and provides copy to the UM Nurse.

b. If the LTC TAR is denied for lack of Medi-Cal eligibility, no action shall be taken until the resident becomes Medi-Cal eligible for long-term care services. When the resident becomes Medi-Cal eligible, a new TAR shall be submitted via the Medi-Cal website for TAR approval according to the requirements specified in the Medi-Cal LTC Provider Manual.

c. If the LTC TAR is denied for failure to meet Nursing Facility-B (NF-B) Level of Care (LOC) requirements, the following actions shall be taken:

   i. The resident shall be issued with the Notice of Proposed Transfer/Discharge according to the facility protocol for issuing discharge notices. If the resident contests the discharge plan, a discharge hearing shall be convened to address the resident's concerns. The designated member of the Resident Care Team shall write a note in the progress notes indicating the resident's decision to contest the discharge notice.

   ii. A single level TAR appeal shall be submitted to the TAR Appeals, TAR Administrative Remedy Section by the Utilization Management designee within the required time frame (180 days from the TAR decision date) with available supporting documentation to demonstrate the resident's NF-B LOC needs.

d. If the LTC TAR is denied for failure to meet the requirement(s) specified in the Medi-Cal LTC Provider Manual the following action shall be taken:

   i. A single level appeal shall be submitted to the TAR Appeals, TAR Administrative Remedy Section by the Utilization Management designee within the required time frame (180 days from the TAR decision date), only when there is available supporting documentation that can be used to refute the basis of TAR denial, or satisfy the documentation requirements specified in the Medi-Cal LTC Provider Manual.

8. LTC TAR Reporting and Performance Improvement

a. Medi-Cal LTC TARs that are denied for reasons other than the lack of patient eligibility shall be reported to the Utilization Management Committee.

b. To minimize future LTC TAR denials, the Utilization Management Nurse Manager shall identify and recommend action plan(s) related to these LTC TAR denials and

request that the action plan(s) be approved for implementation by the Utilization Management Committee.

ATTACHMENT:
None.

REFERENCE:
Department of Health Care Services (DHCS) TAR Medical User Guide
LHHPP 20-04 Discharge Planning
Section T Medi-Cal Long Term Care Provider Manual
State Operating Manual F201 – F204

Revised: 10/08/19, 16/11/08, 20/01/14 (Year/Month/Day)
Original adoption: 05/05/19

TRIPLE CHECK PROCESS

POLICY:

1. All billing claims submitted shall have the proper supporting documentation.

2. Claims submitted for SNF Medicare, Acute Rehab, Acute and SNF Managed Care and other Acute and SNF Private Insurance Payers shall undergo an additional review process known as the Triple Check.

PURPOSE:

1. To ensure compliance with billing requirements.

2. To ensure timely billing for maximum allowable reimbursement.

GOAL:

To ensure timely claims submission by the Billing Department during the monthly bill drop process and appropriate documentation that reflects the actual services rendered are in place.

PROCEDURE:

1. Participants of the Triple Check meeting shall comprise of the following staff: Resident Assessment Instrument (RAI) Coordinator and/or designee, Billing Manager/designee, ~~Rehabilitation Coordinator and/or designee,~~ Admission and Eligibility (A&E) Manager and/or designee, Health Information Systems (HIS) Analyst and/or designee, Utilization Manager (UM) Nurse Manager, and UM Nurses; Compliance and Privacy Officer.

2. The UM Nurse shall start the list of Monthly Triple Check Files before or on the 1st working day of the month. The following are the Triple Check Files in the shared drive: Medicare Part A SNF List; Anthem Blue Cross Medi-Cal Managed Care Patient List; Log of PMR Admission; Log of PMA Admission; SFHP Patient List; Other Payor List.

~~1.~~3. The Resident Assessment Instrument (RAI) Coordinator and/or designee, Billing Manager/designee, Health Information Systems (HIS) Analyst and/or designee, Utilization Manager (UM) Nurse Manager, and UM Nurses shall update the Triple Check Files.

~~2. Prior to the Triple Check Meeting~~

~~a. On a weekly basis, the UM Nurse sends to HIS via email the list of patients covered on Medicare including who is covered on rehabilitation services.~~

~~b. The UM Nurse prepares and completes the Preliminary lists of patient names covered by insurance payers and their covered level of care.~~

~~c. The UM Nurse sends via email the Preliminary Lists to administrative and clinical team members which consist of RAI Coordinator, UM Department, Billing Department, HIS, and designee from Admissions and Eligibility, Pharmacy, and Rehabilitation Department for their review prior to the Triple Check Meeting.~~

~~d.~~4. The ~~UM Nurse or~~ Billing Manager/designee informs the team of the meeting date, time and place.

~~3.~~5. During the Triple Check Meeting

~~a. Review of the Medicare RUGs List~~

~~i.~~a. The RAI Coordinator/designee reports the patient's admission date, Assessment Reference Date (ARD) of MDS, the Payment Category~~RUG scores~~ and the last covered day of Medicare during the review of the Medicare Part A SNF List~~e~~.

~~ii.~~b. For the patient who participated in the rehabilitation program, the RAI Coordinator/designee shall~~will~~ also report on the number of Rehab minutes and the distinct number of therapy days.

~~iii.~~ The RAI Coordinator/designee reports which case is on-hold, and the needed follow-up.

~~iv.~~c. ~~The designee from Rehab reports and verifies if the minutes entered on the MDS match the documentation in the medical records.~~

~~v. For the case of patients with low RUGs, the UM Nurse Manager/designee reports if it is appropriate to submit the claim or not and if follow-up is needed.~~

~~vi.~~d. The A & E Manager or Supervisor shall~~will~~ be available for issues on insurance or need of clarification.

~~vii.~~e. The designee from HIS reports the status of History and Physical (H&P) signature and Rehab Evaluation signature.

~~viii. The Billing Manager/designee reports the status of patient with rehab scores without rehab charges.~~

~~ix.~~f. Based from the previous month's Triple Check Files~~Medicare RUGs list~~, the Billing Manager/designee reports on the outstanding issues that resulted in the delay of claims submission.

~~x.~~g. Issues identified shall be reported and the group shall~~will~~ agree on what follow-up is needed and/or resolution.

~~b. Review of the Private Insurance Lists~~

~~i.The UM Nurse reports on the lists of patients with SFHP, Anthem Blue Cross, other private insurance and the payer source of Acute Rehab patients.~~

~~ii.The Billing Manager/designee gives updates as needed.~~

~~iii.Based from the previous month's Private Insurance list, the Billing Manager/designee reports on the outstanding issues that resulted in the delay of claims submission.~~

~~iv.The A & E Manager or Supervisor will be available for issues on insurance.~~

~~v.Issues identified shall be reported and the group will agree on what follow-up is needed for a resolution.~~

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 20/01/14 (Year, Month, Day)
Original adoption: 16/03/08 ~~(Year, Month, Day)~~

UNUSUAL OCCURRENCES

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that ~~Hospital personnel~~staff primarily utilize the electronic Hospital-wide Unusual Occurrence (UO) reporting system to report ~~document follow-up~~ investigations, communicate with relevant personnel and document corrective actions related to unusual occurrence events.

2. An Unusual Occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student.

3. ~~Unusual Occurrence reports (UOs)~~UO reports shall be completed and ~~timely~~ submitted timely by ~~the charge nurse, department/unit manager or designee, or any~~any LHH employee who witnesses or becomes aware of an unusual occurrence. The initial report shall be completed by the first staff member responding to the event and those who are most knowledgeable about the occurrence.

4. UOs are confidential under Evidence Code 1156/1157. No copies are to be made except by Quality Management (QM) staff.

5. The QM Department shall maintain the UOs as part of Performance Improvement Patient Safety (PIPS) Committee records.

6. Access to the ~~Performance Improvement~~PIPS Committee records and reports shall be strictly limited to QM staff, Departmental and Hospital Performance Improvement Committees, Medical Executive Committee (MEC), and Joint Conference Committee.

PURPOSE:

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

PROCEDURE:

1. General Provisions

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

b. Malicious reports or reports with punitive intent are not appropriate. Interdepartmental conflict are to be discussed by the departments involved and reported on a UO only when not resolved in a timely manner.

c. ~~The Performance Improvement and Patient Safety~~PIPS Committee ~~(PIPS)~~, a Committee of the Medical Staff, is responsible for reviewing and evaluating ~~Unusual Occurrence~~UO Reports as part of the Hospital Quality Assurance and Performance Improvement (QAPI) Program.

2. Reporting, Investigation and Follow-up

a. Before the end of the work shift, the Charge Nurse, reporting employee, or designee shall:

i. Complete~~s~~ the on-line UO which is directly transmitted to the Quality Management Department.

