List of Hospital-wide/Department Policies and Procedures

New Hospital-wide Policies and Procedures

Dept.	Policy #	Title	Notes
_LHHPP	22-07_A02	Physical Restraints - Acute Units	The purpose of the Physical Restraints – Acute Unit policy is to ensure the use of restraints maintain a safe environment, prevents injury, and maintains dignity of patients and staff in the Laguna Honda Hospital (LHH) Acute Units (Acute Medical and Acute Rehab). The Acute Rehab unit is also known as the Inpatient Rehabilitation Facility (IRF).
_LHHPP	22-14	Resident Activities	New policy for resident activities
_LHHPP	22-15	Communications Within and External to the Facility	New policy
_LHHPP	22-16	Effective Communication - Resident Who is Deaf	New policy
_LHHPP	22-17	Resident Email and Video Communications	New policy
_LHHPP	22-18	Resident Right to Privacy in Communication	New policy
_LHHPP	24-01	Culturally Competent Care Policy	New policy
_LHHPP	24-02	Promoting Maintaining Resident Dignity Policy	New policy
_LHHPP	24-04	Trauma Informed Care	New policy
_LHHPP	24-14	Opioid Overdose Prevention	New policy for overdose prevention
_LHHPP	25-14	Unnecessary Drugs Without Adequate Indication for Use Policy	New policy
_LHHPP	72-01 A02	Infection Prevention and Control Program	New policy
_LHHPP	72-01 A03	Infection Preventionist	New policy

_LHHPP	72-01 A04	Infection Reporting Policy	New policy
_LHHPP	72-01 A10	Infection Outbreak Investigation and SURGE Response	New policy
_LHHPP	72-01 A11	Water Management	New policy

Revised Hospital-wide Policies and Procedures

Dept.	Policy #	Title	Notes
_LHHPP	01-06	Administrator on Duty	1. Updated Policy section to include AOD designee during business and non-business hours, when to report issue/event to the AOD, Department Heads, Associate Administrator and/or CEO will be contacted to inform or elicit support, and AOD will activate HICS and assume role as Incident Commander. 2.Updated Purpose section to include administrative responsibility, proper notification process and duties, responsibilities and the authority of the AOD. 3.Update Procedures to Nursing Operations Nurse Manager will be AOD during non-business hours. 4.Removed AOD shall be on call during non-business hours. 5.Updated AOD responsibilities. 6.Removed Administration Services responsibilities
_LHHPP	20-06	Leave of Absence (LOA), Out on Pass (OOP) and Bed Hold	Updated with Phase 3 regulations
_LHHPP	22-07_A01	Physical Restraints	o Revised Policy #4: "Each restraint order is valid only for the specific occurrence of application and cannot be written as a standing or PRN order." o Added definition for "Remove Easily: the manual method and/or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff considering the resident's physical condition and ability to accomplish his or her objective." o Added that a bed rail is considered a restraint when: "The bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently" o Reordered bullet points o Added Standards #7 and #8 o Added "The ordering provider is accountable for evaluating the need for

_LHHPP	22-09	Psychiatric Emergencies	MSPP policy translated to LHHPP hospital-wide
_LHHPP	22-12	Clinical Search Protocol	Updated with Phase 3 regulations
_LHHPP	22-13	Bed Rail Use	the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs." o Added to Policy #4: "When the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently, they fall under the definition of a physical restraint. If they are not necessary to treat medical symptoms, and less restrictive interventions have not been attempted and determined to be ineffective, bed rails used as restraints should be avoided." o Added #7: Appropriate alternatives o Added to procedures information regarding beds with rails that are pre0installed, and the following of manufacturers recommendations regarding disabling or tying rails down
_LHHPP	23-02	Completion of Resident Assessment Instrument Minimum Data Set	Updated with Phase 3 regulations
_LHHPP	24-06	Resident/Patient and Visitor Complaints/Grievances	1. Updated "Resident" to "Resident/Patient" 2. Updated policy to include patients in the acute medical unit to raise concerns for resolution without discriminator or fear reprisal. 3. Added to procedure 1, "If admitted to the acute medical unit at Laguna Honda, the admitting nurse will remind the resident of their right to file a grievance. " 4. Added acute team to policy 5 and procedure 4 Updated Assistant Hospital Administrator to Administrative Director or their designee
_LHHPP	24-07	Resident Visitation	Updated with Phase 3 regulations
_LHHPP	24-10	Close Observation	Updated with Phase 3 regulations
_LHHPP	24-16	Code Blue	Updated with Phase 3 regulations
_LHHPP	24-16	Code Blue Appendix 8 - Crash Cart Injection Reference	1. Updated syringe to syringe/vial 2. Added "follow each dose with 20mL of NS flush to Adenosine 3.For Epinephrine, updated 4 syringes to 5 and added Epinephrine Kit x5.
_LHHPP	24-16	Code Blue Appendix 11 - Emergency Box Contents	Updated emergency box contents.

_LHHPP	24-16	Code Blue Appendix 12 - Crash Cart Medication Drawer	Updated crash care medications.
_LHHPP	24-25	Harm Reduction	1. Minor grammar edits 2. Inclusion of a sentence to help validate Harm Reduction 3. Addition of 3 new definitions: Trauma Informed System, Motivational Interviewing, Cycle of Change 4. Included a general description of Harm Reduction on rationale; descriptions 5. Additions to better describe Harm Reduction Interventions 6. Removed Quality Assurance section
_LHHPP	24-28	Behavioral Health	Updated with Phase 3 regulations
_LHHPP	25-06	Pain Recognition Assessment and Management	Updated with Phase 3 regulations
_LHHPP	25-07	Antimicrobial Stewardship Program	1. Defines members of the antimicrobial stewardship program members and meeting requirements. 2. Eliminated distinction between acute and snf. 3. Expansion of Added language to reflect current program and it's adherence to the CMS critical elements pathway
_LHHPP	25-13	Herbal Supplement	Updated with Phase 3 regulations
_LHHPP	55-04	Triple Check Process	Updated with Phase 3 regulations
_LHHPP	60-04	Unusual Occurrences	1. Add Downtime procedures for reporting an unusual occurrence 2. Added Appendix 1 - Confidential Report of Unusual Occurrence
_LHHPP	70-01 B3	Resident Evacuation Plan	Added how to engage Non-Compliant Residents
_LHHPP	71-12	Fire Drill	1. Added LHH 2. Updated Executive Administrator to Chief Executive Officer (CEO) 3. Updates Officer (NOO) to Supervisor
_LHHPP	72-01 A05	Infection Control Surveillance Program	Updated with Phase 3 regulations
_LHHPP	72-01 B5	Transmission-Based Precautions	Updated with Phase 3 regulations
_LHHPP	72-01 B14	Visitors Guidelines for Infection Prevention	Updated with Phase 3 regulations
_LHHPP	75-05	Illicit or Diverted Drugs and Paraphernalia	Updated with Phase 3 regulations

_LHHPP	76-02	Smoke and Tobacco Free Environment	Updated with Phase 3 regulations
_LHHPP	80-03	Student, Volunteer and Consultant Orientation	contractors 2. Updated non-employee terms and responsible manager 3. Updated Volunteer Services and DET will provide physical tour of the hospital and orientation in accordance to CMS regulations.
_LHHPP	80-05	Staff Education Program	Updated with Phase 3 regulations

Revised Pharmacy Policies and Procedures

Dept.	Policy #	Title	Notes
Pharmacy	01.03.00	Personal Medication	Updated with Phase 3 regulations
Pharmacy	02.01.03	Bedside Storage of Medications	Updated with Phase 3 regulations
Pharmacy	02.01.04	Pass Medication	1. Changed how pass meds are ordered (not eprescribed) 2. Add relabeling with outpatient label for bulk medications on unit being used on pass
Pharmacy	02.01.05	Pharmacy Computer Down Time	Minor change to include printing of the MAR summary report.
Pharmacy	02.01.09	Repacking Medication	1.Added new language for including "Hazardous" on any repackaged meds that meet this criteria. 2. Updated expiration dating 3. Added NDC and barcode on repackaging label. 4. Added elements to the repackaging record.
Pharmacy	02.01.10	Operations When Pharmacist is not Present	Minor grammar changes.
Pharmacy	02.02.02	Fentanyl Transdermal Patches	Updated with Phase 3 regulations
Pharmacy	02.03.00	Emergency and Supplemental Medication Supplies	Remove section on - "documenting medication used" on the sign-out card"
Pharmacy	02.05.00	Investigational Drugs	Minor change
Pharmacy	03.01.00	Quality Assessment and Improvement Plan	1. Removed nursing station refrigerators are reported monthly via DRR to head nurse and Director of Nursing 2. Removed Pharmacy Omnicell Medication Transaction Audit
Pharmacy	03.01.02	Medication Pass Observation	1. Changes to reflect broader pharmacist involvement in the process. 2. Calling out utilization of the critical element pathway and reporting structure to include PIPS

Pharmacy	03.03.00	Infection Control	Updated to refer to Pharm 02.01.06 (instead of 02.01.08) for a list of expiration dates for non-sterile compounding.
Pharmacy	04.01.00	Safety and Emergency Preparedness	1. Remove safety inspection form audits 2. Add fire evacuation information
Pharmacy	04.01.01	Duties and Responsibilities During Disasters and Disaster Drill	Removed reference to attachments
Pharmacy	06.03.00	Discharge Counseling	1. Add "eprescribe discharge orders" 2.Update counseling procedures, grammar changes
Pharmacy	07.01.00	Sterile Product Preparation, Handling and Disposal	Minor edits, few changes to add clarity
Pharmacy	07.02.00	Hazardous Drug Preparation, Handling and Disposal	Minor grammatical changes
Pharmacy	09.01.00	Automated Dispensing Cabinets	1. Removed call outs to "INVISION" and replaced with "EHR" 2. Omnicell login ID is based off DSW ID #. 4. Remove section regarding reporting % compliance of of cycle counts 4. Edit "charging/crediting" section to "Item Return Responsibility" 5. Remove section regarding faxing orders/bringing copies to Pharmacy during pharmacy off hours. Pharmacy reconciles overrides using report + EHR (Epic) 6. Techs retrieve non controlled meds from ERB, but does not reconcile and report discrepancies
Pharmacy	09.02.00	ADC Report Review	Minor change to remove reference to QS/1
Pharmacy	09.03.00	Periodic Check of Registry	1. Removed reporting of non-controlled items 2. Addition of pharmacist monthly random audit
Pharmacy	09.04.00	Medication Unit Dose Packager (Parata ATP)	1. Remove irrelevant sections in operations, remove the troubleshooting section all together add cleaning details and cadence to maintenance section 2. Add pharmacist verification instructions add instructions on medication naming

Revised EVS Policies and Procedures

Dept.	Policy #	Title	Notes
EVS	VIII	Safety	Updated Mopping Procedures

Revised Facility Policies and Procedures

Dept.	Policy #	Title	Notes
Facility	LS-1	Fire Safety	1. Updated terminology 2. Replaced PIPS with EOC
Facility	LS-12	Fire Watch	1. Updated procedure for fire watch initiation 2. Updated group that Facility will notify

New Nursing Services Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	XX	Nursing Staff Education	1. The Laguna Honda Hospital (LHH) Acute unit are defined as the Acute Medical and Acute Rehab units. 2. It is the policy of LHH to maintain an effective training, orientation, and education program to maintain and improve staff competence and support an interdisciplinary approach to patient care. The acquisition, maintenance, and improvement of competency in nursing staff supports the facility's goal to continuously improve the outcomes of patient care, promote patient and employee safety, encourage employee self-development and serve the public. LHH promotes participation in educational activities by all levels of nursing staff. 3. Acute Unit nursing staff must all complete all orientation, education, training, and competencies required by the distinct part SNF. 4. All Acute Unit nursing staff are oriented to their job performance expectations and pertinent organization and unit policies and procedures prior to independent performance. 5. Successful completion of the Acute Unit Orientation is achieved when

Revised Nursing Services Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	A 02.0	Nursing Services	Updated with Phase 3 regulations
Nursing	A 4.0	Nursing Clinical Competency Program	1. 3 new policies: RNs, LVNs, CNAs/PCAs, HHAs responsible and accountable for assuring their own clinical competence consistent with their Board 2. Removed "Clinical Resource Nurse" and replaced with "Nurse Educator" 3. Add charge nurse for person to assign preceptors for orientees 4. Update staff titles 5. Clarified that orientation and training programs are based on CDPH approved orientation program 6. Included completion of POCT training during orientation, 6 months post orientation and then annually thereafter

Nursing	A 5.0	Nursing Clinical Affiliations (Student Placements)	to 8 2. Added that clinical instructor will provide copy of students' daily sign-in sheets to DET 3. Included DET updating Director of DET regarding affiliation concerns 4. Added to policy • LHH nursing staff are not permitted to be paid or unpaid clinical instructors of educational programs and supervise students at their place of employment • LHH nursing staff are not permitted to be placed into a student placement at LHH • LHH nursing staff are not permitted to serve as a nursing student preceptor for other LHH nursing staff 5. Schools must have an approved school affiliation contract with CCSF 6. Clinical instructor will send list of students with complete demographics for
Nursing	A 6.0	Orientation of Nursing Personnel	1. Updated to include Nurse Educator title 2. Included preceptor for discussion with orientee on specific skills and whether or not orientee meets criteria and if it warrants the need for further training. Orientee and Nursing Orientation Coordinator will review documentation
Nursing	A 8.0	Decentralized Staffing	Added new Pavilion Acute Unit section New - Appendix A: PMA Acuity Staffing Grid New - Appendix B: Acute Unity Acuity Tool Form New - Appendix C: Care Indicator Guide
Nursing	B 5.0	Resident Identification and Color Codes	1. Removed ribbon placement 2. Revised sticker placement on ID wristbands and bedcards 3. Added bedside safety alerts
Nursing	C 3.0	Documentation of Resident Care/Status by the Licensed Nurse - SNF	1. Added "SNF" to title to designate this as a SNF policy 2. Removed Acute section – there will be a new acute documentation policy 3. Removed weekly summaries x 4. Summaries are to now be completed weekly. 4. Remove appendix. Most assessments are in EPIC. Appendix refers to paper. 5. Removed MAR items and referred to J1.0 6. Clarified tasks vs. care plan interventions 7. Added allergies documentation 8. Deleted Section E and updated appendix
Nursing	C 9.0	Transcription and Processing of Orders	1. Added cut off times for acknowledging orders (due to staff feedback) 2. Removed nurses reviewing orders monthly – this is not current practice 3. Removed nightly chart reviews – this is not current practice 4. Removed #4-8 regarding STAT orders and specific medication orders Referred to nursing medication policy and Pharmacy policies to remove risk of possible conflicting information 5. Removed monthly review of printed physician order sheets 6. Added lab policy to cross reference list

Nursing	D5 1.0	Foot Care	Updated with Phase 3 regulations
Nursing	D6 3.0	Range of Motion Exercise	1. Removed ROM competency skill evaluation – this is not done during orientation 2. Distinguished between SNF vs Acute practices 3. Removed procedure and "Pictorial Guidelines for Range of Motion" Appendix
Nursing	I 5.0	Oxygen Administration	1. New Policy #5 Disposable oxygen tubing administration shall be labeled with the date and initials every 7 days and PRN. Routine weekly changes shall be documented by the AM shift nursing staff. 2. Nursing will disinfect oxygen cylinder, put "empty tag" on cylinder, and place in the oxygen cabinet in clean utility room in designated area 3. Removed procedure section Refer to Elsevier for procedure
Nursing	J 1.0	Medication Administration	Updated with Phase 3 regulations

Deletion Nursing Services Policies and Procedures

Dept.	Policy #	Title	Notes
Nursing	B 9.0	Documenting and Reporting Resident Allergies	Remove policy. The key points were added into C3.0 Documentation Policy.

