List of Hospital-wide/Department Policies and Procedures Submitted to JCC for Approval on January 10, 2023

Revised Hospital-wide Policies and Procedures

Dept.	Policy #	Title	Notes
_LHHPP	20-12	Discharge Cleaning	1. Removed mention of EHR 2. Added standard work language
_LHHPP	24-18	Resident Locator	1. Clarified that if battery level of Aeroscout is below 20%, Charge Nurse or designee immediately issues a new tag to the resident and places the low-battery tag in a bin to return for battery replacement 2. Revised to indicate writing orders in EHR
_LHHPP	25-01	High Risk - High Alert Medications	Remove intravenous digoxin
_LHHPP	25-02	Safe Medication Orders	Minor change adding – to on call
_LHHPP	26-02	Management of Dysphagia and Aspiration Risk	Removed "Nursing shall include this information when communicating the diet order to Nutrition Services" under Individualized Aspiration Precautions
_LHHPP	26-03	Enteral Tube Nutrition	Updated reference to "Clinical Nutrition Department Policy and Procedure 1.16 Nutrition Screening and Assessment Documentation in the Electronic Health Record (EHR)"
_LHHPP	26-04	Resident Dining Services	1. Added "1. Food and Nutrition services PM dinner meal staff will post the next days 'Daily Menu' in the Great Room sign holder" to Procedure 2. Removed Diet Office will provide hard copies of weekly menus 3. Updated Staff to Nursing Staff 4. Updated FNS staff to clean galley and coffee dispensers in the great room and will be cleaned once a day using the 3-bucket method 5. Removed accuracy of the meal tray ticket will be verified through EHR 6. Removed staff must wear proper hair coverings when entering the galley area. 7. Added P&P 1.91 General cleaning and sanitizing work surfaces and kitchen or galley equipment to References

_LHHPP	26-06	Meal Tray Service Galley Sanitation	1. Added chemicals used in the galley are approved for washing, rinsing and sanitizing process. All the utensils are air dried 2. Added food and nutrition services porter will dispose of compost, recycle and garbage
_LHHPP	72-01 A1	Authority of Infection Control Committee	1. Added SFDPH, CDPH and CMS as regulators in the Purpose section 2. Updated community-associated infection (CAI) definition 3. Replace Chief Operating Officer with a member of senior leadership (C-suite) 4. Updated Functions of ICC and Scope of the IPC Program
_LHHPP	72-01 B2	Hand Hygiene	1. Updated Policy section to indicate times hand hygiene is performed 2. Updated Mechanism of Action and Procedure for Hand sanitizers/ABHR and Handwashing with soap and water 3. Added CD hand hygiene resources and the APIC guide to glove use to References
_LHHPP	72-01 B3	Antibiotic Stewardship and Infection Control	1. Update Purpose section with IPC role in the antibiotic stewardship program 2. Updated procedures
_LHHPP	72-01 B9	Infection Control Post-Mortem Care Guidelines	1. Updated Policy section to include post-mortem care guidelines to minimize infectious pathogens transmission 2. Removed post-mortem specimen collection required by the physician in the event of an outbreak 3. Added airborne/droplet precautions and contact and blood/body fluid precautions to Procedures
_LHHPP	72-01 B24	Respiratory Hygiene/Cough Etiquette	1. Updated use of surgical mask/source control for patients 2. Added "Cleaning surfaces frequently with an EPA registered disinfectant can stop the transmission of infection" 3. Added "physically distance from other by sitting at least 6 feet away" 4. Updated References
_LHHPP	72-01 B25	Isolation Carts	restock carts. 2. Updated Policy section to include isolation cart must remain near the door entrance and cannot by moved inside the room for use. 3. Added Specific individualized PPE will not be placed on the cart but will be obtained by stock supplies on the unit 4. Added HPC and other must perform HH prior to touching items on cart 5. Added laminated signs will be place on the patient's door front 6. Added prior to leaving, use EPC approved to clean the cart exterior. If the room requires a terminal clean, the cart should remain in place until after EVS cleans room

_LHHPP	72-01 C16	Scabies Management	1. Updated Policy section with the prevention and transmission of scabies 2. Updated Purpose of policy 3. Added Prevention through Education, Two forms of Scabies, Crusted (Norwegian) Scabies, Transmission, Screening, Treatment Options, Outbreak Management, HCW/Staff Exposure or Diagnosis, Patient Exposure or Diagnosis, Treatment, and Clean and Disinfection to Procedure
_LHHPP	72-01 C17	Pediculosis (Lice) Management	1. Updated Policy section to include admission screening and contact precautions for suspected lice cases 2. Updated Definitions 3. Updated Live Cycle Stages and Transmission and Disease 4. Added head lice diagnosis and areas, treatment, retreatment, laundry and EVS measures, body lice treatment, and pubic lice treatment to Procedures section
_LHHPP	72-01 C18	Clostridioides Difficile Guidelines	1. Added details to Policy section 2. Updated Purpose 3. Updated Prevention, Symptoms of C. diff (CDI), Standard Precautions, Transmission-based Precautions Implementation, Outbreak Management, Disinfection and C. diff colonization to Procedures 4. Updated Attachments and References
_LHHPP	72-01 C22	Influenza Immunization	1. Updated title with "for Patients" 2. Updated Policy and Purpose section 3. Added Standard RN protocols for influenza vaccine ordering and Education and Consent to Procedures
_LHHPP	72-01 C24	Employee Influenza Vaccination	1. Updated Policy to include employees are require to either get the influenza vaccination or sign a declination statement and follow precautions. 2. Update Background with Influenza Season 3. Added physical distancing for unvaccinated employees to Procedures
_LHHPP	72-01 C26	Guidelines for Prevention and Control of Tuberculosis	1. Added "Effective 9/1/2021, CDPH is following latest CD guidance for tuberculosis. 2. Update definitions 3. Added CDC three-tired level of hierarchy to control tuberculosis to Procedures. 4. Added do no perform skin test on someone with known TB 5. Updated Reference
_LHHPP	72-01 C27	Care of Tuberculosis Patient Placed on Civil Detention	1. Updated background to include mental illness, homelessness, and substance abuse 2. Added purpose of policy to Procedures section

_LHHPP	72-01 E14	Infection Control for Rehabilitation Services	1. Updated Policy to include collaboration with IP team and role of Respiratory Team department in infection control 2. Updated Purpose 3. Updated Responsibilities with collaboration with IP and for staff responsibilities to include understanding standard and transmission base precautions and be familiar with 3 types of TBP 4. Updated Standard and Transmissions-based Precautions, Visitors, Materials and Housekeeping
_LHHPP	72-01 F1	Renovation/Construction Infection Control Guidelines	1. Removed Appendix B: Infection Prevention and Control Construction Clearance Checklist
_LHHPP	72-01 F4	Management of Hospital-Provided Linen	1. Added linens will me hospital laundry requirements to Policy section 2. Updated Clean Linen and Contaminated Linen under Procedures
_LHHPP	72-01 F10	Blood/Body Fluid Clean-Up	1. Added definitions 2. Updated General Cleaning Procedures, Safety, and Blood and/ or body flue must be contained under Procedures
_LHHPP	72-01 F15	Storage of Sterile Medical Supplies	1. Updated Purpose with details of comprise of supplies sterility 2. Minor updates to Procedures 3. Updated References
_LHHPP	80-01	Key Personnel Whereabouts	Updated review and revision dates
_LHHPP	80-02	Employee and Volunteer Identification	1. Deleted "be notified and scheduled by" 2. Deleted "Human Resources Services for Hospital photo identification tag appointments"
_LHHPP	80-04	Employee Regulations	Updated review and revision dates

_LHHPP	80-06	Staff Alcoholic Consumption	1. Updated Purpose to comply with DPH policy and include hospital residents and visitors in healthy environment 2. Policy updated to no consumption of alcoholic beverages on LHH property and only sacramental wine are limited to small amounts for religious ceremonies 3. Added intoxicated employees will be immediately removed and on occasions of drinking without intoxication, supervisors will temporarily reassign the employee 4. Added violation of policy may be grounds for disciplinary actions 5. Added DPH Code of Conduct Section 9.1 Alcoholic Beverages & Drugs in the Workplace to References
_LHHPP	80-09	Prohibition Against Political Activity	1. Updated Policy to unlawful for City officers or employees to use public resources to engage in political activity relating to elective offices and ballot measures. City employees may not engage in political activities while on duty or in the workplace 2. Added Laguna Honda Hospital to Purpose 3. Under Characteristics, added DPH or City resources cannot not be used under any circumstance to contribute to political campaign and city employees are prohibited from using official positions to influence elections. Violations may result in civil and criminal penalties 4. Added "For more information, contact the San Francisco Ethics Commission" 5. Updated References to include DPH Code of Conduct and Employee Handbook
_LHHPP	80-10	Prohibition of Harassment and Bullying	1. Added Bullying to policy 2. Added harassment on the basis of sex, race, age, religion, color, national origin, ancestry, disability, medical condition, marital status, sexual orientation, gender identity, and other protected category is prohibited and unlawful 3. Added definitions of harassment and bullying 4. Added violations of this policy are subject to disciplinary action, up to and including termination 5. Updated References to include DPH Employee Handbook and DPH Code of Conduct
_LHHPP	80-11	Payroll Time Reporting and Controls	Updated review and revision dates
_LHHPP	80-12	Lactation Accommodation for Employees at the Workplace	1. Replaced "nursing mothers" with "nursing employees" 2. Replaced "women" with "employees" 3. Added LHH HR will provide this policy and Lactation Accommodation form to any employee who requests for pregnancy disability or child bonding leave 4. Added key card access is required for Lactation Room and can be requested from Administrative Director of Care Experience via email or telephone 5. Added Reference to include DHR Lactation in the Workplace Policy

Revised Nursing Services Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	D1 2.1	Nurse and Resident Call System	Revised Policy #6 to include PMA as the exception for not assigning licensed nurses to receive Routine Calls o Under Types of Resident's Call Stations #3: Removed "Group and Wireless Phone assignments are added and edited in the Master Stations. Pens or other sharp objects other than fingers should not be used to operate the master station." o Added that both Nurse Call Master Station and wireless phone will receive calls and alerts o Appendix 1: • Added "Assigns residents to a group template" for what the Master Station can be used for • Removed "muted, and when the nurse call master station hangs up the handset" for when audio is disconnected • Clarified that "Pens, markers, or other objects other than fingers should not be used when operating this device" o Appendix 2: • Removed alphanumeric pager as another option for communication • Possibly remove creating a UO for CISCO phones broken due to cracked/damaged screen, water damage or physical damage beyond normal wear and tear o Appendix 3: • Reviewed no changes
Nursing	J 2.5	Monitoring Behavior and the Effects of Psychotropic Medication	Specified that all PCA/CNA staff will observe for presence of target behavior. Included psychotropic medication side effect observation. o Removed timeframe for observing presence of target behavior o Included target behaviors and individualized nonpharmacological interventions for what is to be included in care plans o Specified the purpose of policy to document effectiveness of any non-pharmacological interventions. o Added license nurse to communicate any changes to the provider o Added documentation of any follow up interventions in the EHR o Clarified LHH NSG weekly summary

Deletion Nursing Services Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	M 5.0	Protocol for Using Psychotropic Medications for Emergency Behavioral Situations	Proposed for deletion and replace with Standard Work Emergent Medication

Revised Hospital-wide Policies and Procedures

DISCHARGE CLEANING

POLICY:

1. The Laguna Honda Hospital and Rehabilitation Center (LHH) Nursing and Environmental Services (EVS) departments shall clean the entire room upon resident discharge **as outlined in the room readiness standard work.**

~~2. Nursing shall communicate through the electronic health record (EHR), and EVS will interface with EHR via mobile device Rover.~~

PURPOSE:

To ensure proper cleaning of resident rooms upon discharge, and communication and documentation after completion.

PROCEDURE:

~~1. Licensed Nurse shall update EHR of room vacancy upon resident's discharge.~~

2. Nursing Department shall perform terminal cleaning and bed making (Refer to D9 2.0 Bedmaking and D9 3.0 Bed Stripping and Terminal Cleaning), including cleaning inside cabinets.

3. Nursing Department notifies EVS of room vacancy ~~through EHR~~ **as outlined in the room readiness standard work t**o begin next step of cleaning process.

~~4. Porter receives notification via mobile device Rover to begin cleaning the room.~~

5. Porter begins 7 step cleaning procedure of the room.

~~6. A Utility Worker brings two new pillows to the room and changes curtains (if needed).~~

7. Porter notifies Nursing Department of completion of cleaning via ~~mobile device Rover.~~ **standard work.**

8. After receiving notification, Nursing Department returns to room to make the bed.

ATTACHMENT:

None.

REFERENCE:
~~Standard Work for Terminal Cleaning by Nursing~~

Terminal Cleaning by Nursing (HHA/PCA/CNA)

Room Readiness Guideline (Charge Nurse)

Room Assessment Checklist

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

RESIDENT LOCATOR SYSTEM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) Resident Care Teams (RCT) may use a tracking system (also called locator system) to reduce risk of loss, ~~injury~~injury, and other adverse outcomes for residents.

PURPOSE:

LHH's goal is to provide care in the least restrictive setting. The use of the resident locator system is intended to ensure safety and maximize resident's freedom.

BACKGROUND:

LHH has installed in its new building a Wi-Fi based tracking system (brand named AeroScout®). A tag worn by a resident regularly signals its presence. Standard Wi-Fi access points detect the signal, which system software uses to determine the tag's location and to associate it with the resident's name, MR#, and primary language. Special detectors, called exciters, are installed in critical locations (including exits from the LHH neighborhoods, fire doors, main hospital exits, entrance to swimming pool). These cause a nearby tag to signal its presence. For any resident wearing a tag, the authorized area for wandering is determined and pre-programmed. If the resident attempts to go into an unauthorized location (e.g., an elopement risk resident exits a fire door), the system transmits alerts to predetermined recipients via their wireless devices, so that staff can intervene.

PROCEDURE:

1. Resident Assessment:

a. At every assessment (admission, re-admission, quarterly, annual, significant change of condition, or other as needed), the RCT will assess each resident for wandering/elopement risk.

b. If the RCT determines the resident is cognitively impaired and has a prior history of, or a new episode of, wandering, elopement, or inability to return to the neighborhood without help, the RCT will discuss the risks and benefits of monitoring the resident with the locator system.

c. If deciding to use the locator system, the RCT will identify the resident's risk category as one of the following:

i. Not safe to leave the neighborhood unescorted (resident category is "Unauthorized").

ii. Safe to walk unescorted through LHH's new building (resident category is "Indoor Only").

d. The RCT will discuss the plan and describe the nature and purpose of tracking with the resident and/or surrogate decision maker. The physician then obtains informed consent from the resident and/or the surrogate decision maker.

The physician will ~~write in the resident's chart an~~ order in EHR for both the application of the locator tag and the category of AeroScout authorization (i.e., "Unauthorized" or "Indoor Only").

2. Placement of the Resident Locator Tag:

a. The resident's care plan shall include location tracking, the Charge Nurse or designee shall:

i. Use the system database to assign a tag; place the tag on the resident (usually with a wristband; other options might include attaching to a wheel chair); and set the resident's tag to the appropriate risk category (i.e., "Unauthorized" or "Indoor Only").

ii. Check that the database correctly associates the tag to the resident's full name, Medical Record Number (MRN), date of birth, gender, primary language, and photograph.

iii. Test that the locator tag appears on the monitoring map.

3. Resident Locator System and Communication of Alerts:

a. Location Monitoring: From a nursing station computer, the neighborhood staff can locate the resident's tag on maps of the neighborhoods and ~~the new LHH buildings~~inside the hospital building.

When a Stage 1 Alert is triggered, an audible alert (i.e., "Stop, go back") is heard through the speakers above the first set of exit doors on the neighborhood.

b. When a Stage 2, 3, or 4 alert is triggered, designated AeroScout® computers at the nursing station will display a pop-up message with the resident's name, photograph, and current location on a facility map. Neighborhood staff will also receive alerts on their wireless devices containing the resident's name and location.

c. North and South Residence Neighborhood Alerts:

i. A Stage 1 Alert (Redirection) is triggered if an "Unauthorized" resident approaches the exciters above the neighborhood's first main exit door. The audible alert is a pre-recorded message that states, "Stop, go back.". (Messages are available in several languages).

ii. A Stage 2 Alert is triggered if an "Unauthorized" resident does not respond to the Stage 1 Alert and continues to the door adjacent to the elevators. The resident's name and location is sent to neighborhood ~~staffs~~staff's wireless devices

iii. Pavilion Mezzanine and Pavilion Acute Neighborhood Alerts:

- Due to architectural reasons, the Pavilion Mezzanine and Pavilion Acute neighborhoods will only use Stage 3 and Stage 4 elopement alerts. Staff on these neighborhoods will be trained to monitor the elevator area for elopement risk residents that attempt to leave the neighborhood.

iv. A Stage 3 Alert is triggered for the following:

- If an "Unauthorized" or "Indoor Only" resident exits via a delayed egress fire door. The resident's name and location is sent to the neighborhood staffs wireless devices.

- If an "Unauthorized" resident approaches or enters an elevator. The resident's name and location is sent to neighborhood staffs wireless devices and the resident's tag status is automatically updated to "Wandering".

v. A Stage 4 Alert is triggered if a resident with an "Unauthorized" or "Indoor Only" tag exits the Pavilion main doors, a loading dock door, a ground floor exterior fire exit door, or enters the pool area. The resident's name and last known location is sent to the neighborhood ~~staffs~~staff's wireless devices ~~and to security~~. A pop-up notification will also appear on the neighborhood's designated AeroScout® computers as well as the Sheriff's designated Aeroscout computer. The resident's tag status is automatically updated to "Wandering Outdoors".

Staff should verify the resident's last point of exit within the hospital to determine the resident's last known location as the icon on the hospital map will be seen bouncing around while it is attempting to find the tag it's associated with.

4. Authorized Exits:

a. For All Neighborhoods:

i. Appointments and Activities within LHH: The neighborhood staff can temporarily change a resident's tag status from "Unauthorized" to "Indoor Authorization" via MobileView software. The resident can then be escorted off the neighborhood without triggering an alert.

ii. Appointments and Activities outside of LHH: If a resident needs to be escorted off campus (e.g. SFGH appointment) without triggering an alert, neighborhood staff can change a resident's tag status via MobileView software to "Full Authorization". ~~For Pavilion Residence Neighborhoods, the neighborhood staff must manually reset the resident's tag to the original status using MobileView.~~

iii. For the North and South resident neighborhoods, the resident's AeroScout tag will automatically reset to the resident's original status upon re-entry to the unit. Once the resident has returned to the unit, staff is responsible for verifying that the resident is present and that the resident's tag status has been updated correctly. For Pavilion Residence Neighborhoods, the neighborhood staff must manually reset the resident's tag to the original status using MobileView.

5. Responding to Resident Locator System Alerts:

a. Neighborhood staff is responsible for responding to resident locator system alerts by locating and redirecting the resident safely back to the neighborhood.

b. If the resident cannot be located, staff will initiate post-elopement response procedures. (See Elopement Response Procedure.)

6. Checking Resident Locator Tag and Function:

a. The neighborhood Charge Nurse or designee is responsible for maintaining the database of neighborhood residents who wear locator tags, and for communicating to neighborhood staff which residents wear the tags.

b. The neighborhood Charge Nurse or designee is responsible for the following:

i. Upon admission, readmission, or relocation of a resident assigned an AeroScout® tag, the Charge nurse/designee will assign and/or check that the resident has the appropriate category of authorization on the MobileView as per physician order.

ii. The Charge Nurse or designee will verify that when a resident with an assigned ~~a~~ tag returns to his/her neighborhood (e.g. from OOP, outside appointments, ER visits, LHH clinic or rehab appointments), the resident is still wearing the assigned tag. The Charge Nurse/ designee will also confirm through MobileView that the resident's name, MRN number, category, and status are accurate and have reverted back to the original form.

iii. Every shift, the Charge Nurse/designee will:

- Ensure that each nursing assistant verifies the placement of a resident's AeroScout tag and documents this information in the electronic health record (EHR).

- Print an AeroScout assets list report and check that each resident with an assigned ~~a~~ tag has an associated tag ID, has the correct MRN associated with the resident, has the correct Category and Status, resident is detected in the neighborhood, or the resident's location is otherwise known (e.g., out on pass), and the last update time is current.

iv. Upon discharge of a resident with an AeroScout tag to home or community, the Charge Nurse or designee will remove the AeroScout tag from the resident.

c. The neighborhood Charge Nurse or designee is responsible for checking at each shift the tag's battery status using the AeroScout® battery level report.

i. If battery level is below 20% ~~"LOW~~", the Charge Nurse or designee immediately issues a new tag to the resident and places the low-battery tag in a bin to return for battery replacement.

~~ii. If the battery level is "MEDIUM", the neighborhood Charge Nurse or designee may replace the tag or continue to watch for a few days.~~

d. The assigned care-giver checks the resident's tag and strap for wear and tear at each shift.

7. Staff Education:

a. Neighborhood staff shall be trained upon orientation or if transferred within LHH on the use of the resident locator system and response to its alerts.
b. Additional education shall be provided to staff if a significant system enhancement is implemented or whenever indicated.

c. Neighborhood staff will be trained that residents with elopement/wander risk must be ~~escorted by staff at all times~~always escorted by staff while in the garden areas (detectors do not currently cover the garden areas).

d. All staff are to be educated to be cautious when entering or exiting controlled areas to prevent accidental resident elopement.

8. Performance Improvement:

a. The Licensed Nurse shall complete an Unusual Occurrence report if a resident elopes from the neighborhood.

b. Resident elopement incidents will be periodically reviewed to identify process improvement opportunities and staff training needs.

9. Other Uses:

a. If the Resident Care Team (RCT) identifies possible uses for the locator system that would enhance the resident's safety and quality of life, these possibilities may be discussed with the resident and/or surrogate decision-maker for approval. The use of the resident locator system shall be described in the resident's care plan.

ATTACHMENT:
None.

REFERENCE:
AeroScout® Operation Manual
Nursing System Manual (LagunaNet: Nursing)
LHHPP 24-01 Missing Resident Procedures
LHHPP 24-04 Resident Found Off Grounds
LHHPP 60-04 Unusual Occurrences

Revised: 11/07/26; 12/03/27, 16/07/12, 19/07/09 (Year/Month/Day)
Original adoption: 10/12/03

HIGH RISK – HIGH ALERT MEDICATIONS

PURPOSE:

To identify potential high-risk medications at Laguna Honda Hospital and Rehabilitation Center (LHH) and to outline steps to prevent errors.

POLICY:

LHH will have procedures in place to minimize medication errors and adverse drug events from high-risk medications.

DIVISIONS/DEPARTMENTS AFFECTED:

Medicine, Nursing and Pharmacy

OWNER/AUTHOR:

P&T Committee / Med Executive Committee

FUTURE ISSUE:

1. New drugs added to the Hospital Formulary may meet criteria

2. New reports of harmful errors in the literature, within the hospital, and input from practitioners and safety experts

3. New FDA Med Watch warning or Black Box warning

DEFINITION:

High Risk – High Alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error.

PROCEDURE:

1. Identifying High Risk drugs and preventing harm

    a. The Medical Staff through the P&T Committee will determine the list of drugs designated as High Risk – High Alert and the corresponding monitoring / response to be used when these medications are prescribed.

    b. All staff involved in the medication use process will be educated on these high alert drugs and the monitoring / response associated with each. The education shall

include any specifics involved in procuring, storing, ordering, transcribing, preparing, dispensing, administering and monitoring.

2. High Risk – High Alert Medication list

    i. See Attachment A for a list of medications designated as High Risk – High Alert Medications at LHH and the steps utilized to prevent errors.

3. Steps Utilized to Prevent Errors

    a. See Attachment B for the procedures utilized to prevent errors.

ATTACHMENT:
Attachment A: Laguna Honda High Risk - High Alert Medications
Attachment B: Steps Utilized to Prevent Errors

REFERENCE:
ISMP's List of High Alert Medications e.g., "www.ismp.org"

Revised: 09/07/16, 09/08/13, 13/05/28, 19/03/12, 21/09/14, 22/10/19 (Year/Month/Day)
Original adoption: 08/02/12

ATTACHMENT A: Laguna Honda High Risk - High Alert Medications

Laguna Honda High Risk - High Alert Medications
Anticoagulation (enoxaparin, heparin, warfarin, DOAC)
Antineoplastic/Cytotoxic agents
Clozapine (Psych consult required)
~~Digoxin intravenous~~
Epidural / Intrathecal Agents (~~e.g~~e.g. baclofen)
Haloperidol injection (e.g. Haldol IM, Haldol Dec)
Insulins
Lithium
Morphine Concentrate (e.g. Roxanol)
Magnesium Sulfate (IV)

NOTE:
Potassium chloride for injection concentrate (2 mEq/mL) is not on the formulary and is not available at Laguna Honda. Safer alternatives exist and are available, including Potassium Chloride 10 mEq/100ml IVPB and 10 - 40 mEq /1000 ml large volume solutions.

See Laguna Honda IV administration guidelines for infusion recommendations.

ATTACHMENT B: Steps Utilized to Prevent Errors

LHH High Risk – High Alert Medications / Procedures	Anticoagulation (enoxaparin, heparin, warfarin)	Antineoplastic/Cytotixic agents	Clozapine (Psych consult required)	~~Digoxin intravenous (Acute only)~~	Epidural / Intrathecal Agents (e.g baclofen) Not dispensed at LHH	Haloperidol injection (e.g. Haldol IM, Haldol Dec)	Insulins (SQ only; IV not allowed)	Lithium	Morphine Concentrate (e.g. Roxanol)	Magnesium Sulfate (IV)
Standardize ordering, preparation, and administration										
Use standardized drug/dose expressions	√	√	√	~~√~~	√	√	√	√	√	√
Dispense only in Unit Dose or Unit of Use packaging	√	√	√	~~√~~		√			√	√
Eliminate use of unapproved abbreviations	√	√	√	~~√~~		√	√	√	√	√
Standardize and limit drug concentrations/formulations	√			~~√~~		√	√	√	√	√
Order set/panel available				-			√			
Use oral syringes for administration of oral products				-					√	
Limit the total number dispensed	√	√	√	~~√~~		√		√	√	√
Drug included in LHH IV guidelines				~~√~~						√
				-						
Externalize or centralize drug preparation				-						
Use commercially available, premixed IV solutions				-						√
				-						
Distinguish or warn with labels, container size, or computer alerts										
Use TALL man lettering						√				
Dispensing label includes appropriate warnings		√								
Specific organizer bin in pharmacy		√								
Provide labeling specifying administration instructions for emergency use										√
Limit or restrict drug access										
Dispense from ADC only									√	
Dispense from pharmacy only		√	√		n/a			√		

Limit or restrict drug use										
Certify/privilege staff to order, prepare, or administer drug		√(IV-RN)		~~√(RN)~~						√(RN)
Formulary decisions / restrictions							√		√	
Perform independent double-checks										
Pharmacy double check of drug & drug preparation										
Recalculate the dose		√								
Double-check rate, drug, concentration, and/or line attachments		√(IV)								
Involve the patient (family) through education	√	√	√		√	√	√	√	√	√
Monitor the patient and respond to drug effects										
Obtain and communicate laboratory values per **policy**	√	√	√	~~√~~				√		√
Require close observation/vital sign monitoring (cardiac monitoring, BP)				~~√~~						
Have antidotes and/or resuscitation equipment close at hand							√		√	
Dietician notified for potential food-drug interactions	√							√		
Side effect information provided to nursing for close monitoring		√	√			√		√		

SAFE MEDICATION ORDERS

PURPOSE:

To ensure resident safety by reducing the potential for error or misinterpretation when orders are communicated.

POLICY:

Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal communication of prescription or medication orders is limited to situations in which immediate electronic communication is not feasible. Medication orders from physicians, dentists, podiatrists, physician assistants, nurse practitioners, and pharmacists are accepted if they comply with the requirements listed below.

PERSONS AFFECTED:

Clinical Staff, including but not limited to Physicians, Nurses, and Pharmacists

PROCEDURE:

1. Medication Orders

a. All prescription orders must be electronic and shall contain the following:

   i. Date and time order is written

   ii. Patient name and medical record number

   iii. Medication name (generic preferred)

   iv. Strength or concentration

   v. Dose

   vi. Frequency or time of administration of the medication

   vii. Route, e.g. PO, IM, SC, IV or rectal

   viii. All orders (PRN and scheduled) must include the indication for use of the medication. PRN orders must also include how often the medication may be given.

   ix. Prescribing practitioner signature

b. All verbal or telephone orders shall be immediately recorded in the resident's chart and signed by the prescriber within 48 hours for the acute units and within five days for Skilled Nursing Facility (SNF) units.

c. Orders that are incomplete or unclear shall not be transcribed or processed by nursing or pharmacy. The prescribing practitioner shall be contacted for clarification.

2. Requirements for Specific Categories of Medication Orders

a. "As needed" (PRN) orders: Must include dose, frequency, route and indication for use.

b. There shall be no standing orders for medications or treatments. Standing Orders are defined as orders that allow practitioners to automatically & globally implement patient care without a patient specific order.

c. Automatic stop orders: Drugs not specifically prescribed as to time or number of doses must automatically be stopped as outlined in the Policy and Procedure (P&P) for Automatic Stop Orders (PHARM 01.02.02).

d. Resume, Renew, Continue orders: Blanket reinstatement of previous medication orders is not acceptable. Resume, renew or continue orders must be completed as part of the medication reconciliation process with all specified elements for a medication order as defined by this P&P.

e. Titration orders (orders that a medication is to either progressively be increased or decreased for a specific patient response): "Titration orders" must contain criteria for use and clear parameters as to when to increase or decrease the medication.

f. Taper orders: "Taper orders" refer to those in which the dose is decreased by a particular amount with each dosing interval. Each dose of a tapering regimen must be clearly written out.

g. Range Orders: There shall be no range orders for medications. "Range orders" are defined as those in which the dose or dosing interval varies over a prescribed range. (e.g. instead of Oxycodone 5-10mg PO Q4 hours prn pain prescribe Oxycodone 5mg PO Q4 hours PRN mild pain; Oxycodone 10mg PO Q4h PRN moderate pain).

h. Multiple PRN medications written for the same indication: The parameters for use of each medication must be clearly written to specify when it shall be used (e.g. Milk of Magnesia 30ml PO daily PRN constipation; Bisacodyl 10mg PR daily PRN constipation not relieved by MOM). Prescribers are encouraged to avoid multiple PRN medications for the same indication.

i. Medications written with multiple routes of administration: The parameters for use must be specified (e.g. Famotidine 20mg PO Q12h, give IV if resident unable to take PO).

j. Investigational medication orders: Refer to PHARM 02.05.00 on Investigational Drugs.

3. Verbal Orders

a. Communication of prescription or medication orders is limited to situations in which immediate electronic communication is not feasible. Verbal orders, when indicated, shall be immediately documented by the recipient, read back by the recipient, and confirmed or corrected by the prescriber. The order must be documented before it is read back. The resident's allergy status must be discussed. Refer to LHHPP 25-03 Verbal/Telephone Orders.

4. STAT Orders & Pharmacy Response Time

a. Nursing service and pharmacy (when open) shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered. When the pharmacy is closed, drugs ordered STAT which are available in the emergency drug supply shall be administered immediately. The nursing supervisor shall be notified when access to the supplemental medication room or the on-call pharmacist is needed as outlined in the P&P for Emergency and Supplemental Medication Supplies (PHARM 02.03.00).

b. Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

c. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.

d. Refills shall be available when needed.

5. Discontinued Medication Orders

a. By the end of shift during which the medication is discontinued, the nursing unit shall print "DC" on the prescription label. Room temperature medications are to be placed in the drug pick-up box, and unopened, refrigerated medications are to be returned to the pharmacy immediately. This also applies to the medications of residents who expire, are discharged, or transferred to an acute hospital. The pharmacy shall process discontinued orders within 4 hours of receiving.

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-03 Verbal/Telephone Orders
PHARM 01.02.02 Automatic Stop Order Policy
PHARM 02.03.00 Emergency and Supplemental Medication Supplies
PHARM 02.05.00 Investigational Drugs Policy

Revised: 08/02/12, 15/05/12, 17/07/11, 19/03/12 (Year/Month/Day)
Original adoption: 07/10/20

MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center shall implement procedures to safely manage the care of residents identified to be at risk for aspiration.

2. The facility recognizes the resident's or designated surrogate decision maker's right to make an informed decision where the resident's enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration.

PURPOSE:

To promote resident safety and enhance resident quality of life with respect to diet and feeding interventions.

DEFINITIONS:

1. Line of Sight – resident is within view of staff while eating.

2. Close Supervision – one staff sitting with no more than 4 residents during mealtime. Staff shall ensure that recommended aspiration precautions (e.g., standard precautions or individualized precautions recommended by speech therapy and ordered by the physician) are followed by actively cueing, assisting, and/or observing the resident during ~~meal time~~mealtime.

3. 1:1 – resident needs direct assistance or supervision during oral intake (e.g., impulsive eating behaviors, cues needed, unable to feed self, level of risk for aspiration).

PROCEDURE:

1. Identification of At-Risk Residents

a. Residents shall be evaluated by the Resident Care Team (RCT) and identified as being at risk for aspiration if they have clinical signs of swallowing difficulty/aspiration, demonstrate unsafe eating behaviors or have other conditions that place them at risk (e.g., reduced alertness, need to be fed in a reclined position, partially or completely edentulous with no dentures). At a minimum, the RCT includes a physician and a nurse.

b. If the resident is partially or completely edentulous with no dentures:

   i. The RCT shall assess if the prescribed diet is deemed safe;

ii. The physician shall order a dysphagia evaluation if the residents' ability to safely swallow the prescribed diet is in question.

iii. The registered dietitian shall assess the residents' ability to tolerate the prescribed diet

iv. The physician shall document discussion regarding aspiration risk if the resident is prescribed a diet other than pureed and;

v. The physician shall refer the resident to the dental clinic unless there is documented reason by the physician that the referral is not necessary.

c. Once a resident has been identified as being at risk for aspiration, Nursing shall place a pink dot at the head of the resident's bed and give the resident a pink sticker on their wristband. Staff and volunteers shall be trained on this color coding system and what it means.

d. Residents who are assessed to be at risk for aspiration, excluding those who are unable to eat by mouth (also known as NPO), shall be identified and have a physician's order for standard aspiration precautions, which include the following:

i. Line of sight supervision when eating, unless documented otherwise in the Medical Record.

ii. Resident shall be positioned as upright as possible when eating/drinking, and the resident's head prevented from tilting back, as possible.

iii. Resident shall be fed/cued to eat slowly, taking small bites.

iv. When feeding a resident, make sure that the resident swallows each bite before continuing feeding.

v. Resident shall remain upright for 20 minutes after a meal.

2. Indications for Referral to Speech Pathology for a Dysphagia Evaluation

a. Residents who fall into one or more of the following categories shall be referred, by physician's order, to the Speech Pathology Department for a dysphagia evaluation:

i. Those admitted with a known swallowing disorder, or history that is suspicious for dysphagia (unless NPO and not a candidate for oral feeding).

ii. As described under Procedure 1 b (ii).

iii. Those who have clinical signs of dysphagia or aspiration and are candidates for ongoing oral feeding. Indications for referral to Speech Pathology include, but are not limited to, the following: coughing, choking, holding food in mouth, significant pocketing of food, significantly delayed swallow, significant leakage of food or liquid from mouth, food or liquid coming from tracheostomy, and/or recurrent pneumonias. If in doubt about whether or not a referral is indicated, contact the Speech Pathology Department.

iv. Alert residents who are being considered for enteral feeding, unless clinically inappropriate (Refer to LHHPP 26-03, Enteral Tube Nutrition), and those on enteral feeding whose clinical condition has improved sufficiently that they may be candidates for oral feeding.

v. Residents with a known swallowing disorder or clinical signs of dysphagia and/or aspiration who are being considered for a diet upgrade. (If a decision to upgrade a resident's diet has already been made for quality of life reasons, referral is not necessary, but may be indicated in order for a Speech-Language Pathologist to provide training regarding reducing the risk of aspiration on the upgraded diet. All necessary documentation regarding a resident's or surrogate decision maker's understanding of risks vs. benefits of upgrading diet and agreement to accept risks must be in place prior to the Speech Pathologist's intervention).

b. Referral to the Speech Pathology Department may also be indicated in cases of unexplained weight loss, dehydration, and/or poor oral intake, in order to rule out dysphagia as a contributing factor.

c. Dysphagia evaluation is by physician order only. If the evaluation is considered clinically urgent, the physician shall mark the order "urgent" and call the Speech Pathology Department.

d. RCT members shall alert the physician when signs of dysphagia, aspiration, or change in swallowing function are observed.

3. Dysphagia Evaluation

a. Dysphagia evaluations shall be carried out by a Rehabilitation Center Policy and Procedure #90-05, Establishment of Treatment Programs and Documentation: Dysphagia.

b. Evaluation of Residents for Upgraded Food/Liquid Consistencies

When a dysphagia evaluation involves upgraded food or liquid consistencies not currently included in the resident's diet order, the following Tray Precautions shall be taken:

i. The Speech Pathologist shall contact Nutrition Services and ask them to write "Hold for Speech Therapy" on the tray ticket.

ii. The Speech Pathologist shall notify Nursing and request that the tray not be served until the Speech Pathologist arrives.

iii. Nursing staff shall hold the tray for Speech Pathology and shall not give it to the resident.

iv. The Speech Pathologist is responsible for removing any food or liquid items not included in the resident's current diet order before leaving an unfinished tray with the resident upon completion of the session.