- Necessary information for completing the UO:
  - Include the name of patient/resident (if applicable), unit, date of occurrence, time of occurrence, description of incident and person(s) notified.
  - Include the name(s) of staff, visitors, volunteers, students and other residents who were involved in the incident or witnesses to the incident.
  - Specifically identify who said what and/or who witnessed what part of the incident.
  - List what led up to the incident, other pertinent events occurring at the time, and any contributing acts of friends, relatives, or residents that may have led to the event.
  - Describe any equipment involved.
  - Note any injuries and state what medical care has been provided or is planned.

ii. Informs the supervisor on the shift of the occurrence. ~~If staff suspects resident abuse, the supervisor must be notified immediately and the Report of Suspected Dependent Adult/Elder Abuse form (SOC341 4/90) must be completed and submitted with the Unusual Occurrence report (refer to Hospital-wide Policies and Procedure LHHPP 22-01). On the evening, night and/or weekend/holiday hours, notify the Operations Nurse Manager on duty~~Follow

the reporting protocol as described in LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response.

iii. ~~Notifies~~ Notify the attending physician if the incident involves the clinical care of a resident.

iv. ~~Notifies~~ Notify the resident's family or surrogate decision-maker of the incident as appropriate.

v. Submit~~s~~ other necessary documents to QM Department.

b. The supervisor or Operations Nurse Manager on duty shall determine whether immediate additional follow-up or action is required and whether notification of the ~~Medical Director~~Chief Medical Officer, Division Head, and Administrator on Duty is warranted.

c. If the incident involves a resident, documentation of the event, clinical response, and monitoring activities must be noted in the medical record according to the Hospital-wide Policies and Procedures. Do not document in the medical record the fact that a UO has been completed.

d. A unique log number shall be assigned to each submitted UO. Risk Management ~~Nurses~~ shall triage the UOs within 24 hours or the next business day and request for follow-up information as~~-~~ necessary using the on-line UO system:

i. Follow-up and investigation of UO reports:

- UO notification shall be sent to managers, supervisors and other relevant staff. UO follow-up and or investigation report(s) are requested from managers as necessary to determine contributing factors, corrective actions taken and/or referrals for follow-up actions.

- The manager and or other relevant staff assigned shall log in to the on-line UO system daily, review their respective worklist and read the UO report and or messages no later than the next business day.

- Completed follow-up and/or on-line investigation reports are to be submitted to the QM Department within four business days of the UO report.

- Risk Management ~~Nurses are~~ shall be responsible for tracking the return of follow-up and or investigation reports.

- Staff ~~are required to~~shall use the on-line UO system and not use the email system to address case specific UO issues.

ii. Follow-up of reportable UOs (refer ~~to Hospital Wide Policies and Procedures File 60-03 for a list of reportable events~~to LHHPP 60-03 Incidents Reportable to the State of California):

- ~~The~~ Risk Management ~~Nurse shall notify the designated Division Head(s) and managers of reportable occurrences and~~ may direct further staff actions on reportable occurrences.

- Completed follow-up and/or ~~on-line~~ investigation reports are to be submitted to the QM Department no later than the 4th calendar day following the incident.

- Telephone notification of reportable Unusual Occurrences to California Department of Public Health (CDPH) shall be made by ~~Risk Management Nurses during regular work hours.~~ the mandated reporter.

- ~~Weekend/Holiday reporting of Unusual Occurrences shall be carried out by the Nursing Operations Manager on duty with notification to the Risk Management Nurse on the next business day.~~

- ~~The Risk Management Nurse shall assure that the required follow-up letter is sent to CDPH and a copy placed in the CDPH appropriate file.~~

e. ~~QM staff~~Risk Management shall aggregate ~~Unusual Occurrence~~UO data to identify patterns/trends. UO summary reports shall be brought to the PIPS committee for further review, evaluation, and recommendations (e.g., if patterns/trends are identified, the PIPS Committee may work with the involved departments to institute further studies and develop a plan of correction, which may include a mechanism for ongoing monitoring).

f. The UO report may be classified as closed by ~~the~~ Risk Management ~~Nurse~~ or designee after sufficient essential information is gathered and corrective action(s) implemented to minimize risk of occurrence.

g. UO summary reports shall be submitted to the ~~Medical Executive Committee (~~MEC~~)~~ through the PIPS committee and to the Joint Conference Committee. Recommendations from these Committees shall be forwarded to the MEC.

3. Downtime procedure for reporting an Unusual Occurrence

a. Before the end of the work shift, the charge nurse, reporting employee, or designee shall:

i. Complete~~s~~ the UO form F-821A "Confidential Report of Unusual Occurrence" (~~also~~ refer to LHHPP 96-06 Unusual Occurrence Confidential Report), ~~Revised 06/00, "Confidential Report of Unusual Occurrence"~~:

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

- Complete Part 3 by stating the facts as outlined in Section 2 above.

ATTACHMENT:
None.

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response~~Abuse Protection Program: Prevention, Recognition, Reporting~~
LHHPP 24-06 Resident Suggestions and Complaints
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-08 Risk Management Program
LHHPP 60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)
LHHPP 96-06 Unusual Occurrence Confidential Report
LHHPP 96-07 Unusual Occurrence Follow-up Report
Laguna Honda Form SOC 341 ~~(4/90)~~
Laguna Honda On-line UO Pocket Guide

Revised: 96/07/15, 98/08/10, 00/03/09, 08/01/08, 11/09/27, 15/09/08, 18/11/13, 19/11/12 (Year/Month/Day)
Original adoption: 94/08/15

HEAT EMERGENCY PLAN

POLICY:

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

PURPOSE:

1. To implement procedures for responding to excessively warm climate conditions that may impact operations and pose a threat to the health and well-being of residents and staff.

2. To participate in a coordinated effort to manage any city-wide medical surge resulting from a heat emergency.

PROCEDURE:

1. Recognizing a Heat Emergency

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

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

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

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

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

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

2. Recognizing Heat-related Illnesses

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

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

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

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

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

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

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

Illness	Symptoms	First Aid
Heat stroke	▪ Confusion ▪ Fainting ▪ Seizures ▪ Excessive sweating or red, hot, dry skin with lack of sweating ▪ Very high body temperature	▪ **Call 911** ▪ Place affected person in shady, cool area ▪ Loosen clothing, remove outer clothing ▪ Fan air on affected person; cold packs in armpits ▪ Wet affected person with cool water; apply ice packs, cool compresses, or ice if available ▪ Provide fluids (preferably water) as soon as possible ▪ Stay with affected person until help arrives
Heat exhaustion	▪ Cool, moist skin ▪ Heavy sweating ▪ Headache ▪ Nausea or vomiting ▪ Dizziness ▪ Light headedness ▪ Weakness ▪ Thirst ▪ Irritability ▪ Fast heart beat	▪ Have affected person sit or lie down in a cool, shady area ▪ Give affected person plenty of water or other cool beverages to drink ▪ Cool affected person with cold compresses/ice packs ▪ Affected residents shall be evaluated by the medical staff ▪ Affected employees should seek medical treatment if signs or symptoms

		worsen or do not improve within 60 minutes ▪ Do not return to work that day
Heat cramps	▪ Muscle spasms ▪ Pain ▪ Usually in abdomen, arms, or legs	▪ Have affected person rest in shady, cool area ▪ Affected person should drink water or other cool beverages ▪ Wait a few hours before allowing affected person to return to strenuous work ▪ Have affected person seek medical attention if cramps don't go away
Heat rash	▪ Clusters of red bumps on skin ▪ Often appears on neck, upper chest, folds of skin	▪ Try to work in a cooler, less humid environment when possible ▪ Keep the affected area dry

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

3. Status Reports and Communication

a. Department Operating Status Reports (DOSRs) shall be used to determine whether there has been any potential impact on services or the health of residents or staff. ~~DOSRs shall be completed upon activation of HICS and periodically as requested by the Incident Commander.~~

b. Any change in the DOSR status shall be reported to the command center at 415-759-4636.

c. Any neighborhood or department needing resources to manage the heat emergency shall request assistance from the command center.

~~b.~~d. The HICS Command Center shall establish and maintain regular communication with the Department of Public Health ~~according to Appendix A.~~

4. Maintaining Comfortable Temperatures for Residents and Staff

a. Provide plenty of water to both residents and staff for adequate hydration.

b. Close all windows in the new hospital buildings to ensure the ventilation system can provide the coolest environment possible~~. The ventilation system in these buildings is capable of cooling our interior spaces to about 25 degrees cooler than the outdoor air, but opening windows allows hot air to enter and reverse any effect of the air conditioning~~.

c. Distribution of available fans shall be coordinated through the HICS Command Center and distributed to ventilate the hallways in the neighborhoods.~~Fans shall be available and used to ventilate the hallways in the neighborhoods.~~

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

5. Cooling Centers

a. Cooling centers with air conditioning, ice, and water dispensers shall be set up in various locations throughout the campus to provide relief for anyone experiencing early symptoms of heat stress.

b. Conference rooms B-102, B-104, and A-100 shall be available as cooling centers for staff in the administration building.

~~c. One dining room in each neighborhood in the towers and the Oceanside Room in Pavilion Mezzanine shall be available as cooling centers for residents and staff in the neighborhoods.~~

6. Regional Medical Surge

a. During a heat emergency, San Francisco's health care system may be impacted with an increase in emergency calls.

b. LHH shall be prepared to receive admissions from ZSFG or other acute care hospitals in accordance with the LHH Medical Surge Plan.

ATTACHMENT:
~~None.~~
~~Appendix A: - TO BE DEVELOPED BY, OR INCONJUNCTION WITH, PHEPR~~

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

Revised: ~~19/09/10~~19/11/12 (Year/Month/Day)
Original adoption: 17/11/14 ~~(Year/Month/Day)~~

INFLUENZA IMMUNIZATION

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) residents who meet the established Centers for Disease Control and Prevention (CDC) clinical criteria shall be offered the influenza vaccine seasonally October 1 through March 31, subject to the status of the influenza season within the community.

~~2.~~ Each resident shall be screened for eligibility to receive the influenza vaccine during the influenza season. During this time the resident or surrogate decision maker has the opportunity to refuse immunization.~~Before offering the influenza immunization, each resident or the resident's legal representative shall receive education regarding the benefits and potential side effects of the immunization.~~

2.

~~The resident or the resident's legal representative has the opportunity to refuse immunization.~~

3. The resident's electronic health~~medical~~ record will include documentation indicating that education was provided and if the resident received the influenza vaccine or did not receive the influenza immunization due to medical contraindication or refusal.

PURPOSE:

To reduce morbidity and mortality from influenza by annually immunizing LHH residents who meet the clinical criteria established by the CDC Advisory Committee on Iimmunization Ppractices.