Revised Food and Nutrition Services Policies and Procedures

Dept.	Policy #	Title	Notes
FNS	1.74	Safety Inspection	Updated with Phase 3 regulations
FNS	1.93	Food Preparation Standards	Updated with Phase 3 regulations
FNS	1.94	Safety Standards	Updated with Phase 3 regulations

Deletion Food and Nutrition Services Policies and Procedures

Dept.	Policy #	Title	Notes
FNS	1.120	Isolation Trays	Deletion

New Hospital-wide Policies and Procedures

PHYSICAL RESTRAINTS - ACUTE UNITS

POLICY:

The LHH Acute Units respect the rights of patients to receive safe, quality care though prevention, reduction and elimination of restraints, and restraint-associated risks through the use of preventive strategies, alternatives, and process improvements.
The least restrictive measures will be used to ensure patient and staff safety. Restrictive interventions shall be discontinued as soon as it is safe for the patient and staff.

PURPOSE:

The purpose of the Physical Restraints – Acute Unit policy is to ensure the use of restraints maintain a safe environment, prevents injury, and maintains dignity of patients and staff in the Laguna Honda Hospital (LHH) Acute Units (Acute Medical and Acute Rehab). The Acute Rehab unit is also known as the Inpatient Rehabilitation Facility (IRF).

OVERVIEW:

The Centers for Medicaid and Medicare Services (CMS) defines patient's rights and choices regarding restraints. The CMS Condition of Participation standard in relation to restraint use states: "Each patient has the right to be free from all forms of abuse and corporal punishment. Each patient has the right to
be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may not be used unless the use of restraint or seclusion is necessary to ensure the immediate physical safety of the patient, a staff member, or others. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation."

The decision to use a restraint must be determined based on a comprehensive patient assessment and documented. Once it is decided to use restraint, the least restrictive form of restraint that protects the physical safety of the patient or staff must be used. Restraints may not be used unless it is necessary for the immediate safety of the patient or staff. Restraining a patient because it is convenient is not acceptable. Less restrictive measures must be considered prior to placing a patient in physical restraints. The patient's condition must be monitored on an ongoing basis to ensure the use of restraint is discontinued at the earliest possible time. The decision to discontinue the restraint should be made as soon as the unsafe situation ends or the patient's needs can be met with the use of less restrictive measures.

DEFINITIONS

Restraint: any manual method, chemical, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Methods:

- **Mechanical Restraints:** use of environmental equipment that indirectly impedes movement. Full side rails (use of 2 of 2 full side rails or 4 of 4 half rails) in an up position, or seat belts or alarm belts that cannot be removed by the patient, for the purpose of preventing a patient from falling, wandering, or eloping are considered restraints.
- **Physical Hold (manual restraint):** Physical holds are not permitted in the LHH Acute Units. Holding a patient in a manner that restricts their movement against their will is considered a restraint.
- **Physical Restraint:** any externally applied device used to restrict or manage a patient's behavior or freedom of movement, with the intent of preventing injury to self and/or others and facilitate treatment.
- **Chemical Restraint:** A drug or medication used to restrict or manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Drugs that are used as part of a patient's standard medical or psychiatric treatment and are administered within the standard dosage for the patient's condition are not considered a chemical restraint.

Classifications:

- **Violent or self-destructive Restraint (Behavioral Restraint):** Violent or self-destructive restraints are not used in the LHH Acute Units. The restriction of patient movement or voluntary escape from a location for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others unrelated to the medical diagnosis.
- **Non-violent or non-self-destructive Restraint (Medical Safety Restraint):** The restriction of patient movement for the purpose of immediate patient safety related to medical diagnosis and/or maximizing medical treatment(s). This criterion only applies to restraint use.
- **Seclusion:** Seclusion is not used in the LHH Acute Units. The involuntary confinement of a person alone in an area within a patient care unit where the person is physically prevented from leaving.

EXCLUSIONS

A restraint does not include devices or other methods for the purpose of conducting routine physical examinations, therapeutic procedures, or tests.
Any measure or intervention that can be intentionally removed by the patient in the same manner it was applies is not considered a restraint.

- **Mechanical Support:** devices used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint. Abdominal binders used as abdominal support post-operatively or to promote mobilization (e.g., prevention of orthostatic hypotension or pain) are not restraints.

- **Positioning/Securing Device:** Such devices used to maintain the position, limit mobility, or temporarily immobilize the patient during medical, dental, diagnostic, or surgical procedures is not considered a restraint.
- **Physical escort:** a physical escort using a "light" grasp (from which the patient can easily escape) to escort the patient to a desired location is not considered a physical restraint.
- **Physical hold for medication:** the touching and securing of a patient for a therapeutic consented injection or procedure is not considered a restraint.
- **Stretcher/gurney/hospital bed side rails:** elevated and/or highly mobile carts, with all side rails up, used to transport patients or to treat or evaluate patients are not considered restraints. Raising fewer than 4 (of 4) side rails when the bed has segmented side rails is not considered a restraint.
- **Medications:** medications prescribed for the treatment of a patient's medical or psychiatric condition, or to facilitate diagnostic or therapeutic interventions are not considered restraints.
- **Law enforcement intervention:** the use of law-enforcement designated restrictive devices applied by contracted law enforcement officials for custody, detention, and public safety reasons are not considered restraints.
- **Timeout:** an intervention in which the patient consents to being alone in a designated area for an agreed upon timeframe from which the patient is not physically prevented from leaving. The patient can leave the designated area when the patient chooses. Timeout is not considered seclusion.

PROCEDURE:

1. Restraint Practice Specifications

a. Least restrictive intervention: restraint may be used only when least restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. The least restrictive interventions do not always need to be attempted, but they must be considered and determined by staff to be ineffective. This determination may be made by the physician with input from the registered nurse.

   i. Alternatives attempted must be documented in the electronical medical record (EHR) with the initial application of restraints (not with every order renewal).

   ii. Least restrictive interventions include, but are not limited to: diversionary activities, 1:1 patient care, repositioning, pain management, reorientation to surroundings, or administration of prescribed medications

2. Restraint Application

a. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, staff member, or others from harm.

b. The physical restraint application procedure involves all of the following components:

   i. Restraint consent
   ii. Restraint application order
   iii. Patient monitoring and provision of care
   iv. Documentation
   v. Modification to care plan
   vi. Discontinuation, reapplication and supervised interruptions

c. Restraint consent

   i. Consent must be obtained prior to restraint application.
   ii. Complete consent for Physical Restraint. Consents must include discussion with patient or patient representative regarding:
      - Education on the risk of removing, repositioning or retying restraint
      - Type of restraint, duration of use and discontinuation criteria
      - Possible benefits and risks of using or not using restraints
      - Rights of the patient or patient representative to accept or refuse the use of restraints at any time.

3. Restraint application orders

a. Physician order is required for all restraints when:

   i. A restraint intervention is to be initiated;
   ii. The original order has expired, and the continued use of restraints is necessary;
   iii. The rationale for the restraint or type of restraint has changed from the current order; or
   iv. The restraint needs to be reapplied after it has been discontinued

b. Restraint orders must be written prior to restraint application.

c. Orders involving the restraint of extremities must specify laterality (e.g., LUE, RUE, LLE, RLE)

d. The ordering Physician is accountable for evaluating the need for restraints and completing the restraint order

e. Each restraint order is valid only for the specific occurrence of application and cannot be treated as a standing order nor as a PRN (as needed) order.

f. Restraint use for non-violent, non-self-destructive (medical safety) purposes must be renewed as needed at least every 24-hours.

g. All orders for restraint use require a face-to-face assessment by a Physician documented in the electronic health record. Restraint episodes classified as Non-violent or Non-self destructive require a face-to-face assessment within 24 hours of restraint initiation or order renewal.

h. The Physician must evaluate:

   i. The patient's immediate situation;
   ii. The patient's reaction to the intervention;
   iii. The patient's medical and behavioral condition; and
   iv. The need to continue or terminate the restraint

4. Monitoring and Provision of Care

PROVISION OF CARE	FREQUENCY OF MONITORING FOR NON-VIOLENT OR NON-SELF-DESTRUCTIVE RESTRAINTS
Observation	Every 2-hours, as needed or more frequently if indicated
Physical comfort	NA
Exhibited behavior	NA
Elimination, food/meal, fluids	Every 2-hours
Circulation check	Every 2-hours
Range of motion (ROM)	Every 2-hours
Vital signs	Every 4-hours, as needed, or more frequently if indicated
RN Assessment: Psychological Status and Justification for Continued Restraint Use	Every 2-hours

5. Documentation Requirements

a. Restraint documentation requirements will be completed in the electronic health record.

b. Nursing Assistants (CNA, PCA, PCT, HHA) may complete monitoring documentation excluding the Registered Nurse (RN) Assessment.

c. Record a description of the patient's behavior prior to restraint application and the interventions used

d. Record alternatives or other less restrictive interventions attempted prior to restraint application (as applicable)

e. Record the clinical justification for restraint, the type of restraint used, the time of initiation and discontinuation of the restraints, and the monitoring/frequent provisions of care (e.g., circulation check, ROM, etc.)

f. Record the Physician face-to-face medical and behavioral evaluation within 24 hours for Non-violent or Non-self-destructive restraints

g. Record the patient's response to the intervention(s) used, including the rationale for the continued use of the intervention.

6. Modification to Care Plan

a. Each episode of restraint application and discontinuation will be reflected in the restraint care plan

b. Care plan components include:

   i. Interventions to remain free from injury while restrained
   ii. Interventions to progress towards removal of restraints

7. Discontinuation, Reapplication and Temporary Release/Interruption

a. Restraints are discontinued at the earliest possible time, such as when the patient no longer presents a risk to him/herself or others or when the risk of restraints outweigh the risk of alternative interventions.

b. A physician order is required to discontinue an ordered restraint intervention prior to the ordered expiration time.

c. Any restraints removed for any reason for any length of time other than during or for temporary release/interruption (e.g., feeding, ROM, toileting, etc.) is considered a discontinuation of the restraint.

d. Any trained member of the clinical team may physically apply and remove restraints.

8. Considerations

a. Restraint use is not without risks. Restraints have the potential to cause physical and psychological harm, loss of dignity, traumatization/re-traumatization and even death. Pressure injury formation, hypostatic pneumonia, constipation, incontinence, contractures, and neurovascular impairment can result from the enforced immobility that results from using restraints. Altered sensory perception and thought processes may also result. Humiliation, fear, anger and a decreased sense of self-esteem may occur.

b. When restraints are needed, consider cultural and symbolic perspectives of restraint use to the patient/family.

c. Restrained older adults respond with anger, fear, humiliation, demoralization, discomfort, and resignation.

d. Educate the patient/family/visitors not to remove, reposition or retie restraints.

9. Education

a. LHH trains clinical staff with direct patient contact in appropriate restraint use.

b. Individuals providing staff training in restraint have education, training, and experience in techniques used to address patient behaviors that necessitate the use of restraint. The hospital documents in staff records that restraint training and competency were completed.

c. Clinical staff competence is assessed at orientation, before participating in use of restraint, and with annual review and assessment of competency.

d. Staff involved in use of restraints have, at minimum, a working knowledge of policy and must be able to:
   i. Identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint.
   ii. Identify and provide nonphysical intervention skills.
   iii. Select and utilize least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition.
   iv. Safely apply and use all types of restraint used in the hospital, including completing training in how to recognize and respond to signs of physical and psychological distress.
   v. Identify specific behavioral changes that indicate that restraint is no longer necessary.
   vi. Monitor and provide the physical and psychological care of the patient who is restrained.
   vii. Educate patient and families on the use and discontinuation of restraints.

10. Reporting Mandate for Injuries or Sentinel Occurrences Sustained While Patient is in Restraint

For deaths related to restraint use or that occur while a patient is in restraint, refer to 60-03 Incidents Reportable to the State of California.

CROSS REFERENCE:
27-07 Physical Restraints/Skilled Units
60-03 Incidents Reportable to the State of California
60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)

REFERENCE:

Centers for Medicare & Medicaid Services (CMS), (2020, Feb). State Operations Manual Appendix A – Survey Protocol Regulations and Interpretive Guidelines for Hospitals, Revision 200, §482.13(e) Restraint. Retrieved from http://www.cms.gov/manuals/downloads/som107ap_a_hospitals.pdf

California Code of Regulations (C.C.R.). (2014). Title 22, Division 5, Chapter 1. General Acute Care Hospitals & Chapter 2. Acute Psychiatric Hospitals. Retrieved from http://government.westlaw.com/linkedslice/default.asp?Action=TOC&RS=GVT1.0&VR=2.0&SP=CCR -1000

Original adoption: 22/12/13 (Year/Month/Day)

RESIDENT ACTIVITIES

POLICY:

1. Laguna Honda Hospital (LHH) treats each resident with respect and dignity, and cares for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

2. All LHH Resident Care Team members understand the importance for residents to have a choice about which activities they participate in, whether they are part of the formal activities program or self-directed.