4. Treatment

a. Following a dysphagia evaluation, the Speech Pathologist shall proceed with swallowing therapy, when indicated.

b. If treatment involves upgraded food/liquid consistencies not currently included in the resident's diet order, follow Tray Precautions delineated in paragraph 3b i-iv, above.

5. Referral to Occupational Therapy

a. Occupational Therapy consultation shall be considered if positioning of the resident during feeding is difficult or body posture increases aspiration risk.

b. Occupational Therapy consultation requires a physician order and a referral form.

6. Management of Residents Who Are at Risk for Aspiration

a. Staff who are feeding or supervising residents designated to be at risk for aspiration are responsible for knowing and complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

b. Certified and Licensed nursing staff shall be provided with mealtime competency training by Nursing Education or designated trainers upon hire and annually. Facility personnel shall be trained on choking prevention and intervention upon hire and annually.

c. A sign directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident is located in the Pavilion Lobby and designated areas.

d. Nursing is responsible for ensuring that family members and regular visitors who assist residents with their meals have been trained. If a family or volunteer needs

additional training regarding feeding techniques, nursing may recommend referral to Speech Pathology. Staff shall document family or volunteer training in the medical record and resident care plan, including the date of training.

e. Residents with a pink sticker on their wristbands shall not be given or sold food/liquid by anyone who is not aware of the resident's feeding needs.

f. Diet texture modifications (including thickened liquid) or enteral feeding, may be ordered to reduce the risk of aspiration. These interventions may be suggested by the Speech Pathologist following a swallowing evaluation but shall be implemented only after careful resident assessment by the RCT and orders changed by the physician. Diet texture modification for purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality of life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).

g. For residents whose nutrition is via enteral tube, Nurses shall follow interventions to reduce aspiration risk as per Nursing policies and procedures (Refer to NPP E5.0 Enteral Tube Feeding Management).

Individualized Aspiration Precautions

a. Individualized (vs. standard) aspiration precautions may be developed by the Speech Pathologist following a swallowing evaluation; Examples include:

   i. Close supervision when eating and drinking

   ii. Provide cues/assist for unsafe eating behaviors

   iii. Thin down thick food

   iv. Small sips of liquid

   v. Alternate liquids and solids

   vi. Do not use straw

   vii. Cut food into small pieces

   viii. Cue resident to tuck chin

   ix. Cue or remind resident to swallow twice

   x. Cue to swallow food/liquid before taking the next bite/sip

b. The Speech Pathologist shall review recommended individual precautions with Nursing staff and provide training, as needed.

c. The Speech Pathologist shall list any recommended precautions in the Speech Therapy Dysphagia evaluation and/or treatment notes ~~-~~and notify the diet office regarding specific precautions to be printed on the resident's meal ticket.

d. The physician shall include standard aspiration precautions and/or specific precautions as part of the diet order. ~~Nursing shall include this information when communicating the diet order to Nutrition Services.~~

e.

~~e.~~f. Nutrition Services shall print the list of individualized precautions recommended by speech therapy on the meal ticket, providing an easy reference for caretakers.

~~f.~~g. Residents with individualized precautions, whose swallow function appears to have improved or declined, shall be referred to Speech Pathology for re-evaluation and updating of precautions, as needed. When a ~~reevaluation~~reevaluation is not indicated and Speech Pathology is no longer treating or routinely re-checking the resident, the Speech Pathologist may be invited to attend RCT meetings for that resident with individualized aspiration precautions.

8. Follow-Up

a. The Speech Pathology Department is available to monitor any resident during a meal who has been seen for a dysphagia evaluation, is on the diet recommended by Speech Pathology, and has not had any change in condition. The request may be made by any member of the RCT. No physician's order is required. The Department shall be contacted directly by phone. A physician’s order for a re-evaluation is required for patients whose diet was either upgraded or downgraded without the involvement of the Speech Pathology Department, when there has been a change in condition, or when re-evaluation for diet upgrade is being requested.

b. When an order with aspiration precautions is discontinued without the involvement of the Speech Pathology Department, the reason(s) shall be documented in the medical record by the physician and licensed nurse. The Diet office shall also be notified in order to delete the information from the tray ticket.

9. Documentation on Informed Decision

a. When the resident or surrogate decision maker chooses to accept the risks of a diet upgrade, or not to accept the recommendation/benefits of a therapeutic diet and feeding interventions, documentation of discussion regarding informed decision shall be reflected in the Resident Care Conference meeting notes, advance directives, and the resident care plan.

b. The resident care plan shall include care plan approaches for minimizing the risk of aspiration.

10. Others

a. Regardless of the code status, residents shall be provided with rescue interventions in the case of choking or aspiration events.

b. The Medical Examiner shall be contacted by the physician in the case of choking or an aspiration event that leads to death.

ATTACHMENT:
None

REFERENCE:
LHHPP 24-05 Advance Care Planning
LHHPP 24-10 Close Observation
LHHPP 26-03 Enteral Tube Nutrition
LHHPP 26-04 Resident Dining Services
MSPP C01-04 Death Which Must Be Reported to the Medical Examiner-Coroner
NPP A3.0 Nursing Education Programs
NPP B5.0 Color Codes- Resident Identification
NPP E1.0 Oral Management of Nutritional Needs
Rehabilitation Center P&P 90-05 Establishment of Treatment Programs and Documentation: Dysphagia

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18, 08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12, 17/07/11, 19/03/12, 21/09/14, 22/07/14 (Year/Month/Day)
Original adoption: 98/04/01

ENTERAL TUBE NUTRITION

POLICY:

1. Enteral tube nutrition (ETN) is a form of medical therapy that is to be instituted only after careful resident assessment and if clinically indicated as necessary by the Resident Care Team (RCT). It requires monitoring to assure adequacy and appropriateness.

2. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide treatment and services to residents receiving ETN, to prevent potential complications with enteral feeding and when possible, to restore oral feeding skills.

PURPOSE:

To promote and maintain optimal care of residents with decreased oral intake and for whom ETN is deemed appropriate. ETN may be appropriate when medical problems, including nutritional, clinical, functional, psychosocial and comfort status, result in decreased oral intake. However, decreased oral intake is a common feature of many terminal illnesses. ETN may not be indicated in cases where the burdens of the intervention outweigh the benefits to the resident.

DEFINITION:

“Enteral feeding”: (tube feeding) is the delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum.

“Feeding tube”: a medical device used to provide liquid nourishment, fluids and medications by bypassing oral intake. There are two basic categories: naso-gastric and gastrostomy. The type of feeding tube used must be based on clinical assessment and needs of the resident.

PROCEDURE:

1. Assessment and Decision Making Process

a. Initial evaluation: When the RCT has completed an evaluation, which may lead to placement of an enteral tube, a formal dysphagia evaluation is recommended for all alert residents unless clinically inappropriate or performed prior to admission. The evaluation shall be repeated when the resident's clinical condition improves.

   i. Should a resident have had a feeding tube prior to admission/ in another care setting, the RCT shall review the basis for the initial placement of the tube and the resident’s current condition to determine if tube feeding remains necessary.

b. Initiation: ETN shall be initiated only on written orders of the primary attending physician or designee, and only after informed consent has been obtained from the resident or surrogate decision maker (SDM).

   i. Family consult: The attending physician shall evaluate the prognosis for the individual resident and consider the expressed desires of either the resident or the resident's surrogate decision maker prior to beginning enteral tube nutrition. The decision to insert an enteral tube shall be made after consultation with the resident and/or family and the RCT members, and only after carefully reviewing risks, benefits, and other alternatives. Any advance directives should be carefully reviewed. If it is decided not to begin ETN in a resident for whom other feeding alternatives are not possible, comfort care and palliative interventions shall be considered and provided as appropriate.

   ii. Informed consent: Informed consent for enteral tube insertion shall be obtained from the resident or surrogate decision-maker in accordance with hospital policy (Refer to MSPP C02-01 Patient's Consent for Treatment and Operation). If the resident has no surrogate decision maker, the physician must promptly notify the resident, orally and in writing, of such determination. In instances where the resident is comatose or in a minimally conscious state, notification is not clinically appropriate, but the physician must document his/her determination and shall notify the resident promptly if the resident's condition changes (LHHPP 29-08 Unrepresented Residents Lacking Decisional Capacity and Epple Procedure Implementation).

c. Time-limited trials: When the potential benefits and burdens of enteral tube insertion are unclear, a time-limited trial may be ordered. After a predetermined time, caregivers and the resident and/or family should reassess the response to the therapy, including nutritional parameters, resident well-being, comfort and quality of life. An informed decision may then be made as to whether to continue with the therapy.

   i. There are possible side-effects and discomfort associated with the use of nasogastric tubes. There will be clinically pertinent documentation for extended use of nasogastric tube (e.g., greater than 4-6 weeks).

d. Withdrawal: The resident or surrogate decision-maker (SDM) may request withdrawal of an enteral feeding tube at any time. When withdrawal is not requested by the resident or SDM, or when a resident lacks medical decision making capacity and has no surrogate, consideration of withdrawal of ETN shall follow LHHPP 24-05 Advance Care Planning and LHHPP 29-10 Non-Beneficial Treatment.

2. Care and Management

a. Refer to Nursing Policy and Procedure E5.0 Enteral Tube Feeding Management for the care and management of the resident with a feeding tube.

b. LHH shall strive to prevent possible social isolation or negative psychosocial impacts for residents being fed by a feeding tube.

c. Facilities shall maintain enteral feeding pumps consistent with manufacturer's instructions to ensure proper mechanical functioning and calibration.

3. Replacement of a Dislodged Feeding Tube

a. A dislodged nasogastric tube shall be replaced by the licensed nurse, unless the physician orders state otherwise. Verification of tube placement by X-ray shall be obtained each time that a nasogastric tube is placed or replaced.

b. A dislodged gastrostomy or jejunostomy tube that is less than 6 weeks old shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.

c. A dislodged gastrostomy tube that is 6 weeks or more may be replaced by the registered nurse who has demonstrated knowledge and skill, unless the physician orders state otherwise. A gastrografin study shall be ordered by the physician to confirm tube placement. The physician shall verify results of the radiology study before resuming orders for ETN.

   If there is question about placement of the gastrostomy tube, or if the registered nurse is unable to replace the gastrostomy tube, the physician shall order the transfer of the resident to Interventional Radiology or the Emergency Room for gastrostomy tube re-insertion. There shall be direct communication between the Laguna Honda physician and the radiologist or the Emergency Room physician confirming correct placement of the tube before resuming orders for ETN.

d. A dislodged jejunostomy tube shall be replaced by Interventional Radiology or the gastroenterologist. The registered nurse can place a foley or gastrostomy tube to keep the tract open until the resident is able to be scheduled for the procedure.

4. Monitoring

a. Monitoring of side-effects: Residents should be monitored for problems with ETN. These may include chronic nasopharyngeal irritation, repeated tube removals and resistance to reinsertion, immobilization due to application of restraints, diarrhea, recurrent reflux and aspiration of gastric contents. If the side effects of the therapy are substantial, the physician should reevaluate the appropriateness of the enteral tube in consultation with the resident or the surrogate decision-maker and the RCT.

b. Monthly review: In reviewing monthly orders on residents receiving ETN, the attending physician should review the efficacy of the therapy. This should include a review of the resident's general medical and functional status as well as the resident's weight and nutritional intake. Resident well-being, comfort, dignity and quality of life should be evaluated on an ongoing basis. In addition, the attending physician should review the side effects and response to therapy as outlined above.

c. Periodic reevaluation: As part of the quarterly resident care conferences (RCC), the attending physician in concert with the other RCT members and the resident/family should reevaluate the goals of the enteral tube nutrition. The previous assessments should be considered as well as any change in the resident's condition or prognosis. Options of ongoing enteral tube nutrition, surgical tube placement or palliative care without enteral tube nutrition should be considered. It may be appropriate to consult the Ethics Committee at this time if it is decided to discontinue this therapy.

d. Nutrition reevaluation: The dietitian makes interval assessments of residents on enteral tube nutrition and provides suggestions for changes in nutritional therapy if necessary. During the quarterly RCC, the RCT shall review the nutritional plan and the dietitian's documentation in the EHR for residents receiving ETN.

e. Interaction with medications: Certain medications (e.g., phenytoin) may be affected by enteral nutrition, and others (e.g., extended-release tablet and capsule formulations) should not be crushed or otherwise altered for enteral tube administration. For specific recommendations on medications known to be affected by enteral nutrition, and those with formulations that should not be altered, refer to the Nursing Policy and Procedures or consult the Clinical Pharmacist.

5. Documentation

a. Clinical documentation shall at a minimum include the following elements:

i. Physician – completed physician order that shall include indication(s) for tube feeding, diagnosis and functional impairment(s).

- Should the use of a nasogastric tube be extended, the physician shall document clinically pertinent information and rationale.

ii. Registered Dietitian – assessment of caloric needs, nutritional requirements that includes feeding flow rate and type of formula.

iii. Nursing – technical and nutritional aspect of feeding tubes (e.g. tube size, location, feeding flow rate, care of tube site and replacement) shall be documented in the nursing flowsheet in the EHR; interventions for

management of ETN and to minimize the risk of complications related to feeding shall be documented in care plan in the EHR.

iv. Speech Therapist – evaluation to restore normal eating skills to the extent possible.

b. Each discipline (Physician, Registered Dietitian and Nursing) shall evaluate resident's response to treatment and interventions in their progress notes at least quarterly.

6. Quality Assurance and Performance Improvement

a. An Unusual Occurrence (UO) report shall be completed by the licensed nurse when a resident is identified with a tube feeding complication. Examples of complications requiring the submission of a UO report include:

i. Clogged tube

ii. Dislodgement of tube

iii. Aspiration

iv. Leakage around the insertion site

v. Erosion at the insertion site

vi. Abdominal wall abscess

vii. Stomach or intestinal perforation

viii. Peritonitis

ix. Tracheoesophageal fistula

x. Inadequate nutrition

xi. Metabolic complication

b. The Performance Improvement and Patient Safety Committee shall periodically review UO reports and case reviews to determine trends and patterns, and provide feedback on compliance issues with existing policies and procedures, and possible clinical and other interventions for performance improvement in clinical care.

ATTACHMENT:
None.

REFERENCE:

Clinical Nutrition Department Policy and Procedure 1.16 Nutrition Screening and Assessment ~~– Charting in the Medical Record – MDS/CAA~~Documentation in the Electronic Health Record (EHR)
LHHPP 24-05 Advance Care Planning
LHHPP 29-08 Unrepresented Residents Lacking Decisional Capacity and Epple Procedure Implementation
LHHPP 29-10 Non-Beneficial Treatment
MSPP C02-01 Patient's Consent for Treatment and Operation
NPP E5.0 Enteral Tube Feeding Management

Revised: 98/11/16; 00/04/27, 13/05/28, 13/09/24, 17/09/12, 18/07/10, 19/03/12, 19/05/14, 21/09/14 (Year/Month/Day)
Original adoption: 96/09/16

RESIDENT DINING SERVICE

POLICY:

1. Staff shall encourage residents to dine in the common dining area to promote social dining for all meals unless resident prefers otherwise.

2. Staff shall encourage residents who are not on an oral diet to be grouped together in the common dining area to prevent social isolation.

3. Avoid scheduling staff meal breaks during resident meal periods so that all available staff assists with resident meals.

4. Efforts will be made so that resident appointments within Laguna Honda Hospital and Rehabilitation Center (LHH) will be scheduled outside of resident mealtimes.

PURPOSE:

To describe LHH process of providing an enjoyable dining experience for the resident.

PROCEDURE:

1. Food and Nutrition services (FNS) PM dinner meal staff will post the next days 'Daily Menu' in the Great Room sign holder.

~~1. Diet Office provides a hard copy of the weekly menu for each individual neighborhood via interoffice mail and posts the resident menus on the home page of LagunaNet which can be printed for use. The unit clerk or designated staff shall post the hard copy or print out the two week menu and place the menu in a designated area.~~

2. Nursing Staff will check the meal against the meal ticket diet order and positively match with the correct resident using positive identification.

3. Neighborhood staff will assist the resident as appropriate with the meal. Only trained caregivers may assist in feeding those with individualized aspiration precautions (vs. standard aspiration precautions). All others will assist at the direction of licensed staff. Residents with individualized precautions, as noted on the menu ticket, will be served using a specified colored plate cover.

4. Nursing staff will document meal intake in the EHR for each resident at the end of the shift.

5. If a resident is not available for the meal, alternative meal arrangements will be made.

6. The Nursing Staff will return all dishes, plates, and so forth to the meal cart located in the ~~dining~~ great room. Food service worker will pick up the meal cart. All trays that did not make it to the meal cart shall be place on the rolling shelf inside the galley.

7. Nursing staff will wipe tables using approved disinfectant. Environmental Services (EVS) staff will sweep and mop the dining room and the great room floor as needed. EVS will clean and sanitize around the exterior of the ice machine located in the Great Room.

8. The FNS staff clean the galley and the coffee dispensers located in the great room. The cleaning and sanitizing will be done once a day using the 3-bucket method. (*Reference to Nutrition services Policy & Procedure 1.91 General cleaning and Sanitizing Work Surfaces and Kitchen or Galley Equipment)*~~Once a day the food service worker will clean and sanitize the Galley using the three bucket method which includes the coffee dispensers located in the Great Room~~.

9. Anyone who uses the Galley must clean and sanitize after each use.

10. Special feeding devices and other personal items will be cleaned by the nursing staff and stored at the resident's bedside.

11. Food and beverages stored in the galley are for resident use only.

~~12. Accuracy of the meal tray tickets that come with the tray and the prescribed resident diet order shall be verified through the EHR~~

~~13.~~12. Infection Control in Dining Service:

   a. Staff must wash their hands:

      i. Before and after wearing gloves.

      ii. Before and after serving meals.

      iii. When changing tasks.

      iv. When they are visibly soiled or contaminated.

   b. Gloves are not required for serving of meals provided the server has washed their hands with soap and water prior to proceeding.

   c. ~~Staff must wear proper hair covering whenever they enter the Galley Area to serve or prepare food such as when making a sandwich or dishing up cold or hot food items.~~

ATTACHMENT:
None.

REFERENCE:
~~None~~.P & P 1.91 General cleaning and sanitizing work surfaces and kitchen or galley equipment

Revised: 16/03/08, 19/03/12, 21/09/14 ,22/11/04 (Year, Month, Day)
Original adoption: 10/11/10,

MEAL TRAY SERVICE GALLEY SANITATION

POLICY:

Neighborhood Galley dishwashers may be used to clean, wash and sanitize meal trays and dishware according to established procedures.

PURPOSE:

To properly sanitize resident's meals trays in the Galley for proper ware washing when necessary and maintain food service operations for resident meals.

PROCEDURE:

1. Neighborhood staff shall return soiled meal trays to the tray cart. If tray cart is no longer on the unit, staff shall return remaining soiled meal trays to the Galley ~~in the trolley~~ for proper ware washing by the Food Service Worker.

~~2.~~ Prior to the ware washing process, the Food Service Worker shall record the dishwasher machine temperatures to ensure that it is operating within standards (Temperatures: Wash: 150F – 170 F; Final Rinse: 180F-195F; Pressure: 20-30). The chemicals used in the Galley ~~include:~~ are all department approved for washing, rinsing and sanitizing process. All the untensils are air dryed.

   a. ~~Ecotemp Ultra Dry~~
      ~~3.~~
   b. ~~Solid Power Plus~~
      ~~4.~~
   c. ~~Smart Power~~
      ~~5.~~
   d. ~~Liquid Assure~~
   ~~d.~~e.

~~6.~~2. The Food Service Worker shall wash and sanitize all meal trays and dishware, mugs and silverware through the dishwasher machine located inside the Neighborhood Galley.

~~7.~~3. The Food Service Worker will use the three-bucket cleaning procedure for the following:

   a. The delivery carts

   b. The work counters

   c. The dishwasher machine

(Reference to Nutrition Services Policy & Procedures: 1.91 General Cleaning and Sanitizing Work Surfaces and Kitchen or Galley Equipment)

~~8.~~4. All cleaned and sanitized ware shall be brought back to the Tray Service Area ~~in the Main Kitchen by the Food Service Worker before~~ for the next meal service.

~~9.~~5. The Food Service Worker will sweep and mop galley floors at the end of each ware washing process.

~~10.~~6. The Food Service Worker is responsible for locking and securing the Galley at end of the ware washing process.

~~11.~~7. A Food and Nutrition Services Porter will dispose of compost, recycle and garbage.

~~12.~~8. The Food Service Supervisor and Team leaders are responsible for monitoring the Galleys for sanitation compliance.

ATTACHMENT:
None.

REFERENCE:
Nutrition Services Department Policy & Procedures: 1.91 General Cleaning and Sanitizing Work Surfaces and Kitchen or Galley Equipment

Revised: 17/09/12, 21/09/14, 22/11/04 ~~-~~(Year/Month/Day)
Original adoption: 15/03/10

AUTHORITY OF INFECTION CONTROL COMMITTEE

POLICY:

1. The Infection Control Committee (ICC) is an interdisciplinary ~~medical staff~~ committee responsible for the oversight of Laguna Honda Hospital's infection prevention and control (IPC) program and activities. Infection control policies and procedures, and clinical care guidelines shall be approved by the ICC medical staff prior to implementation.

PURPOSE:

1. The purpose of the ICC committee is to:

    a. Develop and monitor policies, procedures, and practices which promote consistent adherence to evidence-based IPC practices.

    b. Provide IPC program oversight that includes planning, organizing, implementing, operating, monitoring, and maintaining all the elements of an effective IPC program.

    c. Provide oversight and guidance to the IPC team to implement evidence-based practices ~~to prevent the transmission of disease~~ within the facility in accordance with the local regulators including San Francisco Department of Health (SFDPH), the state regulators of California Department of Public Health (CDPH) and national regulations including Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid (CMS) guidelines and recommendations~~.~~ to prevent the transmission of disease.

DEFINITIONS:

1. **Healthcare-associated infection (HAI):** Infections that occur while receiving care in any healthcare setting, including in the long-term care or skilled nursing facility environment.
2. **Community-associated infection (CAI)**: Infections that initially occur outside of a healthcare setting ~~and in~~but may be transmitted to patients from others with whom the ~~case of long-term care~~patient may come into contact with including staff, visitors, contractors, volunteers, or ~~skilled nursing facility environment, an infection that occurs from a transferring facility.~~others
- **Environmental Protection Agency (EPA)**: An independent Executive agency of the United States federal government ~~that oversees~~tasked with environmental protection matters. Including the manufacturing, processing, distribution, and use of chemicals in the environment.

PROCEDURE:

1. Composition of the ICC

The ICC consists of the following interdisciplinary team members, as described in the Medical Staff Bylaws, who shall have duties as infection control officers for their respective departments:

a. At least two physician members of the active Medical Staff will be appointed on an annual basis by the Chief of Staff, one of whom will be appointed as Chair and one Vice-Chair of the committee. Additional representatives may include:

b. Director of Quality Management

c. Infection Control Nurse

d. A representative from Central Processing Department

e. An administrative representative appointed by the Executive Administrator

f. A representative from Nursing Services appointed by the Chief Nursing Officer

g. A Pharmacist appointed by the Director of Pharmacy

~~h.~~ A representative from Environmental Services appointed by ~~the~~a member of senior leadership (C-suite) ~~Chief Operating Officer~~

i. A Director of Nutrition Services or designee

j. A Respiratory Therapy Supervisor or designee

k. Other department representatives or consultants deemed advisable by the Chief of Staff

2. Functions of the ICC

a. To develop and recommend to the Medical Executive Committee (MEC) written standards ~~for hospital sanitization and medical asepsis. These~~based on evidence-based infection control standards to prevent, reduce or eliminate to the extent possible, the transmission of disease across every department. Such standards shall include a definition of infection outbreaks for the purpose of surveillance, as well as specification indications of the need for, and the procedures to be used ~~in, isolation following CDC guidance.~~to reduce transmission of disease within the facility including personal protective equipment (PPE), isolation and quarantine procedures in accordance with federal, state, and local guidelines.

b. To be responsible for quality improvement in developing, evaluating, and revising the procedures and techniques for meeting established sanitation and asepsis

standards, including the routine evaluation of materials used in the hospital's sanitation program. The evaluation may be based upon data supplied from evidence-based sources or upon in-use tests performed within the hospital.

c. To develop a surveillance system for infection prevention measures to identify early clusters, outbreaks, and trends for the purpose of reducing the transfer of infectious diseases to others through appropriate isolation, treatment, and environmental controls. The ICC will identify potential sources, develop monitoring systems and work with other departments to reduce the spread of disease.
d. To develop and monitor infection control policies based on current best practices and guided by the CDC and CMS in cooperation with the MEC, for antibiotic resistant bacteria, influenza, and tuberculosis.
e.
~~e.~~f. Guide staff education related to current infection control issues.

~~f.~~g. To guide quality improvement activities related to the appropriate use of antibiotics. The ICC will provide a summary of the findings of these activities at least quarterly to the Medical Quality Improvement Committee that will be used to guide future practices.

~~g.~~h. To report at least quarterly to the MEC on activities and findings.

~~h.~~i. To request a specific review of individual medical staff practices through the Chief of Staff, as appropriate.

3. Scope of the IPC Program

a. Surveillance for infection clusters and/or outbreaks based on standardized skilled nursing criteria ~~including McGeer criteria and~~using NHSN (National Healthcare Safety Network) criteria.

b. Data analysis including collection and dissemination to appropriate committees and disciplinary teams.

c. Reporting internally to appropriate committees and disciplinary teams and externally to local and state health departments as required.

d. Implementation of ICP interventions and education and communication to management, staff, residents, and visitors as needed.

e. ~~Environmental~~Consult with and provide oversight for all departments regarding cleaning and disinfection using EPA approved products and guidelines.

f. ~~Immunization~~Provide expertise for policies and guidance for immunization of staff and residents including but not limited to ~~tuberculosis,~~ influenza, and other emerging healthcare concerns.

g. To liaison with the local and state health departments for reporting outbreaks and other reportable concerns and to provide guidance for tuberculosis (TB) testing, reporting and follow up of patients and staff as required by local, state and federal agencies.

~~g.~~h. Policy and procedure creation and annual review of infection control policies.

~~h.~~i. Outbreak investigation in accordance with local city and state health departments as required.

~~i.~~j. ~~Consultation~~Provide consultation services for antibiotic stewardship program, disaster planning, and other services related to IPC and hospital-wide projects including but not limited to admissions, hospital readmissions, construction/renovation for safe practices, and emergency drills.

ATTACHMENT:
None.

REFERENCE:
Medical Staff Bylaws
Haque, M., Sartelli, M., McKimm, J., & Abu Bakar, M. (2018). Health care-associated infections - an overview. *Infection and drug resistance*, *11*, 2321–2333. https://doi.org/10.2147/IDR.S177247
Association for Professionals in Infection Control & Epidemiology (APIC). (2013). *Infection Preventionist's Guide to Long-Term Care*. Washington DC, WA: Association for Professionals in Infection Control & Epidemiology.

Revised: 15/03/10, 20/08/16, 20/10/13 22/10/17, 22/10/17(Year/Month/Day)
Original adoption: 05/11/01

HAND HYGIENE

POLICY:

~~1.~~ It is the policy of this facility to adhere to the infection prevention and control (IPC) practices for hand hygiene as established by the Centers for Disease Control & Prevention (CDC) to prevent the transmission of disease-causing illnesses to others. Gloves are not intended to be a replacement for proper hand hygiene. Hand hygiene will be performed at a minimum:
~~2. Gloves are not a replacement for proper hand hygiene.~~

- Prior to beginning work shift
- Before eating
- After using the bathroom
- After sneezing/coughing/tissue use
- Before donning/doffing personal protection equipment (PPE)
    - PPE includes: gloves, gown, mask, face/eye shield

Before and after providing direct resident contact

- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
- Before moving from work on a soiled body site to a clean body site on the same patient
- After contact with blood, body fluids, or contaminated surfaces
- After touching a patient or the patient's immediate environment
- When hands are visibly soiled

PURPOSE:

The purpose of this policy is to provide information regarding hand hygiene practices and to guide staff in the use of proper hand hygiene standards at LHH. Proper hand hygiene has been identified as the single most important factor in reducing the transfer of infectious disease to others. Cross contamination and transfer of infectious organisms to from one person to another causing disease is well documented. Proper hand hygiene also includes proper drying of hands to avoid wet /damp hands during care which has been shown to increase the transfer of disease-causing microbes greater than a thousand times more than dry hands (MMWR, 2003).

PROCEDURE:

Hand Hygiene is the term used for thoroughly cleaning your hands by using either the soap and water technique for handwashing, using an antiseptic hand wash or antiseptic hand rub or gel (i.e. alcohol-based hand sanitizer [ABHR] including foam or gel), or by using the techniques for surgical hand antisepsis (CDC, 2021)

1. In the clinical setting, hand sanitizers~~,~~ must contain between 60%-95% isopropanol or ethanol alcohol ~~only~~ to be effective at reducing infectious

organisms.

2. Centers for Disease Control and Prevention (CDC) recommend ABHR as a primary means of hand hygiene because it is faster, usually contains emollients to prevent dried, cracked (non-intact) skin, and is likely to be used more frequently than soap and water. Soap and water must be used instead of ABHR for hand hygiene when:

~~3. Soap and water must be used instead of ABHR for hand hygiene when:~~

~~a.~~• Caring for residents with *C. diff*, norovirus, potentially infectious diarrheal diseases, or other spore-forming organisms that do not respond to ABHR.

~~b.~~• When hands are visibly soiled.

~~4. Hand hygiene will be performed:~~

~~a. Prior to beginning work shift~~

~~b. Before and after providing direct resident contact~~

~~c. Before eating~~

~~d. After using the bathroom~~

~~e. After sneezing/coughing/tissue use~~

~~f. Before donning and after doffing personal protection equipment (PPE)~~

~~g. When hands are visibly soiled~~

~~5. Hand hygiene procedures:~~

~~a.~~ **Hand sanitizers/ABHR:**
~~Why it works: the~~
Mechanism of Action:

- The alcohol in hand sanitizers act to denature or destroy the proteins of the microorganism serving to inactivate their ability to cause disease

Procedure:

~~i.~~ Apply adequate product to the hands and rub hands and fingers together

~~ii.~~ . Cover all surfaces on both hands, front and back, and between digits

~~iii.~~• . Allow to air dry before donning gloves or providing care for others

~~b.~~ **Handwashing with soap and water:**

~~Why it works: soaps~~

Mechanism of Action:

- Soaps are detergent based and when combined with water form a soapy lather of bubbles. A good soapy lather forms pockets called micelles that trap and remove germs, harmful chemicals, and dirt from your hands.

Procedure:

~~i.~~• Roll up sleeves to expose skin above wrists

~~ii.~~• Turn on faucet and wet hands with running water

~~iii.~~• Use an adequate amount of liquid dispensed soap and thoroughly distribute over hands creating sudsing effect

~~iv.~~i. Vigorously rub hands together for at least 20 seconds, generating friction on all surfaces of the hands and fingers including the sides of the hands and fingers, between fingers, under fingernails, and around cuticles. Microbes are more prevalent on the tips of fingers and under the nails.

~~v.~~• Thoroughly rinse hands under running water without touching sink or faucet, holding hands downward to allow water to run off fingertips

~~vi.~~• Adequately use paper towels to dry all surfaces of the hands and wrists including between each finger space as moisture harbors bacteria and can cause skin breakdown to allow entrance of organisms. Wet hands transfer more microorganisms than do dry hands. Take enough time to dry hands thoroughly.

~~vii.~~• Using a paper towel, turn off faucet without touching surfaces of the sink or handles of faucet which are contaminated with disease causing organisms.

~~viii.~~• Discard the paper towel into a waste container

~~ix.~~ii. Use a clean paper towel to open door, if appropriate, and discard

~~6.~~2. Important Points for LHH; Liquid soaps are recommended over bar soap as bar soaps can collect disease causing microbes over time. Plain soap is effective for hand hygiene and antimicrobial soaps are not necessary as the goal is to capture the microorganisms in the soap, not destroy them. Liquid soap dispensers must be replaced when empty. Liquid soap should not be added (or “topped off”) to partially filled containers due to the potential for contamination and support of microbial growth.

~~7.~~3. Responsibility for monitoring staff hand hygiene compliance ~~lies with~~is a joint effort between the ~~department head~~Infection Control, the Department Head or supervisor

of each specific neighborhood or department.

Staff are responsible for complying with hand hygiene guidelines ~~and for encouraging resident to wash their hand after going to the bathroom, before meal, after sneezing and coughing and as needed.~~ Staff should report irritation, dermatitis or other skin weakening issues that may impact hand hygiene to their direct supervisor and infection control nurse for follow up and other options.

~~8.~~4. Hand lotion may be used to alleviate skin dryness associated with hand hygiene. Lotions are ~~staff's~~ personal items and should not be ~~kept out of~~stored in patient care areas.

~~9.~~5. Fingernails should be short enough to allow thorough cleaning and not cause glove tears. Artificial nails harbor bacteria, create wounds in fragile skin and do not conform to the LHH infection control protocol.

ATTACHMENT:
~~None.~~
CDC hand hygiene resources and the APIC guide to glove use

REFERENCE:
CDC ~~(2021).~~ Hand ~~hygiene~~Hygiene in ~~healthcare settings~~Healthcare Settings for ~~healthcare providers.~~ Healthcare Providers available at https://www.cdc.gov/handhygiene/providers/index.html

HICPAC and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force (2009). Guideline for Hand Hygiene in Health-Care Settings. MMWR (Morbidity and Mortality Weekly Report), Vol. 51, No. RR-16, October 2002 available at: https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

World Health Organization (2009). WHO Guidelines on Hand Hygiene in Health Care available at: http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf

~~MMWR (2002). CDC Morbidity and mortality weekly report. Guideline for hand hygiene in health-care settings. Vol 51/No. RR-16~~

Revised: 14/09/09, 15/09/08, 20/10/13~~,~~ 22/09/~~13~~30 (Year/Month/Day)
Original adoption: 05/11/01


TECHNIQUE MATTERS WHEN CLEANING YOUR HANDS
It only counts if you use the right amount, the right way.
Use enough alcohol-based hand sanitizer to cover all surfaces of your hands.
You might need more than one pump.
For alcohol-based hand sanitizer, your hands should stay wet for around 20 seconds if you used the right amount.
ALCOHOL-BASED HAND SANITIZER


Hands that look clean can still have icky germs!
1 Wet
2 Get Soap
SOAP
WASH YOUR HANDS!
3 Scrub
4 Rinse
5 Dry
www.cdc.gov/handwashing
CDC

ANTIBIOTIC STEWARDSHIP ~~GUIDELINES~~AND INFECTION CONTROL

POLICY:

~~IT IS THE POLICY OF LAGUNA HONDA HOSPITAL & REHABILITATION (LHH) TO PROVIDE AN~~

An integrated approach ~~to~~for the control of emerging antibiotic resistance~~. This~~ will be conducted through the antibiotic stewardship team ~~in accordance~~ with ~~the Centers for Medicare & Medicaid~~ongoing collaboration and cooperation of Medical Services ~~(CMS) and the Centers for Disease Control &~~, Pharmacy, Infection Prevention ~~(CDC) guidelines using the *The Core Elements of Antibiotic Stewardship for Nursing Homes* as the framework. LHH supports~~ and ~~adheres to the principles of antibiotic stewardship defined as a commitment to "optimize the treatment of infections while reducing the adverse events associated with antibiotic use." (CDC, 2015 The Core Elements).~~Control,(IPC) Infection Control Committee (ICC), and Pharmacy and Therapeutics Committee.

PURPOSE:

1. The purpose of the antibiotic stewardship program (ASP) is to provide oversight and guidance for appropriate use of antimicrobials, reduce empirically-prescribed antimicrobials that promote broad spectrum use, and to reduce the total number of antibiotic days. ~~Inappropriate and prolonged use of antibiotics have been shown to increase multi-drug resistant organisms (MDROs) and antibiotic associated diarrhea diseases including *Clostridioides difficile (C.diff)*. The Core Elements included in this guideline includes leadership, accountability, drug expertise, actions, tracking and reporting.~~

2. The role of the IPC (Infection Prevention and Control) in the antibiotic stewardship program is to support the ASP program providing expertise and consulting services for identification of knowledge and skill gaps for educational and compliance purposes, garnering support from front line staff and provide data for the antibiotic stewardship committee.

PROCEDURE:

~~**1. Provides for a Leadership Structure that supports The Core Elements by including the following processes:**~~

1. ~~To Communicate~~Provide healthcare associated infection data for the ASP proposals to garner for C-Suite support.
2. Assist ASP team members with data analysis and ~~message to staff, residents, family~~(data) presentation

~~a.~~3. Partnering with the responsible department, work to ensure the antibiogram is published timely and ~~clinicians~~ accessible to providers.