PROCEDURE:

1. The ~~r~~Registered ~~n~~Nurse (RN) screens upon admission during the influenza season and current in-house residents at the start of the influenza season~~each resident for~~ to order ~~contraindications and precautions for~~ the influenza vaccine using the Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines for Residents Admitted to LHH.

   a. ~~Contraindications~~The following are criteria for fails to meet criteria for the RN to order an influenza vaccine:

      i. Documented confirmation resident received vaccine this season;

      ~~i.~~ii. Serious reaction (e.g. anaphylaxis) after ingesting eggs or after receiving a previous dose of influenza vaccine or an influenza vaccine component;

      iii. History of Guillain-Barre' syndrome;~~.~~

iv. Resident has had fever >38 degrees Celsius in the last 48 hours;

v. Resident conditions with require consultation with a physician;

- Met any criteria for fails to meet criteria (listed above)
- Prior reaction to the vaccine
- Pregnancy
- When resident requests to discuss advisability of vaccine with the physician

b. If the resident does not meet the RN criteria listed in the standardized procedure, the physician shall be consulted for ~~Precautions:~~eligibility to receive the vaccine.

~~i. Moderate or severe acute illness with or without fever.~~

2. The influenza vaccine shall be primarily ordered by the RN for residents who meet the criteria in the standardized procedure.

~~2.~~3. The physician shall order the vaccine for residents who do not meet the RN criteria in the standardized procedure, but are eligible to receive the vaccine (e.g. receiving an egg-free vaccine for residents with a severe egg allergy or waiting a few days for a fever to resolve).~~On admission to LHH, the registered nurse assesses new residents for administration of the flu vaccine for the current season.~~

~~3. The licensed nurse shall provide each resident for whom there is no contraindication education using the most current federal Vaccine Information Statement (VIS). Document in the resident's medical record, the publication date of the VIS and the date it was given to the resident. Provide non-English speaking residents with a copy of the VIS in their native language (available at www.immunize.org/vis).~~

~~4. The licensed nurse administers 0.5ml of injectable inactivated influenza vaccine intramuscularly using a (22-25g, 1-1½") needle in the deltoid muscle.~~

~~5.~~4. The licensed nurse documents each resident's vaccine administration information and education provided through the most current CDC Vaccine Information Statement (VIS) in the electronic health record. If the vaccine was not given, record the reason(s) for non-receipt of the vaccine.

~~a. Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine.~~

~~If vaccine was not given, record the reason(s) for non-receipt of the vaccine.~~

~~6.~~5. Staff (physician and/or licensed nurse) shall document any unexpected or significant adverse reactions to the vaccine ~~and report the occurrence to the LHH~~

~~Infection Control Practitioner.~~ on the electronic health record and submit an Unusual Occurrence report.

ATTACHMENT:
None.

REFERENCE:
Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines For Residents Admitted to LHH.~~CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2004:53 (NO. RR-6).~~

CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2019 – 20 Influenza Season. MMWR 2019:68.
Department of Health and Human Services, C~~c~~enters for Medicare and Medicaid S~~s~~ervices, Federal Register/vol 70, No. 194, 42 CFR Part 483 Medicare and Medicaid Programs, Condition of Participation: Immunization Standard for Long Term Care Facilities.
Immunization Action Coalition, Standing Orders for Administering Influenza Vaccine to Adults, www.immunize.org

Revised: 11/07/26, 17/09/12, 19/05/14, 20/01/14 (Year/Month/Day)
Original adoption: Est. 05/11/01

GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS

POLICY:

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

Website address: https://ctca.org/wp-content/uploads/2018/11/file_490.pdf

DEFINITION:

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

PURPOSE:

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

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

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

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

4. Comply with Federal, State, and City regulations.

PROCEDURE:

1. Resident Admission, Readmission, and Annual Screening

    a. Residents with Known or Suspected TB Disease

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

    b. Residents with Documented History of Positive Tuberculosis Skin Test (TST) or Interferon Gamma Release Assay (IGRA), or History of Active TB Disease

i. No further TST/IGRA required.

ii. TB symptom screen must be performed upon admission:

- Bloody sputum
- Hoarseness lasting 3 weeks or more
- Persistent cough lasting 3 weeks or more
- Unexplained excessive fatigue
- Unexplained persistent fever lasting 3 weeks or more
- Unexplained excessive night sweats
- Unexplained weight loss

iii. Chest x-ray (CXR) must be performed, unless one was already done in the United States within 90 days prior to admission.

iv. Residents shall be screened annually with a CXR and TB symptom screen and if a change in condition suspicious of TB disease occurs. TB screening will include a TB symptom screen and CXR, if indicated. See Procedure 2.b. Room Placement if the CXR result is abnormal.

c. Residents with Documented History of Negative TST/IGRA or no Documented History

i. Only a single TST is needed if documentation of a previous negative TST is done and recorded within 12 months.

ii. A single previous negative TST is acceptable if done and recorded within 90 days of admission.

iii. No additional TST/IGRA test is needed if documentation of a previous negative TST/IGRA is done and recorded within 90 days of admission.

iv. A two-step TST shall be administered to residents who have never been tested, or if more than 12 months have elapsed since the last documented negative TST. The TST shall be read at 48 ~~and 72~~ hours from placement. The second TST shall be administered within 1 to 3 weeks after the first if the first TST is interpreted as negative. The results of the second TST shall be the reported result.

v. Residents who have received the Bacilli Calmette-Guérin (BCG) vaccine shall be considered for IGRA screening instead ~~be included in the~~ of TST screening ~~program~~.

vi. Residents shall be screened annually with a TST/IGRA and if a change in condition suspicious of TB disease occurs. TB screening will include a TB symptom screen and TST/IGRA, if indicated.

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

viii. Residents with positive TST results shall be referred to their attending physician for evaluation and treatment recommendations.

- Induration of ≥5mm is considered positive in:

  - Human immunodeficiency virus (HIV)-infected persons
  - Recent contacts of TB case patients
  - Persons with fibrotic changes on chest radiograph consistent with prior TB
  - Patients with organ transplants and other immuno-suppressed patients

- Induration of ≥10mm is considered positive in:

  - Residents of nursing homes and other long-term facilities for the elderly

d. Readmission Screening

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

ii. Residents who have been discharged for longer than 90 days and are readmitted require a TB screen based on prior TST/IGRA results and history of active TB disease.

2. Resident Conversions and Room Placement

a. Resident Conversions

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

ii. If the CXR result is negative, LTBI treatment shall be offered and a TB symptom screen shall be performed annually.

iii. Conversion cases shall be reported to the Infection Control Nurse during business hours and the Nursing Operations Manager during off-business hours by Nursing. If indicated, roommates and close contacts shall be screened for active TB.

b. Room Placement

i. If CXR result is abnormal, the resident shall be placed in airborne isolation. The case must be reported to TB Clinic within 1 working day. Per TB Clinic protocol, 3 sputum specimens shall be obtained for Acid-Fast Bacilli (AFB) smear and culture. In addition, one of the three sputum specimens, preferably the first sputum specimen, shall have a *Mycobacterium tuberculosis*/resistance to rifampicin (MTB/RIF) polymerase chain reaction (PCR) test (e.g. GeneXpert MTB/RIF) performed.

ii. For high and moderate suspicion cases with an initially positive AFB smear, airborne isolation may be discontinued after 3 negative AFB smears, 14 days of TB treatment is completed, and clearance is obtained from TB Clinic.

iii. For high and moderate suspicion cases with an initially negative AFB smear, airborne isolation may be discontinued after 3 negative AFB smears, 1 negative MTB/RIF PCR, 5 days of TB treatment is completed, and clearance is obtained from TB Clinic.

iv. For low suspicion cases, airborne isolation may be discontinued after 3 negative AFB smears, 1 negative MTB/RIF PCR, and clearance is obtained from TB Clinic. The resident shall be reassessed when cultures are final to determine latent TB treatment.

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

3. HCWs New Hire and Annual Screening

a. Screening Schedule

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

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

b. HCWs with Documented History of Positive TST/IGRA/History of Active TB

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

ii. No further TST/IGRA required.

iii. TB symptom screen must be performed upon prior to employment:

- Bloody sputum
- Hoarseness lasting 3 weeks or more
- Persistent cough lasting 3 weeks or more
- Unexplained excessive fatigue
- Unexplained persistent fever lasting 3 weeks or more
- Unexplained excessive night sweats
- Unexplained weight loss

iv. CXR must be performed, unless the HCW provides a written report of a negative CXR done in the United States within 90 days of hire.

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

c. HCWs with Documented History of Negative TST/IGRA or no Documented History

i. Only a single TST is needed if documentation of a previous negative TST is done and recorded within 12 months of hiring.

ii. A single previous negative TST is acceptable if done and recorded within 90 days of hiring.

iii. No additional TST/IGRA test is needed if documentation of a previous negative IGRA is done and recorded within 90 days of hiring.

iv. A two-step TST shall be administered to HCWs who have never been tested, or if more than 12 months have elapsed since the last documented negative TST.

v. HCWs who have received the Bacilli Calmette-Guérin (BCG) vaccine shall be included in the TST screening program.

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

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

4. HCW Conversions

   a. HCW who convert from a negative to positive TST/IGRA result during employment must have a TB symptom screen and a CXR within 1 week and be promptly referred to a healthcare provider or the local health department for treatment recommendations.

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

5. HCW Post-Exposure Screening

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

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

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

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

6. HCW Reporting of Positive TSTs

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

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

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

7. HCW Training and Education

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

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

8. Resident/HCW Record Keeping and Retention

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

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

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

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

9. Quality Assurance and Performance Improvement

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

ATTACHMENT:
None.