3. LHH provides an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of the resident.

4. All members of the LHH Resident Care Team are responsible for understanding each resident's interest and preferences for activities through, at a minimum, baseline care plans, comprehensive person-centered assessments, and individualized care planning.

PURPOSE:

To assure that each resident is provided an ongoing program of activities designed to meet, in accordance with their comprehensive assessment, their interests, and their physical, mental, and psychosocial well-being.

PROCEDURE:

1. The RCT, comprised of Medicine, Nursing, Social Services, Activity Therapy, MDS Coordinators, Rehabilitation Therapists, Dietitians, and other supportive clinical services, shall complete a comprehensive assessment which supports a resident's physical, mental and psychosocial wellbeing.

2. While the Activity Therapist will complete an individualized comprehensive assessment and activity care plan for each resident, it is also the RCT's responsibility to understand and support a residents activity interests and preferences. This may include, but is not limited to, the following:

- Giving assistance, equipment and supplies needed for a resident to enjoy an independent activity
- Informing residents about the activity schedule on the neighborhood
- Assisting with transport to and from off neighborhood activities
- Adapt activities, individual or group, to support maximum participation

ATTACHMENT: none

REFERENCE:

Appendix PP/Guidance to Surveyors for Long Term Care Facilities F550, F561 section 483.10 (f) 1-3 (8), F679 Activities

CCR Title 22 § 72381 Activity Program- Requirements

Revised: (Year/Month/Day)
Original adoption: 2022/12/13

COMMUNICATIONS WITHIN AND EXTERNAL TO THE FACILITY

POLICY:

Laguna Honda Hospital (LHH) will protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility.

DEFINITIONS:

1. "Reasonable access" means that telephones, computers, and other communication devices are easily accessible to residents and are adapted to accommodate resident's needs and abilities, such as hearing or vision loss.

2. "TTY (Teletype) and TDD (Telecommunications Device for the Deaf)" are acronyms used interchangeably to refer to any type of text-based telecommunications equipment used by a person who does not have enough functional hearing to understand speech, even with amplification.

PROCEDURE:

1. LHH will ensure the resident can send and receive mail, letters, packages and other materials delivered to the facility for the resident through a means other than a postal service.
2. LHH will provide the resident stationery, postage, and writing implements at the resident's own expense.
3. LHH will be permitted to retain and have the use of a cellular phone at the resident's own expense.
4. LHH will provide internet access, to the extent available, for residents to communicate.
5. LHH will provide shared computer access for all residents in a designated area for any resident that has the desire to use them. Shared computers will be available on a first come, first serve basis and will be located in a manner to protect resident privacy in email, video communications, and internet use.
6. LHH will provide reasonable access to a telephone, including TTY and TDD services.
7. Residents will have the option to have personal computers to use at any time that use the facility's internet service.

ATTACHMENT:
NONE

REFERENCE:
NONE

Original adoption: 22/12/13 (Year/Month/Day)

EFFECTIVE COMMUNICATION – RESIDENT WHO IS DEAF

POLICY:

It is the policy of this facility to accommodate needs when communicating with residents who are deaf to promote dignity, understanding, and safety.

DEFINITIONS:

1. "**Effective communication**" describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand.

PROCEDURE:

1. During the pre-screening and admission process, as much information as possible will be obtained regarding the resident's current processes for communication.
2. The resident and his/her representative will discuss plans and goals for communication with facility staff so that care is individualized to meet the resident's needs.
3. The resident's likes and dislikes regarding activity pursuits will be identified, and accommodations will be made as possible to allow for social interaction.
4. The Social Service Director will contact local sign language interpreters to verify availability of services should the need arise. (Examples: need to relay and verify understanding of critical information regarding resident's condition, plan of care, post-discharge plans.)
5. Direct care staff will be educated on effective communication that reflects the needs of the resident population and needs of the staff, and corresponds with the Facility Assessment.
6. Staff will communicate with the resident, using techniques identified in their plan of care, and in accordance with his/her established routine for communication, as possible. Adaptive techniques include, but are not limited to:
    a. Looking at the resident and sit face to face when speaking to them to promote dignity and to facilitate resident's ability to speech read/lip read (if capable).
    b. Standing or sitting under or near a light source and keeping hands and objects away from mouth when speaking.
    c. Using sign language (i.e. assigning care givers, if available, who know sign language).

d. Using written captioning of audio communications (i.e. closed captioning on TV, present educational materials on DVD in closed captioning).
e. Using communication boards or writing materials (i.e. write legibly, in plain terms).
f. Getting the resident's attention by tapping him/her on the arm, waving your hand, or flickering the lights.
g. Speaking one at a time in a group.

ATTACHMENT:
NONE

REFERENCE:

29-05 Interpreter Services and Language Assistance

Original adoption: 22/12/13 (Year/Month/Day)

RESIDENT EMAIL AND VIDEO COMMUNICATIONS

POLICY:

1. It is the practice of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect and facilitate the resident's right to communicate with individuals and entities within and external to LHH through electronic communications, such as email and video communications.

2. LHH shall ensure residents are able to receive and send emails and/or engage in video communications promptly and in a manner that protects the privacy of such information.

DEFINITION:

1. "**Reasonable access**" means that computers and other communication devices are easily accessible to residents and are adapted to accommodate resident's needs and abilities.

PROCEDURE:

1. LHH shall protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility including:

   a. Reasonable access to the internet, to the extent available to the facility;

   b. The ability to send and receive email.

2. LHH shall ensure the resident has reasonable access to and privacy in the use of electronic communications such as email and video communications:

   a. If the access is available to the facility.

   b. At the resident's expense, if any additional expense is incurred to provide such access to the resident.

3. Computers or other electronic devices may be provided in public areas for general use and will be located in a manner to protect resident privacy.

4. Upon admission, residents shall be informed orally and in writing of their right to privacy in written communications, including the right to send and promptly receive mail.

ATTACHMENT:
NONE

REFERENCE:
NONE

Original adoption: 22/12/13 (Year/Month/Day)

RESIDENT RIGHT TO PRIVACY IN COMMUNICATION

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) commits to a resident's right to privacy in communications with individuals and entities within and external to the facility.

DEFINITION:

1. "**Reasonable access**" means that telephones, computers and other communication devices are easily accessible to residents and are adapted to accommodate resident's needs and abilities, such as hearing or vision loss.

2. "**Promptly**" means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours, except when there is no regularly scheduled postal delivery and pick-up service.

3. "**TTY (Teletype) and TDD (Telecommunications Device for the Person who is Deaf)**" are acronyms used interchangeably to refer to any type of text-based telecommunications equipment used by a person who does not have enough functional hearing to understand speech, even with amplification.

PURPOSE

To describe the procedures through which LHH will honor the resident's right to privacy in communications, including the right to:

a. Send and promptly receive mail that is unopened.

b. Have access to stationery, postage, and writing implements at the resident's own expense.

c. Have reasonable access to private telephone conversations.

d. Have reasonable access to the internet, to the extent available at the facility.

e. Have reasonable access and privacy for electronic communications such as email or internet based interpersonal video communications if access is available at the facility and at the resident's expense, should additional expense be incurred.

PROCEDURE:

1. Social Services staff or designee shall ensure each resident receives mail promptly. Mail shall be given to the resident unopened.

2. Social Services staff or designee shall provide assistance if/as needed in obtaining stationery, postage, writing implements and the ability to send mail for the resident. These shall be obtained at the resident's expense.

3. LHH shall provide residents with reasonable access to the use of a telephone, including TTY and TDD services, where calls can be made without being overheard. Reasonable access should include:

   a. Placing telephones at a height accessible to residents who use wheelchairs.

   b. Adapting telephones for use by residents with impaired hearing.

4. Prior to or upon admission, Social Services staff or designee shall inform the resident of provisions LHH has made for access to the use of a telephone and privacy in communications.

ATTACHMENT:
NONE

REFERENCE:
NONE

Original adoption: 22/12/13 (Year/Month/Day)

CULTURALLY COMPETENT CARE

POLICY:

It is the policy of this facility to provide culturally competent care in accordance with professional standards of practice. The facility has established a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices and cultural preference.

DEFINITIONS:

1. "**Culture**" is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.
2. "**Cultural Competency**" is defined as a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.
3. "**Effective communication**" describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand.
4. "**Language Assistance Services**" is defined as language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. This may include oral interpretation, written language translation, or both.
5. "**Health Equity"** is the state in which everyone has a fair and just opportunity to attain their highest level of health.

PROCEDURE:

1. The facility will use the Facility Assessment to identify resident populations having unique cultural characteristics, such as language (including American Sign Language), religious or cultural practices, values, and preferences.
2. Each resident's demographic information will be assessed upon admission to identify at a minimum :race, ethnicity, religious preference, sexual orientation, and gender identity.

3. The facility will provide sufficient guidance for staff, including temporary staff, on how to communicate and deliver care for all residents. Many aspects of cultural preferences may impact the delivery of care. Once identified, these will be added to the resident's care plan. They may include, but are not limited to:
    a. Food preparation and choices.
    b. Clothing preferences such as covering hair or exposed skin.
    c. Physical contact or provision of care by a person of the opposite sex.
    d. Cultural etiquette, such as avoiding eye contact or not raising the voice.

4. The facility social worker or designee will meet with the resident in a calm, non-threatening, private setting to initiate a discussion/interview with the resident. If language assistance services are needed, the interpreter or translator will be present. The resident's cultural beliefs, experiences, expectations, needs, and values will be reviewed, documented, and added to the care plan so that they can be honored.
5. If the resident is non-English speaking, the facility will identify how on-going communication will occur with the resident. If indicated, language assistance services will be arranged for the resident. The care plan will identify the language spoken and tools used to communicate.
6. If communication systems are used, all staff interacting with the resident will know where those materials are kept, will understand how to use them, and consistently implement use of those methods. Staff will demonstrate proficiency in communicating with the resident to assure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services.
7. Resident-specific approaches will be developed and included in the resident's care plan. These interventions will be provided consistently, and supervising staff will monitor the delivery of care and staff interactions with the resident to assure they are implemented as written.
8. The facility will involve the resident and/or his or her family in evaluating the effectiveness of cultural interventions in achieving measurable objectives and resident goals. The facility will engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents.
9. Depending on the Facility Assessment, the facility may consider:
    a. Offering activities that are culturally relevant to resident populations within the facility.
    b. Group activities with both sexes is often not permitted or appropriate in some cultures, or the type of programming may be in conflict with his/her cultural preferences.
    c. Providing reading materials, movies, newspapers in the resident's preferred language may help orient a resident to date, times and events.
    d. Allowing the performance of religious rites at end of life to the extent possible.
    e. Certain medications, procedures or treatments may be prohibited.

10. Residents will be informed in a language they can understand of their total health status and will be provided notice of rights and services both orally and in writing in a language that they understand. This may involve facility staff evaluating how forms, including informed consent forms, are provided in the language used by the resident.
11. Staff will be aware of resident's body language communication.
12. The facility recognizes that it is important for staff to be aware of the impact of culture and cultural preferences on the provision of care, and have an understanding of the cultural norms and practices of the individuals they care for. Direct care staff will be trained on effective communication that reflects the needs of the resident population and needs of the staff, and will correspond with the Facility Assessment.
13. The facility recognizes to achieve health equity, care delivery to all residents, especially those with historical and generational injustices, should be critically reviewed to ensure the avoidance of perpetuating those injustices that give rise to racial and ethnic health disparities. Equitable care supports the resident's ability to attain their highest level of health and function.

ATTACHMENT:
NONE

REFERENCE:
What is Health Equity? | Health Equity | CDC

Original adoption: 22/12/13 (Year/Month/Day)

PROMOTING/MAINTAINING RESIDENT DIGNITY

POLICY:

It is the practice of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect and promote resident rights and treat each resident with respect and dignity. LHH cares for each resident in a manner and in an environment that maintains or enhances the resident's quality of life by recognizing each resident's individuality.

PROCEDURE:

1. All LHH staff members who are involved in providing care to residents shall promote and maintain resident dignity and respect resident rights.

2. During interactions with residents, staff shall report, document and act upon information regarding resident preferences.

3. Assessment and interview results shall be documented; the provision of care and care plans shall be revised, if appropriate, based on information obtained from any resident assessments and interviews.

4. The resident's lifestyle choices and personal preferences shall be considered when providing care and services to meet the resident's needs.

5. When LHH staff are interacting with a resident, the resident shall be treated as an unique individual.

6. LHH responds to each request for assistance by a resident in a timely manner.

7. All staff members shall explain care and/or procedures to the resident before initiating said procedures.

8. Staff members should not talk to each other while performing a task with and for the resident as if the resident is not present. All conversation during the provision of care should be resident focused and resident centered.

9. Residents shall be dressed and groomed according to their preferences.

10. All staff shall speak respectfully to residents and shall avoid discussions about residents that may be overheard.

11. LHH respects the resident's living space and personal possessions. At no time shall staff search a resident's body or personal possessions without consent from the resident, or if applicable, the resident's surrogate decision's maker (SDM). The resident or the SDM shall understand the search is voluntary and why the search is being conducted.

12. LHH shall maintain resident privacy.

13. All LHH staff shall assist residents to participate in activities of their own choice.

14. Each resident shall be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.

ATTACHMENT:
NONE

REFERENCE:
NONE

Original adoption: 22/12/13 (Year/Month/Day)

TRAUMA INFORMED CARE

POLICY:

It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are equitable, culturally-competent, account for experiences and preferences, and address the needs of those who have experienced trauma by minimizing triggers and/or re-traumatization.