~~b. To Create a culture through messaging~~

~~c. To include owners and administration that support antibiotic stewardship with letters of support and communication to the facility community at large~~

~~2. Provide accountability for the antibiotic stewardship commitment by empowering medical directors, nursing directors and pharmacy directors to become actively engaged in meeting oversight, quality measure improvements and medication review.~~

~~a. In addition, the following will provide support to the antibiotic stewardship leadership as needed, and will be included in meetings (face-to-face or virtual) where applicable:~~

~~i. Infection control and prevention director/coordinator~~
~~ii. Consultant laboratories~~

~~iii. State and local health departments~~

4. ~~Provide~~Support management and staff to analyze ICP concerns, and help to mitigate IPC issues
5. Educate nursing services personnel in collaboration with department of education team (DET)
6. Assist with and develop educational material for providers and staff
7. Observe practice while rounding
8. Round with the teams to prevent inappropriate antibiotic use
9. Report HAI surveillance data and practice measures to the ASP team that may affect activities of the ASP (increasing drug resistant microorganisms, local outbreaks etc.)
10. Report and communicate health department outbreak data with the ASP team as appropriate

~~3.~~ Assist with the development of algorithms for **~~drug expertise when indicated, that may include:~~**

~~a. Consultant infectious disease physicians~~

~~b. Consultant pharmacists~~

~~c. Partnering with local hospital experts including Zuckerberg San Francisco General – ZSFG~~

~~d. Develop other community relationships as indicated~~ordering antibiotics, order sets for ~~expertise in specific areas~~

~~4. Take action through the following initiatives, included but not limited~~clinical staff, or order entry criteria to~~:~~

~~a. Develop specific policies that support optimal antibiotic use~~

~~b.~~11. ~~Develop broad interventions to improve~~ decrease antibiotic use ~~including but not limited to:~~

~~i. A planned review "antibiotic time-out" for all antibiotics prescribed for evaluation of clinical signs and symptoms~~

~~ii. Identify clinical situations where antibiotic use is inappropriate (asymptomatic bacteruria, urinary tract prophylaxis, for example) and develop processes for improvement~~

~~iii. Develop policies for empirical use of antibiotics working in coordination with medical staff~~

~~**5. Provide for a method of tracking and reporting antibiotic use and outcomes**~~

~~a. Tracking how often and why antibiotics are ordered~~

~~b. Tracking how many antibiotics are used~~

~~c. Tracking adverse events and cost associated with specific antibiotics including those through the NHSN reporting system~~

~~**6. Provide education for the antibiotic stewardship process with a goal of reduction in the number of inappropriate antibiotic use including but not limited to:**~~

~~a. Clinicians~~

~~b. Nursing staff~~

~~c. Residents~~
~~d. Families~~

~~**7. An approved antibiotic formulary has been developed and is in use at LHH. Please refer to the UCSF/ZSFG/LHH Lexicomp® e-Formulary for details here:**~~

~~http://www.crlonline.com/lco/action/home/switch~~

~~**8. Treatment guidelines for empirical therapy and treatment of common bacterial infections have been developed by UCSF/ZFG/VASF and are in use at LHH. Please refer to the Joint UCSF/ZSFG/VASF Infectious Diseases Management Program (IDMP) website here:**~~

~~http://idmp.ucsf.edu/guidelines-empiric-antimicrobial-therapy~~

~~**9.** Emergence of antibiotic resistance in LHH is monitored prospectively through ongoing infection prevention and control surveillance and adoption of antimicrobial~~

~~management policies and procedures described in LHHPP 25-07 Antimicrobial Stewardship Program.~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-07 Antimicrobial Stewardship Program
UCSF/ZSFG/LHH Lexicomp® e-Formulary available at:
http://www.crlonline.com/lco/action/home/switch
Joint UCSF/ZSFG/VASF Infectious Diseases Management Program (IDMP) available at:
https://idmp.ucsf.edu/guidelines-empiric-antimicrobial-therapy

~~CDC (2015). The Core Elements of Antibiotic Stewardship for Nursing Homes. Atlanta, GA: US Department of Health and Human Services, CDC; 2015. Available at: **http://www.cdc.gov/longtermcare/index.html**~~

Manning, M. L., & Pogorzelska-Maziarz, M. (2018). Health care system leaders' perspectives on infection preventionist and registered nurse engagement in antibiotic stewardship. *American journal of infection control*, *46*(5), 498–502. https://doi.org/10.1016/j.ajic.2017.10.024

Perri, L. (2017). The infection preventionist's role in antimicrobial stewardship programs. Infection Control Today. Retrieved October 17, 2022 from https://www.infectioncontroltoday.com/view/infection-preventionists-role-antimicrobial-stewardship-programs

Revised: 16/01/12, 18/11/13, 20/10/13, 22/~~09/13~~10/17 (Year/Month/Day)
Original adoption: 05/11/01

INFECTION CONTROL POST-MORTEM CARE GUIDELINES

POLICY:

Laguna Honda Hospital (LHH) will adhere to post-mortem care guidelines in accordance with Standard Precautions and transmission-based precautions as appropriate to minimize the transmission of infectious pathogens.

Any specific specimens required during post-mortem care for decedents that are diagnosed with a suspected or confirmed infectious disease will be obtained at the mortuary or by trained professionals.

PURPOSE:

Post-mortem care is provided for the purpose of preparing the decedent's body for a dignified viewing period by the family/significant others at the bedside immediately following death. This time may be used for mourning as part of a metal health transition, for religious, spiritual, or for cultural traditions and rituals. In addition, post-mortem care is useful for preserving the body for the mortuary staff.

Observing the proper use of personal protective equipment (PPE) is an essential element for post-mortem care by staff even after death has occurred. Standard Precautions will be observed when caring for any resident including those who are deceased. Any transmission-based precautions that are in effect at the time of death will continue to be observed with the appropriate PPE until the body has been transported to the morgue.

~~A specimen collection may be required by the physician post-mortem in the event there is a confirmed or suspected outbreak on the neighborhood, if the physician determines there is a need, or if the local health department requires a specimen collection. Additionally, if there are any specimens collected prior to death that are still in the facility, these should not be discarded until the physician has been notified.~~

~~PURPOSE:~~

~~Laguna Honda Hospital (LHH) has adopted guidelines for the post-mortem handling of bodies in accordance with Standard Precautions and additional transmission-based precautions as needed to minimize the transmission of infectious pathogens.~~

~~LHH shall follow infection control guidelines set forth by San Francisco Department of Public Health (SFDPH), California Department of Public Health (CDPH), and Centers for Disease Control and Prevention (CDC) for collection of specimens during post-mortem care for decedents that are diagnosed with a suspected or confirmed infectious disease.~~

PROCEDURE:

1. Post-mortem care is outlined in the LHHPP File: D8.0 Post-Mortem Care.

2. The attending physician of a deceased resident will notify the funeral director of any reportable communicable disease present at the time of death.

3. The attending physician or respiratory therapist will collect any post-mortem specimens that are required by SFDPH in a Health Order issued by the San Francisco Health Officer or other formal communication methods.

4. Nursing staff performs basic post-mortem care following the death of a resident that includes removing visible tubes, bathing, and other tasks to prepare the body for viewing and pick up by the morgue~~.~~ using all proper Standard and appropriate Transmission-based precautions.

~~5. Nursing staff wears PPE for all post-mortem care following Standard Precautions. For residents suspected or confirmed with a contagious illness, staff shall wear the appropriate transmission-based PPE for that infection at the time of death.~~

5. Airborne /Droplet precautions such as masks/respirators may not be required by HCP as there is no exhaling of infectious material from the decedent that may transmit the disease.

6. If applicable, Contact and blood/body fluid precautions should continue to be observed during post mortem care and noted on records for transfer to mortuary.

ATTACHMENT:
None.

REFERENCE:
NPP D8.0 Post-Mortem Care

Revised: 15/09/08, 20/10/13 22/10/10 (Year/Month/Day)
Original adoption: 05/11/01

RESPIRATORY HYGIENE/COUGH ETIQUETTE

POLICY:

1. Staff, residents, and visitors will practice respiratory hygiene, also known as cough etiquette, when in the facility. Practicing respiratory hygiene/cough etiquette has been shown to reduce the risk of transmission of respiratory microorganisms that are spread through droplets and aerosolized spray when talking, sneezing, or coughing.

PURPOSE:

The purpose of this policy is to provide guidance for when and how to practice respiratory hygiene/cough etiquette to interrupt the spread of infection from the respiratory secretions.

Respiratory infections spread primarily through coughing and sneezing, are the leading cause of illness, morbidity, and mortality around the globe. Respiratory pathogens are easily transmitted between people. Despite the high virulence, these illnesses are preventable with good respiratory hygiene practices including but not limited to cough etiquette when used in conjunction with hand hygiene, social distancing, and protective masks.

Most infectious agents transmitted via large respiratory droplets through coughs and sneezes generally travel in a 3-foot radius of an infected person and quickly drop to the ground. However, aerosolized sprays, such as a sneeze, are much smaller in size and can travel up to 6 feet. These smaller particles can be transmitted on dust particles that "hang" longer in the air thus permitting more opportunities to come into contact with eyes, mouth, and nose to infect others.

~~Transmission-based precautions include having the infected person wear~~ If able, a surgical mask ~~when medically able if they~~(source mask) may be used for patients who are coughing/sneezing to minimize exposure to respiratory secretions to others.

PROCEDURE:

1. Signage is posted for instructions for residents, staff, and visitors to practice respiratory hygiene/cough etiquette when in the facility and to encourage staying home if not feeling well. Instructions include, but are not limited to:

    a. Covering the mouth and nose with tissue when coughing or sneezing.

    b. Properly dispose of tissue in a waste container and perform hand hygiene.

    c. If no tissue is immediately available, the cough or sneeze particles can be directed into the upper sleeve or elbow but not directly into the hands.

d. Perform hand hygiene immediately either with soap and water or alcohol-based hand rub (ABHR).

e. Staff will wear a surgical mask (source control) when providing direct resident care if sneezing or coughing.

f. Ill staff should refrain from working and contact their direct supervisor for guidance.

g. Horizontal surfaces can become contaminated with respiratory secretions as droplets land and have been shown to survive on these surfaces for several hours. Touching contaminated surfaces and then touching mucous membranes or open wounds can transmit the pathogens. Cleaning surfaces frequently with an EPA registered disinfectant can stop the transmission of infection.

2. During periods of increased respiratory infection activity in the community offer masks to persons who are coughing. Surgical masks may be used to contain respiratory secretions. Respirators, such as a N95, are not necessary for this purpose.

3. Encourage residents with respiratory symptoms to stay inside their room if possible. If non-compliant, encourage resident to ~~sit~~physically distance from others by sitting at least six feet away from others in common areas~~, otherwise known as social distancing.~~

4. ABHR stands are available at entrance to the facility and neighborhood for residents, staff, and visitors.

5. Daily cleaning and disinfection of horizontal surfaces in the resident's environment is required. For those who are unable or unwilling to practice hand hygiene and cough etiquette for respiratory secretions, additional cleaning may be required. Use and Environmental Protection Agency (EPA) approved disinfectants and cleaners.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHHPP 72-01 B14 Visitors Guidelines for Infection Prevention
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis
Chavis, S., & Ganesh, N. (2019). Respiratory Hygiene and Cough Etiquette. *Infection Control in the Dental Office: A Global Perspective*, 91–103. ~~https://doi.org/10.1007/978-3-030-30085-2_7~~https://doi.org/10.1007/978-3-030-30085-2_7

CDC. (2009, August 1). Respiratory Hygiene/Cough Etiquette in Healthcare Settings | CDC. Retrieved August 22, 2020, from https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm

Revised: 20/10/13 22/09/30 (Year/Month/Day)
Original adoption: 12/05/22

ISOLATION CARTS

POLICY:

1. Laguna Honda Hospital (LHH) will maintain a sufficient supply of mobile isolation carts in Central Processing Department (CPD) for deployment to neighborhoods when transmission-based precautions are implemented.

2. Pre-filled mobile isolation carts allow staff to implement specific precautions quickly and provide the proper personal protective equipment (PPE) based on resident need for point-of-care access. ~~When extended transmission-based precautions are anticipated, the isolation cart allows for a mobile clean, safe unit to be placed near the point of use to stock an adequate supply of specific PPE.~~

3. ~~PPE is readily available in multiple sizes and types on the unit for Standard Precautions and does not require an isolation cart but is not resident specific.~~ Isolation carts are not necessary ~~when~~for isolation rooms with anterooms where adequate supply storage is available. ~~A system will be in place to~~Clinical staff in each unit should monitor PPE use and ~~restocking of~~restock mobile isolation carts to ensure adequate supplies and sizes ~~be available at the resident's door~~.

4. Mobile isolation carts ~~are not placed or moved inside the resident room but~~must remain outside the room~~,~~ near the door entrance~~.~~ and are not to be moved inside the room for use. Cart labels and/or isolation signage will not contain any protected health information (PHI~~) and will be identified with~~.) Carts should house the appropriate transmission-based precautions sign, not the specific organism or disease.

PURPOSE:

The purpose of this policy is to provide instructions on the procurement and use of isolation carts when ~~extended~~ use of Transmission-based precautions is required.

BACKGROUND:

Isolation carts provide a safe and clean portable storage base for adequate supply and point-of-care access for staff for the proper PPE for residents who have been placed on transmission-based precautions. Isolation carts provide quick access to PPE and help prevent cross contamination of supplies. Adequate PPE supplies in multiple sizes and at the point of care promotes safe use to reduce the transmission of microorganisms.

~~DEFINITIONS:~~

- ~~**Standard Precautions**: Infection prevention practices that apply to all residents, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These practices include: hand hygiene; use of gloves,~~

gown, mask, eye protection, or face shield, depending on the anticipated exposure; room placement; safe injection practices, respiratory hygiene/cough etiquette; environmental cleaning and disinfection; and safe management of textiles and laundry.

- **Transmission:** Passage of an infectious agent that is in a person's blood or body fluids to another person either directly or, more commonly indirectly via staff hands or via medical equipment that has not been cleaned and disinfected adequately between residents.

- **Enhanced Standard Precautions**: Expanded use of gloves and gowns in skilled nursing facilities based on resident risk, likelihood of multi-drug resistant organism (MDRO) colonization, and transmission during specific care activities with greatest risk for MDRO contamination of staff hands, clothes, and the environment.

PROCEDURE:

1. When a resident or patient is suspected or diagnosed with an infection that requires additionalPatients placed on transmission-based precautions beyond Standard Precautions,(TBP) will prompt the charge nurse willto contact CPD and request delivery of an isolation cart to the neighborhood.

2. Prior to deployment, the isolation cart will be prepared by CPD technicians by disinfecting and stocking the cart with PPE: disposable gowns, aprons, gloves in various sizes, surgical masks, face shields, goggles, shoe covers, and disinfectant wipes. Specific individualized PPE such as respirators (e.g. N95, PAPR units) will not be placed on the cart but will be obtained by stock supplies on the unit to meet specific fit-testing criteria.

   a. *Clostridioides difficile (C. diff)*, norovirus, and other spore-forming organisms require hand washing with soap and water and not the use of alcohol-based hand rub (ABHR) or hand sanitizer for hand hygiene due to the spore formation that is not inactivated by alcohol. In addition, environmental cleaning should be completed using bleach-based disinfection such as with bleach wipes or bleach-based solution. Alcohol-based products will not be stocked on the carts used for these pathogens.

3. Isolation carts are placed outside the residents' rooms and are to be kept clean and stocked by Nursing while in use until the TBP are discontinued.

4. Health care personnel (HCP) and others must perform HH prior to touching items on the cart for use.

5. If any items on the cart appear contaminated (wet, dirty, dust, debris) the item should be discarded and replaced.

~~4.~~6. Laminated transmission-based precautions signage will be ~~placed~~found in the top drawer of the cart for ~~selection and placement~~placing on the patient's door front at room entrance by Nursing.

~~5.~~7. ~~When~~After transmission-based precautions have been discontinued, the charge nurse or designee will contact CPD for cart retrieval from the neighborhood. Prior to leaving the unit, Nursing will clean the exterior of the cart with EPA approved disinfectant wipes prior to returning the cart to CPD technicians. If the room requires a terminal clean, the cart should remain in place until after EVS cleans the room.

~~6.~~8. CPD technicians will return the cart to CPD for further disinfection of cart exterior and interior, restock the cart and prepare it for use.

~~7.~~9. For inventory tracking of carts, CPD technicians will ensure that each isolation cart is equipped with an ~~Aeroscout~~tracking inventory tag.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
California Department of Public Health (CDPH) Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2019 available at:
https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/Enhanced-Standard-Precautions.pdf

Revised: 18/11/13, 20/10/13, 22/10/05 (Year/Month/Day)
Original adoption: 13/11/21

SCABIES MANAGEMENT

POLICY:

~~1. Residents are to be screened for scabies infestation by the licensed nurse upon admission, preferably before being transferred into a bed.~~

~~A licensed nurse or physician~~It is the policy of Laguna Honda Hospital & Rehabilitation (LHH) to provide preventative measures for scabies transmission, and to manage a scabies outbreak by implementing measures to diagnosis, reduce spread and provide safe and effective treatment to those affected by scabies based on current best practices as outlined by the Centers of Disease Prevention and Control (CDC).

~~2.~~ The Infection control nurse (ICN)/team will ~~promptly assess any resident~~collaborate with ~~a suspicious skin rash and/or pruritus.~~

~~3. Whenever possible, the diagnosis of scabies should be confirmed by identifying the mite or mite eggs or fecal matter (scybala), however, a negative skin scraping does not preclude treatment in the presence of a suspicious rash since as few as 10-15 mites may be present.~~

~~4. The Infection Control Nurse is to be informed of suspected or confirmed cases of scabies.~~

~~5. Contact Precautions are to be implemented promptly for suspected or confirmed cases including appropriate use of gloves when providing direct care.~~

~~6. Scabies outbreaks shall be managed with a comprehensive,~~physician's and other interdisciplinary ~~approach that includes Infection Control, Medicine, Nursing, Pharmacy, Outpatient Medical Clinic/, Employee Health, and Environmental Services (EVS).~~

~~a. An outbreak suggests that transmission has been occurring for several weeks to months since the time from exposure to symptoms may be as long as 4-6 weeks (1-4 days if previous infestation has occurred).~~

~~b.~~ ~~Two (2) or more confirmed cases or one (1) confirmed case and at least two (2) suspect cases occurring among residents, health care workers, visitors or volunteers during a 2-week period should be considered an~~teams to promptly investigate and identify cases to reduce the spread of scabies outbreak.

~~7. Crusted scabies, also known as Norwegian scabies, is a more severe form of scabies in which there are large amounts of mites and eggs (up to 2 million mites may be found) contained in the skin growths.~~

a. Crusted scabies occurs more frequently in those with a weakened immune system, a neurological disease, the elderly and those with physical and mental disabilities. Crusted scabies may require more prolonged treatments due to the large number of mites and eggs.

b. Crusted scabies is considered to be very contagious to others and may transmit the mites through direct or indirect contact by shedding mites on clothing, bedding and furniture.

PURPOSE:

To promptly identify, treat, and reportThe purpose of this policy is to provide information to Healthcare workers (HCW) to aid in the surveillance of scabies infections to preventfor prompt identification, and treatment thereby reducing transmission to others.

PROCEDURE:

1. Suspicious rashes shall be promptly assessed by the licensed nurse and physician and infection control shall be notified when scabies is being ruled out.

1. The Prevention through Education
    a. Human scabies is caused by an infestation of the skin by the human itch mite (Sarcoptes scabiei var. hominis). The microscopic scabies mite burrows into the upper layer of the skin where it lives and lays its eggs
    b. The most common symptoms of scabies includes itching and a skin rash, caused by sensitization to the proteins of the parasite.
    c. Severe itching (pruritus) is the earliest and most common symptom of scabies:
        i. night shift HCW are often the first to be alerted to symptoms of nocturnal restlessness, scratching, and complaints of itching as the mite become more active at night
        ii. screening during shower is an effective method to assess between the folds of skin where the mite often burrows
    d. Scabies is easily transmissible in close living conditions and HCW's must utilize Standard Precautions for all resident care
    e. Transmission-based precautions (TBP) should be added for suspicion of scabies until ruled out
    f. Scabies is not indicative of hygiene practices or cleanliness- handwashing alone will not prevent the transmission of scabies
    g. Scabies is more prevalent in congregate settings such as long-term care and suspicious rashes should be reported immediately to the physician to rule out scabies
2. Two forms of Scabies
    a. Non-crusted Scabies
        i. The more common, milder form of scabies

ii. Is identifiable with symptoms of itching with a rash that may represent only a few mites depending on the infestation
iii. Can affect any age group but common in congregate close living environments such as nursing homes and schools
iv. Is identifiable by the more common symptoms of itching and rash generally found on hands, feet, groin, breast areas, between fingers and toes

b. Crusted (Norwegian) Scabies
i. A more severe form of the same mite infestation that primarily affects those who are immunocompromised, elderly, disabled, or debilitated
ii. Crusted scabies present with thick crusts of skin that contain large numbers of scabies mites and eggs that resemble red or white scaly patches found on the hands, feet, knees and elbow. In a severe form, the plaques can resemble a cauliflower-like appearance on the skin, hands, feet, elbows or knees.
iii. Crusted Scabies is not associated with the severe itching or rash-like appearance of non-crusted scabies.
iv. The mites in crusted scabies are not more virulent than in non-crusted scabies; however, they are much more numerous (up to 2 million per patient) and considered highly contagious.

3. Transmission

a. Non-Crusted scabies is spread by direct, prolonged skin-to-skin contact
b. Crusted (Norwegian) scabies can be spread by indirect contact (clothes, bedding etc.) and may require a shorter period of direct contact
c. First-time infestations may take 2- 6 weeks for symptoms (pruritis and rash) to appear due to the initiation of the immune response but the individual may still spread the mite to others during this time
d. Immunocompromised patient, the frail and elderly produce a less robust immune response and may not exhibit the usual symptoms of itching and rash.
e. HCW should be alert for restlessness or other behaviors not normally observed and report suspicions to ICP team and medical provider for increased surveillance and monitoring.

4. Screening

a. Skin assessment are performed upon admission or transfer from another facility
b. Signs and Symptoms to report if scabies is suspected
i. Non-crusted scabies :
1. Pruritis (intense itching) with Rash is the predominant symptom ~~of scabies is pruritus accompanied by a rash.~~
2. Report suspicious rashes, particularly between fingers and toes, axilla, belt line, under breasts and perineal areas
~~a.~~3. Rash: The scabies rash varies and may appear as small lines, red, raised bumps (papules), pustules or blisters~~.~~

~~Crusted scabies~~ or may appear as ~~thick white or cream colored heavily crusted areas of~~red or brown "tracking" where the mite burrows and moves under the skin ~~instead of the typical tracking rash.~~

ii. ~~Itching~~ Crusted scabies
   1. Presents with less or no itching
   2. Rash may appear as thick white or cream colored heavily crusted (dry) areas of the skin instead of the typical tracking rash

5. Treatment Options

a. Non-crusted scabies
   i. For suspected or confirmed cases, initiate Transmission-based (Contact) Precautions until scabies is ruled out
   ii. Can be treated using a cream or lotion scabicide and applied as directed, usually twice per day
   iii. General instructions include application of the medication over the external body from the neck down. It is important to use the medication as directed and using the amount specified over the entire external body as mites may migrate to unmedicated areas and cause re-infestation
   iv. The next day have the patient shower, change bed linens and wear clean clothing
   v. If a second application is required, apply medication as directed and repeat the shower, change of bed linens and fresh clothing
   vi. Pain and discomfort (itching) should also be considered for treatment
   vii. Monitor the patient for secondary bacterial skin infection from scratching
   viii. Report increased pain, fever, increased redness, or discharge from the rash site to the physician.

b. Crusted scabies
   i. For suspected or confirmed cases, initiate Transmission-based (Contact) Precautions until scabies is ruled out
   ii. Large numbers of mites create a very contagious condition resulting in the potential to spread scabies through only a brief direct skin-to-skin contact.
   iii. Patients with crusted scabies should receive quick and aggressive medical treatment for their infestation to prevent an outbreak of scabies
   iv. Treatment may include the use of a cream or lotion scabicide as well as oral treatments.
   v. Treatments may be prolonged until the physician has determined there is no longer any mites present

vi. Nursing will confer with the ICP team and physician before discontinuing Transmission-based (Contact) Precautions
TBP may be in place for extended periods (months) of time for severe cases.
Monitor the patient for secondary bacterial skin infection from scratching Report increased pain, fever, increased redness, or discharge from the rash site to the physician.

6. Outbreak Management

a. Definition of Outbreak
   i. Two (2) or more ~~intense~~ confirmed cases OR
   ~~b.~~ ii. One (1) confirmed case and at ~~night.~~least two (2) suspect cases occurring among residents, health care workers (HCW), visitors or volunteers during a 2-week period should be considered an outbreak of scabies
b. Contact ICP team immediately with suspected cases for considerations of isolation precautions based on each individual care needs including TBP and Personal protective equipment (PPE) required
c. Contact the physician for skin testing if needed, and begin treatments- aggressive treatments should be considered for crusted scabies including comfort measures for pain and itching
d. ICP will report the scabies outbreak to the local and state health department per CDPH title 17 California Code of Regulations §2500 that requires facilities to report outbreaks
e. ICP will collaborate with nursing staff to coordinate additional skin assessment needs for others on the unit including HCW for potential contact
f. Notification of the clinical, medical, pharmaceutical and EVS leadership for potential contact tracing needs and for resources should additional cases be identified
g. Contact Precautions may be required for up to several weeks until the determination is made that the mites have been eradicated. This may require both oral and topical scabicidal medications with repeated applications and/or other antipruritic/anti-inflammatory medications for secondary infections

~~c. Itching may be absent in immunocompromised residents and persons with decreased sensation and/or decreased cognition.~~

~~d. Scabies rashes are usually found between the webs of the fingers, front of wrists, elbows, axilla, belt line, thighs, genitalia, female breast, abdomen, male genitals and the lower portion of the buttocks. Some lesions may be more predominant on the areas of the skin having contact with moist sheets such as the back and buttocks.~~

~~When~~

7. HCW/Staff Exposure or Diagnosis:

a. Staff must report any known exposure to their supervisor/ICP team such as family members living in the same home as soon as possible
b. Nurse management will refer exposed staff to Occupational Health for further diagnosis and/or treatment options
c. Staff may not return to work until cleared by Occupational Health
d. Nurse manager will report the exposure to the ICP/team

8. Patient Exposure or Diagnosis

a. ICP team and medical provider will be notified immediately for a patient scabies ~~is first~~diagnosis or suspected ~~and continuing throughout diagnosis and treatment of confirmed scabies, Nursing staff are to observe~~ case
b. Contact Precautions will be implemented without delay for suspected cases even without a diagnosis
c. The medical provider will determine testing needs which may include skin scrapings, but treatment should not be delayed while awaiting results
~~2.~~d. Rooms used by a patient with crusted scabies should be thoroughly cleaned and vacuumed daily during ~~resident care activities.~~ treatment and while in Contact Precautions

~~a. This period of Contact Precautions includes 24 hours after initial and subsequent administration of a scabicide (per CDPH guidelines) or until the physician has determined that the infestation has subsided, and the resident is no longer infectious to others.~~

~~Transmission of scabies occurs primarily through prolonged skin-to-skin contact with a person who has scabies.~~

~~b. Crusted scabies is considered highly contagious and can also be transmitted by indirect contact with an infested person's clothing, bedding, or towels.~~

~~3. Shorter periods of skin-to-skin contact with a person with crusted scabies may result in transmission.~~

e. ~~When scabies is suspected, the licensed nurse is to notify the physician and the infection control nurse. A skin scraping is used to positively confirm the diagnosis.~~ Terminal cleaning requires thorough cleaning and vacuuming and after use but environmental disinfestation using pesticide sprays or fogs generally is unnecessary
f. Contact the local / state health department for control measures if continuous transmission or frequent outbreaks are occurring.

9. Treatment

~~4. **Crusted scabies** may not require skin scrapings due to the characteristic skin formation.~~

~~5.~~a. Empirical treatment ~~may~~should be initiated before the lab results are available for highly suspicious rashes or crusted growths.

~~6. A physician who has been properly trained to perform skin scrapings may do so to expedite the diagnosis. Resident skin scrapings can be scheduled at the Outpatient Medical Clinic.~~

b. Notify pharmacy department for potential large volume medication needs
c. A physician's order is required for treatment following current CDC guidelines for appropriate medications
d. Mass treatment may be required for large exposures/outbreaks and will be managed in conjunction with the medical team and local health department
e. Pharmacy will provide support for bulk orders in the event of outbreak
f. Treatments and Contact Precautions will be discontinued on a case-by-case when there is no further evidence of transmission or active disease as determined by the physician in collaboration with ICP.
g. Considerations for discontinuing Contact Precautions include but are not limited to infestation type, cognitive ability of the patient to effectively and consistently adhere to precautions, new infection versus re-infection, co-morbidities of the patient and immune response.

10. Cleaning and Disinfection

a. Considerations for EVS cleaning and disinfection practices will include a single case of non-crusted, any crusted (Norwegian) case(s), and outbreak
~~7.~~b. After a diagnosis of scabies infestation is made either by suspicious rash, skin scraping or both, notify neighborhood staff, including EVS, in order to coordinate interventions.

~~a. One case of non-crusted scabies with a negative skin scraping may not need interventions beyond treatment of the one case and their environment including Contact Precautions until 24 hours after treatment.~~

~~b. One or more cases of crusted scabies or non-crusted scabies confirmed by skin scraping requires contact investigation and treatment of close contacts and additional prophylactic treatment for crusted scabies including Contact Precautions until deemed non-infectious.~~

c. If more than one case of scabies is diagnosed within 2 weeks of another case among residents, staff, or visitors, then coordination among interdisciplinary department heads/ designees is warranted following A8 Outbreak/Epidemic Investigation Protocol and A9 Contact/Exposure Investigation.

~~8. A physician's order is required for treatment; follow current CDC guidelines for appropriate medications.~~

~~a. For mass treatment, pre-printed orders may be provided by pharmacy.~~

~~b. Follow package instructions for prescribed treatment(s) unless otherwise ordered.~~

~~c. After incontinent care, reapply a thin layer of scabicide during treatment period.~~

~~d. Maintain Contact Precautions until treatment is completed and the resident is no longer considered to be infectious.~~

~~i. For treatment of common scabies, Contact Precautions may be discontinued when successful treatment has been completed.~~

~~ii. For treatment of crusted scabies, Contact Precautions may be required for up to several weeks until the determination is made that the mites have been eradicated. This may require both oral and topical scabicidal medications with repeated applications and/or other antipruritic/anti inflammatory medications for secondary infections.~~

~~9.~~d. Bedding, clothing, and towels used by infested persons or their household, sexual, and close contracts anytime during the 3 days before treatment should be decontaminated by machine washing in hot water and drying using the hot dryer cycle (or dry clean).

~~a.~~e. Items that cannot be laundered can be treated by storing in a closed plastic bag for one week. Scabies mites generally do not survive more than 2-3 days away from human skin.

~~b.~~f. Change all bed linens before returning resident to bed after the scabicide has been showered off 8-14 hours after application.

~~10.~~g. Environmental cleaning of rooms used by residents with scabies includes thorough cleaning and vacuuming by personnel wearing long sleeved gown and gloves.

~~a.~~h. In addition to bed stripping and bedside cleaning, Nursing staff shall replace disposable personal care items such as oral hygiene equipment, water pitcher, urinal/ bedpan and personal disposable blood pressure cuff.

~~b.~~i. Usual disinfection is adequate for non-disposable items, such as wheelchairs, glasses. Disinfect wheelchair according to usual wheelchair cleaning procedure.

~~c.~~ EVS shall clean the room and bathroom, including chairs and toilet seats, according to usual procedures and remove and replace the cubicle curtains in the room and bathroom.

~~d.~~j. Request for vacuuming of upholstered surfaces that may have come in contact with infested or exposed resident(s). Use dedicated vacuum; empty bag and wipe down vacuum when finished vacuuming.

~~11.~~k. Post-treatment assessment is conducted by the Infection Control Nurse to determine if treatment was effective. The intensity of the rash and pruritus should gradually resolve over a 7-14 day period. Crusted scabies may require multimodal treatments, longer periods of contact isolation and a longer time for symptoms to resolve. If signs and symptoms persist or intensify or if new lesions are identified within 7-14 days, treatment failure should be considered, and alternative treatments applied.

~~12.~~l. Document in the electronic health record procedures, medications used, description of resident's skin and reaction to treatment. Record and describe any allergic symptoms or persistent pruritis.

~~13.~~m. Nursing completes an Unusual Occurrence report. Include skin description and any medication prescribed. If this is a newly admitted resident, include the name of the facility and the unit the resident came from.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 A9 Contact/ Exposure Investigation
CDC Scabies available at
https://www.cdc.gov/parasites/scabies/index.html
California Department of Public Health Division of Communicable Disease Control, Management of Scabies Outbreaks in California Health Care Facilities, March 2008 available at
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/PrevControlofScabiesinLTCFacilities.pdf

Revised: 16/01/12, 20/10/13, 2022/10/13 (Year/Month/Day)
Original adoption: 05/11/01

PEDICULOSIS (LICE) MANAGEMENT

POLICY:

1. ~~Residents are to be screened~~Admission screening is performed, including observing the skin and hair for abnormalities that may including evidence of lice infestation ~~by the licensed nurse upon admission, preferably before being transferred into a bed.~~.

~~2. A licensed nurse or physician will promptly assess any resident with symptoms of a lice infestation.~~

~~3.~~2. The Infection Control Nurse is to be informed of suspected or confirmed cases of lice for room placement options. Private room with a private bathroom is preferred.

~~4.~~3. Contact Precautions ~~and covering all hair sources (e.g. head hair, facial hair) are to~~should be implemented ~~promptly for~~when lice is suspected or confirmed ~~cases including appropriate use of gloves when providing direct care until~~ and continued for 24 ~~hours~~hrs. post-treatment. Re-treatment may be needed 9-10 days after ~~initiation of pediculosis therapy and no live lice detected.~~initial treatment but Contact Precautions are not required after the initial treatment.

DEFINITONS:

~~The~~There are three (3) distinct types of lice that are human parasites: body lice, head lice~~,~~ and pubic ~~"crab"~~ lice. ~~There are three forms~~Treatments will be specific to the type of lice ~~(see reference link to photograph of actual size of three lice forms compared to~~after a ~~penny):~~diagnosis is made by a healthcare professional trained in identifying. Life cycle stages are important considerations for treatment options.

1. Live Cycle Stages:

~~1.~~a. **Nits**: Nits are lice eggs. They can be hard to see and are found firmly attached to the hair shaft. They are oval-shaped and very small (about the size of a knot in thread), hard to see, and are usually yellow to white.

~~2.~~b. **Nymph**: A nymph is an immature louse that hatches from the nit. A nymph looks like an adult head louse but is smaller.

~~3.~~c. **Adult**: An adult hair and body louse is about the size of a sesame seed, has six legs, and is tan to grayish-white in color. An adult pubic louse resembles a miniature crab when viewed through a strong magnifying glass. Pubic lice have six legs; their two front legs are very large and look like the pincher claws of a crab. Pubic lice are tan to grayish-white in color.

2. Transmission and Disease:

a. Head and pubic lice are not known to spread disease. The itching may lead to excessive scratching that can sometimes increase the chance of a secondary skin infection.
b. Body lice can spread epidemic typhus, trench fever, and louse-borne relapsing fever, all which are no longer widespread.

~~Body, head, and pubic lice are transmitted in the following ways:~~

~~1.~~c. Body Lice: Spread through direct physical contact with a person who has body lice or through contact with articles such as clothing, beds, bed linens, or towels that have been in contact with an infested person.

~~2.~~d. Head Lice: Usually spread by head-to-head contact with an already infested person. Head lice can also be spread by sharing clothing or belongings. This happens when lice crawl, or nits attached to shed hair hatch, and get on the shared clothing or belongings.

~~3.~~e. Pubic Lice: Usually spread through sexual contact. Pubic lice can also be spread by close personal contact or contact with articles such as clothing, bed linens, or towels that have been used by an infested person.

3. Signs and symptoms ~~of body, head, and pubic lice include the following:~~

~~1.~~a. **Body Lice**: Intense itching or pruritus and rash caused by an allergic reaction to the louse bites are common symptoms. When body lice infestation has been present for a long time, heavily bitten areas of the skin can become thickened and discolored, particularly around the midsection of the body (waist, groin, upper thighs); ~~this condition is called "vagabond's disease."~~

~~2.~~b. **Head Lice**: Tickling feeling of something moving in the hair, itching caused by an allergic reaction to the bites of the head louse, irritability and difficulty sleeping as head lice are most active in the dark, and sores on the head caused by scratching.

~~3.~~c. **Pubic Lice**: Itching in the genital area and visible nits (lice eggs) or crawling lice.

PURPOSE:

To promptly identify, treat, and report lice infestations to prevent transmission to others.

PROCEDURE:

~~1. Nursing obtains lice treatment and baby shampoo without conditioner order from the physician for a topical lice medication.~~

a. The hospital-wide combination shampoo/conditioner has a conditioner and cannot be used. Shampoos a resident may own that do not have a conditioner may be used instead of baby shampoo.

b. The physician may opt for an oral lice medication only if a topical treatment is not recommended.