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

Revised: 15/11/09, 16/03/08, 16/07/12, 17/09/12, 18/09/11, 19/05/14, 19/07/09, 20/01/14 (Year/Month/Day)
Original adoption: est. 05/11/01

SECURED NEIGHBORHOOD SAFETY STANDARD

POLICY:

1. Doors on the secured neighborhood (North Mezzanine) are equipped with electronic card key security mechanisms that open with a staff's card key to provide a safe and secured unit for the resident.

2. The main entrance door to the secured neighborhood is equipped with an intercom, security camera and remote door entry system (Aiphone) which allows staff to unlock the front door from either of the nursing stations for visitors without card key access, and to view if residents are near the main entrance door.

3. No earphones or other devices that may serve as distraction are permitted when entering or exiting the secured unit.

4. All staff entering and exiting the neighborhood are required to ensure that the doors are properly closed

PURPOSE:

To describe and maintain safety standards for the secured neighborhood.

PROCEDURE:

1. Maintaining the Secured Environment

a. The secured neighborhood staff will check the functionality of the main entrance egress door during the Day and PM shifts. For North Mezzanine the egress will not automatically unlock without an electronic card key.

b. The secured neighborhood staff will check the remaining non-egress exit doors, leading to the stairwell, during the Day and PM shifts to ensure the doors are locked.

c. The inspection of outer egress doors in each household will be conducted via charge nurse during environment of care rounds .

~~c.~~d. The nurse manager/charge nurse will report card key operational problems to Facility Services during business hours for repair or replacement. Notify Facility Services and Sheriff's Dept. for door security issues.

~~d.~~e. In the event of fire alarm activation, the locking mechanisms on exit doors in the secured neighborhood automatically unlock. Staff will monitor exit doors to ensure resident safety, and evacuate residents if indicated.

f. In the event of power failure, fire alarm activation, one nursing staff from North 1, North 2, North 3, and North 4 will be designated to report to North Mezzanine to assist in monitoring the exits on the neighborhood. Staff members are to be stationed between fire stairwell doors and building exit doors.

N1: send staff to monitor NM **Cypress** household door

N2: send staff to monitor NM **Redwood** household door

N3: send staff to monitor NM **Cedar** household door

N4: send staff to monitor NM **Juniper** household door

~~e.~~

f.g. At the beginning of each shift, the charge nurse will designate which staff member will be responsible to monitor each exit door.

2. Use of the Intercom/Security Camera and Door Entry System

a. There are 2 intercoms located in the North Mezzanine neighborhood, one at each nursing station. The intercom located at nursing station 1 is the master intercom. The on/off switch is located on the left side of the handset. If the master intercom is turned off, both intercoms will be disabled. The doors will remain locked if the Aiphone is disabled – staff must physically go to the door to ~~will~~ manually swipe their badges to allow people to enter/exit.

b. The master intercom may be turned off as a precaution (e.g., at nighttime after visitor's hours) to avoid improper use of the key button when staff are not present at the master stations.

c. The intercom is connected to three cameras. The camera views are as follows:

   i. Camera 1: Intercom - This camera's view can be adjusted (up or down) with the up/down button on the intercom.

   ii. Camera 2: Elevator lobby

   iii. Camera 3: Interlock/Trap area located behind the locked door (allows staff to see if residents are standing behind the locked door)

d. Directions for Using the Intercom

   i. When a visitor rings the doorbell, an audible alert will sound and the intercom's camera will turn on.

   ii. Pick up the handset and talk with the visitor. Only one person can talk (and be

heard) at a time.

iii. Press the up/down button on the intercom to move the camera 1 to better visualize the visitor.

iv. Press the monitor button to switch the camera view between cameras 1, 2 & 3. Staff will check camera 3 before allowing visitors to enter because this view allows the staff to see if residents are standing in the trap area and potentially waiting to tailgate out the door.

v. To allow the visitor to enter, press the key button to unlock the door. This will unlock the door for 5 seconds. Tell the visitor that they may now enter - the visitors will not hear any indication that the door has been unlocked.

vi. Continue to monitor the locked door until the lock re-engages.

3. Staff Education

a. Staff shall be trained upon orientation, and procedures shall be reviewed with new staff. All staff should be reminded and educated to be attentive when entering or exiting the secured neighborhood to prevent resident elopement.

i. All staff are required to look through the window to ensure the foyer is clear before proceeding.

ii. No earphones or other devices that may serve as distraction are permitted when entering or exiting the secured unit.

iii. All staff entering and exiting the neighborhood are required to ensure that the doors are properly closed.

iv. SMART Training Principles shall be utilized if necessary.

v. Only authorized staff and visitors (with visible badge) may be permitted entry with staff entering the neighborhood.

4. Procedures for Nutrition Service Staff Entering Secured Neighborhood

a. For meal deliveries, including early and late trays and special food deliveries, transporters will ring the bell, allow nursing staff to open the door, and wheel the delivery carts into the foyer (the corridor between the first and second doors).

b. Nursing staff will wheel the food carts into the Great Room and distribute meals to the residents.

c. After each meal, nursing staff will wheel the food carts with soiled trays back into the

foyer for Nutrition Services staff to pick up.

d. Transporters arriving to pick up the soiled trays will ring the bell, allow nursing staff to open the door, and retrieve the carts for transport back to the kitchen to be washed.

e. In addition to delivering or retrieving trays, Nutrition Services staff will enter the secured unit to restock nourishment and supplies, clean the galley, or refill the coffee and juice dispensers. Staff members will ring the bell and be escorted into the Great Room where they will proceed with their assigned task. Staff may request an escort upon exiting the neighborhood if they choose.

5. Performance Improvement

a. The licensed nurse shall complete an Unusual Occurrence report when a resident elopes from the secured neighborhood and anytime security is breached.

b. Incidents will be reviewed to identify process improvement opportunities and staff training needs.

ATTACHMENT:
None

REFERENCE:
LHHPP 24-01 Elopement Response Procedure
LHHPP 24-04 Resident Found Off Grounds
LHHPP 60-04 Unusual Occurrences
LHHPP 70-01 Emergency Preparedness and Response Manual C1 Fire response Plan
Aiphone Operation Manual

Revised: 10/12/03, 11/09/27, 13/01/29, 15/07/14, 20/01/14 (Year/Month/Day)
Original adoption: 04/02/12

PARKING ON THE LAGUNA HONDA HOSPITAL CAMPUS

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center ~~(~~("LHH~~)~~") to provide parking for those who have business on the LHH campus. However, parking is limited and not available to everyone who may request it.

2. Parking for eligible staff on the LHH campus is available for a fee as set by the City and County of San Francisco Municipal Code, Administrative Code Section 4.24 Parking Fee For City Parking Facilities, which states:

   "The price of a Municipal Railway monthly pass plus $10.00, or the existing amount being charged as of May 31, 2004, whichever is higher."

3. The City is not responsible for loss or damage to vehicles parked on LHH campus.

   A. Security camera footage is available only in accordance with DPH and CCSF policy when damage to city property is involved.

4. LHH parking areas are subject to applicable local and State traffic codes.

PURPOSE:

To provide rules and regulations governing parking at the Laguna Honda Hospital campus.

PROCEDURE:

1. Employee Parking and Eligibility

   a. Employees are eligible to purchase permits for parking on the LHH campus on a first come-first serve basis. Employees that receive payment directly from CCSF are eligible to apply for a parking permit. Registry employees are not eligible to apply.

      i. Employees must complete and sign:

         - LHH Employee Parking Permit Application
         - Payroll Deduction Parking Fee Application

      ii. If parking space is not available the employee's name will be added to the wait list in the order received.

2. Parking Permit Rules and Enforcement

a. Rules and Regulations

i. Parking privileges are not transferable; permits may be used only by the individual to whom the permit is issued.

ii. A valid LHH Parking Permit must be prominently displayed and visible in vehicle front window at all times while parked on the LHH campus.

iii. Permits are invalid when:

- any portion has been altered
- the appropriate fee has not been paid
- it has been lost, stolen, or cancelled (it must be reported to the Parking Coordinator immediately)
- any portion is not visible or legible.

iv. Oversize vehicles larger than one (1) standard parking space are not permitted to park on the LHH Campus.

v. Vehicles parked on LHH campus in excess of seventy-two (72) hours continuously including those with handicapped placards shall be subject to citation and/or tow.

vi. Permit holders agree to abide by LHH campus and Department of Parking & Transportation (DPT) parking policies. Failure to do so may result in the loss of parking privileges.

vii. Employees who violate the LHH parking policy shall face progressive disciplinary action, including suspension, revocation of parking permit, and/or payment of any applicable unpaid fees.

(1) Employees who are not currently valid LHH Parking Permit Holders and are under investigation for parking violations shall not be eligible to receive a parking permit and cannot be on the waitlist.

viii. Supervisors and/or Managers shall notify the Chief Operations Officer in writing of known violations by direct reports immediately.

b. Parking Permit Enforcement:

i. The Sheriff Department enforces and monitors parking on the LHH campus, in compliance with ~~the Department of Parking & Transportation (DPT) and the~~ State of California regulations.

c. Challenging the Issuance of a Parking Citation

i. Once a citation has been issued, it ~~is illegal for an officer to void the ticket~~cannot be rescinded by the issuing officer (ref. Sec 40202 CA Vehicle Code; S.F. Traffic Code Article 8 Sec. 157).

ii. ~~If an i~~individuals wishing to contest a parking ticket shall follow the procedures noted on the back of the ticket.

iii. ~~In addition to the procedures on the back of the citation, an individual may file a request for citation cancellation with the Department of Parking and Traffic through the SF Sheriff's Department at Laguna Honda Hospital. The ticket will be processed in the manner established by the Department of Parking and Traffic for disputed citations.~~

d. Parking Permit Returns

i. Employees must return their issued permit to ~~the~~ LHH Administration ~~Department~~ in the event that they will no longer be parking on the LHH campus for business purposes.

ii. Reasons to return permits include:

- Voluntary separation
- Dismissal/Termination of employment
- No longer need/want parking permit
- Approved Employee leave(s), in accordance with section seven (7) of the LHH Parking on the Laguna Honda Hospital Campus policy.

e. Lost and Stolen Permit Replacement

i. In the event a permit is misplaced, and the permit holder would like an opportunity to locate the permit, the permit holder may opt to purchase a

temporary permit valid for five (5) business days for a fee of $25.00. This fee is not refundable.