DEFINITIONS:

1. "**Trauma**" results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to:
    a. Natural and human caused disasters
    b. Accidents
    c. War
    d. Physical, sexual, mental, and/or emotional abuse (past or present)
    e. Rape
    f. Violent crime
    g. History of imprisonment
    h. History of homelessness
    i. Traumatic life events (death of a loved one, personal illness, etc.)
2. "**Trauma-Informed Care**" is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.
3. "**Culture**" is the conceptual system that structures the way people view the world—it is the set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.
4. "**Cultural competency**" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Developing cultural competence involves the on-going process of: valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.
5. "**Health Equity"** is the state in which everyone has a fair and just opportunity to attain their highest level of health.

PROCEDURE:

1. The facility will work to facilitate the implementation of trauma informed care based on the following trauma-informed principles:
    a. Understanding Stress and Trauma: Understanding trauma and stress allows actions with compassion and leads to well-informed steps toward wellness.
    b. Cultural Humility and Responsiveness: Understanding that all residents come from diverse social and cultural groups that may experience and react to trauma differently allows for responding sensitively so that residents may feel understood and enhance wellness.
    c. Safety and Stability: Trauma unpredictably violates our physical, social and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our residents' daily lives and having these core safety needs met can minimize their stress reactions and allow to focus on our resources on wellness.
    d. Compassion and Dependability: Trauma is overwhelming and can leave residents feeling isolated or betrayed, which may make it difficult to trust others and receive support. When residents experience compassionate and dependable relationships, they may reestablish trusting connections with others that foster mutual wellness.
    e. Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals.
    f. Collaboration and Empowerment – Trauma involves a loss of power and control that makes us feel helpless. When residents are prepared for and given opportunities to make choices for themselves and their care, they may feel empowered and can advocate for their own wellness. It also places an emphasis on partnering between residents and/or his/her/their representative, and all staff and disciplines involved in the resident's care in developing the plan of care.
    g. Resilience and Recovery: Trauma can have a long-lasting and broad impact on residents' lives that may create a feeling of hopelessness. When residents are able to focus on their strengths and clear steps, they can take toward their wellness they are more likely to be resilient and recover.

2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his/her/their cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others.

3. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. If indicated, language assistance services will be arranged for the resident. The care plan will identify the language spoken and tools used to communicate (See Culturally Competent Care Policy).

4. The facility will collaborate with residents who have experienced trauma, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.
5. In some cases, if the facility has more than one resident who experienced trauma, social services will make a good faith effort at establishing a support group that is run by a qualified professional or allow a support group to meet in the facility. If a group cannot be run/meet at facility, social services will assist the resident in locating a support group in the community as appropriate and feasible.
6. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to:
    a. Experiencing a lack of privacy or confinement in a crowded or small space.
    b. Exposure to loud noises, or bright/flashing lights.
    c. Certain sights, such as objects that are associated with their abuser.
    d. Sounds, smells, and physical touch.
7. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the resident's need to be respected, informed, connected, and hopeful regarding their own recovery.
8. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his/her/their family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.
9. The facility will engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents.
10. In situations where a resident who experienced trauma is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident

ATTACHMENT:
NONE

REFERENCE:
What is Health Equity? | Health Equity | CDC

Trauma Transformed- Overview of Trauma Informed Systems
Original adoption: 22/12/13 (Year/Month/Day)

OVERDOSE PREVENTION

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) protects and promotes the health of all residents. Residents who use substances may be at risk for overdose. This policy outlines LHH overdose prevention process which includes resource posting, staff overdose prevention training, and sets procedures to follow in the event of an overdose.

PURPOSE:

The purpose of this policy is to support the Department of Public Health's (DPH) compliance with local legislation, Ordinance 084-21 (Appendix A). The This legislation requires DPH to annually submit to the Board of Supervisors a departmental policy describing how the department and its grantees that provide direct services to clients who use drugs will promote strategies to reduce drug overdoses ("Overdose Prevention Policy"). This LHH policy is in compliance with DPH Overdose Prevention Policy.

PROCEDURE:

1. Drug Treatment and Harm Reduction Programs and Services

Residents served by LHH include people who use drugs who may be at risk for overdose. LHH provides direct treatment services and supports harm reduction as an effective strategy for overdose prevention. See policies MSPP D08-07 LHH Psychiatry Substance Treatment and Recovery Services and HWPP 24-25 Harm Reduction. LHH will continue to support effective strategies to prevent overdose death such as increasing the provision and use of naloxone to reverse overdose; expanding the use of Medications for Opioid Use Disorder (MOUD) to prevent overdose.

1.2. Resource Posting:

An updatedLHH staff will post the schedules for harm reduction resources schedules available in the community will be posted on the LHH intranet per standing communication procedure and in physical locations that meet LHH posting requirementsthe [specific location/board/wall] of the [list of units] units at LHH. The updated schedules are available to print and save at the Overdose Prevention Resources SF.Gov webpage (https://sf.gov/information/overdose-prevention-resources). LHH Sstaff may will make these schedules available to residents as needed (e.g. printing it for a resident being discharged to the community).

2.3. Training

In collaboration with DPH Population Behavioral Health, LHH will implement Overdose Recognition and Response training for all relevant staff (who engage with residents who use substances) in accordance with DPH policy. Implementation of the training and tracking of completion will be through standing procedures of LHH DET (Department of Education and Training).

3.4. Overdose Reversal and Response:

The following list describes steps that staff can take to respond to an overdose at LHH or where LHH staff are presentif accompanying a resident in the community.

a. If a resident is unresponsive and/or unconscious, LHH staff shall follow Code Blue policy and their CPR/ACLS training. Call for help as soon as possible.

b. Any staff member who has received training in overdose recognition, response and naloxone administration can attend to an individual with suspected overdose (Attachment B). Staff will administer naloxone from the prn supply for the resident or from the crash cart, or from any other available source (e.g., if the person has naloxone nasal spray on them).

c. After the first dose of naloxone has been administered, if the person has a pulse, perform rescue breathing. For individuals without a pulse, perform CPR (rescue breathing + chest compressions). If available, an Ambu Bag (artificial breathing) or breathing shield can be used instead.

d. If there is no response to the naloxone from the person after 2-3 minutes, administer a second dose of naloxone and continue with CPR/rescue breathing while awaiting support.

e. If on LHH campus, Code Blue team will assess the resident and manage accordingly.

f. Overdose reversals shall be reviewed by theThe Code Blue Committee shall review overdose reversals and report to [who]ed through the Unusual Occurrence system.

g. The LHH Pharmacy shall mMonitoring naloxone supplies, expiration andand replacing replace when naloxone supply expires will be through standing existing policies and procedures described in LHH policy #'s[insert those here] of LHH Pharmacy.

h. The Quality Management Department shall Data track dataing for overdose and reversal incidents will be through standing existing policies and procedures described in LHH policy #'s [insert those here] of Quality Management.

4.5. Overdose Prevention Champion and Process Monitoring

a. LHH will identify Overdose Prevention Champion(s), who will develop a process to monitor and evaluate the compliance with established overdose prevention procedures (sections 21-35 above) per DPH policy.

b. The Overdose Prevention Champion(s) will report LHH's implementation of the overdose prevention policy during to DPH Overdose Prevention Champion meetings.

ATTACHMENT:

Attachment A: Administrative Code - Departmental Overdose Prevention Policies FILE NO. 210304 ORDINANCE NO. 084-21

Appendix B: Legal References - California Civil Code Section 1714.22

REFERENCES:

1. DPH Overdose Prevention Policy
2. San Francisco Ordinance 084-21
3. LHH Harm Reduction Policy HWPP 24-25
3.4. LHH Psychiatry Substance Treatment and Recovery Services Policy MSPP D08-07
4.5. LHH Code Blue Policy HWPP 24-16
5.6. LHH Unusual Occurrences Policy HWPP 60-04

Most recent review: 22/110/036 (Year/Month/Day)
Revised: 22/110/036
Original adoption: 22/110/036

ATTACHMENT A - ADMINISTRATIVE CODE - DEPARTMENTAL OVERDOSE PREVENTION POLICIES

FILE NO. 210304
ORDINANCE NO. 084-21
ENACTMENT DATE: 06/25/2021

[Administrative Code - Departmental Overdose Prevention Policies]
Ordinance amending the Administrative Code to require the Department of Public Health, Department of Homelessness and Supportive Housing, Human Services Agency, and Department of Emergency Management to develop and submit to the Board of Supervisors departmental overdose prevention policies.

Be it ordained by the People of the City and County of San Francisco:

Section 1. Findings.

(a) According to data from the Office of the Medical Examiner, the number of people who have died from drug overdoses in San Francisco has been rising at a staggering rate. In 2017, 222 people in San Francisco died from a drug overdose. In 2020, 697 people in San Francisco died from a drug overdose. This represents more than a tripling of the death rate in only three years, such that deaths from drug overdoses now average nearly two a day, and nearly 60 a month.

(b) Fentanyl, which is estimated to be 50 to 100 times more potent than morphine, entered the San Francisco market around 2015, causing eleven deaths that year. In 2016, the number of fentanyl overdose deaths in San Francisco doubled, reaching a total of 22. In 2020, 502 people were reported to have died in San Francisco as a result of overdose from use of fentanyl. Thus, in five years, fentanyl overdose deaths in San Francisco increased by 4500%.

(c) This is a public health crisis of major proportions that is out of control. The number of people who died from a drug overdose in San Francisco in 2020 was more than three times the number of people who died in San Francisco from COVID-19 that same year.

(d) Based on data showing the addresses of fatal drug overdoses in San Francisco over the first eight months of 2020, 111 people died on sidewalks or alleys, or in parks or cars; 296 people were found dead in homes or hotels, many in supportive housing in the Tenderloin; and 60 people were pronounced dead at hospitals.

(e) Consuming drugs alone while sheltering-in-place during the COVID-19 pandemic almost certainly amplified the overdose death risk of strong drugs; more than half of the 561 deaths from accidental overdoses during the period January - October 2020 occurred indoors.

(f) A 2019 study published in Drug and Alcohol Dependence surveyed overdose mortality among residents of single room occupancy (SRO) buildings in San Francisco during the period 2010 – 2017, and found that overdose mortality was substantially higher among SRO residents as compared to non-SRO residents, and that SRO residents were also more likely to die from overdosing at home than elsewhere.

(g) A 2019 study published in the Journal of Urban Health examined the acceptability, feasibility, and implementation of the Tenant Overdose Response Organizers (TORO) program facilitated in ten SROs in Canada. That study concluded that the overdose response interventions used by the TORO program, including peer-led overdose prevention and response trainings, wall-mounted naloxone for emergency response, and peer-led support groups, are effective tools in addressing overdose risk in SROs. The study also concluded that tenants who had participated in the program and were taught about opioid overdoses were better able to respond to overdoses and contribute to wider community responses. This study helped inform the DOPE (Drug Overdose Prevention and Education) Project's SRO initiative in San Francisco.

Section 2. Chapter 15 of the Administrative Code is hereby amended by adding Section 15.17, to read as follows:

SEC. 15.17. DEPARTMENTAL OVERDOSE PREVENTION POLICIES.

By no later than December 31, 2021, and every year thereafter, the Department of Public Health, the Department of Homelessness and Supportive Housing, the Healthy Streets Operation Center through the Department of Emergency Management, and the Human Services Agency shall each submit to the Board of Supervisors a departmental policy describing how the department and its grantees that provide direct services to clients who use drugs will promote strategies to reduce drug overdoses ("Overdose Prevention Policy"), along with a resolution to accept transmission of the policy. Each departmental Overdose Prevention Policy shall, to the extent applicable to the department's activities:

(a) Address how departmental programs will provide drug treatment and harm reduction programs and services;

(b) Describe where the department will post the following materials to ensure that they are available and accessible to all clients:

(1) Up-to-date information about the location and schedule of syringe access and disposal services; and

(2) Up-to-date referral information about naloxone access and the schedule of overdose prevention and naloxone distribution services;

(c) Include an onsite overdose response policy that describes the steps the department will take in the event that an individual overdoses on property managed by the department or in the presence of department personnel;

(d) Ensure that department staff who work with people who use drugs receive training in overdose prevention strategies; and

(e) Describe the process by which the department will ensure that grantees that manage property on behalf of the department and/or provide direct services to people who use drugs implement overdose prevention policies that contain the information required in subsections (a)-(d) of this Section 15.17 as applied to the grantee.

Section 3. Effective Date.

This ordinance shall become effective 30 days after enactment. Enactment occurs when the Mayor signs the ordinance, the Mayor returns the ordinance unsigned or does not sign the ordinance within ten days of receiving it, or the Board of Supervisors overrides the Mayor's veto of the ordinance.

ATTACHMENT B - LEGAL REFERENCES - CALIFORNIA CIVIL CODE SECTION 1714.22

Legal/Liability:

Under California Law, staff who have received opioid overdose prevention and treatment training (meaning any training operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose) are legally allowed to administer naloxone to a person who may be experiencing an opioid overdose. A person who is trained in overdose prevention strategies and administers naloxone shall not be held liable for civil action or be subject to criminal prosecution for possession or administration.

A prescriber may issue a standing order authorizing the administration of naloxone by any trained layperson to someone who may be experiencing an opioid overdose. If the program does not have an authorized prescriber (anyone who has prescribing privileges in the state of California), then they may work with a program that provides training and naloxone distribution to come provide training to staff.

Pursuant to Section 1714.22 of the California Civil Code:

For purposes of this section, the following definitions shall apply:

“Opioid antagonist” means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.

“Opioid overdose prevention and treatment training program” means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:
(A) The causes of an opiate overdose.
(B) Mouth to mouth resuscitation.
(C) How to contact appropriate emergency medical services.
(D) How to administer an opioid antagonist.

(2) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the administration of an opioid antagonist to a person at risk of an opioid-related overdose by a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.

(d) (1) A person who is prescribed or possesses an opioid antagonist pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.

(f) Notwithstanding any other law, a person who possesses or distributes an opioid antagonist pursuant to a prescription or standing order shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this possession or distribution. Notwithstanding any other law, a person not otherwise licensed to administer an opioid antagonist, but trained as required under paragraph (1) of subdivision (d), who acts with reasonable care in administering an opioid antagonist, in good faith and not for compensation, to a person who is experiencing or is suspected of experiencing an overdose shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this administration.