2. Nursing obtains the following items needed for a topical lice treatment from the neighborhood, Pharmacy, and/or Central Processing Department:

a. **Head Lice** medication (Pharmacy):

b. Fine tooth comb (Pharmacy)

c. Shall baby shampoo bottle without conditioner *if resident does not have their own supply of shampoo as hospital-wide combination shampoo/conditioner cannot be used* (Pharmacy)

d. Nail clipper (Central Processing Department or neighborhood supply)

e. Disposable gloves (neighborhood supply)

f. Disposable isolation gowns (neighborhood supply)

g. Disposable suture kit scissors *if resident requests to have hair cut short* (Central Processing Department or neighborhood supply)

3. Keep resident's fingernails short to minimize damage to the skin from itching.

4. If requested by the resident, hair may be cut short using disposable scissors before washing hair and applying lice medication by Nursing. Disposable scissors can be found in suture removal kits supplied by Central Processing Department in the medication room storage trays.

a. Disposable scissors can be found in suture removal kits supplied by Central Processing Department in medication room storage trays. Used disposable scissors are disposed inside the room's sharps container.

b. Cut hair shall be double bagged and disposed inside the room.

c. Do not ask the barber or beautician to cut lice infested hair until it has resolved (i.e. 24 hours from after initiation of pediculosis therapy and no live lice detected).

5. Hair should be shampooed without a conditioner, rinsed, and towel dried (do not blow dry) before lice medication is applied.

~~a. Do not use a combination shampoo/conditioner or conditioner before using lice medication as it decreases the effectiveness of the medication staying on the hair.~~

~~6. Apply the prescribed lice medication onto the affected area(s) according to the label instructions or as directed by the physician.~~

~~7. Remove nits by combing through hair with a fine tooth comb:~~

~~a. Part the hair into 4 sections. Work on one section at a time. Longer hair may take more time (1-2 hours).~~

~~b. Start at the top of the head on the section you have picked. With one hand, lift a 1-2 inch wide strand of hair. Get the teeth of the comb as close to the scalp as possible and comb with a firm, even motion away from the scalp to the end of the hair.~~

~~c. Make sure the hair remains slightly damp while removing nits. If the hair dries during combing, dampen it slightly with water.~~

~~d. Clean the comb completely as you go. Wipe the nits from the comb with a tissue and throw away the tissue in a sealed plastic bag to prevent the lice from coming back.~~

~~e. After combing, recheck the entire head for nits and repeat combing if necessary.~~

~~8. Check the hair daily to remove any remaining nits or lice with a fine tooth comb.~~

~~9. Do not re-wash the hair for 1-2 days after treatment. If no dead lice are found 8-12 hours after treatment and lice activity has not decreased, the treatment may not be effective. Notify the physician and follow additional treatment instructions if ordered.~~

~~10. If live lice are seen seven days or more after the first treatment, a second treatment should be ordered by the physician.~~

~~11. Strip linen from resident's bed, clean and disinfect the bed, and replace with clean linen. Double bag all dirty linen in a regular dirty linen bag. Close the bags securely and place them in the linen chute.~~

1. Do not transmit communicable diseases
2. Do not jump or fly; they can only crawl.
3. Prevalence of infestation is no different in individuals with long hair than in those with short hair; cutting hair is not necessary to control head lice
4. Seldom occur on eyebrows or eyelashes

5. Infest persons from all socioeconomic levels, without regard for age, race, sex or standards of personal hygiene.
6. Do not come from animals or pets
7. Not usually spread by contact with clothing (such as hats, scarves, coats) or other personal items (such as combs, brushes, or towels).
8. Is diagnosed best by finding a live nymph or adult louse on the scalp or hair of a person.
    a. Because nymphs and adult lice are very small, move quickly, and avoid light, they can be difficult to find.
    b. Use of a magnifying lens and a fine-toothed comb may be helpful to find live lice.
9. Can also be diagnosed if crawling lice are not seen. Finding eggs (also called nits) firmly attached within a 1/4 inch of base of the hair shafts strongly suggests, but does not confirm, that a person is infested and should be treated.

Eggs (also called nits)

12. ~~Machine wash and dry all resident's personal clothing used by the infested person in the 2-day period just before treatment is started using the hot water and hot air cycles to kill lice and nits.~~

13. ~~Dispose and replace all personal items for the resident (e.g. water pitcher, comb, toothbrush).~~

10. ~~Items~~ that ~~cannot be laundered~~ are attached more than 1/4 inch from the base of the hair shaft are almost always dead or ~~replaced (e.g. personal hairbrush)~~already hatched.
11. Eggs are often confused with other things found in the hair such as dandruff, hair spray droplets, and dirt particles.
12. If no live nymphs or adult lice are seen, and the only eggs found are more than 1/4 inch from the scalp, the infestation is probably old and no longer active and does not need to be treated.
13. Diagnosis should be made by a healthcare provider, or other person trained to identify live head lice.

Treatment for HEAD LICE

1. Staff who are pregnant or nursing should ~~be double bagged in a regular plastic bag~~ not come into contact with topical medications containing malathion, Check the labels for ingredients and consider non-pregnant/ non-nursing staff for treatment options.
2. Treatment for head lice is recommended for patients diagnosed with an active infestation

3. Before applying treatment, remove clothing that can become wet or stained during treatment and use a hospital gown during treatment period.
4. Do Not shampoo hair prior to treatment; Follow the directions on the label. Many treatments must be applied to dry hair.
~~14.~~5. Don proper PPE including gown and gloves for ~~two weeks.~~Contact Precautions

6. ~~Disinfect any equipment~~Obtain lice medicine, also called pediculicide and ~~items used~~use as directed.

    a. Review the directions contained in the box or printed on the label prior to beginning treatment; do not assume all treatments are the same as treatments vary by ~~the resident (e.g. wheelchair, commode, call light)~~manufacturers.
    b. Improper application may result in the medication not being effective
    c. A second bottle of pediculicide may be required for very long hair (greater than shoulder length). Obtain a second bottle before beginning treatment if indicated.
    d. Follow the directions closely on the label or in the box regarding how long the medication should be left on the hair and how it should be washed out, usually after 8-12 hours .
    e. Use the full amount listed on the label to treat; do not attempt to “save” or “split the dose” of the medication
        i. Not using the proper amount may lead to the treatment not completely killing the lice
    f. For liquid medications/lotions: generally, coat the hair until thoroughly wetted with the ~~standard hospital wide~~medication being particularly careful behind the ear and on the back of the head and neck
    g. The manufacturer generally recommends leaving the medication on the hair, uncovered, for 8–12 hours.
    h. Allow the hair to dry naturally; do not use an electrical heat source, including a hair dryer or curling iron while the hair is wet.
    i. Do not cover the head with plastic or shower caps
    j. Shoulders should be covered with a towel to prevent dripping
    k. Have the patient put on clean clothing once the medication has been applied / dry.
        i. Consider treating just before bedtime allowing time for the lotion/medication to dry before retiring to bed, depending on hair length
        ii. Do not place medication / lotion on other areas of hair on the body (eyebrows, pubic area, chest, under arms)
        iii. Avoid medication near eyes
    l. Remove and discard PPE after treatment; perform HH

m. In 8-12 hours or next morning, Don PPE for Contact Precautions prior to continuing treatment including gown and gloves
n. After 8–12 hours thoroughly shampoo the hair (the shower is preferred)
    i. rinse well and
    ii. use a fine-toothed nit comb, usually included in the package, to remove dead lice and nits from the hair.
    iii. if a second treatment is required, the physician will need to re-order the second application, either the same or a different type and use according to manufacturers directions
o. Have the patient wear clean clothes and change the bed linens before re-entering the bed

7. **Retreatment of head lice**
    a. Is usually is recommended 9-10 days after initial treatment because no approved pediculicide is completely ovicidal (able to kill unhatched nits).
    b. To be most effective, retreatment should occur after all eggs have hatched but before new eggs are produced.
    c. The retreatment schedule can vary depending on the pediculicide used. Follow the directions on the label/ manufacturers directions.

8. Laundry and EVS Measures:

a. Machine wash and dry ~~disinfectant~~clothing, bed linens, and other items that the patient wore or used during the 2 days before treatment using the hot water (130°F) laundry cycle and the high heat drying cycle.
b. Clothing and items that are not washable can be dry–cleaned **OR** sealed in a plastic bag and stored for 2 weeks.
c. Soak combs and brushes in hot water (at least 130°F) for 5–10 minutes. Do not share combs.
d. Vacuum the floor and furniture, particularly where the infested person sat or lay. However, the risk of getting infested by a louse that has fallen onto a rug or carpet or furniture is very small. Head lice survive less than 1–2 days if they fall off a person and cannot feed;
e. Nits cannot hatch and usually die within a week if they are not kept at the same temperature as that found close to the human scalp.
~~15.~~f. Do not use fumigant sprays; they can be toxic if inhaled or absorbed through the skin.

~~16.~~9. Document in the electronic health record procedures, medications used, description of the resident's skin and reaction to treatment. Record and describe any allergic symptoms.

~~17.~~10. ~~Nursing~~If the resident has a reaction to treatment, nursing completes an Unusual Occurrence report. Include hair and skin description and any medication

prescribed. If this is a newly admitted resident, include the name of the facility and the unit the resident came from.

Body Lice Treatment

a. Improved hygiene and access to regular changes of clean clothes is the only treatment needed for body lice infestations.
b. Contact Precautions will be in effect until the IP nurse/ team collaborate with the physician when precautions may be discontinued.

Pubic Lice Treatment

1. Contact Precautions should be in effect during the treatment period; Contact the IP nurse/ team to collaborate with physician when precautions may be discontinued
2. Treatments should be initiated as soon as possible after diagnosis is made
3. Don appropriate PPE for Contact Precautions including gown and gloves
4. Wash the infested area; towel dry.
5. Carefully follow the instructions in the package or on the label. Thoroughly saturate the pubic hair and other infested areas with lice medication. Leave medication on hair for the time recommended in the instructions. After waiting the recommended time, remove the medication by following carefully the instructions on the label or in the box.
6. Following treatment, most nits will still be attached to hair shafts. Nits may be removed by using a fine-toothed comb.
7. Have the patient put on clean underwear and clothing after treatment.
8. To kill any lice or nits remaining on clothing, towels, or bedding, machine-wash and machine-dry those items that the infested person used during the 2–3 days before treatment. Use hot water (at least 130°F) and the hot dryer cycle.
9. Items that cannot be laundered can be dry-cleaned or stored in a sealed plastic bag for 2 weeks.
10. All sex partners from within the previous month should be informed that they are at risk for infestation and should be treated.
11. Persons should avoid sexual contact with their sex partner(s) until both they and their partners have been successfully treated and reevaluated to rule out persistent infestation.
12. Repeat treatment in 9–10 days if live lice are still found.
13. Persons with pubic lice should be evaluated for other sexually transmitted diseases (STDs).
14. For lice or nits on the eyelashes, careful application of ophthalmic-grade petrolatum ointment to the eyelid margins 2–4 times a day for 10 days is effective. Regular petrolatum (e.g., Vaseline)* should not be used because it can irritate the eyes if applied.

ATTACHMENT:
None.

REFERENCE:

Centers for Disease Control and Prevention Lice available at:
https://www.cdc.gov/parasites/lice/index.html
Centers for Disease Control and Prevention Photograph of Actual Size of the Three Lice Forms Compared to a Penny available at:
https://www.cdc.gov/parasites/images/lice/headlice_penny.jpg
Centers for Disease Control and Prevention Body Lice available at:
https://www.cdc.gov/parasites/lice/body/index.html
Centers for Disease Control and Prevention Head Lice available at:
https://www.cdc.gov/parasites/lice/head/index.html
Centers for Disease Control and Prevention Pubic Lice available at:
https://www.cdc.gov/parasites/lice/pubic/index.html

Revised: 16/07/12, 19/03/12, 20/10/13 22/10/16 (Year/Month/Day)
Original adoption: 05/11/01

CLOSTRIDIOIDES DIFFICILE GUIDELINES

POLICY:

~~1.~~ Laguna Honda Hospital and Rehabilitation Center (LHH) will provide prevention measures through education to HCP to identify, report, and manage *Clostridioides difficile (C. diff)* infection ~~according to this policy and in~~ in accordance with Centers for Disease Control (CDC) guidelines~~.~~

~~2.~~1. ~~Ongoing prevention of *C. diff* shall be addressed through surveillance and antimicrobial stewardship efforts along~~ and in collaboration with ~~a rigorous hand hygiene program.~~the Infection Preventionist (IP) and medical staff.

~~3. According to the CDC, *C. diff* is a highly contagious bacterium that causes diarrhea and colitis (an inflammation of the colon). Risk factors include those who are age >65, recent hospitalization (that may or may not include extensive use of antibiotics), long term use of proton-pump inhibitors (PPIs) or H2 blockers, weakened immune system and previous *C. diff* infection or known exposure.~~

~~4. *C. diff* bacteria is shed in feces. Any surfaces that come into contact with contaminated feces can serve as a reservoir for the bacterium and may be transferred via contaminated hands/gloves of healthcare workers to others. Scrupulous use of proper personal protective equipment (PPE) and hand hygiene with soap and water only is required to prevent spreading the disease to others.~~

PURPOSE:

To provide guidance for the prevention~~, assessment~~ and management of outbreaks of *Clostridioides difficile* infection in accordance with ~~current guidelines and~~ evidence-based ~~sources.~~practices (EBP) provided by the Centers for Disease & Control (CDC).

PROCEDURE:

A. Prevention

1. Education of HCP regarding the spread, prevention measures, personal protective equipment (PPE) use during care and management of outbreaks
2. Education of patients to reduce transmission to others including hand washing with soap and water after toileting, showering and clothing changes
3. *Clostridiodes difficile (C.diff)* is a highly contagious bacterium that causes severe diarrhea
4. Risk factors include
   i) age >65 but especially in >85 age group
   ii) recent hospitalization (that may or may not include extensive use of antibiotics)
   iii) long term use of proton-pump inhibitors (PPIs) or H2 blockers that serve to reduce stomach acid production

iv) weakened immune system as occurs with HIV/AIDS, cancer or organ transplant recipients and use of steroids
v) previous *C. diff* infection or known exposure

5. *C. diff* bacteria is shed in feces and can survive on skin even when visible soiling is not evident
6. C. *diff* is spread by direct and indirect contact with the microorganism
7. Implement daily and terminal cleaning of rooms using EPA approved disinfectants for C.*diff*

B. Symptoms of C. *diff* ~~may include~~Infection (CDI)

1. loose, watery stools~~,~~ (typically more than three in a 24 hour period of time)
2. Colitis - severe bowel inflammation
3. fever~~,~~
4. stomach pain or tenderness~~,~~
5. loss of appetite ~~and/or~~ /dehydration
6. nausea~~. A thorough assessment of~~
~~1.~~7. symptoms should be ~~documented~~recorded in the medical record including any evidence of recent exposure and/or previous *C. diff* infections.

~~B. Care providers will adhere to current practices to prevent *C. diff* infection and colonization that includes but is not limited to performing appropriate hand hygiene, consistent use of Standard Precautions, appropriate use of personal protective equipment (PPE), and judicious use of antibiotics.~~

8. ~~Contact~~ Three (3) or more stools in 24 hour period:
   i) Contact provider without delay regarding suspicion of CDI for further testing and empirical treatment before test results are known.
   ii) Contact IP/team for follow up
   iii) Implement Contact Precautions without delay including gloving with every patient care interaction (even if short), and/or contact with patient items
   iv) Contact EVS to clean high touch room surfaces thoroughly on a twice daily basis and upon patient discharge or transfer using an EPA-approved disinfectant with sporicidal kill claims.
   v) In the event of a patient transfers (such as hospital or new facility), notify the new facility if the patient has or had a *CDI*

C. Standard Precautions

1. During every patient contact
2. When unexpected or watery diarrhea is observed, consider CDI as a potential diagnosis and implement contactprecautions to prevent transmission of CDI until diagnosis is ruled out
3. Hand washing using soap and water (c.*diff* is an anaerobic spore-forming bacteria and does not respond to alcohol-based gels)

4. Meticulous hand washing with soap and water, glove and gown use for any patient care interactions – eye protection may be needed

D. Transmission-based Precautions Implementation

1. Enhanced Contact Precautions shallwill be observedimplemented from the time that new or worsening diarrhea that cannot be contained is noted. Contact
3.2. Enhanced Contact Precautions shall be initiated for any unexplained or watery diarrhea and shall not be delayed pending culture results, according to LHH guidelines for diarrheal illness and C. diff infection (72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions) that includeincluding but are not limited to:

a. Provide a private room with private bathroom, as described below.

i.i) A private room with a private bathroom is necessary to prevent the spread of C. *diff* spores to environmental surfaces during showering and toileting.

ii. If a private room with a private bathroom cannot be provided then residents with C. *diff* infection or colonization may be cohortedco-horted in the same room or in closed double or triple rooms.

b.ii) Notify the Infection Control Nurseas long as soon as reasonable and place a Contact Enhanced Precaution sign on or next to the outsidethey do not have additional infectious concerns (presence of the door. multiple drug resistant organisms.)

3. Place an isolation cart outside of the room stocked with gowns and gloves at minimum. Add face shields if procedures that may splatter. Post contact enhanced precautions signs on door entrance
4. Remove alcohol-based hand wipes from cart if present - Wash hands with soap and water only. Alcohol-based hand rub is not effective against *C. diff* spores. ; bleach-based

c. Use an Environmental Protection Agency (EPA)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning products in accordance with label instructions. (Note: Only hospital surface disinfectants listed on EPA's List K are required to eliminate registered as effective against *C. diff* spores.

d.5. Place bleach wipes on cart and use). Use to disinfect high touch surfaces at least twice daily, including but not limited to call light, bed rails, door handles, and faucets.

e. Use bleach solution for daily cleaning by EVS staff.

~~f. Wash hands with soap and water only. Alcohol-based hand rub is not effective against *C. diff* spores.~~

6. Provide dedicated equipment that is disposable ~~or~~if possible

~~g.~~7. Do not ~~removed~~remove medical equipment from the room until Contact Enhanced Precautions are lifted, and the equipment is cleaned with ~~a bleach based~~an EPA-approved sporicidal product (e.g., vital signs equipment and ADL assistive devices).

~~h.~~8. Nursing staff will communicate need for Contact Enhanced Precautions to resident, visitors, and EVS. Educate as appropriate to the level of contact and understanding.

E. Outbreak Management

1. An outbreak of *C. diff* infection is defined as three (3) or more cases of *C. diff* infection (CDI) occurring in the same area/ unit of the facility within a period of six (6) days or less.

~~i. Before entering room, wash hands with soap and water, don gown, then gloves.~~

~~j. Before leaving room, remove and discard gloves, then gown, then wash hands with soap and water.~~

~~D. Cultures for *C. diff* are processed using watery, unformed or loose stool specimen less than 24 hours old. Specimen collection should be placed in a clean, watertight container without preservative. Refrigerate specimens at 4°C pending testing. (The microbiology lab will not process formed stool specimens).~~

~~a. Retesting to verify treatment effect or to screen asymptomatic residents is not advised as colonization can be long lasting without the resident being infectious~~

2. ~~Notify the Infection Control Nurse (ICN) of cultures positive for *C.*~~ Contact the Infection Preventionist (Nursing Ops during weekends/off shifts) for outbreaks.
3. The IP will report to SFDPH following A8 Outbreak/Epidemic Investigation Protocol.

~~b. *diff*. ICN is also informed via daily culture reports.~~

~~5.~~4. Group activities and non-essential appointments should be postponed while the resident(s) has diarrhea that cannot be easily and reliably contained.

~~a. Dialysis Centers do not generally accept residents with active *C. diff* infection until 48 hours without diarrhea and 5 days of therapy, therefore clinical and lab~~

~~monitoring to evaluate the need for acute hospitalization and dialysis is necessary.~~

~~b.~~5. For essential appointments or transfer to another facility, alert the receiving staff, dress resident in clean clothing and contain incontinence (e.g., with adult briefs). Alert facility about the need for Contact Enhanced Precautions.

F. Disinfection

1. *C. difficile* spores can survive in the environment for months or years due to their resistance to heat, drying, and certain disinfectants.
2. Patient room surface environment is frequently contaminated with *C. difficile* , including floors, commodes, toilets, bedpans, and high-touch surfaces, such as call bells and overbed tables (2018 Pubmed)
3. Surfaces should be kept clean, and body substance spills should be managed promptly
4. Routine cleaning should be performed prior to disinfection.

~~F.~~ EPA-registered disinfectants with a sporicidal claim have been used with success for environmental surface disinfection in those patient-care areas where surveillance and epidemiology indicate ongoing transmission of *C. diff*.~~Contact Enhanced Precautions may be lifted once the resident has completed 5 days of treatment and has had no diarrhea for at least 48 hours. Notify the ICN for guidance to discontinue Contact Enhanced Precautions.~~

5.

6. EPA-registered disinfectants (List K) are recommended for use in patient-care areas. Follow product labels for inactivation claims, indications for use, and instructions.

G. C. *diff* colonization (also known as c.*diff* carriers)

1. Colonization of c.diff means that the person has the c.diff bacteria by coming into contact with someone with c.dff but they do not have the infection.
2. Colonization with *C. diff* is more common than infection and may remain colonized for several months
3. No treatment is required for colonization of c.diff
4. It is possible to transmit C.*diff* to others when colonized and good hand washing with soap and water after using the bathroom is required
5. Colonized patients do not have disease caused by *C. diff* and often exhibit NO clinical symptoms (asymptomatic) of infection (e.g., diarrhea)
6. Colonized patients do test positive for the *C. diff* organism or its toxin

7. The difference is that patients with CDI infection exhibit clinical symptoms and test positive for the *C. diff* organism or its toxin
8. Because there is remains the potential of transmission with c.diff colonization, discontinuing contact precautions will be made in collaboration with nursing, IP, and medical staff care team based upon the patients ability to comply with handwashing and other precautions.

~~7.An outbreak of *C. diff* infection is defined as three (3) or more cases of *C. diff* infection (CDI) occurring in the same area/ unit of the facility within a period of six (6) days or less.~~

~~a. Notify the Infection Control Nurse.~~

~~b. Cohort infected residents and implement consistent staffing.~~

~~c. Implement Contact Enhanced Precautions as for an individual case.~~

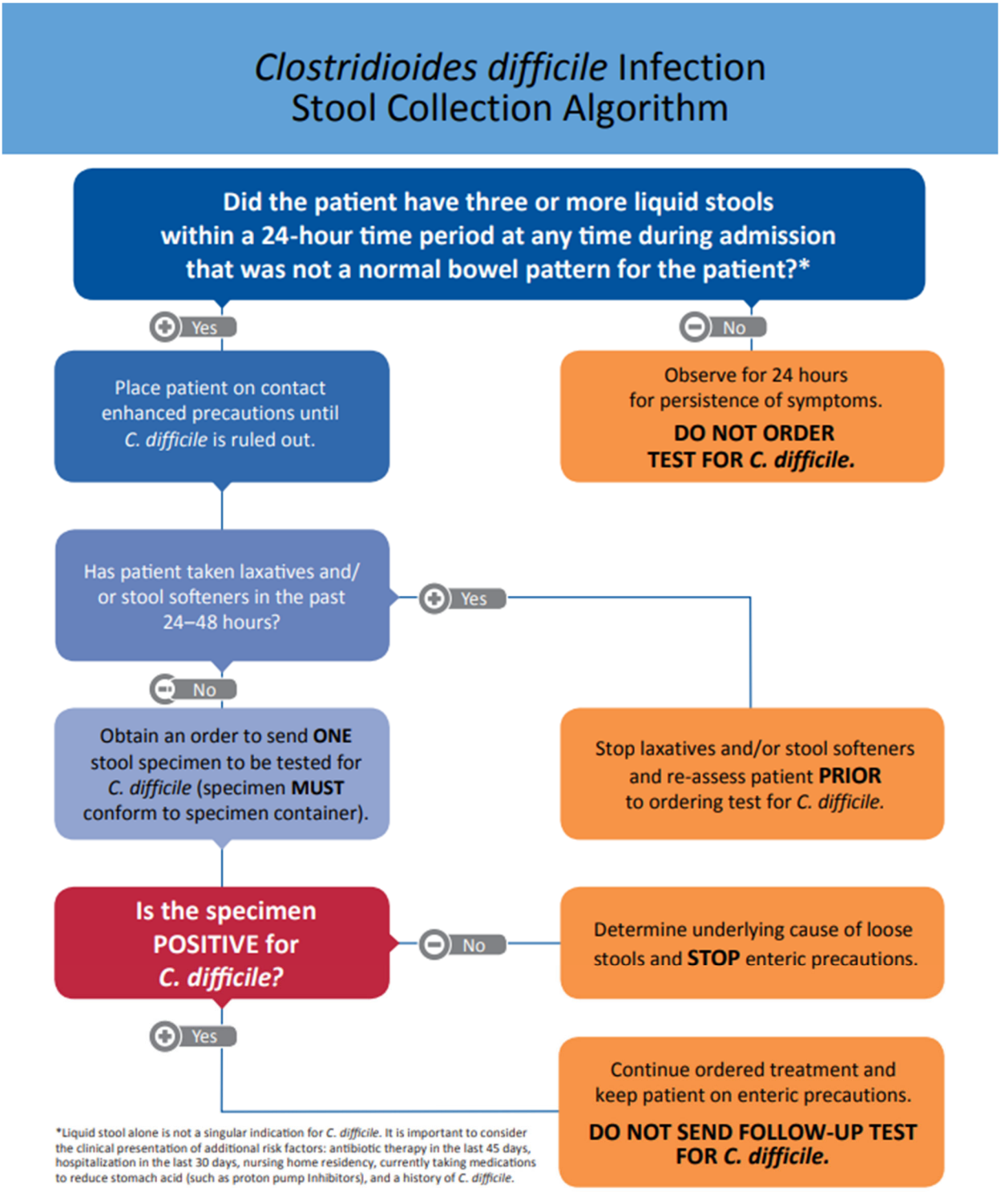
~~d. Report to SFDPH Communicable Disease **Prevention** and Control unit at (415) 554-2830 within 24 hours if outbreak occurs during weekend or evenings following A8 Outbreak/Epidemic Investigation Protocol.~~

~~e. Provide education and monitoring on proper hand hygiene and Contact Enhanced Precautions.~~

ATTACHMENT:
~~None.~~
LHH CDI Testing Algorithm

REFERENCE:
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission Based Precautions and Resident Room Placement
LHHPP 72-01 C1 Alphabetical List of Diseases/ Conditions with Required Precautions
APIC, 2008, Guide to the Elimination of Clostridium difficile in Healthcare Setting
CDC Advancing Excellence, *C. difficile* Infection Prevention Assessment Checklists, updated September 15, 2015~~, available at~~
~~http://www.cdc.gov/longtermcare/prevention/index.html~~
CDC (2022). FAQs for Clinicians for c.*diff*
Pubmed (2018). Crobach, M., Vernon, J. J., Loo, V. G., Kong, L. Y., Péchiné, S., Wilcox, M. H., & Kuijper, E. J. (2018). Understanding Clostridium difficile Colonization. *Clinical microbiology reviews*, *31*(2), e00021-17. https://doi.org/10.1128/CMR.00021-17

Revised: 16/07/12, 18/11/13, 20/10/13, 22/10/03 (Year/Month/Day)
Original adoption: 05/11/01



INFLUENZA IMMUNIZATION FOR PATIENTS

POLICY:

1. Laguna Honda Hospital (LHH) residents ~~who meet~~will be provided the ~~established Centers for Disease Control and Prevention (CDC) clinical criteria shall be screened or evaluated for the~~current influenza vaccine ~~seasonally October 1 through March 31, subject to the status of~~ upon their consent during the influenza season ~~within the community.~~which is generally October to March of each year.

~~2. Before offering the influenza vaccine, the resident or responsible party has the opportunity to refuse the immunization.~~

   Using the Standard Influenza Vaccination Protocol, the LHH RN may order influenza vaccinations under specific criteria provided in this policy. Those patients not meeting that protocol criteria will be referred to a prescriber for follow up.

~~3.~~2. The resident's electronic health record will include documentation indicating education provided and if the resident received the influenza vaccine or did not due to medical contraindication or refusal.

PURPOSE:

~~To reduce morbidity and mortality from influenza, residents who meet the clinical criteria established by the CDC will be vaccinated with the influenza vaccine.~~
The purpose of this policy is to provide HCP information for administration of the annual influenza vaccine to patients / responsible parties including education, annual consent, reporting and documentation.

PROCEDURE:

Standard RN protocol for ordering influenza vaccine annually for patients residing at LHH includes:

~~1.~~ The Registered Nurse (RN) screens upon admission during the influenza season and current in-house residents at the start of the influenza season to order the influenza vaccine using the Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines for Residents Admitted to LHH.

a. ~~The~~ If any of the following are ~~criteria for fails~~applicable to ~~meet criteria for~~ the patient, the LHH RN ~~to~~may not order an influenza vaccine but must obtain a physician consultation prior to administration:

   i. Documented confirmation resident received vaccine this season~~;~~

   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~~

- v. Pregnancy

~~When resident~~

- vi. Patient/responsible requests ~~to discuss~~consult with physician regarding advisability of taking the 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 eligibility to receive the vaccine.~~

~~2. The influenza vaccine shall be primarily ordered by the RN for residents who meet the criteria in the standardized procedure.~~

~~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).~~

3. Education and Consent:

~~4.~~a. The licensed nurse shall provide the resident or responsible party with the current year CDC Vaccine Information Statement (VIS) for the influenza vaccine prior to administering the vaccine.

b. Screening for Influenza Vaccination is completed prior to administration of the vaccine

c. Consent is obtained prior to vaccination administration

~~5.~~d. The licensed nurse documents the resident's vaccine administration and education provided in the electronic health record. If the vaccine was not given, document the reason(s) it was not administered.

~~6.~~e. Adverse Event: Nursing completes an Unusual Occurrence report and documents on the electronic health record if there are any unexpected or significant adverse events to the vaccine.

ATTACHMENT:
None.

REFERENCE:

Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines For Residents Admitted to LHH.

Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Register/vol 70, No. 194, 42 CFR Part 483 Medicare and Medicaid Programs, Condition of Participation: Immunization Standard for Long Term Care Facilities.

CDC Seasonal Influenza Vaccination Resources for Health Professionals available at: https://www.cdc.gov/flu/professionals/vaccination/index.htm

CDC Influenza ACIP Vaccine Recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

CDC Vaccine Information Statements (VIS) available at: https://www.cdc.gov/vaccines/hcp/vis/index.html

Immunization Action Coalition Vaccine Information Statements available at: https://www.immunize.org/vis/

Revised: 11/07/26, 17/09/12, 19/05/14, 20/01/14, 20/10/13 22/10/03(Year/Month/Day)
Original adoption: 05/11/01

EMPLOYEE INFLUENZA VACCINATION

POLICY:

1. Laguna Honda Hospital (LHH) ~~must abide by~~is required to adhere to the California state law (SB739) requiring hospitals and like facilities to offer influenza vaccines free of cost to all employees. Employees are required to either ~~get vaccinated~~receive the annual influenza vaccine or sign a declination statement and follow additional precautions during periods of high viral circulation.

2. LHH ~~is also under~~will adhere to the local health department, San Francisco Department of Public Health (SFDPH), that requires all San Francisco hospitals, skilled nursing facilities, and other long-term care facilities to implement mandatory masking of unvaccinated employees in patient care areas during the defined influenza season for the current season.

3. All LHH employees shall be provided an influenza vaccine, unless medically contraindicated during the influenza season as defined by the local health department.

4. Directors, supervisors, and managers are responsible for enforcing and monitoring masking compliance by unvaccinated employees during the influenza season.

5. Repeated non-compliance with masking by an unvaccinated ~~employees~~employee during the influenza season ~~shall~~may result in disciplinary action ~~according to~~as defined by the Human Resources departmental procedures for repeated non-compliance.

PURPOSE:

1. Provide explicit standards for all employees regarding required documentation of influenza vaccination or influenza vaccine declination.

2. Ensure directors, supervisors, and managers are informed of required influenza vaccination or declination procedures for the current influenza season. This communication can be conveyed, but is not limited to, the following methods: email, intranet web postings, meetings, memorandums, signage throughout the facility, and leadership messaging.

3. Ensure that unvaccinated employees are masking for the duration of the influenza season defined by SFDPH at all times in the hospital building, except for break rooms.

4. The rule announced a requirement for SNFs to report HCP influenza vaccination summary data beginning on October 1, 2022. Beginning with the 2022-2023 influenza season, SNFs must submit data for the entire influenza vaccination season (October 1 through March 31) to NHSN.

~~3.~~5. HCP influenza vaccination summary data submitted to NHSN by May 15 is reported by CDC to CMS for each SNF CMS Certification Number (CCN). CDC provides an HCP influenza vaccination percentage for each reporting SNF CCN.

BACKGROUND:

Influenza is a serious respiratory disease that kills approximately 36,000 persons in the United States every year. Hospitalized patients are particularly vulnerable to disease exposures. Influenza season is generally considered to be October through May for the highest circulation of the virus; however, influenza virus is now considered to be circulating year-round and clinicians should include influenza in any respiratory illness diagnostic consideration regardless of the season. The influenza vaccine reduces the risk of influenza by 40-60% when the vaccine is well matched with the circulating strain. The vaccination may not prevent influenza but can lessen the severity and hospitalization once infected. (CDC, 2022)

PROCEDURE:

1. Before the start of the influenza season, employees may obtain the influenza vaccine from the LHH Medical Clinic or provide proof of vaccination from another location (e.g. primary care provider) to the clinic. LHH Medical Clinic will make reasonable attempts to ensure influenza vaccination is available to all shifts and on weekends.

2. Employees who have not received the influenza vaccine elsewhere and decline receiving an influenza vaccine at LHH must complete a declination form and abide by mandatory masking implemented by SFDPH. ~~Employees who have not received their influenza vaccine shall not eat in the cafeteria. An additional break room will be provided during the mandatory masking period for unvaccinated employees.~~

3. Employees who have not received their influenza vaccine will be asked to physically distance themselves from others during eating and drinking (when universal masking protocols are not in place.)

~~3.~~4. Unvaccinated employees who are non-compliant with mandatory masking shall receive a verbal warning from their director, supervisor, or manager the first time they are observed without a mask or improperly wearing a mask~~..~~. Directors, supervisors, and managers shall report further instances of non-compliance to Human Resources for further disciplinary action.

~~4.~~5. Vaccinated employees shall be given a sticker on their identification badge. LHH Medical Clinic maintains a list of employee influenza vaccination status.

~~5.~~6. Any local, state, or federal public health emergency guidance may supersede the above procedures outlined in this policy.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 D4 Evaluation of Communicable Illness in Employees

Revised: 13/01/29, 14/11/25, 17/01/10, 17/09/12, 18/09/11, 19/03/21, 20/10/13, 22/10/03 (Year/Month/Day)
Original adoption: 09/12/15

GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS

POLICY:

1. Laguna Honda Hospital ~~–~~and Rehabilitation Center (LHH) shall ~~adopt~~adhere to regulations~~ and recommendations~~ provided by Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH) California Tuberculosis Controllers Association (CTCA), and San Francisco Department of Public Health (SFDPH) TB Prevention and Control Program. Effective September 1, 2021, CDPH is following the latest CDC guidance for tuberculosis (Tuberculosis Control Branch, Tuberculosis Guidelines and Regulations.)

PURPOSE:

1. Design and implement a program for screening residents and staff for latent and active TB infection.

2. Reduce the transmission of TB through prompt detection and management of active tuberculosis disease.

3. Comply with federal, state, and local regulation.

DEFINITIONS:

Tuberculosis: According to the CDC, Tuberculosis (TB) is caused by the bacterium *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick with symptoms. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

Tuberculosis Disease (T.B.) (formerly known as active T.B): When TB bacteria are active (multiplying in the body), this is called TB disease. People with TB disease are sick and are capable of spreading the bacteria to others with whom they come into contact.

Latent TB infection: The TB bacteria can live in the body without causing symptoms. In most cases, those who breathe in the TB bacteria from others, become infected but the body is able to fight the bacteria to stop them from growing and causes TB disease with symptoms. Those with LTBI cannot spread the disease to others but may test positive for T.B. because the bacteria is in their body.

PROCEDURE:

1. LHH will follow the CDC three-~~tired~~tiered level of hierarchy to control tuberculosis in the facility:
    a. Administrative
    b. Environmental
    c. Respiratory Protective Equipment

~~1.~~2. 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 SFDPH TB Prevention and Control Program, or when they are no longer infectious.

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. Do not perform a skin test on someone with known TB. This could cause a severe reaction.

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. The TST shall be read at 48 hours from placement.

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 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 of TST screening.

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.~~3. 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 SFDPH TB Prevention and Control Program within 1 working day. Per SFDPH TB Prevention and Control Program 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 SFDPH TB Prevention and Control Program.

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 SFDPH TB Prevention and Control Program.

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 SFDPH TB Prevention and Control Program. 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. Refer to LHHPP 72-01 A9 Contact/Exposure Investigation.