- If the misplaced permit has not been located by the end of the fifth business day, a replacement permit must be purchased if the permit holder wishes to continue parking on the LHH campus.

ii. In the event that a permit is permanently lost, the permit holder must purchase a replacement permit for a fee of $50.00.

iii. In the event that a permit has been stolen, the permit holder may present a valid police report to the Parking Coordinator and the $50.00 fee shall be waived.

iv. Reasons to return permits include:

- Voluntary separation
- Dismissal/Termination of employment
- No longer need/want parking permit
- Approved Employee leave(s), in accordance with section seven (7) of the LHH Parking on the Laguna Honda Hospital Campus policy.

~~2.~~3. Motorcycle Parking

a. Motorcycle/scooter parking is available in designated areas subject to the parking permitting fees based on proration and rules.

b. Employees with an issued permit wanting to use a motorcycle as a secondary mode of transportation may request a motorcycle permit at no additional charge.

~~3.~~4. Disabled Parking

a. Disabled parking is restricted to vehicles properly displaying “Disabled Person” or “Disabled Veteran” plates, placards~~,~~ that have been issued for the employee and are parked in disabled designated space only.

b. Employees with valid disabled plates or placards are required to pay the appropriate parking fee & display a valid LHH parking permit.

5. Reasonable Accommodation Parking “Special Permit”

a. Reasonable Accommodation permits are restricted to employees who have obtained an approval from the DPH Equal Employment Opportunity ("EEO") office for a Reasonable Accommodation special permit.

b. Reasonable Accommodation parking is restricted to vehicles properly displaying a "Special Permit" placard and parked in the appropriate designated space only.

c. Employees approved for "Special Permit" placards are ~~still~~ subject to all applicable LHH parking fees & must display a valid LHH parking permit. Permit must be returned when an accommodation has expired.

d. Reasonable Accommodation parking will be reviewed periodically. ~~–~~Employees must contact the EEO office no less than thirty (30) days prior to the expiration of the accommodation in order to request an extension.

~~4.~~6. Parking Permit Categories

a. Red – Executive Committee Members and designated SFSD Site Watch Commander.

   i. Valid in all red designated parking spaces and/or general staff (Purple) parking spaces

b. Purple – Staff

   i. Valid in all otherwise non-designated parking spaces

c. Black – Physicians

   i. Valid in all black designated parking spaces and/or general staff (Purple) parking spaces

d. Blue – Employees exempt from parking fee through MOU

   i. Valid in all otherwise non-designated parking spaces

~~i.~~

e. Paper Red Holders – requires review annually

   i. Night/Weekend & Clinic MDs

      - Valid in all black designated spaces marked "Clinic MD"

ii. ~~Executive members~~Employees with ~~affiliation~~certain affiliations at LHH ~~but~~ already paying for parking ~~with other entities~~ (at Zuckerberg San Francisco General Hospital may be issued a red paper or standard purple permit ~~includes red dot sticker)~~at the discretion of the LHH CEO and/or COO.

- ~~Valid~~Red paper permits are valid in ~~all red~~ designated parking spaces only.
- Purple permits are valid in purple parking areas only.

~~5.~~7. Collection of Monthly Parking Permit Fees

a. Monthly parking fees are collected by automatic payroll deduction.

~~a.~~i. Employees ~~with parking permits~~ must complete a payroll deduction form prior to permit issuance.

~~b.~~ii. ~~Staff~~Employees ~~on paid vacation/leave~~ ~~remain~~are responsible for paying their monthly parking fees~~, which will continue through payroll deduction,~~ in order to maintain a space on campus. ~~If taking unpaid leave, alternative payments must be arranged in advance. Failure to continue payment will remove the employee from the active list for parking privilege and the open space will be given to the next person on the waiting list. result in forfeiture of parking privileges.~~

iii. Parking fees cannot be prorated.

iv. In the event that payment is not received for any reason, the employee shall be required to pay all unpaid fees.

v. Monthly payroll deduction processing dates are determined by the Office of the Controller.

vi. When permits are issued after the payroll deduction processing date for the month of issuance, the Parking Fee Remittance Form shall be completed and presented with a receipt to the Parking Coordinator. Fees shall be paid by cash or check to the Laguna Honda Cashiers Office.

8. Employee Leaves

a. Employees on approved paid leave for greater than one (1) month and no more than six (6) months may opt to surrender their parking permit and stop parking deductions.

i. The employee will be reissued a permit upon return from leave without having to be added to the waitlist.

ii. Prior to reissuance a Parking Deduction Authorization Form shall be completed and submitted to the Parking Coordinator.

iii. In the event that the employee resumes parking after the payroll deduction processing date for the month of reissuance the full monthly fee shall be paid. The Parking Fee Remittance Form shall be completed and presented with a receipt to the Parking Coordinator.

iv. Fees shall be paid by cash or check to the Laguna Honda Cashiers Office.

b. Employees on approved paid leave for greater than six (6) months who wish to retain their parking privileges shall continue to pay monthly parking fees by automatic payroll deduction. Employees who do not wish to continue paying parking fees during approved paid leave of greater than six (6) months must surrender their permit and complete a Parking Deduction Cancellation Form. Upon return from leave employees wishing to park on campus shall be added to the waitlist.

c. Employees on unpaid leave of any duration that wish to retain their parking privileges shall make arrangements to pay monthly parking fees by alternative means. Payment arrangements shall be made through the Parking Coordinator. Failure to continue payment shall result in forfeiture of parking privileges.

i. Employees on unpaid leave who do not continue to pay the monthly parking fees shall:
- Surrender their permit.
- Be added to the waitlist upon return from leave if they wish to resume parking on campus.

d. All parking related decisions regarding leaves are at the discretion of the LHH CEO and/or COO.

~~6.~~9. Non-employee Parking ~~and Eligibility~~

a. Volunteer Parking

i. Permits are issued by the Volunteer Department

ii. Parking is restricted to designated areas

iii. Permits must be renewed every six (6) months

b. Temporary Vendor/Auditor Parking

i. Permits are issued by Materials Management or Administration

ii. Parking is restricted to thirty (30) days

iii. Temporary parking permits are valid only for the dates specified. ~~If no dates are specified, the temporary parking permits are valid only for 24 hours from the date of issue.~~

c. Visitor Parking

i. Is subject to availability.

~~i.~~ii. Is available ~~for~~to visitors for up to three (3) hours in designated areas.

~~ii.~~iii. Employees parked in visitor parking ~~will~~ shall be ticketed~~.~~ and/or towed.

d. Special Event Parking

i. Requests for parking for special events must be submitted to Administration ~~one week prior.~~ for approval at least one (1) week in advance of requested date(s).

~~7. Enforcement of Parking Permit and Rules~~

~~a. Parking Permit Enforcement:~~

~~i. The Sheriff Department enforces and monitors parking on the LHH campus, in compliance with the Department of Parking & Transportation (DPT) and the State of California.~~

~~b.~~a. ~~Challenging the Issuance of a Parking Citation~~

~~i. Once a citation has been issued, it is illegal for an officer to void the ticket (ref. Sec 40202 CA Vehicle Code; S.F. Traffic Code Article 8 Sec. 157).~~

~~ii. If an individual wishes to contest a~~Requests for reserved parking ~~ticket he/she may follow the procedures noted on the back of the ticket.~~

~~iii.~~i. ~~In addition to the procedures on the back of the citation, an individual may file a request for citation cancellation with the Department of Parking and Traffic through the SF Sheriff's Department at Laguna Honda Hospital. The ticket will be processed in the manner established by the Department of Parking and Traffic for disputed citations.~~

~~c.~~a. ~~Rules and Regulations~~

~~i. Parking privileges are not transferable; permits may be used only by the individual to whom the permit is issued.~~

~~ii.~~i. ~~Permits are invalid when:~~

- ~~any portion is not visible or legible,~~
- ~~any portion has been altered~~,
- ~~the appropriate fee has not been paid~~,
- ~~it has been lost, stolen, or cancelled (it must be reported~~ immediately).

i. ~~Vehicles~~ cannot be "parked" on LHH campus in excess of 72 hours continuously including those with the handicapped placards. Otherwise, the car owners are subject to citation and/or tow.

~~ii.~~i. ~~Permit holders agree to abide by LHH campus and DPT parking policies. Failure to do so may result in the loss of parking privileges.~~

iii. Employees who violate the LHH parking policy may face progressive disciplinary action, including suspension or revocation of parking permit

~~d.~~a. ~~Parking Permit Returns~~

~~i.~~ii. ~~Employees must return their issued permit to the~~shall be submitted to Administration ~~Department in the event that they will no longer be on the LHH campus for business purposes.~~ for approval at least twenty-four (24) hours in advance of requested date(s). ~~Reasons to return permits include:~~

- ~~Voluntary separation~~
- ~~Dismissal/termination of employment~~
- ~~No longer need/want parking permit~~

~~8.~~10. Laguna Honda Parking and City Car Use Committee Membership and Responsibilities

a. LHH Parking Committee Membership, including staff representative from the following departments appointed by the department head:

i. Administration

ii. Medicine

iii. Facilities

iv. Finance

v. Human Resources

vi. Nursing

vii. Sheriff

viii. Others as needed

b. Committee meetings are held on a bi-monthly basis.