UNNECESSARY DRUGS-WITHOUT ADEQUATE INDICATION FOR USE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall strive for each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs.

DEFINITION:

"Adverse consequence" is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status.

"Dose" is the total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the daily dose.

"Indications for use" is the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.

PROCEDURE:

1. The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, shall be determined by assessing the resident's underlying condition, current signs, symptoms, expressions, preferences, and goals for treatment including identification of underlying causes (when possible).

2. The attending physician shall assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals, and the resident care team. Each resident's drug regimen shall be reviewed on an ongoing basis, taking into consideration the following elements:

    a. Dose (including duplicate therapy)

    b. Duration of use

    c. Indications and clinical need for medication

d. Adequate monitoring for efficacy and adverse consequences

e. Preventing, identifying and responding to adverse consequences

f. Any combination of the reasons stated above.

3. Documentation shall be provided in the resident's electronic health record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed.

4. The resident care team shall evaluate the resident to identify their needs, goals, comorbid conditions, and prognosis to determine factors (including medications and new or worsening medical conditions) that are affecting signs, symptoms, and test results, and in the selection of initial medications and/or non-pharmacological approaches and when deciding on modification or discontinuation of a current medication.

5. Should a resident experiences an acute medical problem or psychiatric emergency (e.g., the resident's expression or action poses an immediate risk to the resident or others), new medications may be required and the following should be considered:

    a. Identifying and addressing the underlying cause(s) of the problems or symptoms.

    b. Once the acute phase has stabilized, the staff and prescriber consider whether medications are still relevant.

    c. Reduction or discontinuation of the medication as soon as possible, or documentation of the clinical rationale for continuing the medication.

    d. A new order for a psychotropic or antipsychotic medications used on a PRN basis should follow the requirements for PRN use of psychotropic or antipsychotic medications.

    e. When psychopharmacological medications are used as an emergency measure, adjunctive approaches, such as individualized, non-pharmacological approaches and techniques must be implemented.

6. Circumstances that may warrant evaluation of the resident and medication(s) include:

    a. Admission or re-admission;

    b. A clinically significant change in condition/status;

    c. A new, persistent, or recurrent clinically significant symptoms or problem;

d. A worsening of an existing problem or condition;

e. An unexplained decline in function or cognition;

f. A new medication order or renewal of orders;

g. An irregularity identified in the pharmacist's medication regimen review.

h. Orders for PRN psychotropic and/or antipsychotic medications which are not prescribed to treat a diagnosed specific condition or do not meet the PRN requirements for psychotropic and antipsychotic medications.

7. Information gathered during the initial and ongoing evaluations shall be incorporated into the resident's comprehensive care plan that reflects resident-centered medication related goals and parameters for monitoring the resident's condition, including the likely medication effects and potential for adverse consequences.

8. Periodic re-evaluation of the medication regimen shall be conducted as necessary to determine whether prolonged or indefinite use of the medication is indicated.

9. A medication initiated as a result of a time-limited condition (such as delirium, pain, infection, nausea and vomiting, cold and cough symptoms, or itching) shall be discontinued when the condition has resolved, or there is documentation indicating why continued use is relevant.

10. Nursing staff shall notify the attending physician regarding a significant change in the resident's condition in relation to a potential adverse consequence of a medication, or if the resident has not responded to medication therapy as anticipated and/or indicated.

ATTACHMENT:
NONE

REFERENCE:
Centers for Medicare & Medicaid Services, Dept. of HHS. Appendix PP: Guidance to Surveyors for LTC facilities. State Operations Manual: 42 C.F.R. 483.45, F757, (October 2022 revision).
DPH 16.35 Medication Reconciliation
LHHPP 23-01 Resident Care Plan, Resident Care Team and Resident Care Conference
LHHPP 25-02 Safe Medication Orders
LHHPP 25-04 Adverse Drug Reaction Reporting Program
LHHPP 25-10 Psychotropic Medication Use
LHHPP 25-11 Medication Errors and Incompatibilities
MSPP 001-01 Primary Care Services
MSPP D01-05 Psychoactive Medications

Pharm 02.01.00B Distribution of Medications and Medication Order Processing
Pharm 06.01.00 Medication Regimen Review

Original adoption: 22/12/13 (Year/Month/Day)

INFECTION PREVENTION AND CONTROL PROGRAM

POLICY:

This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national, state, and local standards and guidelines.

DEFINITIONS:

"**Staff"** includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions.

PROCEDURE:

1. The Infection Preventionist is responsible for oversight of the program and serves as a consultant to staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.
2. Staff are responsible for following policies and procedures related to the ICP program.
3. Surveillance:
    a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national, state, and local standards.
    b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.
    c. The clinical staff participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections.
4. Standard Precautions:
    a. Staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.
    b. Hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures.

c. Staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.
d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies.
e. Environmental cleaning and disinfection shall be performed according to facility policy using approved EPA cleaning and disinfection products. All staff have responsibilities related to the cleanliness of the facility, and are to report concerns outside of their scope to the appropriate department.

5. Isolation Protocol (Transmission-Based Precautions):

a. A resident with an infection or communicable disease shall be placed on transmission-based precautions in consideration of local, state, and CDC guidelines in consultation with their physician and the ICP practitioner.
b. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances.
c. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines.
d. Residents with tuberculosis disease (not latent tuberculosis) are placed on airborne precautions and placed in a special room that is equipped with special air handling and ventilation capacity. If no such room is available, the resident(s) will be discharged to a facility with such capabilities.
e. Immunocompromised and myelosuppressed residents shall be placed in a private room if possible and shall not be placed with any resident having an infection or communicable disease.

6. Antibiotic Stewardship:

a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program.
b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.
c. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program in consultation with the pharmacy leadership.
d. The Medical Director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program.

7. Influenza and Pneumococcal Immunization:

a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time or if the local health department determines a longer season for that year with recommendations to extend.
b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.

c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines.
d. Residents will have the opportunity to refuse the immunizations.
e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.

8. COVID-19 Immunization:

a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.
b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions and contraindications to determine candidacy for the vaccination.
c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine.
d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance.
e. Staff will have the opportunity to receive the COVID-19 vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current guidelines and facility policy.
f. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine.

9. Equipment Protocol:

a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with current procedures governing the cleaning and sterilization of soiled or contaminated equipment.
b. Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident.
c. Reusable items potentially contaminated with infectious materials shall be cleaned and disinfected using hospital approved disinfectants after each use or when visibly soiled.

10. Supplies Protocol:

a. Sterile supplies shall be appropriately packaged and sterilized or purchased prepackaged and sterile from the manufacturer.
b. Sterile supplies are routinely checked for expiration dates and are replaced as necessary.
c. Prepackaged sterile items are considered sterile until opened or damaged. Packaging shall be inspected prior to use.
d. Non-sterile supplies are stored and maintained as clean prior to use.

11. Linens:

a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection.
b. Clean linen shall be separated from soiled linen at all times.

c. Clean linen shall be delivered to resident care units on covered linen carts with covers in place to protect the linens.
d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.
e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled facility linen shall not be kept in the resident's room or bathroom.
f. Environmental services staff shall not handle soiled linen unless it is properly bagged.

12. Resident/Family/Visitor Education and Screening:

a. Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff.
b. Information on various infectious diseases is available from the Infection Preventionist.
c. Isolation signs are used to alert staff, family members, contractors, volunteers, and visitors of transmission-based precautions.
d. Passive screening, such as signs, are posted at the facility entrances and in the facility to alert family members and visitors to adhere to handwashing, respiratory etiquette, and other infection control principles to limit spread of infection from family members and visitors.
e. More active screening, such as the completion of screening tools or questionnaires that elicits information related to recent exposures or current symptoms may be used as per facility policy.

13. Staff Communicable Disease Screening and Immunization:

a. Direct care staff shall comply with physical examinations and immunization screening requirements upon employment, and annually.
b. Direct care staff shall be tested for TB upon hire and screened annually per local and state health department requirements.
c. Influenza vaccine shall be offered annually to the staff, at no cost.
d. Tetanus, Diphtheria, and Pertussis (Tdap) vaccine shall be offered to those employees who have not previously received this vaccine. Tetanus-Diphtheria vaccine shall be offered as a booster dose as needed (i.e. every ten years).
e. Hepatitis B vaccine and education, shall be offered to all staff that have the potential for contact with blood/body fluids, or other potentially infectious materials.
f. Varicella vaccine shall be offered to all staff that are serologically non-immune to varicella.

14. Staff Referral to Treatment Centers/Services:

a. Staff shall be referred to the appropriate medical treatment center/service when he/she:
    i. Is feverish and appears to be in the infectious stages of an illness.
    ii. Experiences an occupational exposure to blood/body fluids.
    iii. Has been exposed to a communicable disease.
    iv. Exhibits infected skin lesions.

b. Based on the specific circumstances, employees with a communicable disease or infected skin lesion will be prohibited from direct contact with residents or their food, if direct contact will transmit the disease.
c. The Infection Preventionist shall coordinate screening procedures in case of widespread exposure of staff to any infectious disease.

15. Staff Education:

a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function.
b. All staff shall demonstrate competence in relevant infection control practices.
c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.

16. Water Management:

a. A water management program has been established as part of the overall infection prevention and control program.
b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems.
c. The Maintenance Director serves as the leader of the water management program with the IP serving as consultant.

17. Annual Review:

a. The facility will conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures based upon the facility assessment which includes any facility and community risk.
b. Following review, the infection and prevention control program will be updated as necessary.

ATTACHMENT:
NONE

REFERENCE:
Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (May 2021) F887 – COVID-19 Immunization. 42 C.F.R. §483.80 (d)(3)(i-vii).

Original adoption: 22/12/13 (Year/Month/Day)

INFECTION PREVENTIONIST

POLICY:

The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.

DEFINITIONS:

"Infection Preventionist" is defined as the individual(s) designated by the facility to be responsible for the infection prevention and control program who has been appropriately trained and educated according to CMS requirements.

PROCEDURE:

1. The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program and consult with the water management program as needed.
2. The facility will ensure the Infection Preventionist is qualified by education, training, experience or certification.
3. The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field. These may include:
    a. A professionally-trained nurse with a certificate/diploma or degree in nursing;
    b. A professionally-trained medical technologist (also known as a clinical laboratory scientist) that has earned at least an associate's degree in medical technology or clinical laboratory science;
    c. A professionally-trained microbiologist that has earned at least a bachelor's degree in microbiology;
    d. A professionally-trained epidemiologist that has earned at least a bachelor's degree in epidemiology;
    e. Other related fields of training such as physicians, pharmacists, and physician's assistants.
4. The IP will have the knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities.
5. The facility will ensure that the individual selected as the IP has the background and ability to fully carry out the requirements of the IP based on the needs of the resident population, such as interpreting clinical and laboratory data.
6. The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its IPCP. Designated IP hours per week may vary based on the facility and its resident population.

7. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA.
8. The IP will physically work onsite in the facility.
9. The IP must be sufficiently trained in infection prevention and control. Specialized training in infection prevention and control may include care for residents with invasive medical devices, resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high-acuity conditions. If the facility's resident population changes, the IP may need to obtain additional training for the change in the facility's scope of care, based upon re-evaluation of the IP's knowledge and skills.
10. The IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation. Specialized training should include the following topics:
    a. Infection prevention and control program overview;
    b. Infection preventionist's role;
    c. Infection surveillance;
    d. Outbreaks;
    e. Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment);
    f. Principles of transmission-based precautions;
    g. Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing);
    h. Water management;
    i. Linen management;
    j. Preventing respiratory infections (e.g., influenza, pneumonia);
    k. Tuberculosis prevention;
    l. Occupational health consideration (e.g., employee vaccinations, exposure control plan and work exclusions);
    m. Quality assurance and performance improvement (QAPI);
    n. Antibiotic stewardship; and
    o. Care transitions.
11. The Infection Preventionist reports to the Chief Nursing Officer.
12. Responsibilities of the Infection Preventionist include but are not limited to:
    a. Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment.
    b. Establish facility-wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff and visitors.

c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control.
d. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program.
e. Oversight of resident care activities (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, performing fingersticks, medication administration, etc.)
f. Review and/or revise the facility's infection prevention and control program, its standards, policies and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections.
g. Review/revise and approve infection prevention and control training topics and content, and ensure facility staff are trained on IPCP. The infection preventionist is not necessarily required to perform the IPCP training if the facility has designated staff development personnel.

13. The Infection Control Preventionist will participate on and is part of the quality assessment and assurance committee (QAA) and will report regularly on the infection prevention and control program activities.

ATTACHMENT:
NONE

REFERENCE:
Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F882 – Infection Prevention and Control. 42 C.F.R. §483.80(b)(1)-(4)(c).

Original adoption: 22/12/13 (Year/Month/Day)

INFECTION REPORTING

POLICY:

It is the policy of this facility to timely report suspected incidents of communicable disease or infections to appropriate personnel or authorities.

PROCEDURE:

1. Any staff member must, and any resident, family member, or visitor may report changes in a resident's condition to the resident's nurse or physician when a possible infection is suspected.
2. A nurse with responsibility for the resident will assess the resident, document findings, and report any changes in condition or signs and symptoms of infection to the physician in accordance with the facility's Notification of Changes policy.
3. The resident or resident's representative will be notified of the findings and the practitioner's orders.
4. Changes in condition and/or signs and symptoms of infection will be notated on the 24-hour shift report by the nurse and communicated to the oncoming nurse at shift change.
5. New orders for antibiotics or new lab orders, such as to obtain cultures, will be notated on the 24-hour shift report.
6. Positive culture results will be reported to the physician and IPC nurse in accordance with the facility's Lab Notification policy in a timely manner
7. The IPC will communicate the type of precaution (e.g., contact, droplet, airborne) ordered for the resident, and room number, to all departments, the Director of Nursing/ Chief Nursing Officer, and Administrator, the in-house communication methodology.
8. Transmission-based precautions (TBP) will be noted with a sign on the resident's door for the duration the resident is on transmission-based precautions.
9. The Infection Preventionist will review medical records and lab reports. Any infection or communicable disease that is a reportable disease will be reported to public health authorities by the IPC /IPC team.
10. The Infection Preventionist will report findings of surveillance activities, including at a minimum, incidence rates and types of infections, to the QAA committee, physicians, and other appropriate staff.