~~3.~~4. Employee New Hire and Annual Screening

a. Screening Schedule

i. Employees shall be screened for tuberculosis within 90 days prior to work, and annually thereafter.

ii. Employees will receive a notification from LHH Medical 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 LHH Medical Clinic or Department of Education and Training (DET) to department directors, supervisors, and managers each month. Department directors, supervisors, and managers are responsible for follow up on annual health requirement non-compliances reported to them. Employees who are non-compliant for their annual TB screening will be followed up according to Human Resources departmental protocols.

b. Employees with Documented History of Positive TST/IGRA/History of Active TB

i. Employees 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 employee 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 employee must be promptly referred to their healthcare provider for evaluation. The employee must not be allowed to work until they ~~is~~are determined not to have infectious TB. Written medical clearance must be provided.

c. Employee 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 employees who have never been tested, or if more than 12 months have elapsed since the last documented negative TST.

v. Employees who have received the Bacilli Calmette-Guérin (BCG) vaccine shall be included in the TST screening program.

vi. In uninfected employees, a positive result on any future TST shall be interpreted as a skin test conversion.

vii. Employees 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.~~5. Employee Conversions

a. Employee 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 employees must be excluded from work until active TB disease is ruled out and written medical clearance is provided

~~5.~~6. Employee Post-Exposure Screening

a. Employees who have been exposed to a confirmed case of active pulmonary TB disease must receive a TB symptom screen.

b. Symptomatic employees must have a CXR immediately and referred for medical evaluation.

c. If an employee 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 employee shall be tested in 8-10 weeks following exposure.

d. If an employee is asymptomatic and has a negative TST/IGRA greater than 3 months of exposure to a confirmed case of active pulmonary TB disease, the employee shall be (TST/IGRA) tested as soon as possible, and the test repeated in 8-10 weeks following the last exposure.

~~6.~~7. Employee Reporting of Positive TSTs

a. Employees who test positive following initial negative TST/IGRA results upon hire are classified as conversations and shall be reported to Zuckerberg San Francisco General (ZSFG) Occupational Health Services (OHS), which oversees LHH Medical Clinic for employees.

~~7.~~8. Employee Training and Education

a. Employees are trained upon hire and annually in methods to identify, prevent, and control the transmission of TB.

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 available at: https://ctca.org/guidelines/cdph-ctca-joint-guidelines/
SFDPH Communicable Disease Control and Prevention, TB Control, Information for Medical Providers available at: http://sfcdcp.org/tbinfoforproviders.html

CDPH Tuberculosis Control Branch (9/2021). Tuberculosis Guidelines and Regulations. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Guidelines-and-Regulations.aspx

CDC.(5/2019).TB Infection '\Control in Healthcare Settings. https://www.cdc.gov/tb/topic/infectioncontrol/TBhealthCareSettings.htm

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, 20/10/13, 22/10/31 (Year/Month/Day)

Original adoption: 05/11/01

CARE OF TUBERCULOSIS PATIENT PLACED ON CIVIL DETENTION

BACKGROUND:

The San Francisco Department of Public Health (SFDPH) Health Officer has authority under state law to detain a patient for the purposes of diagnosis, treatment, and/or isolation of tuberculosis infection. The California Department of Public Health (CDPH) and the California Tuberculosis Controllers Association (CTCA) have established guidelines for the civil detention of persistently non-adherent tuberculosis patients in California.

When the SFDPH Health Officer issues a civil detention order, the order must describe less restrictive alternatives attempted and only if those alternatives fail, and public safety is put at risk by a patient's continued non-adherence (including mental illness, homelessness, and substance abuse) with less restrictive alternatives, may detention be considered appropriate. Detention is a very costly intervention and shall only be used when less costly interventions have been unsuccessful.

The SFDPH shall initiate civil detention at SFDPH facilities after other less restrictive means to ensure compliance with examination/isolation/quarantine protocols have been exhausted, and it is determined that placement within a SFDPH facility is needed to ensure compliance with support from the San Francisco Sheriff's Department (SFSD) and to avert a health threat to the public.

POLICY:

1. The purpose of this policy detention is primarily to guide staff during the detention of non-infectious TB patients for the purpose of completing an adequate course of therapy. However, detention may be necessary for certain patients for the period during which they are infectious and where respiratory isolation is possible in some long-term care sites.

~~1.~~2. Laguna Honda Hospital (LHH) shall admit and provide care to a person who has been placed on a civil detention order for persistently being non-adherent with their tuberculosis (TB) treatment, failed to complete their TB treatment when placed in a less restrictive environment, and poses a health threat to the public.

~~2.~~3. The decision on the appropriateness of admitting a patient under a civil detention order shall be made by the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Infection Preventionist (IP), and Chief Nursing Officer (CNO) based on the facility's ability to provide quality care to the patient. The patient may or may not meet skilled nursing facility (SNF) level of care criteria.

~~3.~~4. These patients shall be admitted Monday to Friday excluding holidays secondary to the extra coordination between services that is required, and the limited availability of resources during those times.

~~4.~~5. LHH shall utilize the CDPH/CTCA joint guidelines when appropriate in providing care for the TB patient who is under a civil detention order.

5. LHH staff shall work collaboratively with staff from the SFDPH TB Prevention and Control Program to plan the patient's admission, ongoing care, and discharge plans.

6. The conditions of civil detention shall be as therapeutic as possible and be designed to protect the rights of the individual, while at the same time balanced with the legal, ethical, and moral responsibilities of a health care provider to protect the public from TB.

7.6. A patient placed under a Health Officer's Civil Detention Order shall not be detained for more than 60 days without a court order authorizing detention.

8.7. The facility shall obtain a subsequent court review; within 90 days of the initial court order, and thereafter within 90 days of each subsequent court review; if the patient requires on-going detention to complete their TB treatment and continues to pose a health threat to the public

PURPOSE:

1. The purpose of this policy is to provide guidelines for the following considerations:

   a. Decision-making for appropriateness of patient placement at LHH,

   b. Room placement and additional transmission-based precautions as required,

   c. Supervision by personnel from the San Francisco Sheriff's Department,

   d. Patient's rights,

   e. Collaboration with SFDPH TB Prevention and Control Program on patient care management,

   f. Patient need for a higher level of care,

   g. Patient need for a lower level of care,

   h. Discharge planning, and

   i. Release from civil detention.

PROCEDURE:

1. The SFDPH Health Officer identifies a person in the community who has violated an examination or isolation order or has persistently been non-adherent to tuberculosis treatment and poses a health threat to the public. The Health Officer prepares and issues a "Civil Order of Detention and Completion Treatment for TB" to the patient and the SFDPH TB Prevention and Control Program refers the patient for placement at LHH.

2. The CEO, CMO, IP, and CNO reviews the information submitted by SFDPH TB Prevention and Control Program and if deemed appropriate for SNF placement, agrees to accept the patient for placement at LHH.

3. The patient shall be admitted to an airborne infection isolation room (AIIR) if still actively infectious or regular room if not deemed to be infectious by SFDPH TB Prevention and Control Program TB Controller or designee.

4. The patient who is placed under a Civil Detention order shall be monitored by staff from SFSD, who shall be stationed outside of the patient's room, and shall accompany the patient whenever they participate in activities held outside of the patient's room if the patient is not in respiratory isolation.

5. The SFDPH TB Prevention and Control Program shall be consulted for TB medication treatment orders and the frequency of acid–fast bacilli (AFB) sputum smears and cultures to determine the infectiousness of the patient.

6. The required SNF admission and continuing care orders and processes shall be completed in the same manner as other LHH patient admissions.

7. The required SNF comprehensive assessment, care planning, patient care conference meetings, informed consent and documentation processes shall be completed according to LHH policies and procedures.

8. If the patient requests release from detention, the request shall be communicated to SFDPH TB Prevention and Control Program, LHH Quality Management department and the Deputy City Attorney to enact the following:

    a. An application for a court order authorizing continued detention shall be made within 72 hours after the request.

    b. Patient detention shall not continue for more than 5 business days in the absence of a court order authorizing detention.

9. The patient with a civil detention order with or without a court order may be detained only until they complete treatment and cannot be forced to take medications.

10. Weekly reviews on the patient's progress with TB treatment and patient's expressed interests for activities or schedule at LHH shall be conducted by staff from Nursing, Medicine, and other members of the patient care team, Infection Control, SFDPH TB Prevention and Control Program, Deputy City Attorney and other members of the administrative team. The frequency of reviews may be decreased when deemed appropriate based on the consensus of the entire team.

11. Weekly reviews shall be conducted to determine appropriateness of continued placement at LHH. The frequency of reviews may be decreased when deemed appropriate.

12. Discharge planning back to the community shall be initiated when the SFDPH Health Officer or the SFDPH TB Prevention and Control Program TB Controller determines the patient has completed their course of TB treatment and civil detention is no longer necessary.

13. If civil detention is no longer required, the patient shall be discharged in conjunction with advice from SFDPH TB Prevention and Control Program to the appropriate level of care.

ATTACHMENT:
None.

REFERENCE:
CDPH/CTCA Joint Guidelines for the Civil Detention of Persistently Non-Adherent Tuberculosis Patients in California available at: https://ctca.org/wp-content/uploads/2018/11/FINLCivil_Detention092311_.pdf
LHHPP 20-01 Admission to LHH Acute and SNF Relocation Between SNF Units
LHHPP 72-01 B5 Transmission-Based Precautions and Patient Room Placement

Revised: 20/10/13, 22/11/03 (Year/Month/Day)
Original adoption: 18/05/08

INFECTION CONTROL FOR REHABILITATION SERVICES

POLICY:

1. ~~Every member~~Members of the Laguna Honda Hospital (LHH) Respiratory Therapy department play an active role in preventing and controlling the spread of infection when providing therapy, and shall adhere to established infection control policies, procedures, and standards when in the facility.

2. Department managers are responsible for training their staff on department specific infection control procedures~~,~~ in collaboration with the Infection Preventionist (IP), including isolation precautions that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

~~To maintain effective infection prevention and control practices to support safe, sanitary and comfortable environment and prevent the development and transmission of infection in the rehabilitation department and Wellness Center areas.~~
The purpose of this policy is to provide guidance for the Respiratory Therapy team members for the prevention and transmission of infections while providing respiratory therapy to patients.

Responsibilities:

1. Occupational, Physical, and Speech Therapy Senior Therapists

   a. Assess resident care and safety within the department.

   b. Evaluate products for use with direct patient care.

   c. Ensure proper maintenance and cleaning of all equipment.

   d. Periodically review and update all procedures and equipment.

   ~~e. Submit all policies and procedures that may present an infection hazard to the Infection Control Committee for review.~~

   e. Collaborate with the Infection Preventionist (IP) for infection control policy, education, and training to reduce the transmission of infectious diseases during the care of the patient with respiratory needs.

2. Staff Responsibilities

   ~~a. To be aware of procedure and follow through on their use.~~

~~b. To present possible problems to their respective department head.~~

a. Understand the general principles of Standard and Transmission-based Precaution (TBP) and be familiar with 3 types of TBP: Contact, Respiratory (droplet) and Airborne Precautions and the associated PPE and precautions for each
b. Adhere to Standard and Transmission-based precautions as directed

c. Collaborate and report to manager and IP, for infection control concerns

PROCEDURE:

1. Residents

~~a. Isolation precautions~~

a. Standard and Transmission-based Precautions

i. Rehabilitation Services ~~follow orders for isolation within~~ will comply with Standard Precautions when in the ~~resident medical record and follow instructions is placed on room signage.~~facility include use of required PPE

ii. ~~Most residents who are in private isolation rooms are there to rule in or rule out contagious~~ Rehabilitation Services will comply with Transmission-based Precautions (TBP) where appropriate, including required use of personal protective equipment (PPE), hand and respiratory hygiene, and other safety measures as required for TBP during the infectious ~~disease. These residents should receive rehabilitative~~ period.
iii. TBP's include Respiratory/Droplet Precautions, Contact Precautions and Airborne Precautions
iv. Rooms will be clearly marked with signage for TBP and Isolation (ISO) carts will be in close proximity of the room with needed PPE supplies.
    a. Notify the nursing staff if these items are not present or if supplies need to be replenished
    b. Strict adherence is required

~~ii.~~v. In room therapy ~~within their room or in the department by arrangement~~may be provided for some residents, after an interdisciplinary consultation ~~including~~with Infection Control ~~professionals.~~, and medical teams

- For residents on ~~wound~~Contact precautions, if the wound can be adequately covered, the resident may attend therapy sessions.
- Residents with ~~active~~ tuberculosis disease, chickenpox, measles, rubella, disseminated herpes zoster, and infectious diarrhea shall not attend therapy sessions outside of their rooms since the risk of transmitting infection to others is ~~possible~~higher.

- Residents ~~can~~may have therapy sessions in their room, following appropriate infection precautions as outlined on the sign posted outside the resident's room.

b. All mat tables, plinths, wheelchairs, wheelchair cushions, tables and other therapeutic materials such as walkers, canes, tilt tables and exercise machines will be cleaned with EPA approved disinfectants daily and after each treatment when the resident is in direct contact with such equipment, ~~-~~or resident's body substances or fluids have come into contact with the therapeutic equipment.

c. Linen on mats will be changed by staff after each resident's use.

d. Soiled linen shall be placed in impervious plastic bags and must be securely closed during transport.

e. Floor mats will be cleaned with EPA approved disinfectants daily and after use by an incontinent resident.

f. Rehabilitation staff with cuts, abrasions, rashes, or minor infections on hands shall be covered with gloves or finger cot while working. Employees with draining skin lesions shall not provide resident care requiring direct resident contact and may be referred to Occupational Health or the Infection Control Nurse.

g. All body substances and fluids are considered to be potentially infectious.

   i. Use gloves for anticipated exposure to mucous membranes and body substances from all residents.

   ii. Dispose of sharps carefully in puncture-resistant containers.

h. For potential or anticipated exposure to body substances or fluids, staff must wear gloves. Hands must be washed or sanitized before and after glove use.

2. Visitors

a. Visitors can be permitted in the rehabilitation areas for teaching and demonstration purposes.
b. Visitors are asked to follow hand hygiene, and cough /sneeze hygiene
c. Alcohol-based hand sanitizers and handwashing sinks with soap and papers towels will be provided and readily accessible

3. Materials

a. Sterile products

i. All instruments and materials must be packaged according to approved procedures. IP will provide oversight and collaborative assessments for maintaining sterility as needed

ii. Senior Therapists (OT, PT, and ST) must be certain that all requirements of cleaning, sterilizing, wrapping, packaging, and storage are met, and that all stored sterile supplies are routinely checked for wrapper integrity and expiration dates.

b. Disposable items

i. Must be properly stored and not reused.

ii. Must be discarded via proper procedure for type of material and hospital regulations.

iii. Infectious waste will be disposed of in the red waste container in the biohazardous waste storage room.

iv. Needles or sharps are single-use only items and will be properly disposed of immediately after use into the needle box

v. Needle boxes will not be overfilled but emptied at ¾ fill line; safety lid must close completely with nothing protruding outside the safe zone of the closed lid. Dispose of filled needle containers per hospital requirements.

4. Equipment

a. Senior Therapists (OT, PT, ST) are responsible for written policies on proper maintenance and cleaning of all equipment. A yearly routine preventive maintenance schedule for all equipment has been established.

b. Records of maintenance and cleaning will be kept.

5. Housekeeping - The Apartment

a. Kitchen counter tops shall be cleaned by a therapy aide daily and after each use of the kitchen utilizing the 3 bucket (wash, rinse, sanitize) method~~.~~ using the appropriate EPA approved cleaner/disinfectant

b. Oven is cleaned daily and as needed.

c. Refrigerator is cleaned weekly.

6. Food Preparation, Handling and Storage

a. Most food used for food preparation training is obtained from Food Service.

b. When a resident requires training with specific items not available from Food Service (e.g., boxed food; cultural food choices, etc.) items are purchased from an approved or reputable supplier (supermarket).

7. Storage of Food

a. Staple food is stored in dated, closed containers, in small amounts.

b. All perishable foods are date labeled and stored at proper temperatures and temperature records are kept:

i. Fruits, vegetables, dairy products, meats and poultry are stored at temperatures below 41° F. Digital temperatures are tracked centrally by Facilities Services.

ii. Frozen foods are stored at temperatures below 0° F

iii. When food or liquid is given to a resident, any unused portion is to be discarded, unless it is to be consumed by the same resident within 1-2 days in which case, it will be labeled with the current date, resident's name, and refrigerated.

iv. Separate and color-coded chopping boards are used for raw meats. These chopping boards shall be washed thoroughly using the 3-bucket method, followed by sterilization in the industrial dishwasher located in the Apartment.

v. Chopping boards used for raw meats shall not be used for other foods.

ATTACHMENT:
None.

REFERENCE:
LHHPP 26-05 Neighborhood Specialty Meal Program
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement

Revised: 14/01/29, 16/01/12, 20/08/25, 20/10/13, 11/04/22 (Year/Month/Day)
Original adoption: 11/01/01

RENOVATION / CONSTRUCTION INFECTION CONTROL GUIDELINES

POLICY:

1. The Centers for Disease Control and Prevention (CDC) requires healthcare facilities to perform an Infection Control Risk Assessment (ICRA) before any renovation, construction, or repair projects.

2. The completed ICRA provides for a controlled plan for the removal of building materials or construction project in healthcare facilities that does not place residents at risk for transmission of pathogens in a vulnerable population.

3. The Infection Control Nurse (ICN) shall be consulted by Facility Services or project manager during preconstruction planning for facility renovation and construction projects.

4. Construction and/or remodeling on the campus will be completed by construction teams that are skilled and trained in the standards for healthcare construction.

5. Construction teams will include the ICN during the planning, pre-construction, construction, and post construction phases at a minimum.

6. The ICN will provide regular surveillance and oversight of the project and the project area to report back to the Infection Control Committee (ICC).

PURPOSE:

1. To provide guidance to the healthcare and construction team for containing dust, fungi (including *Aspergillus*), chemicals, bacteria (including *Legionella*), and other microbial contamination that can be transmitted via the air, plumbing, or from ground disturbance during construction that is required to be minimized during the work phases of construction/renovation projects.

    a. Soil, water, dust, and decaying organic matter can provide a source of infections when introduced to a vulnerable population that can gain entrance to the facility on construction materials, tools, and the construction workers' clothes and shoes.

2. To engage best practices and healthcare construction standards are integral in the design, demolition, and construction of resident care and other areas that facilitate the desired infection control practices that is guided by completion of the ICRA.

3. To minimize infectious risks associated with internal renovation projects in resident care areas, and that the necessary controls and interventions are in place.

PROCEDURE:

1. Project Planning

The ICN and Industrial Hygienist shall be advised by the Facility Services department or project manager of plans for renovation and/or new construction. The ICRA shall be a part of integrated facility planning, design, construction, and commissioning activities; and shall be conducted during the early planning phase of a project, before construction begins; and continue through project construction and commissioning. Life Safety requirements must also be met.

a. A multidisciplinary team that includes the ICN, Industrial Hygienist, Facility Services, and clinical staff shall conduct a proactive ICRA during the design and planning phase for all demolition, renovation, and new construction projects. The scope of the project may require other subject matter experts to be involved.

b. After completing the ICRA, precautions shall be taken according to the matrix reflecting the risk level of the resident population and the hazard level of the construction work. A complete field review of infection control implications shall be conducted before any demolition or construction begins.

c. Specific areas of consideration but are not limited to:

    i. Determination of if, where, when, the duration, and how resident care area(s) closures and/or interruptions will occur

    ii. Mitigation of external air flow into the facility where there is ground disturbance or demolition of other structures external to the facility that may release air pollution that can enter windows, doors, or other ventilation mechanisms

    iii. Traffic patterns for residents, staff, and visitors to minimize contamination

    iv. Resident area risk assessment; criteria for emergency work interruptions (stop and start processes)

    v. Planning for air handling and water systems/plumbing as appropriate

    vi. Education (or whom and by whom)

    vii. Dust control expectations for subcontractors before start, as needed including workers clothing and shoes when entering the facility

    viii. Transport and approval for disposal of waste materials

d. ICRA expectations shall be incorporated into initial project agreements to ensure contractor accountability.

2. Contractor Dust Control Procedures

Contractor must provide dust control procedures for review and approval by the ICN and Industrial Hygienist.

a. Renovation areas must be isolated from resident-occupied areas using decreased air flow barriers to eliminate airflow of particles into patient areas. Critical barriers i.e. sheetrock, plywood, or plastic, to seal areas from non-work area shall be completed before beginning any construction work. Porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) residents with at least one coat of a cleanable/washable no or low volatile organic compound (VOC) paint.

b. Temporary construction barriers and closures above ceilings shall be dust tight. A ceiling-to-floor sealed plastic barrier, enclosing the ladder, shall be constructed to contain the dust whenever more than one ceiling tile is to be removed within a resident care area.

c. Whenever work is performed in which dust contamination has occurred, the area is to be cleaned as soon as possible using a vacuum cleaner equipped with a High Efficiency Particulate Air (HEPA) filtration system or damp mopping procedure to prevent the “tracking” of dust throughout the facility. Sweeping and dry mopping are never appropriate in a hospital environment. Floor “tack” or “sticky” mats are to be placed in areas of construction crew egress, and replaced when they lose their ability to capture dust and debris from a user’s shoe soles.

d. If negative pressure is required (based on ICRA), negative pressure shall be established and continuously maintained to the renovation work area enclosure to contain dust generated by work activities inside the enclosure until all work is complete.

e. Negative pressure shall be monitored continuously. Recording manometers shall be used to display and record pressure differentials automatically. Pressure differential records shall be collected and reviewed by project personnel on a daily basis, as evidenced by their initials along with the date and time of the review, and maintained available on site for review by infection control and health and safety personnel upon request.

f. Construction waste and demolition debris shall be covered and sealed during transport, and transport equipment cleaned prior to removal from the work area. Transport is to be done during the lowest activity periods. A schedule shall be drafted to inform contractor of times to avoid transport area. Elevators shall be avoided for debris transport. If an elevator is used, it shall be designated for construction use only. Appropriate signage postings are required

g. Removal of construction barriers and ceiling protection shall be done outside of normal working hours unless otherwise authorized in advance of activities. Areas will be wet mopped and/or HEPA vacuumed following barrier removal. Vacuuming outside of negative pressure areas shall be performed with a HEPA-filtered vacuum which has been aerosol challenge tested prior to initial use at the LHH site.

3. Monitoring

a. The ICN will monitor construction areas for bioaerosols**,** general particle (dust) levels, or other project specific contaminants or indicators in the vicinity of the project.

b. If monitoring results exceed background levels, or other infection control risk becomes apparent, the contractor shall be notified to correct the condition immediately to avoid fines and work stoppage as described below:

   i. All work may be stopped on a project whenever a hazardous material/waste deficiency, infection control deficiency, or dust control complaint exists.

   ii. The contractor shall take immediate action to correct the deficiencies.

4. Enforcement

a. Determination of violations shall be based on periodic rounds in collaboration with the Facility Services staff, ICN, and/or Industrial Hygienist. Findings will be reported to the ICC. Photographs may be taken to document violation(s), as feasible.

b. The contractor, project manager/coordinator, Facility Services, and others as appropriate, shall be informed in writing.

c. A record of all ICRA violations shall be maintained.

5. Documentation

a. Primary representatives shall be identified on the Infection Prevention & Control Construction Clearance Checklist (Attachment B), which contains an overview of the ICRA results and the required precautions from ICN, Industrial Hygienist, Facility Services, contractor, project manager/coordinator, and others as deemed appropriate.

b. The Clearance Checklist shall be signed by the ICN or designee and a copy shall be maintained at the work site.

ATTACHMENT:
Appendix A: Infection Control Risk Assessment (ICRA).
~~Appendix B: Infection Prevention and Control Construction Clearance Checklist~~

REFERENCE:
LHH Facility Services Policy LS-6: Life Safety Management, Building Standards
Centers for Disease Control and Prevention's *"Guidelines for Environmental Infection Control in Health-care Facilities"* (2003)
Association for Practitioners in Infection Control & Epidemiology (APIC) State-of-the-Art Report: *"The role of infection control during construction in health care facilities." (2000)*

Revised: 16/07/12, 18/11/13, 20/10/13, 22/11/03 (Year/Month/Day)
Original adoption: 05/11/01

Appendix A: Infection Control Risk Assessment

Step One:
Using the following table, *identify* the Risk categories by construction type (Type A-D)

Type A	**Non-Invasive Activities and Inspection** Includes but is not limited to: • Removal of ceiling tiles for visual inspection (limit 1 tile per 50 square feet with limited exposure time) • ~~Painting (but not sanding)~~ • ~~Wall covering~~Limited building system maintenance (e.g., pneumatic tube station, HVAC system, fire suppression system, electrical ~~trim~~and carpentry work~~, minor plumbing, other activities~~ to include painting without sanding) that ~~do~~does not ~~generate~~create dust~~, require cutting of walls, nor accessing ceilings~~ or debris. • Clean plumbing activity limited in nature.
Type B	**Small scale, short duration activities that create minimal dust and debris** Includes but is not limited to: • Work conducted above the ceiling (e.g., prolonged inspection or repair of firewalls and barriers, installation of conduit and/or cabling, and access to mechanical and/or electrical chase spaces) • Fan shutdown/startup • Installation of ~~telephone and computer cabling~~electrical devices or new flooring that produces minimal dust and debris • ~~Access to crawl spaces~~ • ~~Cutting walls or ceiling~~The removal of drywall where minimal dust ~~migration can be controlled~~and debris is created • Controlled sanding activities (e.g., wet or dry sanding) that produce minimal dust and debris •
Type C	**~~Work~~ Large-scale, longer duration activities that ~~generates~~create a moderate ~~to high levels~~amount of dust~~, requires demolition,~~ and debris.** Includes but is not limited to: • Removal of preexisting floor covering, walls, casework or ~~removes fixed~~other building components ~~or assemblies~~ • ~~Sanding walls for painting or wall covering~~ • ~~Removal of floor coverings, ceiling tiles, and casework~~ • New ~~wall construction~~drywall placement • ~~Minor duct~~Renovation work~~,~~ in a single room • Non-existing cable pathway or invasive electrical work above ceilings~~, major cabling activities~~ • The removal of drywall where a moderate amount of dust and debris is created • Dry sanding where a moderate amount of dust and debris is created • Work creating significant vibration and/or noise • Any activity that cannot be completed within a single work shift
Type D	**Major demolition and construction projects** • ~~Activities that require consecutive work shifts~~ ~~Require heavy demolition~~Includes but is not limited to:

	• Removal or ~~removal~~replacement of ~~a complete cabling~~building system component(s) • ~~New~~Removal/installation of drywall partitions • Invasive large-scale new building construction • Renovation work in two or more rooms •

Step Two:

Using the following table, *identify* the Risk categories by patient care areas that will be affected. If more than one risk group will be affected, select the higher risk group:

Low Risk **Non-patient care areas such as:**	**Medium Risk** **Patient care support areas such as:**	**High Risk** **Patient care areas such as:**	**Highest Risk** **Procedural, invasive, sterile support and highly compromised patient care areas such as:**
• Public hallways and gathering areas not on clinical units • Office Areas not on clinical units • ~~Dining Hall~~Breakrooms not on clinical units • Bathrooms or locker rooms not on clinical units • Mechanical rooms not on clinical units • EVS closets not on clinical units •	• ~~Cardiology~~ • ~~Echocardiography~~ • ~~Endoscopy~~ • ~~Nuclear Medicine~~ • ~~Physical Therapy~~ • ~~Radiology~~ • ~~Respiratory Therapy~~Waiting areas • Clinical engineering • Materials management • Sterile processing department – dirty side • Kitchen, cafeteria, gift shop, coffee shop, and food kiosks •	• ~~CCU~~ • Patient care rooms and areas • All acute care units • Emergency ~~Dept.~~department • ~~Labor & Delivery~~ • ~~Specimen Labs~~ • ~~Nursery~~ • ~~Outpatient Surg.~~ • ~~Pediatrics~~ • Employee health • Pharmacy – general work zone • ~~PACU~~ • ~~Surgical Units~~Medication rooms and clean utility rooms • Imaging suites: diagnostic imaging • Laboratory •	• ~~Burn~~ • ~~Cardiac Cath Lab~~ • All transplant and intensive care units • All oncology units • Or theaters and restricted areas • Procedural suites • Pharmacy compounding • Sterile ~~Central Supply~~processing department – clean side • ~~ICU~~ • ~~Medical Units~~ • ~~NPIR~~ • ~~Oncology~~ • ~~Operating Room~~ • ~~Any area caring for Immunocompromised patients~~Transfusion services • Dedicated isolation wards/units

			• Imaging suites: invasive imaging •

Step Three:

Match the Patient Risk Group (Low, Medium, High, Highest) from Step Two with the planned Construction Activity Project Type (A, B, C, D) from Step Two using the below table to find the Class of Precautions (I, II, III, IV or V) or level of infection control activities required. The activities are listed in Table 5 – Minimum Required Infection Control Precautions by Class.

Table 3 – Class of Precautions

Construction Project Type

Patient Risk Group	Type A	Type B	Type C	Type D
Low	I	II	II	III*
Medium	I	II	III*	IV
High	I	III	IV	V
Highest	III	IV	V	V

Infection control permit and approval will be required when Class of Precautions III (Type C) and all Class of Precautions IV or V are necessary.

Environmental conditions that could affect human health, such as sewage, mold, asbestos, gray water and black water will require Class of Precautions IV for LOW and MEDIUM Risk Groups and Class of Precautions V for HIGH and HIGHEST Risk Groups.

*Type C [Medium Risk groups] and Type D [Low Risk Groups] work areas [Class III precautions] that cannot be sealed and completely isolated from occupied patient care spaces should be elevated to include negative air exhaust requirements as listed in Class IV Precautions.

Step Four:

Assess potential risk to areas surrounding the project. Using the below table, identify the surrounding areas that will be affected and the type of impact that will occur. If more than one risk group will be affected, select the higher risk group using Table 2 - Patient Risk Group.

Table 4 – Surrounding Area Assessment

Unit Below:	Unit Above:	Unit Lateral:	Unit Behind:	Unit in Front:
Risk Group:	Risk Group:	Risk Group:	Risk Group:	Risk Group:
Contact:	Contact:	Contact:	Contact:	Contact:
Phone:	Phone:	Phone:	Phone:	Phone:
Additional Controls: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water
Noise & Vibration Mitigation Strategies				
☐ Use diamond drills instead of powder-actuated fasteners. ☐ Schedule noise-making periods with adjacent spaces. ☐ Use beam clamps instead of shot. ☐ Prefab where possible. ☐ Use tin snips to cut metal studs instead of using a chop saw. ☐ Install metal decking with vent tabs, then use cellular floor deck hangers. ☐ Consider compression style fittings instead of soldering, brazing or welding. ☐ Wet core drill instead of dry core or percussion. ☐ Instead of jackhammering concrete, use wet diamond saws. ☐ Use HEPA vacuums instead of standard wet/dry vacuums. ☐ Use mechanical joining system sprinkler fittings instead of threaded. ☐ Where fumes are tolerated, use chemical adhesive remover (flooring glue) instead of mechanical. ☐ To remove flooring, consider abrasive blasting instead of using a floor scraper. ☐ Use electric sheers instead of reciprocating saw for ductwork cutting. ☐ Install exterior man/material lifts.				
Ventilation & Pressurization Mitigation Strategies				
☐ HEPA to exterior. ☐ Install temporary ductwork. ☐ Utilize temporary HVAC equipment. ☐ Vacate the area. ☐ Install temporary partitions. ☐ Use carbon filtration to filter odors.				
Impact to Other Systems Mitigation Strategies				
☐ Schedule outages. ☐ Provide temporary systems. ☐ Back-feed electricity or medical gases.				

Table 5 - Minimum Required Infection Control Precautions by Class | Before and During Work Activity

Class of Precautions	Mitigation Activities (Performed Before and During Work Activity)
Class I	1. Perform noninvasive work activity as to not block or interrupt patient care. 2. Perform noninvasive work activities in areas that are not directly occupied with patients. 3. Perform noninvasive work activity in a manner that does not create dust. 4. Immediately replace any displaced ceiling tile before leaving the area and/or at end of noninvasive work activity.
Class II	1. Perform only limited dust work and/or activities designed for basic facilities and engineering work. 2. Perform limited dust and invasive work following standing precautions procedures approved by the organization. 3. This Class of Precautions must never be used for construction or renovation activities.
Class III	1. Provide active means to prevent airborne dust dispersion into the occupied areas. 2. Means for controlling minimal dust dispersion may include hand-held HEPA vacuum devices, polyethylene plastic containment, or isolation of work area by closing room door. 3. Remove or isolate return air diffusers to avoid dust from entering the HVAC system. 4. Remove or isolate the supply air diffusers to avoid positive pressurization of the space, 5. If work area is contained, then it must be neutrally to negatively pressurized at all times. 6. Seal all doors with tape that will not leave residue. 7. Contain all trash and debris in the work area. 8. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 9. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 10. Maintain clean surroundings when area is not contained by damp mopping or HEPA vacuuming surfaces.
Class IV	1. Construct and complete critical barriers meeting NFPA 241 requirements including: Barriers must extend to the ceiling or, if ceiling tile is removed, to the deck above, and all penetrations through the barrier shall meet the appropriate fire rating requirements. 2. All (plastic or hard) barrier construction activities must be completed in a manner that prevents dust release. Plastic barriers must be effectively affixed to ground and ceiling and secure from movement or damage. Apply tape that will not leave a residue to seal gaps between barriers, ceiling or floor. 3. Seal all penetrations in containment barriers, including floors and ceiling, using approved materials (UL schedule firestop if applicable for barrier type). 4. Containment units or environmental containment units (ECUs) approved for Class IV precautions in small areas totally contained by the unit and that has HEPA-filtered exhaust air. 5. Remove or isolate return air diffusers to avoid dust entering the HVAC system. 6. Remove or isolate the supply air diffusers to avoid positive pressurization of the space. 7. Negative airflow pattern must be maintained from the entry point to the anteroom and into the construction area. The airflow must cascade from outside to inside the construction area. The entire construction area must remain negatively pressurized. 8. Maintain negative pressurization of the entire workspace by use of HEPA exhaust air systems directed outdoors. Exhaust discharged directly to the outdoors that is 25 feet or greater from entrances, air intakes and windows does not require HEPA-filtered air. 9. If exhaust is directed indoors, then the system must be HEPA filtered. Prior to start of work, HEPA filtration must be verified by particulate measurement as no less than 99.97% efficiency and must not alter or change airflow/pressure relationships in other areas. 10. Exhaust into shared or recirculating HVAC systems, or other shared exhaust systems (e.g., bathroom exhaust) is not acceptable. 11. Install device on exterior of work containment to continually monitor negative pressurization. To assure proper pressure is continuously maintained, it is recommended that the device(s) have a visual pressure indicator. 12. Contain all trash and debris in the work area.

	13. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 14. Worker clothing must be clean and free of visible dust before leaving the work area. HEPA vacuuming of clothing or use of cover suits is acceptable. 15. Workers must wear shoe covers prior to entry into the work area. Shoe covers must be changed prior to exiting the anteroom to the occupied space (non-work area). Damaged shoe covers must be immediately changed. 16. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 17. Consider collection of particulate data during work to monitor and ensure that contaminates do not enter the occupied spaces. Routine collection of particulate samples may be used to verify HEPA filtration efficiencies.
Class V	1. Construct and complete critical barriers meeting NFPA 241 requirements including: Barriers must extend to the ceiling, or if ceiling tile is removed, to the deck above, and all penetrations through the barrier shall meet the appropriate fire rating requirements. 2. All (plastic or hard) barrier construction activities must be completed in a manner that prevents dust release. Plastic barriers must be effectively affixed to ground and ceiling and secure from movement or damage. Apply tape that will not leave a residue to seal gaps between barriers, ceiling or floor. 3. Seal all penetrations in containment barriers, anteroom barriers, including floors and ceiling using approved materials (UL schedule firestop if applicable for barrier type). 4. Construct anteroom large enough for equipment staging, cart cleaning, workers. The anteroom must be constructed adjacent to entrance of construction work area. 5. Personnel will be required to wear disposable coveralls at all times during Class V work activities. Disposable coveralls must be removed before leaving the anteroom. 6. Remove or isolate return air diffusers to avoid dust entering the HVAC system. 7. Remove or isolate the supply air diffusers to avoid positive pressurization of the space. 8. Negative airflow pattern must be maintained from the entry point to the anteroom and into the construction area. The airflow must cascade from outside to inside the construction area. The entire construction area must remain negatively pressurized. 9. Maintain negative pressurization of the entire workspace using HEPA exhaust air systems directed outdoors. Exhaust discharged directly to the outdoors that is 25 feet or greater from entrances, air intakes and windows does not require HEPA-filtered air. 10. If exhaust is directed indoors, then the system must be HEPA filtered. Prior to start of work, HEPA filtration must be verified by particulate measurement as no less than 99.97% efficiency and must not alter or change airflow/pressure relationships in other areas. 11. Exhaust into shared or recirculating HVAC systems, or other shared exhaust systems (bathroom exhaust) is not acceptable. 12. Install device on exterior of work containment to continually monitor negative pressurization. To assure proper pressure is continuously maintained, it is recommended that the device(s) have a visual pressure indicator. 13. Contain all trash and debris in the work area. 14. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 15. Worker clothing must be clean and free of visible dust before leaving the work area anteroom. 16. Workers must wear shoe covers prior to entry into the work area. Shoe covers must be changed prior to exiting the anteroom to the occupied space (non-work area). Damaged shoe covers must be immediately changed. 17. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 18. Consider collection of particulate data during work to monitor and ensure that contaminates do not enter the occupied spaces. Routine collection of particulate samples may be used to verify HEPA filtration efficiencies.