~~b.~~c. The LHH Parking Committee is responsible for reviewing issues and special requests related to parking on the LHH campus, in accordance with current City Policy and final approval by the LHH ~~Executive Committee~~Chief Operating Officer.

~~c.~~d. The Chief Operating Officer is responsible for determining changes to the parking policy, rules, and regulations that may be affected by campus activity or condition, i.e. on-site construction.

ATTACHMENT:

Appendix A: Employee Parking Permit Application
Appendix B: Payroll Deduction Authorization/Cancellation
Appendix C: SFMTA Administrative Review Form

REFERENCE:
Sec 40202 CA Vehicle Code; S.F. Traffic Code Article 8 Sec. 157
City and County of San Francisco Municipal Code, Administrative Code Sec 4.24 Parking Fee For City Parking Facilities.

SEC. 4.24. PARKING FEE FOR CITY PARKING FACILITIES.

Where the City provides parking to City employees or to City tenants at facilities under the City's management or control, the City may charge the following monthly fee for parking to those employees or tenants:

The price of a Municipal Railway monthly pass plus $10.00, or the existing amount being charged as of May 31, 2004, whichever is higher.

This section shall not apply to parking facilities under the management or control of the San Francisco Parking Authority, the Airport, or the Port. (Added by Ord. 182-04, File No. 040743, 7/22/2004)

Revised: 15/11/09, 20/01/14 (Year/Month/Day)
Original adoption: 15/09/08

Appendix A: Employee Parking Permit Application

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

EMPLOYEE PARKING PERMIT APPLICATION

Directions: Please fill out completely, along with the "Payroll Deduction Authorization/Cancellation" form (available on the intranet under the "Parking" icon). Bring both forms to Linda Hmelo in the Administration Office or fax to 415-759-2374. Please allow up to a week before your name will appear on the waitlist.

SHIFT: **DAY** ☐ **NIGHT** ☐ **AM** ☐

Request Date:	DSW or EMPLOYEE #:	
Last Name:	First Name:	Home Phone:
Department:	Location:	Ext.
Pager:	Personal E-Mail:	

Vehicle Information				
Vehicle 1	Make: (i.e. Ford, Honda)	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		
Vehicle 2	Make: (i.e. Ford, Honda	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		
Vehicle 3	Make: (i.e. Ford, Honda	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		
Vehicle 4	Make: (i.e. Ford, Honda	Model:	Color:	Year:
	License Plate No.:	Registered Owner if other than applicant:		

-------Internal Use – Do Not Write Below----------

Permit #:	Tag Color:	Date Issued:	Initials:

I _____ have received a copy of Policy 90-04, Parking on the LHH Campus, and accept the provisions of this policy. I have also been informed and accept that the CITY is not responsible for loss or damage to vehicles parked on LHH campus.

Revised 3/10/2015

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Employee Parking Permit Application

Directions: Please fill out completely, along with the "Payroll Deduction Authorization/Cancellation" form(available on the intranet under the Parking icon).
Bring both forms to the Administration Office or fax to 415-759-2374.
Please allow up to a week for your name to appear on the waitlist.

Employee information *Please Print Clearly*

Shift: Day ☐ Night ☐ AM ☐

Request Date:	DSW/Employee #	
Last Name:	First Name:	Home Phone:
Department:	Location	Ext.
Pager:	Personal Email:	

Vehicle information *Please Print Clearly*

Vehicle 1	Make:	Model:	Color:	Year:
	License Plate No.	Registered Owner if Other than Applicant:		
Vehicle 2	Make:	Model:	Color:	Year:
	License Plate No.	Registered Owner if Other than Applicant:		
Vehicle 3	Make:	Model:	Color:	Year:
	License Plate No.	Registered Owner if Other than Applicant:		

Internal Use- Do Not Write Below This Line

Permit #	Tag Color	Date Issued:	Initials

I_____ have received a copy of Policy 90-04, Parking On the LHH Campus and accept the provisions of this policy. I have also been informed and accept that the CITY is not responsible for loss or damage to vehicles parked on LHH campus.

Revised 2/15/18

Appendix B: Payroll Deduction Authorization/Cancellation

CITY AND COUNTY OF SAN FRANCISCO
PAYROLL/PERSONNEL SERVICES DIVISION

Payroll Deduction Authorization/Cancellation Form

If no response after two pay periods, call PPSD. Do not resubmit.

PPSD use only

☐ NEW AUTHORIZATION ☐ CHANGE AUTHORIZATION ☐ CANCELLATION

EFFECTIVE DATE		
MM	DD	YY
/	/	

EMPLOYEE ID	RECORD #	EMPLOYEE NAME LAST FIRST M.I.	DEPT. ID	DEPT. NAME	JOB CLASS

INDICATE THE DEDUCTION NAME AND DEDUCTION AMOUNT:

✓	DEDUCTION NAME	DEDUCTION CODE		MONTHLY DEDUCTION AMOUNT
	PARKING FEE FOR DPH – LAGUNA HONDA HOSPOTAL	PRK001	$	
	PARKING FEE FOR LHH MOTORCYCLE/SCOOTER ONLY	PRK010	$	
			$	
			$	
			$	

☐ NEW AUTHORIZATION

☐ CHANGE AUTHORIZATION

I hereby authorize the Controller of City and County of San Francisco to withold from each of my salary warrants the deduction amount stated above and to transmit said sum to the organization named above.

I consent to the adjustment of such deduction (1) to conform to future pay period change or (2) reflect any change in union dues of which the Controller may be advised by the organization. This authorization shall be in full force and effect until revoked by the undersigned or by the organization.

Any discrepancies in my voluntary deductions as reported on my pay stub must be reported by me in writing to PPSD, One South Van Ness Ave., 8th floor, San Francisco, CA 94103 within 30 days after the occurrence.

_____ _____
SIGNATURE OF EMPLOYEE TODAY'S DATE

☐ CANCELLATION—*SIGN AND DATE THIS SECTION AND FORWARD TO YOUR UNION, IF APPROPRIATE*

Please cancel my payroll deduction as soon as possible.

_____ _____
SIGNATURE OF EMPLOYEE TODAY'S DATE

UNION / AGENCY / DEPARTMENT USE ONLY

AUTHORIZED BY _____ PHONE_____ DATE_____
SIGNATURE

DO NOT WRITE BELOW THIS LINE

PPSD USE ONLY

PREPARED BY _____ PHONE _____ DATE_____

KEYED BY _____ PHONE _____ DATE_____

F1001.DOC Revised: 08/07/2015

Appendix C: SFMTA Administrative Review Form

ADMINISTRATIVE REVIEW FORM

SFMTA
Municipal Transportation Agency

Use this form, or your own letter, to request administrative review of a citation(s). Submit protest request within 21 calendar days of the issuance of the citation, or 21 calendar days of the date of the first mailed citation notice. Include copies of any documents that support your statement of facts. Documents submitted cannot be returned. **(PLEASE PRINT LEGIBLY)**

I PROTEST THIS CITATION(S) FOR THE FOLLOWING REASON:

☐ **METER PAID / MALFUNCTION**	☐ **CURB PAINT FADED**	☐ **MISSING OR OBSCURED SIGN**
☐ **STOLEN VEHICLE**	☐ **SOLD/NOT OWNED YET**	☐ **VALID PERMIT / DP DISPLAYED**
☐ **COMPLIANCE / FIX IT CITATION**	☐ **DISCLAIMER**	☐ **TRANSIT AND OTHER, EXPLAIN DETAILS:**

VEH PLATE NO: _____

NAME: _____ PHONE: (___)_____ CITATION NUMBER(S):

ADDRESS: _____ 1._____ 2._____

CITY/STATE: _____ ZIP: _____ 3._____ 4._____

EMAIL: _____

STATEMENT OF FACTS: (EXPLAIN SPECIFIC DETAILS)

I declare that the foregoing is true and correct: _____
SIGNATURE **DATE**

***MAKE A COPY FOR YOUR RECORDS AND MAIL OR BRING FORM TO:**
CITATION REVIEW CENTER – 11 SOUTH VAN NESS AVENUE, SAN FRANCISCO, CA 94103

San Francisco Municipal Transportation Agency | Citations & Permits |
11 South Van Ness Avenue, San Francisco, CA 94103 | Tel: 415.701.3000 | Fax: 415.701.5200 | www.sfmta.com

Hospital-wide
Policies and Procedures
For Deletion

FOR DELETION

ACCOUNTING FINANCIAL STANDARDS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) will operate in accordance with "generally accepted accounting principles," and standards of the American Institute of Certified Public Accountants; the United State General Accounting Office; and Structures and Guidelines, rules and regulations of the City and County of San Francisco Controller's Office.

2. All division and department heads shall assure that accounting and auditing standards are in place and appropriate controls are met for all programs operating under their auspices.

PURPOSE:

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

PROCEDURE:

1. Laguna Honda's Finance Division will implement and maintain the Structures and Guidelines of the City and County of San Francisco Controller's Office.

2. Laguna Honda's Finance Division will assure that financial transactions are completed in accordance with Federal, State and City regulatory standards and are maintained for audit review for an appropriate duration following the close of fiscal year.

3. Division and department heads shall request the assistance of the Finance Manager for Finance in matters requiring application of generally accepted accounting principles and existing financial guidelines.

ATTACHMENT:

None

REFERENCE:

None

Revised: 03/01/09, 07/12/18, 12/09/25 (Year/Month/Day)
Original adoption: 92/05/20

FOR DELETION

SIGNATURE CARD FOR EXPENSE PAYMENTS

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. All Executive Staff and a designate must complete the attached signature card and submit it to the hospital Accounting Office.