ATTACHMENT:

NONE

REFERENCE:

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

Original adoption: 22/12/13 (Year/Month/Day)

INFECTION OUTBREAK INVESTIGATION AND SURGE RESPONSE

POLICY:

The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional infections and has a departmental plan in place for Surge or rapid response deployment for resources including but not limited to personal protection equipment (PPE) procurement, staffing and temporary isolation units.

DEFINITIONS:

"Outbreak" generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time. If a condition is rare or has serious health implications, an outbreak may involve only one case.

"Case definition" includes criteria for person, place, time, and clinical features specific to the outbreak under investigation.

"Surge" – as defined by Laguna Honda Hospital & Rehab Center (LHH) will be for implemented to trigger specific protocols to accommodate a surge in numbers (e.g. staffing, rooms defined as COVID units, etc,) See COVID-19 facility specific protocol for additional details.

PROCEDURE:

1. Prompt recognition of outbreak:
    a. Changes in condition and/or signs and symptoms of infection will be reported according to procedures for infection reporting.
    b. The following triggers shall prompt an investigation as to whether an outbreak exists:
        i. An increase over baseline infection rate (i.e. ten percent or more increase).
        ii. A sudden cluster of infections on a unit or during a short period of time (i.e. three or more cases).
        iii. A single case of a rare or serious infection (i.e. invasive group A Strep, foodborne pathogens, active TB, acute hepatitis, Legionella, chicken pox, measles, COVID-19).
    c. An outbreak will be defined according to the characteristics of a given organism. Current definitions used by local and state health departments will help guide the determination.
    d. An outbreak will be reported to the local and/or state health department in accordance with the state's reportable diseases website as defined by each organism/disease process
2. Implementation of infection control measures:

a. Symptomatic residents will be considered potentially infected, assessed for immediate needs, and placed on empiric precautions while awaiting physician orders.
b. Symptomatic employees will be screened by the Infection Preventionist, or designee, and referred to appropriate medical provider.
c. Standard precautions will be emphasized. Transmission-based precautions will be implemented as indicated for the particular organism.
d. Staff will be educated on the mode of transmission of the organism, symptoms of infection, and isolation or other special procedures. This includes special environmental infection control measures that are warranted based on the organism and current CDC and CDPH guidelines.
e. Surveillance activities will increase to daily for the duration of the outbreak.

3. Outbreak investigation:

a. When the existence of an outbreak has been established, an investigation will begin.
b. The Infection Preventionist will be responsible for coordinating all investigation activities. (Note: the health department may assume decision making and coordination activities. In this case, the Infection Preventionist will be the liaison between the health department and the facility.)
c. A case definition will be developed in order to identify other staff and residents who may be affected. Criteria for developing a case definition includes and will be defined by local, or state health departments in coordination with CDC :
    i. Person – key characteristics the patients share in common
    ii. Place – the location associated with the outbreak
    iii. Time – period of time associated with illness onset for the cases under investigation
    iv. Clinical features – objective signs and symptoms, such as sudden onset of fever and cough
d. A line list about each person affected by the outbreak will be maintained.
e. The incubation period, period of contagiousness, and date of most recent case will be used in making the determination that the outbreak is resolved.
f. A summary of the investigation will be documented and reported to QAA committee and health department, if indicated.

4. SURGE Protocol:

a. While outbreaks may be defined as one or more cases for certain diseases, the facility will be prepared to take on a surge of new cases in a short period of time due to rapid transmission (such as respiratory) that may overwhelm immediate resources including personal protective equipment (PPE), staff, and isolation units.
b. A surge will be defined as
    i. An increase over baseline infection rate (i.e. ten percent or more increase).
    ii. A sudden cluster of infections on a unit or during a short period of time (i.e. three or more cases).
    iii. Surge protocols will be prepared by each department based on a rapid response for resources including but not limited to PPE, staffing and available temporary clinical units /isolation units

c. Note: this will also trigger outbreak investigations as well as SURGE protocol implementation

ATTACHMENT:
NONE

REFERENCE:
Centers for Medicare & Medicaid Services. State Operations Manual (SOM), Appendix PP: Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control.

Original adoption: 22/12/13 (Year/Month/Day)

WATER MANAGEMENT PROGRAM

POLICY:

It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) in the facility's water systems based on nationally accepted standards (e.g., ASHRAE, CDC, EPA).

DEFINITIONS:

"Control limits" are the maximum value, minimum value, or range of values that are acceptable for the control measures being monitoring to reduce the risk for Legionella growth and spread.

"Control measures" are things done in the building water systems to limit growth and spread of Legionella, such as heating, adding disinfectant, or cleaning.

"Control points" are locations in the water systems where a control measure can be applied.

"Definite healthcare-associated Legionnaires' disease" refers to a case of Legionnaires' disease in a resident who spent the entire 10 days prior to onset of illness in the facility.

"Legionellosis" refers to two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches). Legionellosis is caused by Legionella bacteria.

"Possible healthcare-associated Legionnaires' disease" refers to a case of Legionnaires' disease in a resident who spent only part of the 10 days before symptoms began in the facility.

"Water management plans" refer to the documents that contain all the information pertaining to the development and implementation of the facility's water management activities for reducing risk of Legionella and other opportunistic pathogens.

PROCEDURE:

1. A water management (WM) team has been established to develop and implement the facility's water management program, including facility leadership, the Infection

Preventionist, maintenance employees, safety officers, risk and quality management staff, and Chief Nursing Officer.

   a. Key team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team member's role.
   b. The water management team has access to water treatment professionals, environmental health specialists, and state/local health officials.

2. LHH will employ outside expert water management services to assist/consult with the WM program, provide professional assessments and make recommendations, as well as educate staff on options for remediation as appropriate.
3. The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder and/or on the web based platform.
4. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements:

   a. Premise plumbing: This includes water system components as described in the documentation of the facility's water system.
   b. Clinical equipment: This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration.
   c. At-risk population – This facility's entire population is at risk. High risk areas shall be identified through the risk assessment process. Supporting documentation of any areas or resident population that exhibit greater risk than the general population shall be kept in the water management program binder.

5. Data to be used for completing the risk assessment may include, but are not limited to:

   a. Water system schematic/description
   b. Legionella environmental assessment
   c. Resident infection control surveillance data (i.e. culture results)
   d. Environmental culture results
   e. Rounding observation data
   f. Water temperature logs
   g. Water quality reports from drinking water provider (i.e. municipality, water company)
   h. Community infection control surveillance data (i.e. health department data)

6. Based on the risk assessment, control points will be identified. The list of identified points shall be kept in the water management program binder/web based platform.
7. Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan.

8. Testing protocols and control limits will be established for each control measure.
    a. Individuals responsible for testing or visual inspections will document findings.
    b. When control limits are not maintained, corrective actions will be taken and documented accordingly.
    c. Protocols and corrective actions will reflect current industry guidelines (i.e., ASHRAE, OSHA, CDC, EPA).
9. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible.
10. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data, and rounding data shall be utilized to validate the effectiveness.
11. All cases of healthcare-associated legionellosis or other opportunistic waterborne pathogens shall be reported to local/state health officials, followed by an investigation.
    a. The Infection Preventionist will investigate all cases of definite healthcare-associated Legionnaires' disease for the source of Legionella.
    b. The Infection Preventionist will also investigate for the source of Legionella when two or more possible healthcare-associated Legionnaires' disease are identified.
    c. Elements of an investigation may include:
        i. Reviewing medical and microbiology records
        ii. Actively identifying all new and recent residents with healthcare-associated pneumonia and testing them for Legionella using both culture of lower respiratory secretions and the Legionella urinary antigen test
        iii. Developing a line list of cases
        iv. Evaluating potential environmental exposures
        v. Performing an environmental assessment
        vi. Performing environmental sampling, as indicated by the environmental assessment
        vii. Subtyping and comparing clinical and environmental isolates
        viii. Decontaminating environmental source(s)
        ix. Working with local and/or state health department staff to determine how long heightened disease surveillance and environmental sampling should continue to ensure an outbreak is over
        x. Reviewing and possibly revising the water management program, with input from local and/or state health department staff
12. The facility may utilize outside resources such as microbiologists, environmental health specialists, or state/local health officials for investigations and revising the water management program in consultation with the IP team .
13. The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program, and as needed, such as when any of the following events occur:
    a. Data review shows control measures are persistently outside of control limits,

b. A major maintenance or water service change occurs (including replacing tanks, pumps, heat exchangers, distribution piping, or water service disruption from the supplier to the building),
c. One or more cases of disease are thought to be associated with the facility's systems, or
d. Changes occur in applicable laws, regulations, standards, or guidelines.

14. In the event of an update to the water management program, the water management team shall:
    a. Update the water system schematic/description, associated control points, control limits, and any pre-determined corrective actions.
    b. Train those responsible for implementing and monitoring the updated program.
15. Documentation of all the activities related to the water management program shall be maintained with the water management program binder/web based platform for a minimum of three years.
16. The water management team shall report relevant information to the QAPI Committee.

ATTACHMENT:
NONE

REFERENCE:
American Society of Heating and Air-Conditioning Engineers (ASHRAE). ANSI/ASHRAE Standard 188-2015: Legionelellosis: Risk Management for Building Water Systems, Normative Annex A - Health Care Facilities. Located at www.ashrae.org. (Note: 2018 version is available, but CDC's toolkit references 2015 version. This is a voluntary standard.)

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings. Located at www.cdc.gov/legionella/WMPtoolkit. Accessed April 2022.
U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. QSO-17-30-Hospitals/CAHs/NHs. (July 6, 2018 revision.).

Original adoption: 22/12/13 (Year/Month/Day)

Revised Hospital-wide Policies and Procedures

ADMINISTRATOR ON DUTY

POLICY:

1. The Laguna Honda Hospital and Rehabilitation Center (LHH) Chief Executive Officer (CEO), or designee, is the Administrator on Duty during regular business hours (8am to 5pm, Monday through Friday) and is responsible for all facility operations.

2. During non-business hours (5:00pm until 8:00am), and all hours on weekends and legal holidays, the AOD is the highest ranking on-site administrative authority for LHH. The AOD is:

   a. Authorized to act on behalf of the CEO for the immediate resolution of problems or incidents which occur during the assigned shift;

   b. Responsible for the proper application of LHH policy and procedure;

   c. Responsible for implementing or directing administrative actions; and

   d. Authorized to activate the Hospital Incident Command System (HICS) and serve as the Incident Commander as directed by the LHH Emergency Response Plan

3. During all off shifts, LHH staff are expected to problem-solve unit and/or department based operational issues. When departmental staff experience a patient crisis, internal disaster, and or external crisis, they should notify the AOD. Any event or issue that will impact patient safety or hospital operations must also be reported to the AOD.

4. Department Heads have the responsibility for their assigned areas and the AOD will contact the appropriate LHH Department Head, Associate Administrator, and/or CEO to inform or elicit support if required.

5. In cases of emergency or disaster, the AOD will activate HICS, assume the role of Incident Commander, immediately establish the Hospital Incident Command System per the LHH Emergency Response Plan, and initiate and direct all activities and communication.

~~During business hours, the Laguna Honda Hospital and Rehabilitation Center (LHH) Chief Executive Officer (CEO) or designee is the highest ranking administrator for LHH and campus. The CEO or designee is available to respond to emergency situations during business hours (M-F 8am to 5pm, except holidays and weekends). During non-business hours (M-F 5pm-8am, weekends and holidays 24/7), the LHH Administrator on Duty (AOD) is the highest ranking administrative authority for the hospital. The AOD on schedule is available to respond to emergency situations during non-business hours.~~

PURPOSE:

1. Institute clear lines of administrative responsibility and proper notification processes that are in effect twenty-four hours a day.

2. Set forth the conditions for operationalizing the authority of the AOD.

3. Define the duties, responsibilities, and authority of the position.

~~To provide clear lines of administrative communication and oversight during non-business hours.~~

PROCEDURE:

1. The AOD shall be the Nursing Operations Nurse Manager on schedule during non-business hours (M-F 5pm-8am, weekends and holidays 24/7)..~~CEO is responsible for identifying members of the Executive staff who are designated as AOD and listed on the AOD rotation~~.

~~The AOD schedule shall be posted on the DPH/LHH intranet.~~

~~2.~~ The AOD shall act on behalf of the CEO to address immediate problems and/or incidents that occur during non-business hours. S/he is responsible for application of administrative actions guided by LHH policy and practice.

~~3.~~

~~4.~~2. ~~The AOD shall be on call during non-business hours (M-F 5pm-8am, weekends and holidays 24/7).~~

~~5.~~3. AOD responsibilities:

a. Functions as the on-site Administrative and Clinical Coordinator.

b. Notifies the administration office, nursing office and telephone switchboard operator of any temporary changes in telephone numbers.

c. Problem-solves with hospital staff and physicians and recommends efficient resolution to operational problems.

d. Responds to, evaluates and manages emergency situations.

e. Makes decisions based on ZSFG policy and correct administrative actions indicated by policy and circumstances.

~~a. Responds within 30 minutes when notified by Operations Nurse Manager/Supervisor or Nursing Office Staff.~~

~~b. Responds onsite, if requested by the Operations Nurse Manager/Supervisor and shall assume administrative responsibility for emergency situations.~~

~~c.~~f. Notifies the CEO and LHH executive leadership of any emergency situations ~~during~~ while AOD.

~~d.~~g. Collaborates with ~~the Operations Nurse Manager/Supervisor,~~ Nursing Office Staff, ~~Executive Colleagues~~executive leadership and/or Department Heads to address areas of concern(s).