Table 6 - Minimum Required Infection Control Precautions | Upon Completion of Work Activity

Class of Precautions	Mitigation Activities (Performed upon Completion of Work Activity)
Classes I, II and III	Cleaning: 1. Clean work areas including all environmental surfaces, high horizontal surfaces and flooring materials. 2. Check all supply and return air registers for dust accumulation on upper surfaces as well as air diffuser surfaces. HVAC Systems: 1. Remove isolation of HVAC system in areas where work is being performed. Verify that HVAC systems are clean and operational. 2. Verify the HVAC systems meet original airflow and air exchange design specifications.
Classes III, IV and V	Class III (Type C Activities only), IV, and V precautions require inspection and documentation for downgraded ICRA precautions. Construction areas must be inspected by an infection preventionist or designee and engineering representative for discontinuation or downgrading of ICRA precautions. Work Area Cleaning: 1. Clean work areas including all environmental surfaces, high horizontal surfaces and flooring materials. 2. Check all supply and return air registers for dust accumulation on upper surfaces as well as air diffuser surfaces. Removal of Critical Barriers: 1. Critical barriers must remain in place during all work involving drywall removal, creation of dust and activities beyond simple touch-up work. The barrier may NOT be removed until a work area cleaning has been performed. 2. All (plastic or hard) barrier removal activities must be completed in a manner that prevents dust release. Use the following precautions when removing hard barriers: i. Carefully remove screws and painter tape. ii. If dust will be generated during screw removal, use hand-held HEPA vacuum. iii. Drywall cutting is prohibited during removal process. iv. Clean all stud tracks with HEPA vacuum before removing outer hard barrier. v. Use a plastic barrier to enclose area if dust could be generated. Negative Air Requirements: 1. The use of negative air must be designed to remove contaminates from the work area. 2. Negative air devices must remain operational at all times and in place for a period after completion of dust creating activities to remove contaminants from the work area and before removal of critical barriers. HVAC systems: 1. Upon removal of critical barriers, remove isolation of HVAC system in areas where work is being performed. 2. Verify that HVAC systems are clean and operational. 3. Verify the HVAC systems meets original airflow and air exchange design specifications.

Other Decision-Making Considerations:

1. Identify specific site of activity e.g., resident rooms, medication room, etc.

2. Identify issues related to: ventilation, plumbing, electrical in terms of the occurrence of probable outages.

3. Identify containment measures, using prior assessment. What types of barriers? Will HEPA filtration be required?

4. Consider potential risk of water damage. Is there a risk due to compromising structural integrity?

5. Can or will the work be done during non-resident care hours?

6. Do plans allow for adequate number of isolation/negative airflow rooms?

7. Plan to discuss containment issues with the project team regarding traffic flow, housekeeping, debris removal.

Appendix B: Infection Prevention and Control Construction Clearance Checklist (double sided form)

Infection Prevention and Control Construction Clearance Checklist

Infection Prevention & Control Construction Clearance Checklist				
Contractor Performing Work:				
Location of Construction:				**Project Start Date:**
Project Coordinator/ Manager:				
Industrial Hygienist:				**Estimated Duration:**
Infection Control Nurse:				
Assessment Performed by: Project Coordinator / Manager — Industrial Hygienist Infection Control Committee Chair — Infection Control Nurse Director of Quality Management — Director of Facilities Services Chief Operations Officer — Director of Environmental Services **Copy of Assessment Submitted to:** Chief Nursing Officer — Department Managers affected by project Chief Medical Officer — Contractor performing work (via Project Coordinator/Manager)				
Resident Risk Level	**Construction Activity Type**			
	Type A	**Type B**	**Type C**	**Type D**
Low	I	II	II	III/IV
Medium	I	II	III	IV
High	I	II	III/IV	IV
Highest	II	III/IV	III/IV	IV
Determination:				
Exceptions / Additions to the permit are noted by attached memoranda:		Initials:		Date:
Updated Precautions Classification (required if any changes occur in Patient Risk Group or Construction Activity):		Initials:		Date:
Infection Control Nurse or Designee: Printed Name/ Title — Signature				Date:

~~IC Matrix Class of Precautions: Construction Project by Patient Risk~~

	~~During Construction Project~~	~~Upon Completion of Project~~
~~CLASS I~~	~~**Execute work to minimize raising dust from construction operations:**~~ ~~1. Use methods to minimize creating/disturbing dust from construction operations.~~ ~~2. Using hospital-approved disinfectant, mist tiles and work surfaces to control dust before beginning work.~~ ~~3. Immediately replace a ceiling tile displaced for visual inspection. HEPA-vacuum obvious dust collection.~~	~~1. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area.~~
~~CLASS II~~	~~**Actively work to prevent airborne dust from dispersing into atmosphere:**~~ ~~1. Seal unused doors with duct tape.~~ ~~2. Block off and seal air vents.~~ ~~3. Place dust mat at entrance/exit of work area.~~ ~~4. Remove or isolate building HVAC system in areas where work is being performed.~~ ~~5. Provide active means to prevent airborne dust from dispersing into atmosphere.~~ ~~6. Using hospital-approved disinfectant~~	~~1. Wipe work surfaces with disinfectant.~~ ~~2. Contain construction waste before transport in tightly covered containers.~~ ~~3. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area.~~ ~~4. Restore HVAC system in areas where it was isolated or disconnected.~~
~~CLASS III~~	~~**Remove or isolate HAC system in area where work is being performed to prevent contamination of duct system:**~~ ~~1. Follow precautions for class I and II, above, and:~~ ~~2. Before construction begins, complete all critical barriers i.e. sheetrock, plywood, or plastic, to seal areas from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit).~~ ~~3. All porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) patients with at least one coat of a cleanable/washable no or low-VOC paint.~~ ~~4. Maintain negative air pressure with work site utilizing HEPA equipped air filtration units.~~ ~~5. Contain construction waste before transport in tightly covered containers.~~ ~~6. Cover transport receptacles/ carts. Tape covering unless solid lid.~~	~~1. Do not remove barriers from work area until completed project is inspected by the owner's (LHH) Safety Department and Infection Control Department and thoroughly cleaned by the owner's Environmental Services Department.~~ ~~2. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction.~~ ~~3. Vacuum work area with HEPA filtered vacuums.~~ ~~4. Wet mop area with disinfectant.~~ ~~5. Restore HVAC system in areas where it was isolated or disconnected.~~
~~CLASS IV~~	~~**Isolate HVAC where work is being done to prevent contamination of duct system:**~~ ~~1. Adhere to ALL precautions above, and:~~ ~~2. Seal holes, pipes, conduits, and punctures appropriately.~~ ~~3. Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.~~ ~~4. All personnel entering work site are required to wear shoe covers. Shoe covers must be changed each time the worker exits the work area.~~ ~~5. Do not remove barriers from work area until completed project is inspected by the owner's (LHH) Safety Department and Infection Control Department and thoroughly cleaned by the owner's Environmental Services Department.~~	~~1. Remove barrier material carefully to minimize spreading of dirt and debris associated with construction.~~ ~~2. Contain construction waste before transport in tightly covered containers.~~ ~~3. Cover transport receptacles or carts. Tape covering unless solid lid.~~ ~~4. Vacuum work area with HEPA filtered vacuums.~~ ~~5. Wet mop area with disinfectant.~~ ~~6. Remove isolation of HVAC system in areas where work is being performed.~~ ~~7. Clean or replace HVAC filters and verify appropriate ventilation parameters for the area have been re-established.~~ ~~8. Flush the main water system to clear~~

MANAGEMENT OF HOSPITAL-PROVIDED LINEN

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) hospital-provided linen and laundry management practices as it pertains to infection control and prevention precautions, will be consistent with Centers for Disease Control and Prevention (CDC) guidelines.
2. LHH contracts with a commercial linen laundry facility that meets the requirements for hospital laundry requirement temperatures, detergents, and other disinfection agents.

PURPOSE:

To manage hospital-provided linen in a manner to minimize the risk of contamination with soiled linens or other contaminated items for sorting, packaging, transporting, and storing.

DEFINITIONS:

- **Hospital-provided linen:** Hospital-provided items such as towels, washcloths, bed linens, patient gowns, pants, and tops. Resident's personal clothing is not addressed in this policy.

PROCEDURE:

1. Clean Linen

a. Clean linen is delivered to the neighborhood by Environmental Services (EVS) staff in an appropriate cart and kept covered to prevent dust and debris contamination and placed into the neighborhood clean linen room/area.

b. Each neighborhood has dedicated clean linen ~~rooms designated as clean~~ areas used for sorting and storing clean linen.

~~a.~~c. Clean linen is not ~~to be worn by~~for staff personal use.

~~b.~~d. Perform hand hygiene before handling clean linen.

e. Clean ~~linens~~linen must be covered when transporting or storing.

~~c.~~f. Do not take more clean ~~linens~~linen than what is needed into the resident's room.

~~d.~~a. Do not store clean linen in resident rooms, drawers, or closets inside resident rooms. ~~Linens inside a resident room is considered contaminated and should not be used for others; place unused linens in dirty hamper for laundering.~~

e. Transport clean linens to Linens inside a resident care areas on designated clean linen carts.

f. Clean linen room doors are to be kept closedconsidered contaminated and locked at all times.

g.b. Clean linen is delivered to the neighborhood by Environmental Services (EVS) staff should not be used for others; if this occurs, place even unused linens in an appropriate cart and kept covered to prevent dust and debris contamination. dirty hamper for laundering.

2. Contaminated Linen

a. All used linen is considered contaminated and handled with gloves followingObserve Standard Precautions. If contaminated when handling used linen including but not limited to gloves or wet linen is anticipated, wear a fluid resistant apron or gown. Perform hand hygiene after for overly wet items.

a.b. When removing gloves.linen, have a hamper just outside the resident room in the hallway to dispose of soiled linens. Linen cart should not be taken into resident rooms. If this is unavoidable, the care will need to be wiped down with a hospital grade disinfectant prior to being returned to service.

c. Do not allow contaminated linen to come into contact with yourstaff clothing as microorganisms can be spread by holdingthis method
   a. Hold linen away from your the body.
   b. Do not agitate or shake contaminated linen; place
   c. Gently remove linen and roll contaminated or wet areas inward

b.d. Place soiled linen immediately in dirty hamper lined with a dirty linen bag.

c.i. Do not carry contaminated linen into common areas. Contain contaminated linen in a dirty hamper for transportation. Do not place on a chair, other beds, or soiled linen on the floor in either cleanor other non-hamper area including furniture, or dirty areas.over-bed tables

ii. Do not carry soiled linen in the hallway or other common areas nor drag bags on floor.

e. Contaminated linen shall be placed ininside a covered dirty hamper.

f. The dirty hamper should not be stored inside a resident's room.

d. Do not overfill the hamper exposing contaminated linen.

e.g. Clean torn, worn, or threadbare linen is to identifiedDirty linen bags are removed from the hamper frame, secured and placed insidein the designated hamper inside the clean linen room for proper disposal and

~~management of supply list for replacement~~dirty linen area to be picked up by EVS~~.~~ for removal.

~~3. Hospital-provided linen is laundered at contracted commercial linen laundering facility.~~

h. Access to the dirty linen area must be secured from accidental entrance by unauthorized personnel

ATTACHMENT:
None.

REFERENCE:
EVS Policy II Housekeeping Services
EVS Policy IX Collection, Handling, Storage, and Disposal of Biohazardous Waste
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 C17 Pediculosis (Lice) Management
LHHPP 72-01 F3 Management of Resident's Personal Clothing
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
CDC website (updated 2020, March). Appendix D-Linen and laundry management. Retrieved August 26, 2020 from website https://www.cdc.gov/hai/prevent/resource-limited/laundry.html#anchor_1585334108204

Revised: 14/05/27, 20/10/13 22/10/20 (Year/Month/Date)
Original adoption: 05/11/01

BLOOD/BODY FLUID SPILL CLEAN-UP

POLICY:

1. Blood and/or body fluid (e.g. vomitus, urine) spill clean-up requires a 2-step process of cleaning followed by disinfection that is completed immediately after the spill utilizing the appropriate personal protective equipment (PPE).

Definitions:

Clean/Cleaning: Cleaning is the first step to be performed for a spill that contains blood/body fluids which may potentially transmit infectious disease. Cleaning involves removing the material that has been spilled (blood, body fluid, vomitus, urine etc.) using the process outlined below

Disinfect/Disinfection: Disinfection of the area is the second step to be performed for a spill that contains blood/body fluids which may potentially transmit infectious disease. Disinfection involves using an EPA- approved disinfectant for such materials, applying after cleaning, and allowing for the appropriate wet contact time in order for deactivation of the organism to occur. This step may also include a clean water rinse.

EPA: Environmental Protection Agency – federal agency responsible for the protection of people and the environment from significant health risks including chemicals.

PURPOSE:

To provide guidance ~~to staff) in order to minimize~~that minimizes the potential for exposure to pathogens that may be transmitted in blood or body fluids when spills occur. Safety of the immediate area must be secured prior to cleaning and disinfection.

PROCEDURE:

1. General Cleaning Procedures: (all may not apply to every type of spill)

a. Clean in a manner “from cleaner to dirtier”
b. Clean in a manner “from highest to lowest” or “top to bottom” to prevent dripping or falling of spillage that may contaminate (ex: clean bed rails before cleaning floors)
c. Clean floors last
d. Blood and body fluid spills must be immediately confined using absorbent paper towels or absorbent granules (if available)
e. Safety of others
f. Environmental Services (EVS) is responsible for the clean-up and disinfection of the blood/body fluid spill.
~~1.~~g. Nursing staff may need to provide appropriate barriers and signage to prevent others from entering the contaminated area until EVS arrives.

~~2.~~h. Nursing staff may clean up smaller spills (not including blood and body fluids which require both cleaning and disinfecting and waste removal) when there is no broken glass or debris in which ~~incorporates~~ both cleaning and disinfection with the standard hospital-wide approved disinfectant can be accomplished.

~~3.~~2. Blood spill kits are available from Central Processing Department (CPD) and contain absorbent powder and PPE. (These should be on each floor for immediate use)

3. ~~Standard Precautions are utilized~~**Safety :**

a. A visual inspection / assessment of the spill will be made prior to cleaning up a body fluid spill in order to determine:
   i. Patient or others safety including self, during ~~clean-up~~ cleaning process
   ii. The spill is addressed and ~~disinfection. Additional~~confined immediately, without delay

~~4.~~b. Don appropriate PPE which may ~~be required, such as~~include utility gloves ~~when cleaning~~ for broken ~~glassware or~~glass, fluid resistant gowns ~~if there is~~ for splashing or potential ~~for~~ contamination of clothing ~~or splashing/splattering is likely.~~

c. ~~Contain~~Standard Precautions will be observed for clean-up and disinfection

4. Blood and/or body fluids must be immediately contained

~~5.~~a. Confine or contain the spill ~~and remove gross material with~~using absorbent paper towels or ~~other~~ absorbent ~~materials/crystals.~~ granules if immediately available

~~6. Disinfection shall not be done until all gross material is removed and the area is cleaned with detergent solution.~~

b. ~~Send~~Dispose of towels or granules as infectious waste
c. Disinfect the same area using a facility approved EPA intermediate-level disinfectant which may include a chlorine-based disinfectant following the manufacturers instructions
d. Do NOT use a chlorine-based disinfectant on a urine spill which can release chlorine gas when mixed with urine. Chlorine gas is an immediate irritant to eyes, causing watering eyes, and cough
e. Allow disinfectant to remain in wet contact with the surface(s) for the allotted time and rinse area with clean water, if indicated
f. Immediately send all reusable ~~supplies and equipment (e.g. cleaning cloths, mops)~~items for reprocessing ~~after the spill is cleaned.~~(mop heads, cloths)

~~7.~~

ATTACHMENT:

None.

REFERENCE:
Environmental Services Policy and Procedure XI. Collection, Handling, Storage and Disposal of Bio-hazardous Waste
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
OSHA Bloodborne Pathogen Standard, 2015

Revised: 16/01/12, 20/10/13 22/10/09 (Year/Month/Day)
Original adoption: 05/11/01

STORAGE OF STERILE MEDICAL SUPPLIES

POLICY:

1. Handling, transportation, and storage of medical supplies shall be done according to the accepted standards of practice for infection prevention and control to reduce contamination of products which compromise sterility.

2. Packages that have been compromised (damaged, wet, torn etc.) will be removed from circulation and not used.

3. A central processing location will be maintained for large bulk storage.

4. Each neighborhood will have smaller designated storage rooms for frequently used items utilizing the same storage standards that must adhere to standard storage requirements.

PURPOSE:

Laguna Honda Hospital (LHH) utilizes event-related sterility for packaging materials dependent upon package material, storage conditions, transport and handling. An event must occur to compromise package content sterility which ~~allows~~may include seal breakage or loss of package integrity (holes, tears, punctures), moisture penetration ~~of the initial sterilizing agent and then maintains the sterility of the processed item indefinitely after sterilization as long as the product~~, or exposure to airborne contaminants. Event-related sterility is ~~handled and stored properly.~~not dependent on dates of expiration but a "first in/first out" rotation should be utilized with older packages used first.

PROCEDURE:

1. Items that have a time-limited shelf life shall have a label attached which states, "Sterile Until (manufacturer's recommended date shall be written in here)."

2. Staff are responsible to visually inspect any sterile package prior to use to check for time-limited shelf life label and conditions which would constitute a presumptive break in package integrity. Items shall not be used past the labeled date if present or, if there is any evidence that the package integrity has been compromised. Situations that would indicate this include a broken seal, tears or holes in packaging material, evidence of water damage, etc.

3. All items are to be transported to neighborhoods will be in covered tote bins, carts, or shelves.

4. Storage of sterilized items shall be as follows:

a. All items are to be stored in a segregated, designated storage area or room. Storage area shall not be in a high traffic area or in an area where there is a likelihood of damage or contamination.

b. Open shelving is acceptable if items are being stored in a segregated room designated only for the storage of sterile items. Closed shelving should be used any time there may be potential for contamination or, when items are stored in a non-dedicated room.

c. Shelving must have a solid bottom shelf~~.~~ to protect from dust / debris. Storage requirements include the bottom shelf being at least 10 inches above the floor, at least 2 inches from the walls and at least 18 inches from the ceiling.

d. Efforts to reduce contamination must include regular environmental cleaning, keeping door closed in the designed room, and avoiding direct sunlight on the supplies for temperature and humidity control.

e. Do not store items near water sources

~~e.~~f. Outside shipping cartons including cardboard boxes are considered contaminated and shall not be used as dispenser boxes~~.~~ or shelf storage . Remove outside carton before transport to clean storage area

5. Inventory control

a. Inventory (shelf) counts shall be determined and utilized to avoid long shelf lives.

b. Inventory counts shall be evaluated periodically (a minimum of annually).

c. Items shall be stocked and rotated on the principle of “first in, first out.”

ATTACHMENT:
None.

REFERENCE:
APIC (2018) APIC Implementation guide: Infection Preventionist’s guide to the OR
Central Processing Department Policies and Procedures

Revised: 16/03/08, 20/10/13 22/09/30 (Year/Month/Day)
Original adoption: 05/11/01

KEY PERSONNEL WHEREABOUTS

POLICY:

Key personnel for Laguna Honda Hospital and Rehabilitation Center (LHH) shall~~will~~ keep their supervisors informed as to their whereabouts when they are off-campus during working hours.

PURPOSE:

To ensure the availability of key personnel during emergencies and to ensure that appropriate coverage is provided at all times.

~~CHARACTERISTICS~~DEFINITION:

~~Definition of key personnel status:~~Key Personnel: This includes but is not limited to the Chief Executive Officer, Chief Operations Officer, Chief Medical Officer, Chief Nursing Officer, Chief Quality Officer, Administrative Directors, ~~Executive Administrator, Senior Associate Administrators, Associate Administrators, Assistant Administrator~~s, division heads, department heads, and selected employees designated by their department or division heads. The employees' essential functions during an emergency, rather than organizational hierarchy shall be the governing factor in assignment of key personnel status.

PROCEDURE:

1. Department supervisors shall inform each employee, so designated in writing, of his/her status as a key person and of the extent to which the supervisor expects to be kept informed of the employee's whereabouts.

2. Executive staff members must inform the ~~Administrator's~~Administration office when, why, and how long they will be off ~~Laguna Honda Hospital and Rehabilitation Center (Laguna Honda)~~LHH premises, their destinations, and the number where they can be reached, as well as who will provide coverage during their absence. Department heads shall provide the same information to their respective division heads.

3. Executive staff, department heads and certain employees designated by their respective division heads must request supervisorial approval for vacation or other personal leave at least two (2) weeks before they wish it to begin.

4. A list of key personnel shall be maintained in the Communications Center and shall be available to the AOD on a 24/7 basis.

REFERENCES:

None

~~Reviewed: 22/09/12 (Year/Month/Day)~~
Revised: 97/06/11, 08/04/22, 23/01/10 (Year/Month/Day)
Original adoption: 92/05/20

EMPLOYEE AND VOLUNTEER IDENTIFICATION

POLICY:

All Laguna Honda Hospital and Rehabilitation Center (LHH) employees, in-house consultants, clinical interns and long-term students, and volunteers will wear above the waist, on the chest, lapel, or other safe location designated by the respective department, name tags that identify name, position and department.

~~The Hospital will~~ LHH shall furnish photo identification tags to employees, volunteers, in-house consultants, and long-term students. ~~–~~Other volunteer organizations will furnish appropriate organizational identification tags to volunteers, subject to the approval of the ~~Hospital~~facility.

PURPOSE:

To assure that persons providing services can be role-identified by ~~Hospital Institutional Police~~San Francisco Sheriff's Office (SFSO) ~~Department~~, as well as others; to assist residents to identify staff members and their roles in providing direct treatment; and to limit the access of unauthorized persons to the facility.

PROCEDURE:

1. Upon employment or commencing activity, new staff members will ~~be notified and scheduled by~~ receive their badge access form during new hire orientation. After acquiring the appropriate signatures for their badge access, new staff member will bring completed form to the ~~Facilities~~ Facility Services office during normal badge drop-in hours, or by calling the ~~Facilities~~Facility Services office for an appointment outside of drop-in hours.~~Human Resources Services for Hospital photo identification tag appointments.~~ Identification tag policies and procedures will be presented to the new member at that time.

2. Ancillary service organizations will provide identification prior to permitting volunteers to participate in activities serving residents or the public.

3. Failure by employees to comply with this policy, or the Identification Badge Policy and Procedure presented at the time of receipt of the badge, will result in appropriate disciplinary action.

REFERENCES:

LHHPP 80-03 Employee and Volunteer Orientation

Revised: 97/06/11, 08/04/22, 22/09/30 (Year/Month/Day)

Original adoption: 92/05/20

EMPLOYEE REGULATIONS

POLICY:

Every Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) employee shall be provided with information necessary to understand the conditions of employment.

PURPOSE:

To clarify the rights and responsibilities of employees, the Hospital's most valuable resource.

PROCEDURE:

1. Laguna Honda Hospital Human Resources Services department shall generate and maintain complete and accurate personnel files as required by law and regulation. The personnel file of separated employees will be maintained for at least three years after separation.

2. Employee personnel records are considered confidential records, and as such are open to review by only those authorized by the employee, in writing, and authorized departmental management.

3. The Payroll Office will maintain, for at least the most recent twelve-month period, pay records of hours and dates worked by every employee.

4. Human Resources Services shall provide a current Employee Handbook to each employee, and periodically shall provide updates to the handbook and shall disseminate relevant information to employees as necessary.

REFERENCES:

LHHPP 01-03 Hospital Organization
LHHPP 72-01 Infection Control Policy for Healthcare Providers Infected with Bloodborne Pathogens
LHHPP 73-01 Injury and Illness Prevention Program (IIPP)
LHHPP 75-07 Theft and Lost Property Reports
LHHPP 76-02 No Smoking Policy
LHHPP 77-01 Medical Emergency: Employees, Volunteers & Visitors
LHHPP 80-02 Employee and Volunteer Identification
LHHPP 80-03 Employee and Volunteer Orientation
LHHPP 80-06 Alcoholic Beverages Prohibited
LHHPP 80-01 Key Personnel Whereabouts
LHHPP 90-04 Parking Restrictions

Reviewed: 22/09/12 (Year/Month/Day)
Revised: 97/06/11~~/1997~~, 08/04/22~~/2008 (Year/Month/Day)~~
Original adoption: 92/05/20~~/1992~~

STAFF ALCOHOLIC CONSUMPTION

~~**POLICY:**~~

~~Alcoholic beverages (or other intoxicants) may not be served at staff parties held on Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) property.~~

PURPOSE:

~~1.~~ To comply with DPH ~~ordinance~~ policy and to promote a healthy environment for employees and Laguna Honda Hospital residents and visitors.

~~2. Authorized scheduled religious services that utilize sacramental wine are exempted from this policy.~~

~~3. Employee use is limited to small amounts consumed during religious ceremonies.~~

~~**PROCEDURE:**~~

~~1. Staff parties shall be approved by the appropriate division head prior to the scheduled event.~~

~~2. Alcoholic beverages shall not be served during regular staff parties held on Laguna Honda premises.~~

~~3. Employees shall be held responsible for their personal conduct at hospital parties on and off campus.~~

~~4. Division heads are responsible for enforcing and taking disciplinary action, if necessary, when the employee behaves inappropriately.~~

~~5. For special events, requests to bring alcoholic beverages onto the premises for consumption by employees must be submitted to and approved by the Executive Administrator prior to the scheduled event.~~

POLICY:

1. Alcoholic beverages (or other intoxicants) may not be consumed at any time on Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) property.

   Authorized scheduled religious services that utilize sacramental wine are exempted from this ~~policy.~~

   ~~Employee~~policy. Employee use is limited to small amounts consumed during religious ceremonies.

2. Employees may not consume alcoholic beverages as part of pre-approved resident events where alcoholic beverages are served.

3. Employees who are intoxicated while on the job will be immediately removed from the workplace.

4. On occasion, there may be evidence of drinking without intoxication where issues of safety or job performance are involved; in these cases, supervisors may need to temporarily reassign an employee.

5. Violations of this policy may be grounds for serious disciplinary action up to and including termination of employment and possible criminal charges.

REFERENCE:
~~LHHPP 22-02 Resident Alcohol Consumption~~DPH Code of Conduct Section 9.1 Alcoholic Beverages & Drugs in the Workplace

Revised: 97/06/11; 00/05/18, 12/09/25, 22/09/12 (Year/Month/Day)
Original adoption: 92/05/20

PROHIBITION AGAINST POLITICAL ACTIVITY

POLICY:

It is unlawful for City officers or employees to use ~~work hours,~~ public resources or personnel to engage in political activity relating to elective offices and ballot measures~~while on duty~~. ~~Such activities constitute an expenditure of public funds for purposes not authorized by law.~~City employees may not engage in political activities while on duty or in the workplace.

PURPOSE:

To assure that Laguna Honda Hospital employees understand the prohibition of ~~specific activities~~political activities during work hours or using public resources.

CHARACTERISTICS:

~~This policy is a summary excerpt from the City & County of San Francisco Employee Handbook.~~

~~1. The use of work time or public resources for political activity is unlawful because the law proscribes any misuse of public funds, no matter how small.~~

~~2. Examples of the use of work time may include: advocacy; lobbying; engaging in election activities; contacts or communications with the Mayor's Office, the Board of Supervisors, or other elected officials for the purpose of influencing the outcome of deliberations (unless you have been officially assigned to represent the Department in those deliberations); addressing envelopes; circulating materials; composing, forwarding or responding to emails concerning political activities attending advocacy planning meetings. This policy also prohibits political activities conducted by recognized employee organizations, during work time.~~

~~3. Examples of the use of public resources may include: use of equipment, supplies, or systems, such as computers, the email system, copy machines, facsimile machines, pre-paid stamping machines, the interoffice mail system, stationery, or telephones to advocate, lobby, or influence.~~

~~4. City employees are free to engage in political activities while off duty, on their own time and expense. Please be mindful of what is appropriate activity during working hours.~~

1. ~~Violators are subject to disciplinary action and possible criminal charges.~~ DPH or City resources cannot be used under any circumstances to contribute to political campaigns or for gifts or payments to any politician or any of their affiliated organizations.

2. Employees may not use City resources, such as photocopier or fax machines, telephones, postage, or email, for political activities. The ban on engaging in political activity while on duty prohibits such activities as circulating petitions, addressing campaign mailers, or engaging in any other political activities that use City resources or divert employees from their assigned duties.

3. City employees are prohibited from using their official positions to influence elections, and from using City funds or resources for political or election activities. Further, City employees may not participate in political activities of any kind while in uniform (i.e., part or all of a uniform they are required or authorized to wear when engaged in official duties).

4. Violation of these rules may result in considerable civil and criminal penalties, as well as discipline, up to and including dismissal.

~~5.~~ For more information, DPH employees should contact the San Francisco Ethics Commission (www.sfethics.org) or review the City Attorney's opinion (www.sfcityattorney.org) regarding political activities.

REFERENCES:

DPH Code of Conduct Section 8.9 Political Contributions and Activities
DHR Employee Handbook Section Political Activity

Revised: 97/06/11, 08/04/22, 22/09/09 (Year/Month/Day)
Original adoption: 92/05/20

~~**REFERENCES:**~~

~~Battin, supra, 77 Cal. App. 3d at 658~~
~~California Penal Code Section 424 (embezzlement or misappropriation of public funds)~~
~~Mines v. Del Valle (1927) 201 Cal.273~~
~~People v. Battin (1978) 77 Cal. App.3d 635~~
~~People v. Nathanson (1955) 134 Cal. App.2d 43 (sustained felony conviction for use of city stationery)~~
~~Stanson v. Mott (1970) 17 Cal.3d 206~~

~~Revised: 97/06/11, 08/04/22 (Year/Month/Day)~~
~~Original adoption: 92/05/20~~

PROHIBITION OF ~~SEXUAL~~ HARASSMENT AND BULLYING

PURPOSE:

To ensure that ~~all~~ Laguna Honda Hospital employees ~~in the City and County of San Francisco are aware of and apply the following policy that is mandated by Administrative Code Section 16.9-25, and the DPH Policy Prohibiting Sexual Harassment. The ordinance in italics follows for reference.~~are aware of and comply with DPH's commitment to maintaining an environment free of unlawful harassment, intimidation, and bullying. DPH does not tolerate harassment, intimidation or bullying of any kind by anyone working in our facilities.

~~SUMMARY~~POLICY:

Harassment on the basis of sex, race, age, religion, color, national origin, ancestry, disability, medical condition, marital status, sexual orientation, gender identity or other protected category is prohibited and unlawful. It undermines our ability to work together and is contrary to our beliefs in personal dignity and respect for each other.

Harassment includes any behavior or conduct that unreasonably interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment. A few examples of harassment are:

- Jokes, insults, threats, and inappropriate comments concerning a person's race, color, gender, gender identity, age, religions, national origin, ancestry, citizenship, physical or mental disability, veteran status, or sexual orientation.
- Unwelcome or inappropriate sexual advances, sexual remarks, display of offensive material, requests for sexual favors, and other unwelcome verbal or physical conduct of a sexual nature.
- Verbal or physical conduct that disrupts another's work performance or creates an intimidating or hostile work environment.
- Communicating or displaying of offensive material in the workplace.

Bullying involves repeated incidents or a pattern of behavior that is intended to intimidate, offend, degrade, or humiliate a particular person or group of people. It can also be described as the assertion of power through aggression. Bullies often use tactics such as blaming for errors, unreasonable work demands, sabotaging someone's work, insults, putdowns, stealing credit, threatening job loss, and discounting accomplishments.

Violations of this policy are subject to disciplinary action, up to and including termination. ~~This section of the Administrative Code prohibits sexual harassment of employees, establishes a complaint procedure, provides for appropriate disciplinary action for violation of this code Section, requires distribution of these provisions,~~

~~provides for remedies for victims of sexual harassment, and requires the imposition of disciplinary action as the official City and County policy on sexual harassment.~~

~~Additional information on this section and on training packages about the prevention of sexual harassment is available from the Department of Human Resources' Equal Employment Opportunity Unit.~~

~~*1. San Francisco Administrative Code - Section 16.9-25*~~

~~*Prohibiting sexual harassment of City employees; establishing a complaint procedure; providing remedies for persons who have been found to be victims of sexual harassment including the setting aside of disciplinary action against these persons; requiring the imposition of disciplinary action against persons violating this section; requiring distribution of the policy; interpretation.*~~

~~*a. Sexual harassment of a City employee or applicant for employment by a City official or employee is prohibited.*~~

~~*b. Behavior which constitutes sexual harassment by City officials and employees includes, but is not limited to:*~~

~~*i. verbal harassment, e.g., epithets, derogatory comments or slurs;*~~

~~*ii. physical harassment, e.g., assault, impeding or blocking movement, gestures, or any physical interference with normal work or movement;*~~

~~*iii. visual forms of harassment, e.g., derogatory posters, letters, poems, graffiti, cartoons or drawings; or*~~

~~*iv. requests for sexual favors or unwanted sexual advances; when the foregoing behavior unreasonably interferes with work performance, creates an intimidating, hostile or offensive working environment, influences or affects the career, salary, working conditions, job, or other aspects of career development or an employee or prospective employee, or is an explicit or implicit term or condition of employment.*~~

~~*c. For the purpose of this section, the following behavior by City officials and supervisory employees also constitutes sexual harassment:*~~

~~*i. failing to take corrective action when the officials or supervisory employees know, or reasonably should know, that an employee in the line of supervision of the officials or supervisory employees is being subjected to prohibited sexual harassment on the job by anyone; or*~~

~~ii. retaliation against an employee or applicant for employment who complained of sexual harassment, or who testified on behalf of one who made a complaint, or who assisted or participated in any manner on behalf of a complainant in an investigation, proceeding or hearing conducted under this section.~~

~~d. A supervisory employee receiving a complaint of sexual harassment shall inform the department head of such complaint within three working days. Upon receipt of such information the department head shall inform, in writing, the Equal Employment Opportunity Unit of Civil Service within five working days. Within five working days after receiving notice of a complaint, the Civil Service Commission shall report that complaint to the Commission on the Status of Women. The Civil Service Commission's report to the Commission on the Status of Women shall not contain information identifying the parties involved in the events giving rise to the complaint, but shall include all other relevant details. The Civil Service Commission shall report the outcome of each complaint to the Commission on the Status of Women promptly after the complaint is resolved. The Civil Service Commission and the Commission on the Status of Women the number of claims filed, the number of claims pending, the departments in which claims have been filed and such other information the Commission determines necessary regarding problems in enforcement under this section.~~

~~e. The discrimination complaint procedure established by the Civil Service Commission pursuant to Section 3.661© of the Charter shall be used to review and resolve allegations of sexual harassment. The determination reached under the Civil Service Commission procedures shall be final and shall forthwith be enforced by every employee and appointing officer.~~

~~f. During any hearing on a complaint of sexual harassment, evidence of the sexual conduct of the complainant offered to attack the credibility of the complainant shall be permitted only as provided in the Civil Service Commission hearing procedures and with the express approval of the Civil Service hearing panel.~~

~~g. Upon a finding that a City official or employee has engaged in prohibited sexual harassment as defined herein against a City employee or applicant for employment, the City official or employee shall receive disciplinary action up to and including demotion or dismissal in accordance with the applicable provisions in the Charter. A statement of those findings, of the disciplinary action taken, and of any final determination of subsequent acts of sexual harassment shall be made a part of the employee's personnel file and shall be included in the employee's performance evaluation.~~

~~h. Whenever a final determination is made that an action taken against a City employee, such as but not limited to, a reassignment, transfer, termination, disciplinary action or demotion, constitutes sexual harassment, the responsible appointing officer in the subject department shall set aside that action and provide a make-whole remedy to the complainant including but not limited to reinstatement~~

~~*of all benefits, seniority and back pay. After a final determination is made that sexual harassment did occur, the appointing officer in the subject department shall provide written notification of compliance with the requirements of this section to the General Manager, Personnel.*~~

~~*i. Prevention is the best tool for the elimination of sexual harassment. All City and County commissions, departments, boards and agencies shall provide to each of their supervisory employees a copy of this ordinance with a written explanation of the Civil Service procedure for filing a complaint for violation thereof, and shall adopt a specific departmental policy delineating that sexual harassment will not be tolerated and shall provide to or acquire for its supervisory personnel a training program designed to educate and thereby prevent sexual harassment.*~~

~~*j. This policy shall be construed in a manner consistent with the right of free speech, association and privacy.*~~

~~*k. The offices of the Human Rights Commission and the Commission on the Status of Women shall be available to provide assistance upon request to any employee, applicant for employment, or City department whenever appropriate.*~~

~~*l. Nothing in this section is intended to limit the power of a department head to discipline a department employee found guilty or responsible for sexual harassment or retaliation.*~~

REFERENCES:
DHR Employee Handbook Section Policy Prohibiting Harassment
~~None~~DPH Code of Conduct Section 4.3 Non-Harassment
DPH Code of Conduct Section 4.4 Bullying in the Workplace

Revised: 97/06/11, 08/04/22, 22/11/03 (Year/Month/Day)
Original adoption: 96/07/15

PAYROLL TIME REPORTING AND CONTROLS

POLICY:

All employees shall be paid accurately and on a timely basis in accordance with established personnel practices, Collective Bargaining Agreements, and Civil Service Rules.