2. Accounting Office will not process payments until the applicable Signature Card is on file.

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

_____	_____
Division Head Name: Print -Last, First	Division Name
_____	_____
Division Head Signature	Division Head Title
_____	_____
Designate Name: Print-Last, First	Designate Title
_____	_____
Designate Signature	Date

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

New Clinical Nutrition Policies and Procedures

1.20 Nutrition Screening and Assessment Documentation for Acute Hospital Admissions

Established 12/19

Policy: All residents admitted to the medical or rehabilitation hospital acute unit shall receive a Nursing nutrition screen within 24 hours of admission. A complete comprehensive assessment and follow up shall be documented by the RD in the EHR according to the guidelines established and outlined for determination of priority level.
Purpose: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT).
Procedure:
Residents admitted to the medical or rehabilitation hospital acute unit shall have a nutritional assessment completed within the guidelines established for low, medium and high risk

1. Newly admitted residents shall have a Nursing Nutrition Screen completed in the EHR to identify nutrition needs. The RD follows the guidelines for identifying risk level and completes the nutrition assessment.

2. The Nutrition Care Process (NCP) is used to provide a standardized language through the use of terminology organized by each NCP step, which include: Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD in providing individualized high-quality nutrition care. The RD documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical staff and ancillary departments. The ADIME guidelines are below:
    i. ADIME:
        a. ASSESSMENT: Nutrition assessment is a systematic method for obtaining, verifying and interpreting data needed to identify nutrition-related problems, their causes and their significance. It consists of the following elements:
            i. Food/Nutrition related history
            ii. Anthropometric measurements
            iii. Biochemical data, medical tests, and procedures
            iv. Nutrition-focused physical findings
            v. Client history
        b. DIAGNOSIS: The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
            i. Intake
            ii. Clinical
            iii. Behavioral-Environment
        c. INTERVENTION: Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. Four domains of nutrition intervention have been identified:
            i. Food and/or Nutrition Delivery
            ii. Nutrition Education

iii. Nutrition Counseling
iv. Coordination of Nutrition Care

d. MONITORING/EVALUATION: The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
   i. Food/Nutrition-Related History
   ii. Anthropometric Measurements
   iii. Biochemical Data, Medical Tests, and Procedures
   iv. Nutrition-Focused Physical Findings

3. Clinical nutrition protocol and guidelines are used by the RD to determine level of nutrition risk for each resident. RD shall document any nutritional recommendations and notify provider through the EHR.

4. The nutrition follow-up schedule is determined by the RD using the Clinical Nutrition guidelines below or shall be adjusted on an individual basis when:
   a. Resident is stable on current nutrition regimen.
   b. Nutrition problems have resolved
   c. Resident transfers to a higher or lower level of care

Nutrition Risk Level Guidelines for Clinical Nutrition: LHH Food and Nutrition Services

Admission Day = Day Zero*

Category*	High (1 or more from below) (within 24hours)	Moderate (within 72 hours)	Low (within 72 hours)
Nutrition History	• < 50% of goal nutrition intake ≥ 5 days	• <50-75% of goal nutrition intake > 7 days • Food Allergies/intolerances • Food insecurity not addressed Complicated food preferences	• No significant change in recent intake • >50-75% goal nutrition intake • Food insecurity addressed Routine food preferences
Diet Order	New TPN: Assess **within 24 hours** New Tube Feed: Assess **within 24 hours**	NPO/Liquid diet All other diet orders not listed as high/low (ex. GI related diet, Aspiration risk diet, Liquid diets) Evolving TF/TPN +/-PO plan Stable TF/TPN plan	Regular Mechanical Soft Consistent CHO Renal Cardiac or Low Sodium Fluid Restricted Vegetarian/Vegan
Weight History and Nutrition Focused Physical Exam	• Weight loss (unintentional) o > 2% one week o > 5% one month o > 7.5% 3 months • >10% 6 months	• Weight loss (unintentional) o ≤ 1-2% one week o ≤ 5% one month o ≤ 7.5% 3 months o ≤ 10% 6 months	• No weight change or otherwise planned intentional weight loss

Nutrition Diagnosis	• -Inadequate enteral/parenteral infusion • -Malnutrition (acute)	• -Non healing wound • -Altered labs r/t nutrition • - No prior knowledge of therapeutic diet, drug-nutrient interaction or reinforce new diet education	• -Stable or healing wound • -Reinforce existing therapeutic diet or drug-nutrient interaction
Other Clinical Indicator	• -Medical dx: malnutrition, failure to thrive, refeeding syndrome, burn, SBO or GI injury • -Unstable outputs (ostomy, emesis, large GI drain output)	• -Medical dx: new nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia) • pressure ulcers all stages • Change in acuity increasing AMS) • -Need to monitor output management (emesis, -ostomy, GI drain) • - Unstable labs warrants nutrition change (i.e. lytes, glucose, triglycerides, renal)	• -Medical dx: stable nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia) • -Stable clinical course • -No persistent GI complaints • -Labs stable or addressed with medication or diet prescription
Reassessment/ Follow Up	• Within 3 days	• Within 5 days	• Within 7 days
Responsible Party	RD	RD	RD

*Per RD clinical judgement to assign nutrition risk w/ categories and examples to provide general framework.

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics https://www.ncpro.org/nutrition-care-process

CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 5 CHAPTER 1, ACUTE HOSPITAL - 70273 Dietetic Service General Requirements

Revised Medical Staff Policies and Procedures

Laguna Honda Acute Medical Unit Admission Guidelines

POLICY:

For optimal clinical care, LHH residents who meet criteria for intensity of care and severity of illness shall be transferred to the Acute Medical Unit. ~~Admissions to the Acute Medical Unit will meet criteria for intensity of care and severity of illness and will be consistent with the wishes of the patient or surrogate decision maker.~~

PURPOSE:

To provide guidelines to be used when evaluating residents for admission to the Acute Medical Unit.

PROCEDURES:

~~1. Advanced Directives must be reviewed on all residents being considered for admission to the Medical Acute Unit. Residents who have "No transfer off neighborhood" orders should not be admitted to the acute unit except in very unusual circumstances (for example higher level of care required for resident comfort) and after discussion with family, surrogate or conservator.~~

~~2.~~1. Medical Acute Unit admissions are done at the discretion of the Medical Acute Unit admitting physician. Any disagreement between the SNF and Acute physicians regarding admission to the acute unit or discharge back to the SNF unit shall be referred to the Chief of Medicine for resolution.

~~3.~~2. When a resident is ready for discharge back to their SNF unit after Medical Acute Unit admission, the SNF physician shall write admission orders.

~~4.~~3. Appropriate admissions shall be consistent with Interqual Acute Admission Criteria and include:

a. Acute infections (pneumonia, urosepsis, skin infections) with hypoxia, abnormal electrolytes or WBC, or abnormal vital signs.

b. Dehydration or acute renal insufficiency requiring continuous IV hydration.

c. Significant electrolyte abnormalities requiring continuous IV hydration and electrolyte correction.

d. Altered mental status.

e. Acute exacerbation of chronic conditions such as COPD, CHF or ESLD.

~~5.~~4. Consider acute admission to outside facility for:

~~a.~~ Residents requiring ICU level care, telemetry or surgical intervention~~ and whose advanced directives are consistent with receiving this~~.

~~level of care, ie "Full Code".~~

a.

~~b.~~ Residents with abdominal pain or tenderness who require evaluation for possible surgical intervention and whose advanced directives are consistent with receiving this level of care.

~~c.~~b. ~~Other circumstances:~~

~~d.~~c. Residents who have a known infection requiring a prolonged course of antibiotics (i.e. osteomyelitis) may initiate their treatment on the Medical Acute Unit if they are acutely ill, but once stabilized should be readmitted to their SNF unit to complete their course of therapy.

~~e.~~d. SNF residents who require blood transfusion, but are not otherwise candidates for Medical Acute Unit admission, should transfer to Medical Acute Unit on a "come and go" basis in order to received close monitoring during the transfusion. This is not an admission to the Acute Unit. Informed consent is required prior to starting transfusion, and should be obtained by the primary physician.

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

Revised Nursing Policies and Procedures

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring and documenting medications consistent with their scope of practice.

    a. Only RN may administer intravenous medications, whether by IV piggyback or IV push
    b. The LVN may administer medications per LVN scope of practice.
    c. The Nursing Assistant (CNA / PCA) may, under supervision of Licensed Nurses, administer: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions and solutions when applied to intact skin surfaces.
        - Moisture barrier cream to macerated areas is acceptable for CNA/PCA to apply.

2. All medications, including over the counter drugs, require a physician's order which includes:
    a. Medication name/agent
    b. Dose
    c. Frequency
    d. Route of administration
    e. Indication for use.
        - If indication for use is not on order, consult with ordering physician.

3. Licensed nurses will follow the "6 Rights" of medication administration:
    a. Right resident
    b. Right drug
    c. Right dose
    d. Right time
    e. Right route
    f. Right documentation

4. Bar Code Medication Administration is not a substitute for the Licensed Nurse performing an independent check of 6 Rights.

5. Arm bands should only be scanned if arm band is secured on resident. Arm bands should be replaced if worn, torn or not scanning.

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

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

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

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

10. Medication times are standardized in the EHR. Medication administration times may be modified to

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

11. The safe administration of psychotropic, hazardous and high risk/high alert medications and reporting of Adverse Drug Reactions will be followed as outlined in other LHH policies and procedures.

12. Medications may not be added to any food or liquid for the purpose of disguising the medication unless informed consent has been granted by the resident or the surrogate decision maker.