~~e. If the AOD does not respond within 30 minutes from receiving a call, the Operations Nurse Manager shall first call the most appropriate Executive Staff member for the issue needing to be addressed. If the appropriate Executive Staff member is not available, the Operations Nurse Manager/Nursing Office Staff shall then call the next AOD scheduled on the list.~~

~~f. Informs DPH Central Office/Director's Office when HICS is activated.~~

~~6. If the AOD has a scheduling conflict, the scheduled AOD shall contact another AOD on the rotational cycle for coverage. The AOD who has the scheduling conflict is responsible for notifying the CEO's office to make the scheduling changes.~~

~~7. Administration Services is responsible for:~~

~~a. Maintaining the AOD schedule and posting the schedule on the intranet.~~

~~b. Notifying the AOD two weeks before the assigned schedule, which begins at 5:00 p.m. Thursday afternoon.~~

~~c. Maintaining the list of Executive Staff who are on the AOD rotational cycle and their current contact information.~~

~~d. Making changes of contact information and scheduling, and notifying the Nursing Office and the operator in writing 24 hours prior to the effective date of the change when notified by the AOD of the changes.~~

~~8.~~4. When the following events occur, ~~the AOD will be contacted by the Operations Nurse Manager and~~ the AOD will then inform necessary LHH ~~E~~executive staff, including the ~~LHH CEO and the Health Director:~~CEO, CMO, CNO, COO, ~~and~~ CQO, and the Administrative Directors.

a. Adverse events (i.e. suicide, assault or abduction, major accident or injury, unexpected or unusual death)

b. epidemic/communicable disease

c. serious security breach

d. significant security issue(s)

e. significant utility malfunction

f. significant communication issues (e.g. downtime)

g. fire, earthquake or other major disaster

h. hazardous material spill

i. media event

j. regulatory visit outside regular business hours

k. other concerns or issues as needed

~~9.~~5. If HICS is activated, the AOD~~/designee~~ shall notify the DPH Central Office/Director's Office at (415) 554-2526 during business hours and via appropriate and available means (e.g. cellular phone) during non-business hours.

~~10.~~6. The ~~Executive Staff~~executive team are responsible for:

a. Serving as consultative resources to the AOD when necessary~~; and~~.

~~b. Contacting Administration Services staff if there are changes to their contact information.~~

ATTACHMENT:
None.

REFERENCE:
AOD Schedule
LHHPP 60-01 Quality Assurance and Performance Improvement Program
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-04 Unusual Occurrences
LHHPP 60-08 Risk Management Program
LHHPP 60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)

Revised: 92/05/20, 00/07/13, 07/08/13, 07/12/04, 09/10/27, 11/05/13, 13/01/29, 15/11/09, 18/11/13, 19/03/12, 22/10/11 (Year/Month/Day)
~~Reviewed: 22/06/01 (Year/Month/Day)~~
Original adoption: 88/01/22

LEAVE OF ABSENCE (LOA), OUT ON PASS (OOP) and BED HOLD

POLICY:

1. A leave of absence (LOA) may be granted to a resident of Laguna Honda Hospital and Rehabilitation Center (LHH) in accordance with the residenet'sresidnet's individual plan of care and for the reasons outlined below.

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

~~2. The following patient movements shall be considered LOA:~~

a. Therapeutic Leave - for purposes other than required hospitalization based on the resident's plan of care.
   ~~a.~~i. Scheduled appointments (Clinic/Dialysis, OR/IR/Cath Lab)

b. Out on Pass (day/overnight/weekend) - Absences for purposes other than required hospitalization which shall be appropriate to the physical and mental well-being of the resident. It is the responsibility of the unit Resident Care Team (RCT) and may be granted for, but is not limited to, the following in accordance with the resident's plan of care:
   i. A visit with relatives or friends.
   ii. Participation by developmentally disabled residents in an organized summer camp for developmentally disabled persons.

~~i.~~

~~b.~~c. Annother acute facility for higher level of care (Emergency department/Psychiatric emergency services/Acute care)

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

~~3. Out on Pass (OOP) is the responsibility of the unit Resident Care Team (RCT) and may be granted for, but is not limited to, the following in accordance with the resident's plan of care:~~

~~a. A visit with relatives or friends.~~

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

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

2. A resident shall ~~not~~ be admitted, granted LOA or discharged on ~~the basis of race, color, religion, ancestry or national origin.~~the resident's level of care and services provided at a skilled nursing facility.

3. Bed Hold – When a resident is admitted to an acute care hospital and LHH holds the resident's bed.
   a. The attending LHH physician writes an order regarding transfer to the ER or acute hospital.
   b. The bed hold is limited to maximum of seven days per acute hospitalization.

~~d.~~

~~4. For LOA due to acute hospitalization~~

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

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

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

~~d. The facility shall submit claims for resident LOA days based on allowable reimbursement.~~

PURPOSE:

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

BACKGROUND:

1. A resident who is receiving Medicare Part A SNF benefits is permitted to go OOP as necessary; however, Medicare will not provide reimbursement to the facility for that day of leave if the resident does not return to the facility by midnight.

2. If the LOA is an overnight visit (or longer) to the home of relatives or friends, LOA reimbursement by Medi-Cal is restricted as follows: Maximum time period of 18 days per calendar year for non-developmentally disabled recipients; Up to 12 additional days of leave per year may be approved in increments of no more than two (2) consecutive days when the following conditions are met:

   a. The request for additional days of leave shall be in accordance with the individual resident care plan and appropriate to the physical and mental well-being of the patient.

   b. At least five days of SNF inpatient care must be provided between each approved overnight OOP.

   c. Maximum of 73 days per calendar year of developmentally disabled recipients.

   d. At the time of admission, if resident has not been an inpatient of any SNF facility for the previous 2 months or longer, the resident is eligible for full complement of leave days.

   e. A resident's return from overnight OOP may not be followed by a discharge within 24 hours.

3. For LOA due to acute hospitalization
   1.
   a. The Laguna Honda Hospital Patient Flow Coordinator shall coordinate bothreadmissions from an LOA and bed reservation procedures in conjunction with Admissions and Eligibility (A& E) department and the neighborhood physician representing the neighborhood RCT. A bed reservation is a bed designated for a resident's anticipated admission, transfer, or for a missing resident for whom LHH receives no remuneration. A bed reservation may be cancelled if, due to a bed shortage, that bed is needed for a new admission to LHH.
      1.
   b. Medi-Cal and some insurances pay for up to seven days of LOA due to acute hospitalization. Further clarification regarding insurance coverage shall be routed to Utilization Management.
      1.
   c. A resident whose hospitalization exceeds the LOA period under the State plan is re-admitted to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident requires the skilled nursing services provided by the facility and is eligible for Medi-Cal nursing facility services or Medicare skilled nursing facility services.
      1.

d. The facility shall submit claims for resident LOA days based on allowable reimbursement.

~~3.~~

PROCEDURE:

1. Notification of LOA Policy

a. Upon admission, A&E provides the resident, or family member, or legal representative with the California Standard Admission Agreement which includes written information regarding LOA-acute hospitalization. The MSW provides bed hold information at the time of transfer, or within 24 hours of transfer in cases of emergency transfer. Should the written information change, LHH shall reissue the new information to the resident, their family member, or legal representative.

2. An order from the Physician for a LOA for OOP (day/overnight/weekend) and for sending out to Another facility (ED/PES/Acute Care) shall be written in the EHR. The Physician and the Licensed Nurse shall follow the process as specified in the EHR.

3. For all LOAs, the Notice of Bed Hold Policy form should be provided to the resident and/or representative.

~~3.~~4. LOA-admitted to Acute Hospital from ED/PES

a. The Physician shall write a discharge summary note and enter a discharge order with the appropriate disposition code.

b. The Licensed Nurse or Unit Coordinator shall update the LOA to discharge.

c. The day of departure from SNF is counted as day 1 of LOA; the day of return is not counted.

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

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

f. LHH ~~claims~~Patient Financial Services must identify the inclusive date of the LOA.

g. LHH residents discharged to an acute care at another hospital (other than ZSFG, PM Acute Medical):

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

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

~~4.~~5. Request for OOP

a. ~~A~~A resident and/or SDM or representative may request a pass from the physician. Such residents will be assessed by the RCT in arranging for pass privilege.

b. An OOP order from the physician shall be written in the EHR with medications if appropriate

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

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

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

f. The nurse shall note in EHR that the resident is OOP, time of departure, instructions given, expected time of return, and actual time of return.

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

~~5.~~6. Census Management

a. The Licensed Nurse/Unit Coordinator shall complete the OOP information in Unit Manager in EHR. When the patient returns from LOA, the Licensed Nurse/Unit Coordinator shall mark the resident back in bed in Unit Manager in EHR.

b. In the event the resident does not return form LOA, the Licensed Nurse/Unit Coordinator shall update the LOA to discharge.

~~6.~~7. Compliance/Adherence with Pass Privilege

a. Resident's/SDM's obligation to participate in and comply with the procedure.

i. When leaving on pass and on returning from pass, residents shall check in and out with the nursing staff on the care unit.

- The License Nurse (LN) shall check-in with the resident within an hour of returning to LHH. The LN shall complete the *Check-In Form – Resident Returning from an Out On Pass* (see attachment A).

- When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, staff shall conduct searches ~~of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors~~based on the ~~(~~LHHPP 22-12 Clinical Search Protocol~~)~~.

- Patients who are going out on pass and would like tobacco products shall request products from the pavilion greeter. All unused tobacco products shall be returned to greeter upon return to LHH.

- Tobacco products purchased while OOP shall be surrendered in the lobby and picked up by designated unit staff.

ii. Non-adherence or non-compliance with the pass privilege shall result in a counseling meeting with the resident and the (RCT and, if appropriate, development of an interdisciplinary care plan addressing the problem.

iii. Residents who remain OOP longer than the duration specified by the physician or residents who can understand the risks of leaving hospital grounds and who leave the hospital grounds without a pass order shall be considered an elopement and may be subject to discharge.

b. Extension/Re-order of OOP may be granted provided the following conditions are all met:

i. The resident's whereabouts is known.

ii. There was a verbal contact between the resident/responsible party and the Nursing Unit Staff or Physician.

iii. Therapeutic LOA.

iv. The reason for extension of OOP is appropriate/valid.

c. The Physician documents the reason for the extension of OOP in the medical record.

ATTACHMENT:
Attachment A: Check-In Form – Resident Returning from an Out on Pass
REFERENCE:
LHHPP 22-12 Clinical Search Protocol
Pharmacy Services P&P 02.01.04
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold

Revised: 09/10/27, 14/01/28, 14/03/25, 17/11/14, 19/05/14, 19/09/10, 22/07/12 (Year/Month/Day)
Original adoption: 99/04/29

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

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

ADDRESSOGRAPH

CHECK IN FORM RESIDENT RETURNING FROM AN OUT ON PASS

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

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

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

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

NAME OF LICENSE STAFF **DATE**

PHYSICAL RESTRAINTS/SKILLED UNITS

POLICY:

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

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

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

4. Each restraint order is valid only for the specific occurrence of application and cannot be ~~A restraint order shall not be~~ written as a standing or PRN order.

5. The restraint consent form shall be updated annually.

6. **Physical restraints as an intervention** do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom.

7. Thorough evaluation shall be completed to identify a clear link between physical restraint use and how it benefits the resident by addressing the specific medical symptom. There shall be a physician order reflecting the use and specific medical system being treated.

    a. The medical record shall reflect the medical symptoms that support the use of the restraint, as well as ongoing assessments, and resident centered care plans.

PURPOSE:

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

DEFINITIONS:

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

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

~~a.~~

~~b. Remove easily: the manual method and/or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff **considering the resident's physical condition and ability to accomplish his or her objective.** (e.g., transfer to a chair, get to the bathroom in time).~~

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

~~a.~~ The bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. ~~The purpose is to keep a resident from getting out of bed when he/she wants to get out of bed.~~

a.

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

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

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

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

5. Trunk restraints: include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body.

6. Limb restraints include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category

~~4.~~7. Convenience: as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest.

~~5.~~8. Discipline: any action taken by the facility for the purpose of punishing or penalizing residents.

~~6.~~9. Manual Method: to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint

~~7.~~10. Medical symptom: is defined as an indication or characteristic of a physical or psychological condition.

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

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

~~9.~~ .

~~**EXCLUSIONS**:~~

~~**Mechanical/postural Support:**~~

~~Mechanical/postural support is not considered a restraint. It is used to achieve proper body position, balance, or alignment to allow greater freedom of mobility that would not be possible without the use of the mechanical support~~

STANDARDS / GUIDELINES FOR RESTRAINT USE:

1. Use of physical restraints should be the exception, not the rule. A physical restraint can only be used when least restrictive interventions have been tried, documented and determined to be ineffective to protect the resident from harm. ~~to provide safety if less-restrictive interventions have been ineffective.~~ A physician order must be completed via EHR.

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

~~3.~~2. The physician must conduct a face-to-face assessment within one calendar day of initiation when initial restraint order is verbal.

~~4.~~3. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition (see the definition section above).

   a. This shall be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body, and the effect it has on the resident.

~~5.~~4. Restraints are to be applied to permit easy removal in emergency situations (e.g., in the event of a fire or disaster).

~~6.~~5. Assessments shall be conducted by following the below steps:

a. Determine the resident's cognitive and physical status/limitations.
b. Considering the physical restraint definition and incorporating the definitions listed above, observe the resident to determine the effect the restraint has on the resident's normal function.
   - ~~Do not focus on the type of device, intent, or reason behind the use of the device.~~
c. Evaluate whether the resident can easily and voluntarily remove the device, material, or equipment. If the resident cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the resident's access to his or her own body.

7. Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually decrease the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.

8. While a resident, family member, legal representative, or surrogate may request use of a physical restraint, LHH is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. Prior to employing any physical restraint, LHH must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the physical restraint is being employed to address. *The legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.* That is, the facility may not use restraints in violation of regulation solely based on a resident, legal surrogate or representative's request or approval. *While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate.* Statutory requirements hold LHH ultimately accountable for the resident's care and safety, including clinical decisions."