PURPOSE:

To define the procedures for preparing, submitting and approving time records to ensure accurate compensation of employees based on established controls and approvals. Time reporting approval is limited to City managers and supervisors.

PROCEDURE:

1. Laguna Honda Payroll Department transmits electronically to the City's payroll system to generate the bi-weekly payroll processing.

    a. The Nursing Department uses an electronic time reporting process to transmit work hours on a daily basis to Payroll. Nursing staff sign in and out at their assigned Neighborhood daily.

    b. All other departments use prepared timesheets to record work hours and time off and submit timesheets to Payroll on a weekly basis.

    c. Time reporting is an important management control function and each supervisor is responsible for approving/disapproving an employee's pay/work status in accordance with established personnel practices, Collective Bargaining Agreement (CBA), and Civil Service Rules, and to accurately report time to payroll.

    d. Supervisors shall not report an employee as working for any given time if the employee has not actually worked. Employees are responsible for accurately reporting their hours worked.

    e. Prior to transmitting the payroll data to City's payroll system, Laguna Honda's Payroll staff reviews the records for accuracy. Any discrepancies needing adjustment/correction are processed using the City's "Problem Description Form" after the Department Head submits a Laguna Honda "Payroll Changes for Prior Pay Periods Justification for Symbols/Changes" form.

    f. Following each payroll cycle, the department head verifies the Labor Production Data reflecting each employee's pay. Department heads are required to notify Payroll of payment discrepancies.

2. Laguna Honda Payroll in collaboration with Accounting monitors personnel cost based on the approved budget.

ATTACHMENT:

None

REFERENCE:

None

Reviewed: 22/09/07 (Year/Month/Day)
Revised: N/A
Original adoption: 12/07/31 ~~(Year/Month/Day)~~

LACTATION ACCOMMODATION FOR EMPLOYEES AT THE WORKPLACE

POLICY:

Laguna Honda Hospital will provide a private space, supportive environment, and reasonable time for lactation purposes for nursing ~~mothers~~employees who work at Laguna Honda.

The Lactation Room is located on the 2nd floor in the H Building (connecting corridor between Administration Building and Hospital) across from the Mailroom. The Lactation Room is a private room with capacity for one individual using the room at a given time.

The Lactation Room is available 24 hours a day, 7 days a week.

PURPOSE:

1. The Lactation Room provides a reasonable private, non-bathroom location for nursing ~~mothers~~ employees to express breast or chest milk during the work~~-~~day.

2. Lactation accommodation goals are to:

   a. Ease the transition of ~~mothers~~ birthing employees who return to work following the birth of a child.

   b. Assist ~~mothers~~ birthing employees to return to work rather than having to take time away from work to express milk.

   c. Ensure that ~~women~~ employees who are pregnant or considering pregnancy know that breast and chest feeding will be accommodated by their employer.

   d. Assist employees to experience work-life balance by providing a motivating, employee-supportive work environment.

PROCEDURES:

1. The Department of Human Resources at Laguna Honda shall provide this policy, a Request for Lactation Accommodation form, and related parental information to any employee who submits a request for ~~maternity or~~ pregnancy disability ~~leave~~or child bonding leave, or upon request.

2. Upon return from leave, the nursing employee ~~(nursing mother)~~ and direct supervisor will work together to plan a reasonable schedule to accommodate time for lactation.

3. Key card access to ~~T~~the Lactation Room may be requested from the Administrative Director of Care Experience via email or telephone. The room is available on a first come, first serve basis. ~~The Lactation room~~It is available when the Lactation sign says "Vacant~~.~~", and ~~The Lactation room is~~ not available when the ~~Lactation~~ sign says "Occupied."

4. Lockers for employees using the Lactation Room are available in the locker room (located next door to the Lactation Room) to store their breast or chest pump and other necessary accessories. Employees are responsible to provide their own lock.

5. Employees who use the Lactation Room shall leave the room clean and tidy.

ATTACHMENT:
None

REFERENCES:

~~San Francisco Department of Public Health – Policy and Procedure, Lactation Accommodation at the Workplace (HUR23)~~

~~AB 1025 Lactation Accommodation Legislation~~
DHR Lactation in the Workplace Policy

Revised: ~~N/A~~2022/10/28 (Year/Month/Day)
Original Adoption: 2015/03/10

Revised Nursing Services Policies and Procedures

Attachment 1: Nurse Call System User Guidelines and Procedures in Responding to Calls

A. Definition:

A Nurse Call System is a method for hospital staff to communicate with residents. Different call stations (i.e., Master Station, Patient Station, Staff Station) allow staff to respond to resident's call, make calls directly to resident's room, and monitor any requests that have been dispatched to staff members. The call system will also alert staff to respond during emergencies (i.e., Code Blue, staff emergency, or bath calls).

Master Station

- A Nurse Call system monitor that is in each nurse's station and used to:
  - Answer and cancel a routine call from the resident's room.
  - Call a resident's room.
  - Send Requests and/or messages to staff.
  - Assign residents to a group template.
  - Assign a staff member's Wireless Phone to a group (e.g., Licensed Nurse, CNA, HHA, etc.)
  -
- A Request that is a pre-set or manually entered will ONLY send a reminder notification (when not addressed) to the sending master station. All calls, alerts, and duration of calls are time stamped and recorded in the log bin of the Nurse Call Master Station.
- This is a touch-screen device with an attached mouse. Pens, markers, or other objects other than fingers should not be used when operating this device.

Patient Station

- When a resident presses the routine call using the pillow speaker, adaptive device or the button on the patient station, tone sounds are emitted with LED illuminations for notifications. The call is also displayed on the nurse call master station. When a call is answered, two-way communication is established between the patient room and nurse master station. Audio is disconnected when a call is canceled or, put on hold, muted, and when the nurse call master station hangs up the handset.

Staff Station

- For voice communication between the nurse station and non-patient occupied areas such as staff break rooms, conference room, chart room, dining room, solarium, etc.

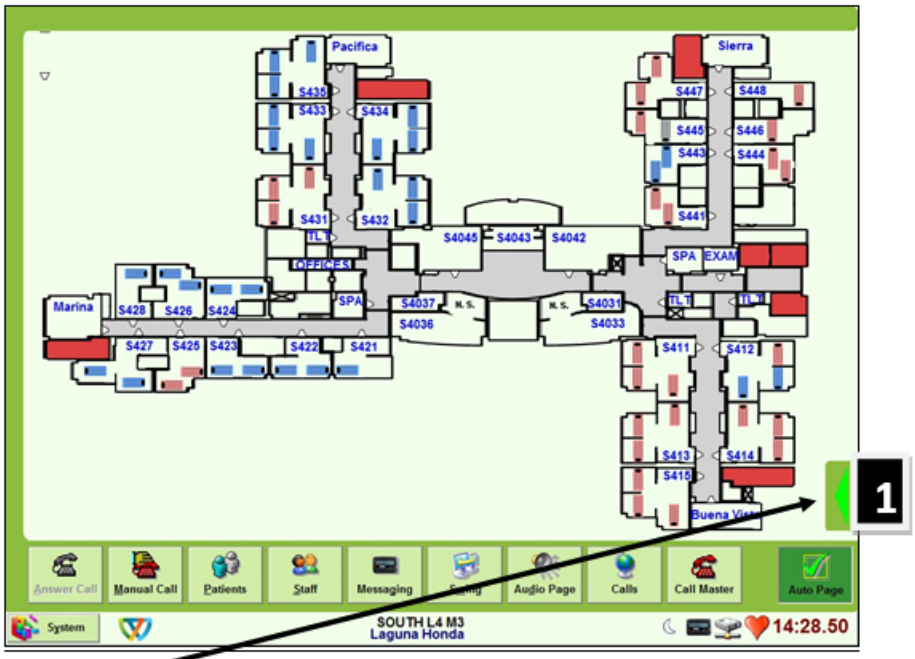
Group Assignment Worksheet

- This should be completed before performing any changes in the master station. Group templates of resident assignments and staff Wireless Phone extensions are listed and recorded on this worksheet. Group Assignment Worksheets should also be retained for a minimum of 3 years for record keeping and documentation purposes.
- Charge nurses or designee(s) can change the worksheet details if there is a staffing shortage or a broken Wireless Phone. If a regular assigned staff is off or sick, the replacement staff and assigned phone extension should also be updated in the Worksheet. Any changes to the worksheet should be reflected in the Master Station.
- Assignment of Support Staff is made according to each neighborhood's preference. Support Staff is an additional recipient of a call or a request in case the assigned staff does not answer after 3 attempt calls (Attachment 3 – C).

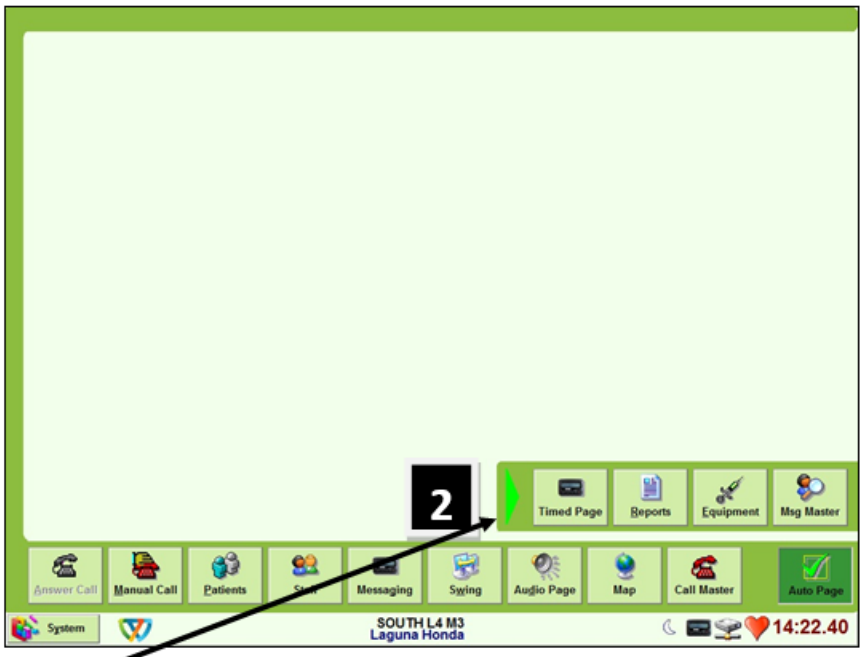
– All master stations use TEMPLATE Names based on the neighborhood (e.g., Marina, Redwood, Sierra, and Pacifica). Examples of Group Templates: S4 License 1 AM, N2 License 2 PM, N6 Charge Nurse Day.

II. PROCEDURES

A. Viewing the Hidden Icons in the Master Station



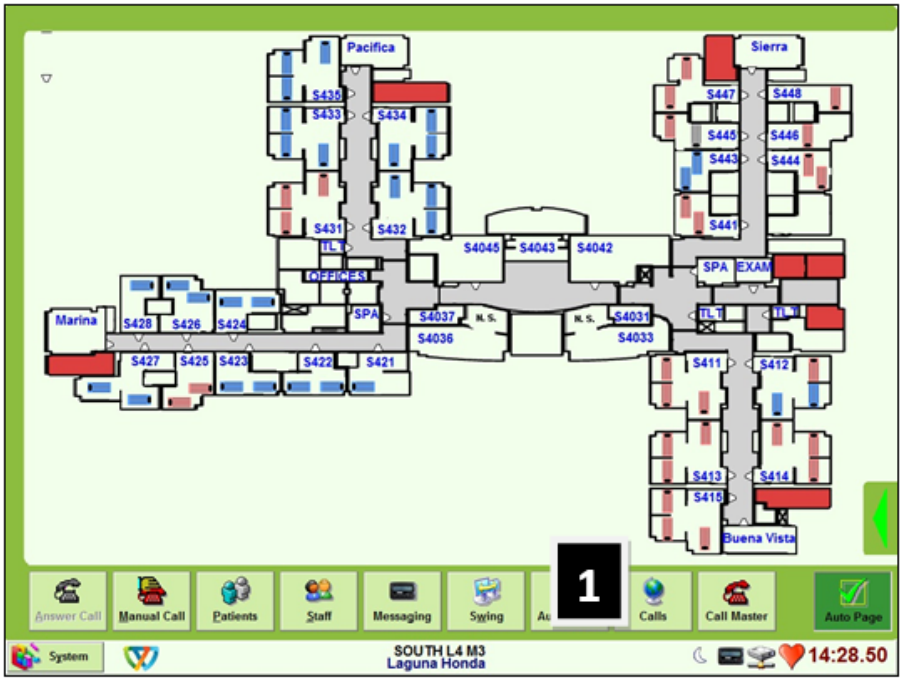
1. Click or touch ◀ to display more option tabs



2. Click or touch ▶ to hide the option tabs

B. Two view options of the master station

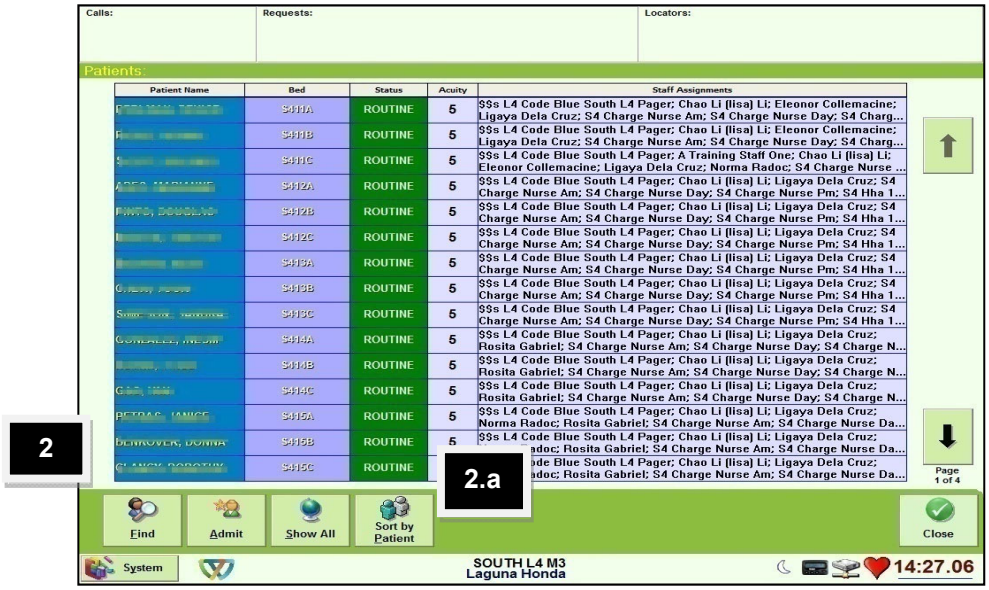
1. Click or touch the **Calls** button to view a list of calls.



2. Click or touch the **Map** button to view the neighborhood's room layout.

C. Viewing the Resident's List

1. Click or touch the **Patients** button to view the list of residents on that neighborhood.
2. Use the **Find** button to search for a resident by name. Or you can click on the down arrow button & scroll down through the list of residents' names. The names can be sorted by:
    a. Resident's Last Name
    b. Resident's Room Number



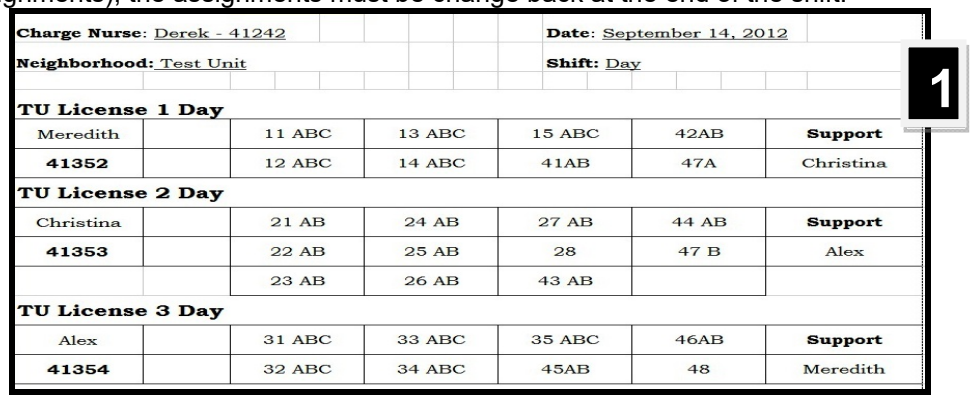
D. Calling a Resident's Room

1. Lift the NurseCall handset.
2. Click or touch the **Manual Call** button.
3. A window containing the resident room numbers and names will appear.
4. Click or Touch the **bed number/resident's name** to call that resident.

a. Use the **right arrow** to move to the next page of resident room numbers and names.
b. Once connected, address the resident, and introduce yourself.

5. Click or Touch the **Cancel** button to end the call.

E. **Assigning/Re-assigning a resident and/or a Wireless Phone to a group template**
Always refer to the neighborhood's group assignment worksheet when assigning a resident or a Wireless Phone to a group template. DO NOT change the master station assignment unless changes were made in the group assignment worksheet. If this is a temporary change (ex: pick up assignments), the assignments must be change back at the end of the shift.

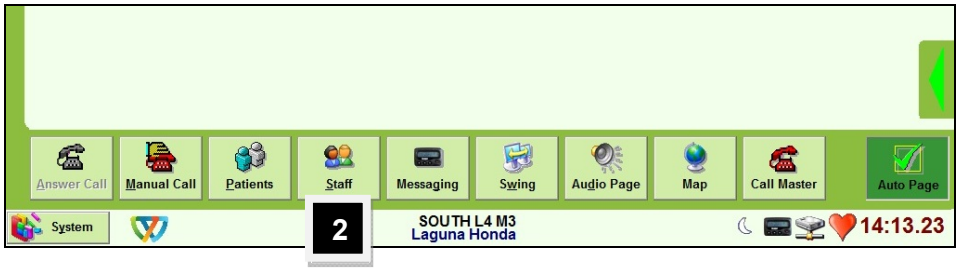


Charge Nurse: Derek - 41242 **Date**: September 14, 2012
Neighborhood: Test Unit **Shift:** Day

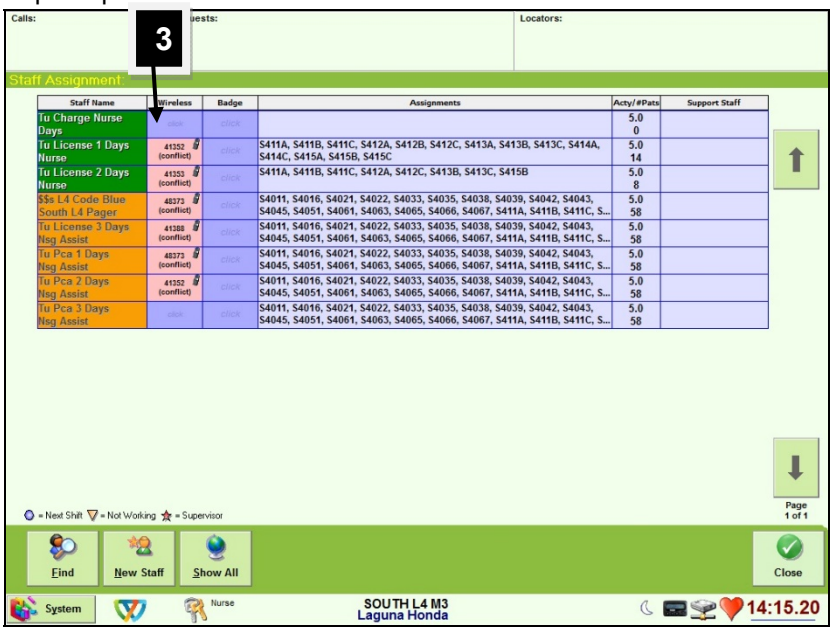
1

TU License 1 Day						
Meredith		11 ABC	13 ABC	15 ABC	42AB	**Support**
41352		12 ABC	14 ABC	41AB	47A	Christina
TU License 2 Day						
Christina		21 AB	24 AB	27 AB	44 AB	**Support**
41353		22 AB	25 AB	28	47 B	Alex
		23 AB	26 AB	43 AB		
TU License 3 Day						
Alex		31 ABC	33 ABC	35 ABC	46AB	**Support**
41354		32 ABC	34 ABC	45AB	48	Meredith

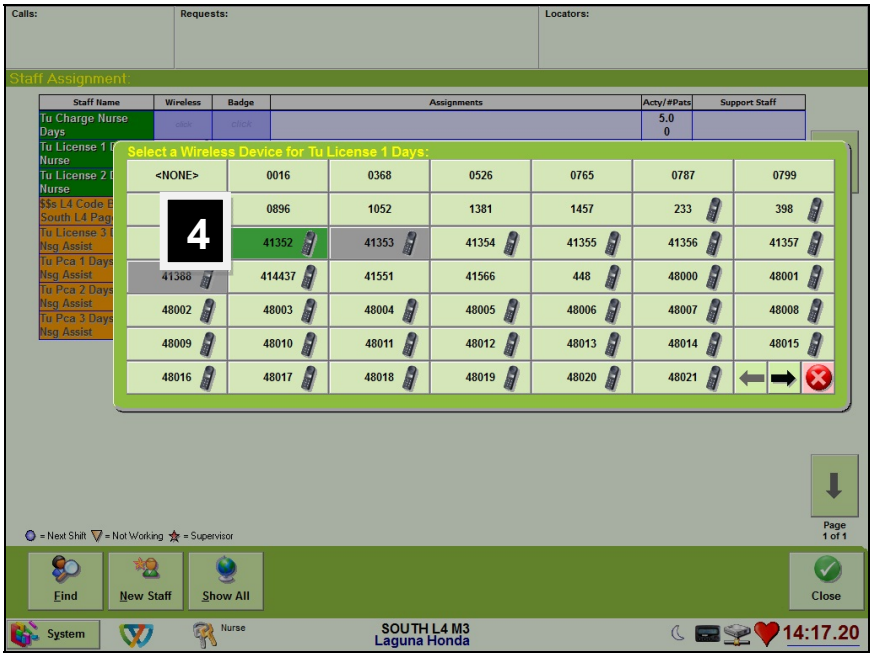
1. Review, confirm and mark the changes made in the **Group Assignment Worksheet**.
2. Click or touch the **Staff** button to view or assign/re-assign a resident and/or a Wireless Phone.



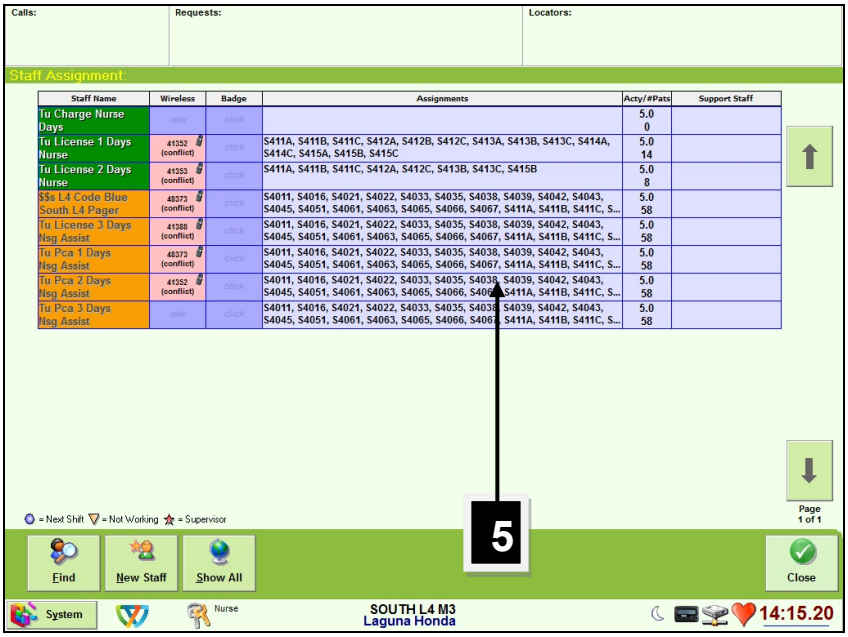
3. To assign a Wireless Phone extension, click or touch the box under the **Wireless** column of the group template.



4. A window containing of all the Wireless Phone extensions assigned to a neighborhood will appear. Referring to the worksheet, click or touch the Wireless Phone extension that needs to be assigned to the group template.

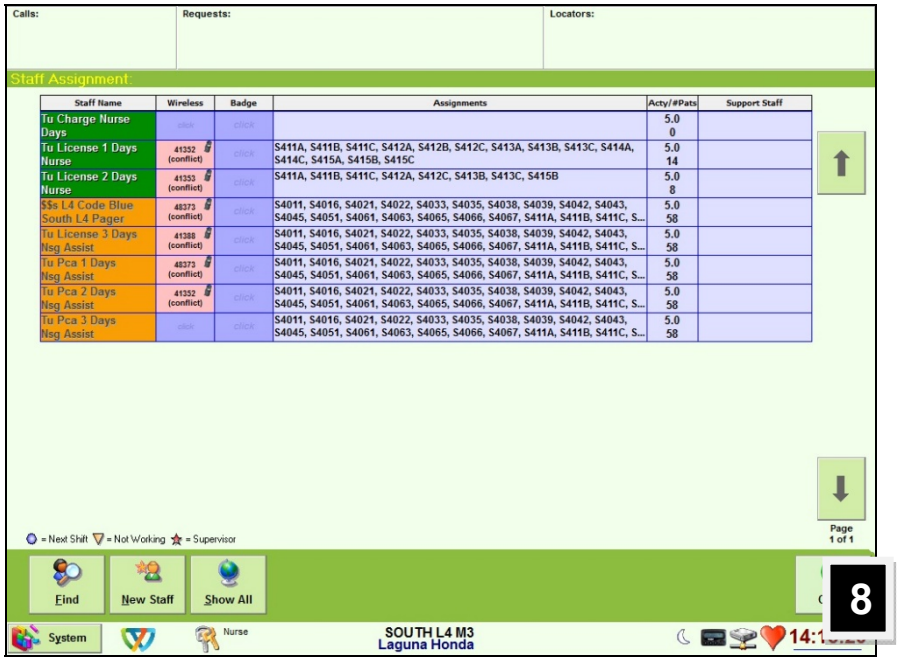


5. To assign/re-assign a resident, click or touch box under the **Assignment** column of the work group template.



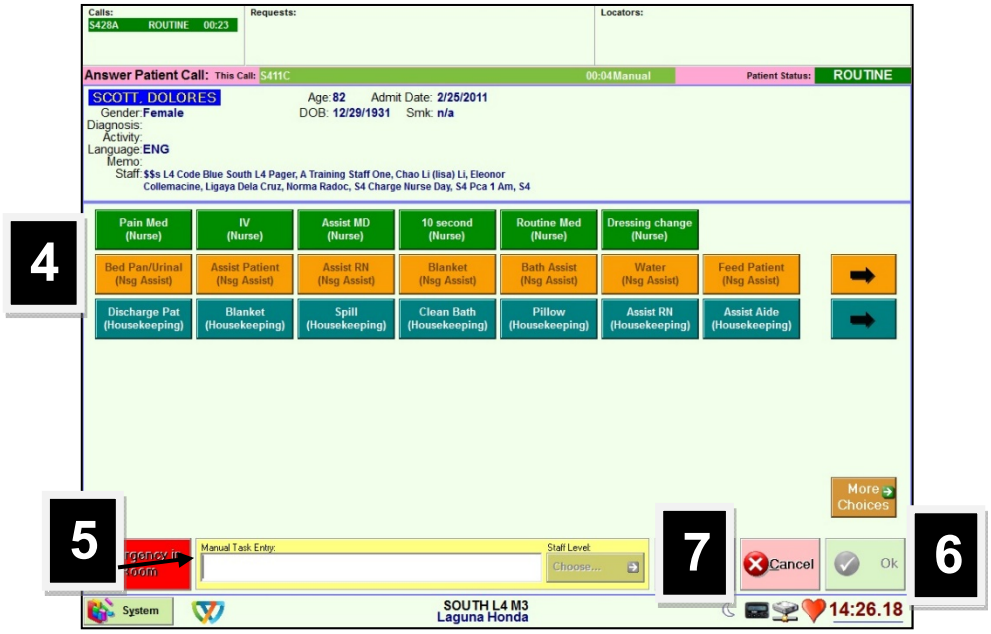
6. A window containing the list of residents will appear. Referring to the worksheet, click, or touch the **Room Number** assigned to the resident's name that you want to re-assign or remove from the group template.

7. Click or touch the **OK** button.
8. Verify that the data in the master station matches the details of the Group Assignment Worksheet. Then click or touch the **Close** button.



F. Receiving and Responding to a Routine Call

1. Lift the NurseCall handset. ONLY Routine Calls can be answered and/or cancelled using the Master Station
2. Click or touch the **Answer Call** button to speak to the resident.
3. Once connected, address the resident and introduce yourself.



4. The Request screen will appear. Select the pre-programmed **request** button according to the resident's need.
5. If a resident has a specific request, a message can be entered manually in the **Manual Task Entry** box. This allows you to submit a customized request and select the staff level required by the resident.
6. Click or touch the **OK** button to send the request.
7. To end a call without a sending request, click or touch the **Cancel** button. Do not cancel a call without first determining the resident's need.

NOTE:

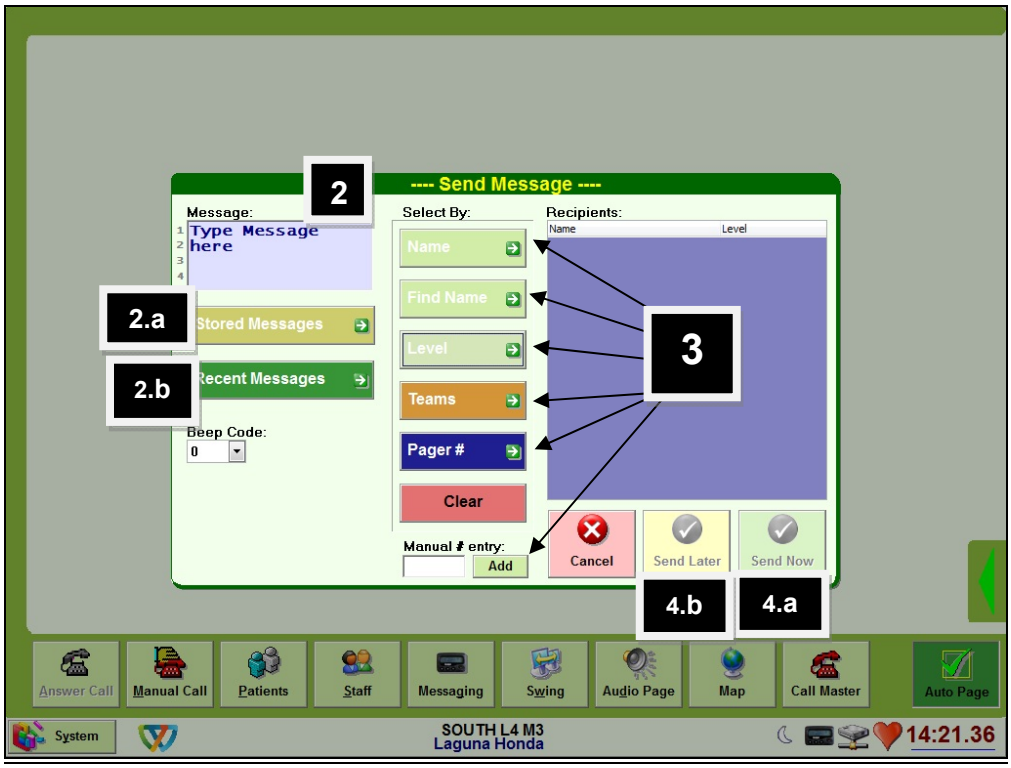
If the request of the resident is not answered within 3 minutes, another routine call (Patient Recall Screen) will be sent to the wireless phone to remind the staff. However, this call will ONLY be sent to the master station where the request was made.

G. **Sending NOTE**: **a message or text page**

1. Click or touch the Messaging button.

2. When the **Send Message** window appears, type in your message in the **Message** box or select a message that was previously sent or was stored:
   a. **Stored Messages** button

b. Recent Messages button



3. Select the recipient by any of the following options:
   a. **Name** - specific group assignment
   b. **Level** - all nurses, all nurse assistants, or all home health aides
   c. **Team** - Code Blue, Lift Team
   d. **Pager** - Wireless Phone extensions
   e. **Manual # entry** - type in the Wireless Phone extension (then click or touch the **Add** button)
4. To send, click or touch one of the following buttons:
   a. **Send Now** - when your message is completed and ready to be sent
   b. **Send Later** - to choose a specific day or time when the message will be sent

REFERENCE:

West-Call FocusCare® Nurse Call System Manual Operating Instructions

New Document: 2010/11/21

Reviewed: 2010/12; 2011/01/31; 2021/04/13

Approved: 2021/04/13

Attachment 2: Wireless Phone Operating Guidelines

A. Definition:

1. The wireless phone is a means of communication between residents, staff, neighborhoods, and outside callers.

2. The wireless phone uses wi-fi connection to place or receive calls from another Wireless Phone, Desk phone, and outside call. The wireless phone can receive alerts and messages when used in conjunction with the nurse call system to:

    a. Receive calls alerts coming from a resident's room, resident's bathroom and/or spa room.
    b. Receive alert messages from third-party applications (e.g., Johnson Controls Inc (JCI), Resident Tracking Locator System, etc.).
    c. Receive text messages sent from the NurseCall -master station.

3. The wireless phone cannot make a direct call to the Master Call Station or to a resident's room.

~~4. Another means of communication is through the alphanumeric pager. An assigned pager will receive text messages when the nurse call system or resident locator system is activated.~~

B. Operating the Wireless Phone

Turning on the phone	1. Press and hold the red Power/End Call button until the LED light on the top left corner of the phone turns on. 2. Verify the Wi-Fi signal  on top right-hand corner is present. 3. Verify the phone's 11-digit (**ex: +16285555555**) telephone number on top left-hand side of the screen is present.
Nurse Call System/Patient Room	**Answering Calls:** 1. Press the Answer/Send button and press the softkey  button to select "Connect" to talk to the patient. 2. To end or cancel the call and/or remove the call from the Nurse Call Master Station: Press "3". 3. To end a call but keep the call on in the Nurse Call Master Station: Press any number or the Power/End Call button. **Checking Missed Calls/Messages:** 1. Use the Navigation ring and the Select button to open "Apps". 2. Select "LHH Nurse Call". 3. Scroll down through the messages to review them (the most recent messages are displayed at the top of the list).
Non-Nurse Call	**Making and Answering Calls:** 1. Making a call: To call other wireless phones, enter the desired 5-digit extension number. For outside calls, dial 9, 1, area code, then the outside number and press the Answer/Send button. (To redial the last call, press the Answer/Send button twice.) 2. To answer a call: Press the Answer/Send button. 3. To end a call: Press the red Power/End Call button. *****To dial 911, dial 911 directly or 9-911***** **Checking Missed Calls:** 1. Use the Navigation ring and the Select button to open "Recents". 2. Scroll down using the Navigation ring and use the Select button to select the desired entry. 3. Press the Answer/Send button. *****Voicemails cannot be left on the wireless phones*****
Turning off the Phone	1. Press and hold the red Power/End Call button for 4 seconds. 2. Press the softkey  button to select "Power off".

C. Staff's Responsibilities

1. The nurse manager, charge nurse or designee will use the Group Assignment Worksheet Template to assign the residents to a designated phone number. Changes in a resident's group, assigned staff, or assigned phone number must be updated in the Group Assignment Worksheet and master station by the nurse manager, charge nurse or designee.
    a. Prior to their shift, each staff member must sign-out or initial their name in the Wireless Phone's Inventory sheet acknowledging receipt of their assigned Wireless Phone. All staff will be held accountable for the Wireless Phone that has been assigned to them during their shift.
    b. Receiving Phones:
        i. Staff must turn on their phone
        ii. Check the phone's battery level (change the battery if needed)
        iii. Check that the phone is functioning appropriately
        iv. Check that the phone's ringer is not turned off or on vibrate only.

v. Clean their assigned wireless phone at the start of the shift. Wipe the wireless phone with facility-approved disinfectant wipes. Remove excess fluid from the wipe to ensure the wipe is damp, but not soaking before wiping down the phone. Allow to air dry. (Excess liquid can damage screen and buttons).

2. At the end of the shift, each staff member:
    a. Must turn off their assigned Wireless Phone
    b. Must clean the wireless phone with facility-approved disinfectant wipes and allow them to dry before returning them to the charging doc.
    c. Must handoff their phone to the incoming charge nurse or designee who will initial their name in the Wireless Phone Receipt log to acknowledge the phone's return.
    d. The outgoing shift's charge nurse/designated person must perform an inventory count of all the Wireless Phones with the incoming charge nurse/designated person.

3. Each shift has their own designated set of phones. Phones that are not being used will be stored in the designated Wireless Phone cabinet behind nursing station two except for the Pavilion (in Conference Room P025) and South 4 (behind nurse station 1) neighborhoods which have alternative locations for storing the wireless phone cabinets.
    a. There are a minimum of four (4) wireless phone multi-chargers in each Wireless Phone cabinet.
    b. The wireless phone cabinet must be locked when it is not in use.
    c. A total of three keys have been distributed to each unit.
        a. The Nurse Manager will keep the master copy and the spare key will be locked in his/her office.
    d. At the start of the shift, the outgoing shift charge nurse or designated staff will hand over the third key to the incoming shift's charge nurse.
    e. Do NOT place anything on top of the wireless phone cabinet as this will block the circulation vents.