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

~~13.~~14. Each p~~P~~owdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

~~14.~~15. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

~~15.~~16. Oral medications that are safe to be crushed can be crushed at discretion of LN. Each crushed medication must be given individually unless ordered by physician to crush and combine medications, pharmacy reviews for compatibility and ~~is care planned~~documents in the EHR.

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

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

~~16.~~19. Topical creams/ointments available in the neighborhood (e.g., Dimethicone, Enzo) do not require a physician's order.

~~17.~~20. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.

RELEVANT DATA & DEFINITIONS:

BCMA: Bar Code Medication Administration
eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record
EHR: Electronic Health Record
WOW: Workstation on Wheels

CRITICAL POINTS:

A. SIX RIGHTS OF MEDICATION ADMINISTRATION

1. RIGHT RESIDENT

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

- Successful scan of identification band. Only if arm band is on resident.
- Resident is able to state his/her first and last name (Ask for first and last name without prompting)
- Resident Medication Profile Photograph matches resident. Bring image next to the resident for comparison.
- Resident is able to state date of birth (Ask without prompting)
- In situations where the licensed nurse can positively identify the resident, visual identification is acceptable as a second form of identification.
- Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

2. RIGHT DRUG
   - Review eMAR for drug/medication ordered.
   - Review resident allergies to medications or any other contraindication.
   - Check medication label and verify with eMAR for accuracy. Check with physician when there is a question.
     - Checks or verifies information about medication using one or more of the following references, when needed:
       - Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
     - Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

3. RIGHT DOSE
   - Review eMAR for dose of drug/medication ordered.
   - Check medication label and confirm accuracy of dose with eMAR.

4. RIGHT TIME
   - Review eMAR for medication administration time
     - Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin and any medication ordered more often than q4 hours will be administered within 30 minutes before or after schedule time.
     - All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
     - See Appendix I for routine medication times and abbreviations.
     - Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.

5. RIGHT ROUTE
   - Review routes of administration
     - Aerosol/Nebulizer: Refer to NPP J1.3
     - Enteral Tube Drug Administration: Refer to NPP E 5.0
     - Eye/Ear/Nose Instillations: Refer to J1.4
   - IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

6. RIGHT DOCUMENTATION

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

B. OVERRIDE OF MEDICATION ADMINISTRATION

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

2. Document override reason.

C. TWO LICENSED NURSE INDEPENDENT CHECK OF MEDICATIONS:

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

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

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

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

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

6. Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food).

7. Separating crushed medications may not be appropriate for all residents. If combining crushed oral medications is in the best interest of the resident:
   a. Requires a physician order
   b. Requires pharmacy review for safety and efficacy of combining crushed medications
   ~~c. Care planned~~

E. HAZARDOUS MEDICATIONS:

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

F. PHYSICIAN ORDER

1. Licensed nurses may accept telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident’s medication allergies with prescriber and read back the order for accuracy before carrying out. Verbal orders should only be taken during emergent situations when provider is unable to enter order due to care being provided to resident.

2. Stat medication orders are processed immediately, and administered no later than four hours after the order was written.

3. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

PURPOSE:

Medications will be competently and safely administered.

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.

2. Retrieve any due medications that are stored in OmniCell and retrieve medication cassette from medication cart for the resident you will be administering medications and bring to resident's bedside/chair side with WOW. Carry only one resident's medications at a time.

3. Log into EHR. Scan arm band of resident to correctly identify resident and open their eMAR.

    a. If wearing arm band, this is one form of identification, then use second form of identification to confirm Right Resident.
    b. If not wearing arm band, navigate to eMAR of resident who will receive medications.
    c. Use two forms of identification to confirm Right Resident. Document an override and select the reason why bar code scanning of resident is not used.

4. Confirm with resident they are ready to receive their medications.

5. Scan medication(s) barcode(s) at bedside/chairside.

6. Compare each medication package to medication prescribed in eMAR according to first 5 Rights.

7. Immediately prepare if appropriate. (i.e., crush) and administer medication(s).

    a. If this is first dose being given, document 1st dose resident education has been performed, as appropriate.

8. Remain with resident until all medications have been taken.

    a. Never leave medications at bedside/chairside.

9. Document in real time in EHR medication(s) given, not given, etc.

10. Log out of EHR and return cassette to medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

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

2. Do not add medication directly to an enteral feeding formula.

3. **Prior to administering medication, stop the feeding and flush the tube with at least 15 mL water.**

4. Dissolve tablets or dilute medication in at least 30 mL of water to sufficiently allow for medication to pass through the tube.

5. **Each medication should be administered separately. After each medication flush the tube with 15 mL of water.**

6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

7. Give medication at the appropriate time in relation to feeding. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension). For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

8. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document amount of flush used for medication administration in flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

A. Monitor resident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

2. Whenever resident's condition warrants and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or change in treatment.

3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Appendix 4, follow Manufacturer's Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

3. When using multiple inhaled medications, **wait 5 to 10 minutes between drugs** to get maximum benefit. **NOTE:** If both bronchodilator and a steroid inhaler are prescribed, **use the bronchodilator first**.

4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

5. Compressor/ Nebulizer (brand name Misty-Fast)

   a. Use with nebulizer face mask, which has medication cup and lid.
   b. Pour medication into the cup. Connect blue end of the tubing to the cup and the green end of the tubing to the air source.
   c. Air source
      i. Nebulizer machine: Do not place machine on soft surfaces. Turn on machine until mist is no longer produced.
      ii. Compressed wall air: Turn on flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.
      iii. For residents with a physician's order for oxygen AND is not a known carbon dioxide (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.

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

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

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

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

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

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

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

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

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

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

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

SHAKING MEDICATIONS OR MIXING A SUSPENSION

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

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

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

physician.

c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.
d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.
e. If a resident is on weekly cardiovascular monitoring schedule and a medication is held the licensed nurse will monitor and record cardiovascular monitoring before each dose for a minimum of 3 additional days to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring and the resident's vital signs has been outside of the hold parameters for 3 consecutive days.

2. PRN Cardiovascular Medication Orders
   a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics
   a. Document VS once every shift for duration of therapy, and response to therapy.

2. Pain
   a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT TO SHIFT LN REPORTING

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

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

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

b. If resident currently has a patch on, remove the old patch before applying a new patch.
c. Select appropriate site for patch, on flat area, such as chest, back, flank or upper arm. Apply patch to non- irritated, non-irradiated skin.
d. Clip hair if needed (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.

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

f. The LN observing the resident taking the appropriate medications, LN will document in eMAR as given and will note "self administered".
g. Documentation will also include the following;
    i. Topic/training skills taught and resident's progress with learning in the EHR education section.
    ii. Resident's agreement for participation in the self-administration of medications on the care plan.
    iii. Any follow-up plan identified by the RCT necessary to reinforce safe and skilled medication self-administration will be documented in the education section of EHR.

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

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

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

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

4. No controlled drugs shall be kept at bedside.

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

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

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

WASTING MEDICATION

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

Hazardous Drugs management).

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

~~1.~~2. The LN must secure narcotics/controlled substances from time of receipt/removal from OmniCell to administration by having in physical possession or constant surveillance.

~~2.~~3. Narcotics/controlled substances that are removed and not administered and/or are only partially administered, shall be immediately wasted in pharmaceutical waste container with witness of a 2nd LN.

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

~~3.~~4. If resident refuses medication, LN shall ~~medication~~ return medication to original package.
a. LN shall get a 2nd LN to initiate controlled substance waste.
b. 2nd LN shall validate and ID medication since packaging has been opened.
(i) This may be done via looking up the IC medication tag through Lexicomp.
c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.
d. Both LNs shall document waste in Omnicell and eMAR.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

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

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

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

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

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

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

PERSONAL MEDICATION

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

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

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

MISSING MEDICATIONS

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

EXCESS MEDICATIONS

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

ATTACHMENTS:

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

Appendix III – LN Wasting Controlled Substance (Partial Dose)

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

REFERENCES:

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

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

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

CROSS REFERENCES:

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

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

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

~~**ATTACHMENTS:**~~

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

~~Appendix III – Anticoagulant Administration Protocol~~

~~Appendix 4: Various Inhaler Instructions~~

REFERENCES:

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

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

CROSS REFERENCES:

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

LHH Pharmacy P&P 01.02.02 Stop Orders
LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets
LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P 02.02.00 Controlled Substances

Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds
Nursing P&P J 1.3 Aerosol/Nebulizer Medications.

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

Revised Pharmacy Policies and Procedures

POLICY AND PROCEDURE FOR DISPOSITION OF MEDICATIONS

Policy:

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

Purpose:

To ensure residents' medications are appropriately disposed or destroyed.

Procedures:

I. Returned medications from Automated Dispensing Cabinets (ADCs). *See Automated Dispensing Cabinet Dispensing Procedures (PHAR 09.00)*

II. Returned medications from units

A. Controlled Substances: Schedule II, III, IV, and V not in ADC

1. Sign-out sheets with unused medications are returned to pharmacy.
2. Sheet must be properly signed.
3. Amount of medication returned must correspond with sign-out sheet inventory.
4. Returned medications, if in unit dosages, properly labeled and identified, will be reissued to other units.

B. Nonscheduled Medications

1. Pharmacy staff will check all medications returned to the pharmacy.
2. Unopened, properly labeled medications may be returned to stock and credit applied when appropriate.
3. Contaminated medications will be disposed.
4. Unidentifiable medications will be disposed.
5. Outdated medications will be returned to manufacturer for credit.

III. Medications on Hold

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

IV. Pharmaceutical Waste Disposal

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

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

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

Reviewed: 0403dw, 06/04dw, 02/06, 01/08, 04/09, 2/10, 5/11, 4/12, 8/13, 5/14

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