4. To avoid overloading the system with phone calls, staff must keep the conversations to a minimum.

5. Broken/Lost phone:
    a. Nursing staff should inform their charge nurse if the designated phone ~~or pager~~ is lost, damaged, or not functioning.
    b. Refer to the attached standard work on replacing a broken Cisco phone (Attachment 3~~m~~ – D)
    c. The charge nurse must reassign the loaned~~r~~ phone in their NurseCall Master Station to replace the previously assigned broken wireless phone.
    d. Do NOT borrow a phone from another staffer on a different shift.
    e. Complete an unusual occurrence (UO) report generated if a phone is:
        i. Lost
        ii. Broken due to:
            1. A cracked or damaged screen
            2. Water damage
            3. Physical damage (beyond normal wear and tear)

6. Downtime procedure: In the event of a Wireless Phone downtime:
    a. Refer to the red system downtime manual binder located in nursing stations 1 & 2 or refer to the System Manual on the LHH Intranet Nursing Department website: https://in-dphsp01.in.sfdph.net/lagunanet/Nursing/_layouts/15/start.aspx#/SitePages/System-Manual.aspx
    b. Network Downtime - The wireless phone call features and alert messages will be inactive. Staff must regularly round on the residents during the downtime.
    c. NurseCall Liaison Downtime - Staff will not receive any alert messages. During this time, a staff member must be assigned to monitor the Master Call Station when the nurse call system is activated.

D. Cleaning Wireless Phones and pagers:

1. Wipe phones with facility-approved disinfectant wipes. Squeeze excess fluid from the wipe to ensure it is damp, but not saturated before wiping down the phone.

2. The phone should not be cleaned with harsh and/or caustic chemicals (i.e., Sani-cloth® Plus wipes) because the chemicals in the wipes may seep into the keypads and damage the phone.
3. Alcohol wipes or alcohol-based cleansers also cannot be used to clean the phone.

REFERENCES:

Cisco Wireless IP Phone 8821 and 8821-EX User Guide

New Document: 2010/11/23
Reviewed: 2010/12; 2011/01/31; 2021/04/13
Approval: 2021/04/13

Attachment 3 - A: Sample of Group Assignment Work Sheet

Charge Nurse: Derek - 41242 **Date:** September 14, 2012

Neighborhood: Test Unit **Shift:** Day

TU License 1 Day

Meredith		11 ABC	13 ABC	15 ABC	42AB	**Support**
41352		12 ABC	14 ABC	41AB	47A	Christina

TU License 2 Day

Christina		21 AB	24 AB	27 AB	44 AB	**Support**
41353		22 AB	25 AB	28	47 B	Alex
		23 AB	26 AB	43 AB		

TU License 3 Day

Alex		31 ABC	33 ABC	35 ABC	46AB	**Support**
41354		32 ABC	34 ABC	45AB	48	Meredith

TU PCA 1 Day

Izzy		11 ABC	13 ABC	15 ABC		**Support**
41355		12 ABC	14 ABC			George

TU PCA 2 Day

George		21 AB	23 AB	25 AB	27 AB	**Support**
41356		22 AB	24 AB	26 AB	28	Izzy

TU PCA 3 Day

Bailey		31 ABC	33 ABC	35 ABC		**Support**
48373		32 ABC	34 ABC			Callie

TU PCA 4 Day

Callie		41 AB	43 AB	45 AB	47 AB	**Support**
48374		42 AB	44 AB	46 AB	48	Bailey

HHA 1 :	**41388**	Richard
HHA 2 :		
Coach #1 :		
Coach #2 :		

Attachment 3 – B: Light Illumination Patterns

Types of Calls	Light Illumination Patterns	
	Dome light	**Zone light**
Fire Alert	Solid red	All lights alternately blinking
Code Blue Call	Flashing strobe lights (all colors)	Flashing strobe lights (all colors)
Staff Emergency Call	Flashing white light with solid green light	Flashing red light
Bath Call	Flashing white light	Flashing red light
Routine Call	Solid white light	Flashing white light

Attachment 3 - C: Table of Wait time

Order of Call	Recipient and Duration
First Call/ Request	goes to the assigned Nurse Asst. - after 3 min
First Recall	goes to the assigned Nurse Asst - after 3 min
Second Recall	goes to the assigned Nurse Asst - after 3 min
Third Recall	goes to the assigned Nurse Asst and the support staff - after 3 min
Fourth Recall	goes to the assigned Nurse Asst and the support staff and the charge nurse

Attachment 3 - D: Standard Work for Replacing a Broken Phone

LAGUNA HONDA
HOSPITAL AND REHABILITATION CENTER
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Standard Work Instructions

Title: Cisco Phone Repair and/or Replacement Request
Area: LHH

Title: Cisco Phone Repair and/or Replacement Request

Performed By: Nursing Staff **Date: 8/12/21** (created or last updated)

Owner: Clinical Liaison Team **Revised By:** **Revision #: 5** **Time:**

Purpose: To streamline the process of repairing nursing staffers malfunctioning Cisco phones.

	Major Steps	Details (if applicable)	Time	Diagram, Workflow, Picture, Time Grid
1	Staff will complete the Broken Cisco Phone Checklist & attach to the broken phone.	Staff will check all applicable boxes.		
2	The **charge nurse** or **nurse manager** will email the clinical liaison team notifying them of a broken/malfunctioning Cisco phone. **DPH-LHH-NSGClinicalLiaison@sfdph.org**	CN or NM will include the following details in the email: • **Unit** • **Cisco extension** • **Contact name & title** of person experiencing the issue • **Issue** (i.e., Network, Ringtone, Can't hear caller, Not receiving calls,		

Broken Cisco Phone Checklist:

Date:

Cisco Extension:

ISSUES:	Yes	No
Not connecting to the Network?		
Phone NOT ringing when called?		
Unable to turn on the phone or phone won't stay on?		
Calling Features: • The caller can't hear you • You can't hear the caller • Can't receive calls • Can't make calls • Background noise during calls		
NurseCall Message Features: • Phone NOT receiving NurseCall Messages *(Please check that the phone is correctly assigned in the NurseCall system)*		
Other:		

LAGUNA HONDA
HOSPITAL AND REHABILITATION CENTER
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Standard Work Instructions

Title: Cisco Phone Repair and/or Replacement Request
Area: LHH

		Phone turns off, etc.) • **Attempted troubleshooting** (i.e., resetting phone, checking sound settings, changed battery, etc.)		
3	Staff will place the broken Cisco phone with checklist in the designated box in the Cisco closet labelled "Broken Cisco Phones."			
4	Clinical informatics staff will retrieve the broken Cisco phone and swap it out for a functioning phone.			

Page 1 of 1

San Francisco Health Network

Standard Work Instructions

System Technology

Title: Replacing a Broken Cisco Phone

Performed By: Nursing Staff **Date: 04/01/2020**

Owner: Clinical Liaison Group **Revised By: Clinical Liaison Group** **Revision #: 7** **Takt Time: 1**

Purpose: To provide continuous mobile device services for the nursing staff.

	Major Steps	Details relevant details and tips, diagram, workflow, picture, time grid)	Time	Reason
1.	Prepare the broken Cisco Phones in the neighborhood before bringing in the Nursing Office. **Wipe Cisco Phones and any broken pieces with the Sani-Cloth Germicidal Disposable Wipes (purple cover or top) and place this in a plastic bag (specimen bag).**			

San Francisco Health Network

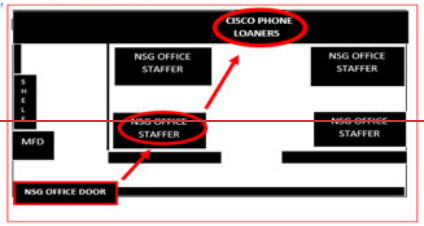
Standard Work Instructions

System Technology

Title: Replacing a Broken Cisco Phone

Performed By: Nursing Staff **Date: 04/01/2020**

Owner: Clinical Liaison Group **Revised By: Clinical Liaison Group** **Revision #: 7** **Takt Time: 1**

	Major Steps	Details relevant details and tips, diagram, workflow, picture, time grid)	Time	Reason
2.	Bring the broken Cisco Phone to the **Nursing Office** and ask **Nursing Staffer** for a Cisco Phone Loaner replacement.	**Nursing Office Map:** 		
3.	Nursing Staffer takes the broken Cisco Phone and places it in the bin labeled **Broken Phones**.			

San Francisco Health Network

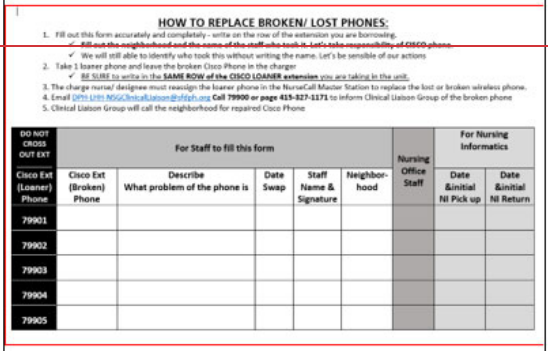
Standard Work Instructions

System Technology

Title: Replacing a Broken Cisco Phone

Performed By: Nursing Staff **Date: 04/01/2020**

Owner: Clinical Liaison Group **Revised By: Clinical Liaison Group** **Revision #: 7** **Takt Time: 1**

	Major Steps	Details relevant details and tips, diagram, workflow, picture, time grid)	Time	Reason
4.	Nursing staffer gives a loaner phone and the **LOANER PHONE LOG LIST** form to the borrowing staff.			
5.	**Borrowing staff** completes the **LOANER PHONE LOG LIST** form and includes the extension, problem, date, signature, & unit. Be as specific as possible when describing the problem such as: • **Cisco does not turn on** • **Cannot hear the other person** • **Broken/Cracked Screen** • **Broken/Cracked Battery Cover** • **Keypad button doesn't work** • **Does not receive message** • **Does not have ringtone** **Nursing Staffer** verifies that the: • Loaner Cisco Phone extension is written on the same row as the broken Cisco Phone extension. • All fields are completed.	 **HOW TO REPLACE BROKEN/ LOST PHONES:** 1. Fill out this form accurately and completely - write on the row of the extension you are borrowing. ✓ Fill out the neighborhood and the name of the staff who took it. Let's take responsibility of CISCO phone ✓ We will still able to identify who took this without writing the name. Let's be sensible of our actions 2. Take 1 loaner phone and leave the broken Cisco Phone in the charger ✓ BE SURE to write in the **SAME ROW of the CISCO LOANER extension** you are taking in the unit. 3. The charge nurse/ designee must reassign the loaner phone in the NurseCall Master Station to replace the lost or broken wireless phone. 4. Email DPH.LHH.NSGClinicalLiaison@sfdph.org **Call 79900 or page 415-327-1171** to inform Clinical Liaison Group of the broken phone 5. Clinical Liaison Group will call the neighborhood for repaired Cisco Phone			

DO NOT CROSS OUT EXT	For Staff to fill this form					Nursing Office Staff	For Nursing Informatics	
Cisco Ext (Loaner) Phone	Cisco Ext (Broken) Phone	Describe What problem of the phone is	Date Swap	Staff Name & Signature	Neighbor-hood		Date &initial NI Pick up	Date &initial NI Return
79901								
79902								
79903								
79904								
79905								

San Francisco Health Network

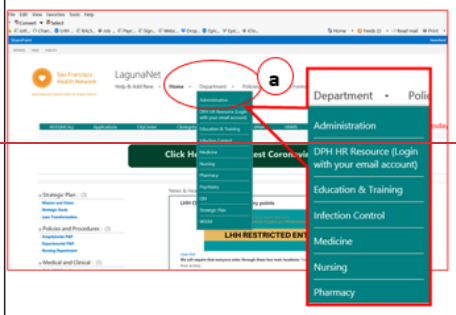
Standard Work Instructions

System Technology

Title: Replacing a Broken Cisco Phone

Performed By: Nursing Staff **Date: 04/01/2020**

Owner: Clinical Liaison Group **Revised By: Clinical Liaison Group** **Revision #: 7** **Takt Time: 1**

	Major Steps	Details relevant details and tips, diagram, workflow, picture, time grid)	Time	Reason
6.	A designated person from the borrowing neighborhood assigns the Loaner Phone's extension to the **assigned group template** in the Nurse Call Master Station to ensure calls and alerts from resident's room go to the Cisco Phones.	Refer to the  Instruction Sheet on the LHH Intranet: a. Department b. Nursing c. Resource Center → NurseCall Reference Sheets d. **Assigning Re-assigning a Resident and/or Cisco Phone to a Group Template** **Continued ...**		

San Francisco Health Network

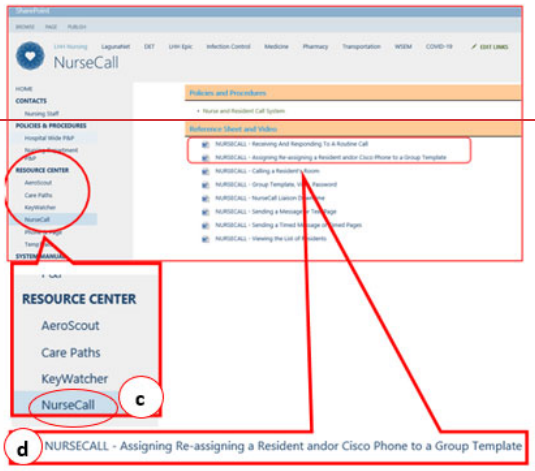
Standard Work Instructions

System Technology

Title: Replacing a Broken Cisco Phone

Performed By: Nursing Staff **Date: 04/01/2020**

Owner: Clinical Liaison Group **Revised By: Clinical Liaison Group** **Revision #: 7** **Takt Time: 1**

Major Steps	Details relevant details and tips, diagram, workflow, picture, time grid)	Time	Reason
			

NURSE AND RESIDENT CALL SYSTEM

POLICY:

1. The LHH Executive Committee must grant authorization prior to turning off the NurseCall system or before modifying any system settings that may impact resident safety.

2. Group Assignments Worksheets must be entered accurately in the Master Station by charge nurse or designee. If any changes are made in either the resident grouping or wireless phone assignment, the Group Assignment Worksheet must be updated first then in the Master Station by the same designated staff.

3. Any changes or updates related to a resident's demographic information that can be seen in the Master Station are done by an authorized staff member from Admission& Eligibility (A&E).

4. Residents with limited hand mobility, aphasia, and/or hard of hearing will be evaluated by a licensed nurse using adaptive devices guidelines for the correct adaptive device. Complex situations will be referred to appropriate rehabilitation staff for evaluation.

5. Unit clerks can answer the routine calls and forward the call/request to the assigned nursing staff.

6. Nursing staff assigned to a resident will respond to the nurse call system by going to the location of the calling resident. However, routine calls can also be answered directly through the Nurse Call Master Station or via the Wireless phone. All license nurses are not assigned to receive Routine Calls (except PM Acute). Calls made from any emergency pull cord station (i.e., bathroom/toilet and shower/tub room), bed exit alerts, code blue alerts, and staff emergency calls must be answered immediately by going to that location.

7. Fire alerts in residents' rooms are triggered automatedly by the system and are not manually activated by any residents.

8. Any call where the listener is unable to determine the resident's need requires the responder to physically go to the resident/location.

9. Designated HHA may respond to routine calls, bed exit alarms, and bath calls as requested by the LN (Licensed Nurse) and within the scope of HHA responsibilities.

10. Daily checking of all bedside call lights and weekly checking for shower and bathroom call lights for proper function are part of the nursing assistant's work list in the Electronic Health Record (EHR). Please confirm if this also apply to the PM Acute

PURPOSE:

To be able to communicate with residents and staff in order to meet the resident's need in a timely and prompt manner.

CHARACTERISTICS:

Each neighborhood has two master call stations, one for each nursing station in the South Residence Building (SRB) and the North Resident Building (NRB); Pavilion Mezzanine (PM) will have three master stations (PM-SNF; PR- Acute Rehab, PA- Acute Medical).

The Master Station allows staff to answer the resident's routine call, view new calls/alerts, monitor the active calls and alerts, make calls directly to resident's room, and monitor requests that have been dispatched to staff members and schedule/send text messages to the staff.

Each neighborhood has their own template for the Group Assignment Worksheet. This is printed out daily by each shift. Charge nurses or designee changes the worksheet details if there staffing shortage or a change in the assigned staff or there is a broken Wireless Phone. Any changes in the Group Assignment Worksheet should be duplicated in the Master Station. This Group Assignment Worksheet needs to be kept by charge nurse or designee for three (3) years in case an unusual occurrence may occur.

A. Types of Nurse and Resident's Call Stations

1. Master Call Station - comes with a computer with the vendor's software, a touch-screen monitor, mouse, keyboard, and connected telephone handset that is used to talk to the resident when answering a routine call. The touch screen has a floor map displaying all resident rooms and beds in the neighborhood. Group and Wireless Phone assignments are added and edited in the Master Stations. Pens or other sharp objects other than fingers should not be used to operate the master station.

2. Patient's Station - located in each room next to the resident's bed. All calls activated in patient station, pillow speakers, and other adaptive nurse call devices will show in the Master station screen and are routed to the assigned caregiver's Wireless Phone

3. Patient Pillow Speaker -connected to every patient call station. The pillow speaker is also used as remote control and speaker for the television. ~~Group and Wireless Phone assignments are added and edited in the Master Stations. Pens or other sharp objects other than fingers should not be used to operate the master station~~ – DELETE, THIS IS DUPLICATE AND OUT OF CONTEXT. Pillow speakers or adaptive nurse call devices must be within the resident's reach.

4. Emergency Pull Cord Station -located in every bathroom, toilet, shower or tub room in every neighborhood.

5. Staff Call Stations and Staff Duty Stations – are located in commonly used areas by staff and residents. These include the living rooms at the end of each household, the great rooms and the staff lounge rooms.

B. Group Assignment Worksheet

See Attachment 3–A for a sample of Group Assignment Worksheet

C. Hallway Light Illumination Patterns

For each type of call, a corresponding light illumination pattern is displayed on the ceiling light at the end of the hallway (zone light) and outside each resident's door (dome light). These lights will provide visual cues to the staff signaling the location where a call has been made.

See Attachment 3-B for list of identified Light Illuminating patterns and the type of calls it identifies.

1. Zone lights – located at the end of each household in the living room area, and in between nurses' stations, and great rooms. The zone light remains lit if there is an active call in the neighborhood.

2. Dome lights –located outside each resident room, above the door. The dome light remains on if there is an active call/alert inside the room

PROCEDURES:

A. Receiving and Responding to Calls

When calls and alerts are activated, it will be sent to both NurseCall Master Station and ~~they are~~ displayed according to their priority ranking, and ~~,~~also auto paged to the wireless phone.
~~-~~Listed below are the available calls and alerts in order of highest priority.

1. Fire Alert – this highest priority call is always activated by the fire alert system. It is only triggered when there is fire within the resident's room. The alert is displayed in the NurseCall Master Station and will send alerts to all staff Wireless Phones. It will not trigger if the fire is detected in any other area of the neighborhood (but will trigger the fire alert system). Smoke Detectors are connected directly to the Patient Stations.

2. Code Blue Call – this highest priority call is intended only for life-threatening medical emergencies. This call overrides any routine call, bed exit alarm, bath call, or staff emergency call. This call must be responded to by any LN and/or nursing staff by going directly to the resident's location where the call was activated. A Code Blue Call can only be initiated at the patient station where medical emergency assistance is needed. This call can only be cancelled from the originating patient station after the Code Blue has been cleared by the Code Blue Team. Refer to LHHPP 24-16 (Code Blue). NOTE: There are also code blue in the clinic, rebab and wellness. Please confirm

3. Staff Emergency Call – high priority calls activated by pressing the "STAFF" button in the patient's station, ~~staff duty station~~ or NurseCall master call station. This call will override any routine call. Available staff working in the neighborhood should respond and check the resident's status immediately. This call can only be cancelled in the originating patient station.

   Examples of staff emergency calls, but not limited to:
   a. Resident found on the floor
   b. Resident with unsafe behavior needing staff interventions
   c. Any emergent situation that may require a second nursing staff for assistance

4. Bath Call – a high priority call activated from the pull cord stations located in every resident's bathroom or toilet room, tub room, or tub room in every neighborhood. When activated, a "Bath" call appears on the Master Station and the wireless phone of assigned staff. However, due to the hospital building's wiring and sharing of bathroom, the room or bed number that is closest to the bathroom is displayed in the alert message. The assigned staff or any available staff should respond and check the resident's status or condition immediately. This call can only be cancelled in the originating toilet station. Each shower pull cord station will state "Cancel at Toilet" (station).
   a. Bath Calls activated from the toilets on the ground and first floors – Pavilion Building go to the nursing office Master Station – MONIQUE: We should move this to additional appendix because as faras I know the bath call from the ground floor also go to rehap master station. And Pav first floor also go to xray and nursing office. Have a separate page may we easier to update/change. Also we need decision from the nursing leader

5. Routine Call – regular call initiated from pillow speaker, patient's station, or other adaptive nurse call devices.
    a. For some simple requests, a pre-programmed "Send Request" button from the Master Station will send a text message to the assigned staff's Wireless Phone indicating the request, room number and resident's name. Alternatively, a designated staff member answering the call from the Master Station can type a specific request, which is then sent to the assigned staff's Wireless Phone. Once a request is sent to a Wireless Phone, the request must be cleared by pressing the *cancel* button on the patient station. If the request is not cleared in a pre-determined time, the request will re-appear on the Master Station and will be resent to the Wireless Phone.
    b. See attachment 3-C for Table of Wait time

6. Cord-out Call - activated when certain devices (i.e. pillow speaker, adaptive nurse call device, ~~bed exit alarms~~smart bed ~~,~~ cord and the beds power cord. ~~electric bed~~) are accidentally pulled out from the patient station, disengaged from a connector, or unplugged from the electric outlet. These calls can only be cancelled from the resident's room by reconnecting items that were pulled out, disengaged or unplugged.

7. Bed Exit Alarm –a priority call activated when a resident is trying to get out from his or her bed. When activated, a message is sent to the assigned Licensed Nurse, CNA, or PCA's Wireless Phone. The assigned staff or any available staff should respond and check the resident's status or condition immediately. This call can only be cancelled in the resident's room by resetting the bed alarm.

8. Medevice – an alarm that is sent to the Master Station and Wireless Phone for a portable bed exit if the resident is using a bed that does not have a built-in bed alarm or one that is not compatible with the Nurse Call System. For those bed, a portable bed alarm is used and is manually connected the Nurse Call System.

B. Checking Function of Resident Call System

1. Testing the Patient Station: a call initiated from the resident's pillow speaker or adaptive device should appear as a routine call in the Master Station as well as on the assigned (CNA or PCA staff's Wireless Phone). The call should be answerable both at the Master Station and by a Wireless phone, with both parties able to hear each other talking. Both dome light outside of the resident's room and the zone light at the end of each hallway should turn on.

2. Testing the Bath Call: when the bathroom pull cord is activated, the call should appear as a bath call in the Master Station as well as the assigned staff's Wireless Phone with the room number. Both dome light outside of the resident's room and the zone light at the end of each hallway should turn on.

    a. For the bath calls made from the spa rooms and public toilets within the neighborhood, a designated group of nursing staff are assigned to respond when the pull cord is pulled. The same steps should be followed as stated above when testing pull cords from the spa room and public toilets within the neighborhood.

3. Acknowledged in the Work List in EHR of the assigned Nurse Assistant upon completion of checking:

    a. Daily for the bedside call lights
    b. Weekly on bed stripping days for shower and bathroom call lights

4. Reporting of Non-Working Resident Call System

    a. Report to Facility Services
        - **i.** if the nursing staff is unable to hear a call to or from the Master Station, Patient Station, Pillow Speaker, Adaptive Nurse Call Devices, or from Wireless Phone.
        - **ii.** If nursing staff is unable to receive a bath call message on the Wireless Phone or in the Master Station, or if the pull cord needs repair.
        - **iii.** If the dome or zone light is not working.

    b. Open a ServiceDesk ticket
        - **i.** If the name of the resident displayed was incorrect

    c. Contact Central Supply
        - **i.** To replace a pillow speaker.
        - **ii.** To order a Portable Bed Alarm

C. Downtime Procedures

During a planned downtime, ~~a page will~~email notification will be sent to all ~~the Charge Nurse pagers~~users.
During unplanned downtime, email notification, communication tree and/or text page is used for communication. ~~indicating which Downtime System Manual on the Nursing Intranet should be followed.~~

ATTACHMENTS:

Attachment 1: Nurse Call System User Guidelines
Attachment 2: Wireless Phone Operating Guidelines
Attachment 3: Step by Step Procedure when Responding to Calls
Attachment 4: DNCR (Intervention Page): Checking Call Lights

REFERENCES:

West-Com Nurse Call Systems, Inc., West-Call® FocusCare® User's Interface Software, Installation and Configuration Version 1.1.8 October 2014
Cisco Wireless IP Phone 8821 and 8821-EX User Guide

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-16 Code Blue

Nursing Policy and Procedure
D9 3.0 Bed Stripping and Bedside Cleaning
M 12.0 Adaptive Devices Operating Guidelines

Original: 2010/10

Revised: 2011/07/26; 2013/09/24; 2015/03/10; 2015/10/16; 2016/07/12; 2021/04/13

Reviewed: 2021/04/13

Approved: 2021/04/13

MONITORING BEHAVIOR AND THE EFFECTS OF PSYCHOTROPIC MEDICATIONS

POLICY:

1. Behavior is monitored to assist the Resident Care Team in assessing the response to treatment, which includes the gradual reduction of psychotropic medication dosage.

2. Behaviors shall be monitored for each resident who receives psychotropic medication(s) and/or for those with challenging behaviors identified by the Resident Care Team but not requiring management by the use of psychotropic medications.

3. All Patient Care Assistants (PCAs)/Certified Nursing Assistants (CNAs) staff will ~~regularly~~ observe ~~every shift~~ for presence of target behavior (and/or side effects of psychotropic medication) and report to the licensed nurse if observed~~)~~.

4. The licensed nurse will review the behavior monitoring record and compare it to the goals of Nursing Care Plan to assess whether the goals of target behavior symptoms, as identified by provider, have been adequately addressed.

5. ~~Behavior Nursing C~~care P~~p~~lans should include target behaviors for behavior monitoring, individualized nonpharmacological interventions ~~-~~and any potential side effects.

~~6. The electronic health record flowsheet will be used to monitor the effectiveness of medications prescribed to induce sleep when ordered by physician.~~

PURPOSE:

To document the effectiveness of pharmacological and non-pharmacological interventions, such as:

a. the increase/decrease of observable target behavior symptoms
b. effectiveness of a prescribed psychotropic medication
c. effectiveness of any non-pharmacological interventions in the management of behavior/ mood.
d. any observed side effects of psychotropic medications.

BACKGROUND:

Psychotropic medications are medications that affect brain activities associated with mental processes and behavior. Psychotropic medications also include any other drugs used for the purpose of effecting mental status or behavior. These include medications used to treat anxiety, depression, mania, schizophrenia, psychosis or to induce sleep. (Refer to MSPP D01-05 Psychotropic Medications**)**

The goal with the use of psychotropic medications is to use the lowest dose possible for the shortest amount of time to effectively manage behaviors.

DOCUMENTATION:

A. Monitoring and documenting behaviors using Behavior Monitoring flowsheet in EHR:

1. Documenting target behavior(s) in the BMR:

a. TheEach shift, licensed nurse collaborates with the CNA/ Patient Care Assistant (PCA) and/or other members of the Resident Care Team (RCT) regularly to identify and document the target behavior trigger(s), side effects, and the effectiveness of interventions and the prescribed medications.

2. The licensed nurse will summarize the presence or absence of target behavior(s) and side effects on the LHH NSG Weekly Behavior Summary and communicate any changes to the provider.

3. At least monthly, a summary of Behavioral Monitoring must be conveyed to the MD.

B. Monitoring and documenting presence of side effects

1. The nurse will identify and observe the resident for known common medication side effects in the EHRand document any follow up intervetnionsinterventions in the EHR.

2. The nurse will indicate the side effects and the follow up nursing interventions.

3.2. For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect in the LHH NSG weeklynursing summary.

CROSS REFERENCES:

Hospitalwide Policies & Procedures
25-10 Use of Psychotropic Medications

Nursing Policies & Procedures
C 3.0 Guidelines for Documentation of Resident Status/Care by Licensed Nurses
C 3.2 Documentation of Resident Care by Nursing Assistant
J 1.0 Medication Administration

Medical Staff Policies & Procedures D01-05
Psychotropic Medications

Document originated: 6/2006

Revised: 2010/10; 2013/01/29; 2015/07/19; 2019/05/14

Reviewed: 2019/05/14

Approved: 2019/05/14

Deletion Nursing Services Policies and Procedures

PROTOCOL FOR USING PSYCHOTROPIC MEDICATIONS FOR EMERGENCY BEHAVIORAL SITUATIONS

This protocol is followed when it is necessary to administer a psychotropic medication on an unanticipated or emergency basis, (for example, a resident develops any behavior that poses a risk of harm to self or others).

Selection of therapy for individual patients is ultimately based on physicians' assessment of clinical circumstances and resident needs. This protocol is not intended to interfere with clinical judgment. Rather, it is intended to assist practitioners in providing consistent, high quality care.

NOTE: As needed or PRN drug use is considered planned when its use is anticipated, the indication for use is clearly specified and the conditions are not emergent. For PRN psychotropic use in these cases, this protocol does not apply**.**

PURPOSE:

1. To ensure appropriate prescribing and administration of psychotropic medications if used on an unanticipated or emergency basis.

2. To ensure adequate monitoring and observation of residents.

PROTOCOL:

1. The clinical staff will assess the resident and document any physiological and/or environmental “triggers". All non pharmacological interventions should be attempted and well documented before the administration of any medications.

2. Emergency use of psychotropic medications

    a. In an emergency, psychoactive medications may be ordered by the physician when necessary to ensure the physical safety of the resident, other residents, or members of the staff. This shall be done in accordance with all applicable state and federal regulations.

    b. There should be appropriate documentation in the electronic health record of the specific circumstances for which the medication is prescribed.

    c. Nursing staff shall monitor, document, and notify the provider of the effectiveness of the medications as well as any adverse reactions.

    d. Emergency orders will be continued only as required to treat the emergency.

    e. Before continuing psychoactive medication, which was initiated on an emergency basis, informed consent must be obtained. For residents without a Surrogate Decision Maker (SDM), the Resident Care Team (RCT) must meet to discuss the issue and provide consent.

    f. When psychoactive medication has been used in an emergency situation and the patient is unable to consent and there is no surrogate, informed consent must be obtained through the RCT (refer to LHHPP 25-10).

3. When administration of a psychotropic medication is necessary on an unanticipated or emergency basis:

    a. The nursing supervisor shall be notified.

    b. The resident shall be monitored for medication effectiveness and any side effects following administration.

    c. A physician shall observe the effect of the medication by personally visiting the resident and /or consulting with the licensed nurse observing the resident.

    d. The Licensed Nurse will note the target behavior symptom triggering factors, interventions, outcomes and any observed drug side effects on the electronic health record.

    e. The RCT shall evaluate and update the resident care plan in order to determine additional behavioral intervention needs.

4. The Licensed Nurse will discuss with the physician any recommendations for any further evaluation by the psychiatric team.

CROSS REFERENCES:

LHHPP 25-10 Use of Psychotropic Medications

REFERENCE:

The Long Term Care Survey (2009)

Original: 11/2008

Revised: 2016/01/12; 2019/07/09

Reviewed: 2019/07/09

Approved: 2019/07/09

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Standard Work Instructions

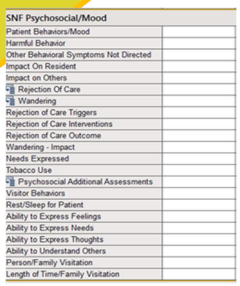
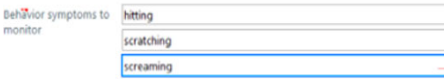
Title: Administering Emergent Psychotropic Medications for Behavior			
Performed By:		**Date: 10/27/22** (created or last updated)	
Owner: A Michaud	**Revised By:**	**Revision #:**	**Takt Time:**

Purpose: To ensure appropriate prescribing and administration of psychotropic medications if used on an unanticipated or emergency basis while appropriately monitoring behaviorally challenged residents.

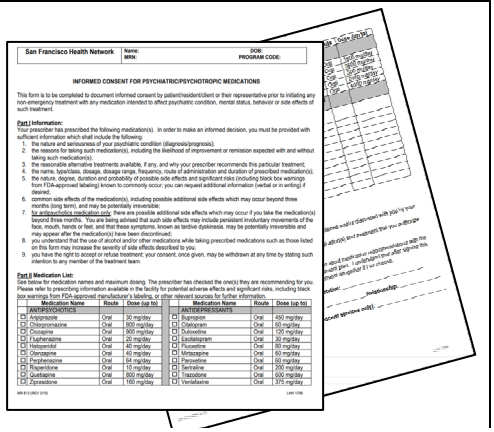
NOTE: As needed or PRN drug use is considered planned when its use is anticipated, the indication for use is clearly specified and the conditions are not emergent. For PRN psychotropic use in these cases, **this protocol does not apply**.

	Major Steps	Details (if applicable)	Time	Diagram, Work Flow, Picture, Time Grid
1.	The clinical staff will assess the resident's behavioral and psychosocial needs and notify the provider of any emergent change in condition. ~~and document to ensure psychotropic medications shall never be used for staff convenience and/or to discipline a resident~~	Licensed Nurse will document their observation and assessment using the Nursing Significant Event Note in the electronic health record (EHR) ~~Prescribing provider must document in the electronic health record (EHR) the **specific circumstances** for which the medication is prescribed.~~		**Behavior Chart** 
2.	Physician assesses resident and determines psychotropic medication needs ordered.	Prescribing provider must document, in the EHR, the **specific circumstances** for which the medication is prescribed.		
~~2.~~**3**	All triggers and non-pharmacological interventions should be assessed and documented ~~before~~ when the administration of any emergent medications occurs.	Licensed Nurse (LN) shall document in EHR all known **triggers** and **all non-pharmacological** interventions that have been attempted ~~**before**~~ when the administration of any emergent medication occurs.		**Triggers:** acute infection blood glucose change in medication constipation fatigue, poor sleep hunger thirst toileting pain soiled briefs bath needs boredom excessive noise, family relations interactions with others missing glasses or hearing aids staff approach uncomfortable shoes or clothes unknown other *** **Non-Pharmacological Interventions:** encourage sleep offer food or drink give pain meds as ordered reposition hot or cold pack balm offer other meds continence care adjust clothing or shoes adjust temperature attend to sensory (glasses/hearing aids) deficit one to one time activity reduce noise redirect return to room other: ***

Standard Work Instructions

Major Steps		Details (if applicable)	Time	Diagram, Work Flow, Picture, Time Grid
~~3.~~4	The nursing supervisor shall be notified.	LN shall notify **Nurse Manager** or **Nursing Operations** at X41502 and document details in ~~H~~EHR		 **Nurse Manager** and/or Nursing Office to inform **Nursing Operations** (X41502)
~~4.~~5	Nursing staff shall monitor, document, and notify the provider of the effectiveness of the medications as well as any adverse reactions.	LN must Assess the resident: 1) Document vital signs **30 mins and 2 hours after** PO/IM administration in **SNF Psychosocial /Mood Scale Flowsheet,** 2) Write **a nursing note**, and 3) Notify provider of resident response to one-time emergent medication.		**Notify provider if** **BP > 180/110 or** **< 90/50** **T > 38.5C** **P > 120, <50 or unable to obtain VS** 
~~5.~~6	A physician shall observe the effect of the medication by performing ~~personally~~ a face to face **visit~~ing~~ with the resident** and ~~/or~~to consult~~ing~~ with the licensed nurse observing the resident.	Prescriber of the one-time medication must **physically view the resident** to: 1) Assess **efficacy.** 2) ~~.~~ Discuss /document specific observable and quantifiable **target behaviors.** 3) Review possible **side effects with nursing.**		 

Standard Work Instructions

	Major Steps	Details (if applicable)	Time	Diagram, Work Flow, Picture, Time Grid
~~6.~~7	If a patient is unable to consent and there is no surrogate, **informed consent** must be obtained through the **RCT within one week of administration**.	In an emergency, after obtaining a physician's order, the LN may administer a one-time emergent medication that requires informed consent **prior** to a special RCT review. **Within one week** of the emergency RCT shall meet to: 1)**Evaluate** the medical efficacy of the medication .2) **Obtain consent** as appropriate. 3)Update the **resident care plan** in order to determine **additional behavioral interventions** . **NO CONSENT REQUIRED** for psychotropic medications used to treat **medical conditions**, such as seizures, spastic disorders, hiccups, terminal delirium, and pain.		 San Francisco Health Network INFORMED CONSENT FOR PSYCHIATRIC/PSYCHOTROPIC MEDICATIONS "I" TARGET SX: Yelling Screaming and attempting to strike others INTERVENTIONS: 1. "I" Non pharmacologic interventions (I) Plays piano on unit 2. Assess efficacy of drug therapy and monitor for potential side effec 3. Assess and re-assess patient's level of orientation, daily