PROCEDURE:

1. **Procedure for Using Restraints:**

   a. Before applying a new restraint:

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

         - Circumstances leading to the use of restraints and what alternative ~~less-restrictive~~ interventions were tried first
         - Alternative interventions may include, but are not limited to: diversionary activities, 1:1 resident care, repositioning, pain management, reorientation to surroundings, or administration of prescribed medications~~.~~

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

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

      i. The ordering provider is accountable for evaluating the need for restraints and completing the restraint order. Orders are to be completed via EHR.

      ii. The provider will obtain ~~Complete CConsent~~consent ~~will be obtained~~ for p~~P~~hysical r~~R~~estraint. Consents must include discussion with the resident or resident representative regarding:

         - Educate family/resident representative on risk of removing, repositioning, or retying restraint.
         - Type of restraint and duration of use.
         - Possible benefits and risks of using, or not using, restraints.
         - Rights of resident or resident representative to accept or refuse the use of restraints at any time.

      iii. Nursing will ~~U~~update the resident's c~~C~~are p~~P~~lan after RCT discussion:

         - The type of restraint and whether the restraint used is the least restrictive device.
         - The reason for the restraint (medical symptom) and restraint use duration
         - Document ongoing efforts to evaluate/eliminate use of the restraint.
         - Interventions (restorative) to address potential functional decline.

- Interventions to remain free from injury while restrained

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

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

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

~~vi.~~v.

c. For continued restraint use:

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

ii. Discussion shall include:

- Resident's response to restraint being used.

- Possible alternatives other than current restraint ~~/least-restrictive restraint~~ to be used.

- Referrals to ancillary departments, as appropriate.

- Continuation of restraint use must be renewed via EHR.

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

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

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

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

DOCUMENTATION

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

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

~~i.~~ Any changes to c~~C~~irculation (including vascular checks such as capillary refill, temperature, edema and color of skin) ~~if hand mitten is used~~

~~,~~

Skin integrity of the restrained extremity(ies) ~~if used~~

i.

~~ii.~~ Signs of injury associated with a restraint

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

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

   a. Proper placement of restraint as ordered

   b. Release of restraint every 2 hours for:

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

      ii. Turning and repositioning

      iii. Hygiene/elimination

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

3. Staff Training

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

      i. Methods to reduce and eliminate restraint use;

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

      iii. Use of non-physical intervention skills;

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

v. Safe application of physical restraints;

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

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

~~**ATTACHMENT:**~~
~~Appendix A: Alternatives to Restraint Suggestions~~

REFERENCE:
~~Barclays Official California Code of Regulations: §72319, Nursing Service - Restraints and Postural Supports~~
State Operations Manual Appendix PP - Survey Protocol, Regulations and Interpretive Guidelines for Long Term Care (Rev. 17~~368~~, 11-22~~03-08-~~2017)
~~Title 22~~

CROSS-REFERENCE:
LHHPP 22-13 Bed Rail Use
LHHPP 24-13 Falls
Revised: 97/04/15, 00/01/27, 02/09/06, 08/08/08, 09/01/13, 09/08/21, 10/09/24, 10/11/10, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 21/10/12, 22/08/31 (Year/Month/Day)
Original adoption: 96/07/15

PSYCHIATRIC EMERGENCIES

POLICY:

LHH residents who require acute psychiatric attention shall be attended to in a timely manner.

PURPOSE:

To assure that acute psychiatric issues or crisis situations are addressed appropriately in a timely manner.

DEFINITIONS

A psychiatric crisis is an emergency condition in which thoughts, feelings, or actions are seriously disturbed and require immediate therapeutic intervention(s) to prevent injury, deterioration of health, or loss of life. Crises may include violent or destructive behavior, or serious threats of such behavior, aimed at self or others; crises may also include nonviolent behaviors that place an individual in imminent danger (e.g., insistence on leaving “against medical advice” even though an individual has no means to provide food, clothing, or shelter).

PROCEDURE:

1. LHH Psychiatry providers shall be contacted by a physician when there is a psychiatric crisis. See policy MSPP-D08-03, Access to LHH Psychiatry Services. During regular business hours, LHH Psychiatry Urgent Pager (415-327-5130) may be contacted. During afterhours/weekends/holidays, the on-call psychiatrist may be contacted per posted call schedule on the Intranet.

2. If a psychiatric crisis situation occurs or is developing and it is the opinion of Primary Physician, the LHH Psychiatry provider, and/or the Chief Medical Officer (CMO) that the resident cannot be adequately cared for at LHH, the LHH Psychiatry licensed provider shall notify the Psychiatric Emergency Service (PES) clinician/psychiatrist of the day to discuss the case and arrange for an emergency evaluation. Should ZSFG be on diversion status, a local 5150-accepting emergency room via paramedic knowledge of diversion status shall be considered.

3. If a resident (who is NOT LPS conserved) is assessed by a LHH Psychiatry clinician, who is trained and certified by the Department of Public Health in the 5150 process,

as a danger to others, or to themselves, or gravely disabled, as a result of a mental disorder, and is in need of a psychiatric evaluation, the LHH 5150 Guideline (Attachment 1) should be followed.

4. If the PES clinician/psychiatrist of the day does not agree to a transfer, or if resident's behavioral needs cannot be adequately cared for at LHH but does not meet 5150 criteria, the case will be referred to the Chief of Psychiatry or Chief Medical Officer for immediate consideration.
5. Close observation measures and/or North Mezzanine placement are not intended for residents who are actively suicidal or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting. (Also see LHHPP 24-10 Close Observation.)
6. If a resident is transferred to Psychiatric Emergency Services (or any medical or psychiatric acute care setting due to a behavioral crisis), a LHH Psychiatry licensed provider must evaluate the resident (either by phone report with clinician/psychiatrist, or by in-person assessment) for behavioral risks, prior to the resident returning to LHH. Both the LHH Psychiatry provider and the attending physician must agree to the return. The attending physician makes the ultimate decision as to taking the resident back or not. Disputed cases shall be referred to the Chief of Psychiatry or Chief Medical Officer.

ATTACHMENT:

LHH 5150 Guideline

REFERENCE:

LHHPP 24-10 Close Observation
LHHPP 22-10 Management of Resident Aggression

Original adoption: 09/16/10 (Year/Month/Day)
Revised: 09/24/13, 01/28/14, 5/14/19, 03/05/20; 08/04/22, 22/12/13

CLINICAL/ SAFETY SEARCH PROTOCOL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall act to ensure the safety of residents and staff, and to provide necessary care for each resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being.

2. Active substance use, drug dealing, unsafe smoking and use of dangerous objects endangers the safety of residents and staff and does not promote a resident's well-being.

3. For the safety of residents and staff, and the well-being of residents, dangerous objects, illegal drugs, non-prescribed medications, cigarettes, lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame, alcohol and/or drug paraphernalia are prohibited at LHH.

~~3.~~4. Facility staff will have knowledge of signs, symptoms, and triggers of possible ~~illegal~~ prohibited substance use, which includes but is not limited to:

   a. Changes in resident behavior

   b. Increased, unexplained drowsiness

   c. Lack of coordination

   d. Slurred speech

   e. Mood changes

   f. Loss of consciousness

5. When there is a potential risk and/or reasonable suspicion that a resident possesses contraband, clinical or facility staff shall conduct searches of the resident, a resident's room and personal belongings, as well as property and packages brought by visitors as described below, ~~if and~~ only if the resident or their representative provides consent ~~has been provided by the resident or surrogate decision maker~~for each separate search. This policy shall not in any way prohibit or limit law enforcement from conducting lawful searches.

   ~~g.~~a. Including but not limited to:

      i. Out on pass

      ii. Return from appointment and resident and/or escort verbalizes any deviations from the appointment

iii. Leaving campus without out on pass

6. Clinical or facility ~~S~~staff may also conduct a search after completion of the *Check-In Form – Resident Returning from an Out On Pass* (OOP) when a resident returns from leave and when there is a potential risk and/or reasonable suspicion that a resident possesses contraband, ~~if and~~ only if the resident or their representative provides consent for each separate search. This policy shall not in any way prohibit or limit law enforcement from conducting lawful searches.

~~4.~~7. ~~has been provided by the resident or surrogate decision maker~~.

~~5.~~8. If facility staff identifies items or substances that pose risks to residents' health ~~and~~ or safety and are in plain view, they will confiscate them.

PURPOSE:

To outline the process of contraband clinical search protocol at LHH to maintain resident/visitor/staff safety, protect our residents from error and harm, and providing the safest care possible in protection of the well-being of each resident

BACKGROUND:

LHH recognizes that residents have a right to (1) privacy, dignity, and to be free from unnecessary searches; and (2) retain and use personal property. However, residents, staff, and visitors also have the right to a safe and therapeutic environment, which under certain circumstances necessitates taking steps to ensure residents are not in possession of items that may present a hazard to personal safety or the therapeutic environment. LHH also recognizes that some of its patients may have substance use disorders, and possession of contraband may be related to symptoms of that condition.

DEFINITION:

Contraband: Illegal or prohibited items, such as dangerous objects, prohibited drugs (including cannabis and cannabis products) and drug paraphernalia, unapproved alcohol, and smoking or tobacco paraphernalia.

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

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

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

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

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

PROCEDURE:

1. Indications for Searches

~~Property of all newly admitted residents shall be inventoried when the resident arrives to the unit.~~For each of the following situations, clinical or facility staff may search the resident and/or their belongings **only if the resident or their representative provides consent** for each instance, and for each separate search, when a search is warranted. This policy shall not prohibit or limit law enforcement from conducting lawful searches.

a. All packages for residents who are smokers, ~~on oxygen,~~ and/or those who have a diagnosis of substance use disorder shall be searched in the presence of the resident. Packages brought into the unit that clinical staff reasonably suspect contain contraband shall be searched in the presence of the resident before giving the package to the resident.

   a. Staff may search a resident, their property, and their room when clinical staff believes there is a potential risk and/or reasonable suspicion that the resident is in possession of contraband.~~, i~~
   ~~a. f and only if consent has been provided by the resident or surrogate decision maker.~~

b. Staff may search a resident, their property, and their room upon reasonable belief by clinical staff that the resident is suicidal, homicidal, or necessary to prevent serious harm to themselves or to others.

c. Residents who return from pass privileges may be asked to empty their pockets and their packages may be searched if contraband is reasonably suspected.

d. Staff may search a resident's property and their room when staff reasonably suspects that a resident has taken another person's property. If the property is found, the property may be returned to the owner.

e. Staff may conduct unit-wide searches when there is a potential risk and/or reasonable suspicion that drug using/dealing may be occurring on a unit or multiple units.

f. Staff may search a resident, their property, and their room when a resident exhibits a change in mental status or behavior and substance use is suspected.

g. Staff may search a resident, their property, and their room when a resident exhibits unsafe smoking practices such as smoking while on, or near an oxygen delivery device.

2. Search Procedures

1. LHH clinical or facility staff may initiate searches to ensure the health and safety of residents and staff~~, if and~~ only if the resident or their representative provides consent for each separate search. This policy does not in any way prohibit or limit law enforcement from conducting lawful searches.

~~has been provided by the resident or surrogate decision maker.~~

a.

b. Searches shall be conducted in a reasonable manner that respects the individual's dignity and privacy. A search should be conducted only to the extent required to assure contraband is not present. The method and purpose of the search shall be explained to the resident.

c. To the extent possible, residents shall be present while their property (including intended packages) and rooms are being searched.

d. The permission of the resident must~~should~~ be requested prior to any search ~~(except in cases of danger to self or others).~~ It is recommended that a SFSO deputy be present for searches that involve a resident who may display behavioral escalation during the search.

~~e. See Standard Work for procedure if a resident does not give permission for search but a Clinical/Safety search is indicated.~~

~~f.~~e. Repeated searches of resident's rooms and property are permitted when there is a potential risk and/or reasonable suspicion that they are in possession of contraband, but only if the resident or their representative provides consent . Examples include but are not limited to:

i. Resident appearing to be under the influence of drugs or alcohol;

ii. Reasonable suspicion that contraband is in a resident's possession (Risk factors may include the resident having history of bringing and/or selling alcohol, street drugs and/or other contraband in LHH);

iii. Resident having current suicidal or homicidal ideation or expressed feelings of inflicting serious harm to themselves or others;

iv. Reasonable suspicion of theft (Risk factors may include resident history of theft while on the unit, credible witness report, etc.); and/or

v. Resident deemed an unsafe smoker and/or smoking while on, or near an oxygen delivery device.

~~g.~~f. Staff shall take Universal Precautions such as wearing double gloves, a mask, a gown, and face shield or eye protection when handling resident belongings or suspected contraband. Staff shall avoid reaching into any pockets. Instead, staff shall pour out the contents of bags, boxes, packages, or other personal belongings, ask the resident to empty their pockets, and/or gentle patting.

~~h.~~g. A minimum of two staff shall be present during a search.

~~i. New Admissions:~~

~~i. All newly admitted residents shall be informed that admission procedures require a routine inventory of his/her property by LHH staff.~~

~~• The resident shall be asked to empty his/her pockets, purse, suitcase and other belongings.~~

~~• Any contraband shall be removed from the resident's possession.~~

~~• Any weapons or dangerous objects shall be turned over to the SFSO.~~

~~• Illicit or illegal drugs shall be turned over to the SFSO.~~

~~• A notation shall be made in the electronic health record and the resident shall be given a property receipt for items that are being held by staff.~~

~~j.~~h. When a resident is assessed as suicidal or homicidal, or has a history of drug use or violent behavior, or is suspected of having contraband, a search may be initiated by clinical or facility staff only if the resident or their representative provides consent for each separate search. Staff shall notify SFSO of the search and request stand-by for support, if needed. Types of searches which may be conducted by clinical or facility staff include:

i. Pocket Searches – resident shall be asked to empty his/her pockets and contents shall be inspected by staff for contraband.

ii. Pat Down or Frisk Searches – shall be conducted by designated staff who are of the same sex as the individual being searched in the presence of a witness. If during the pat-down search a suspicious object is discovered, which reasonably could be, for example, a weapon, pills or other contraband – staff may remove the object for closer inspection.

iii. Clothing Searches – the resident shall be escorted to a private area accompanied by two staff members, at least one staff member of the same sex whenever possible and requested to change into a hospital gown. The clothing shall be checked for contraband. Once contraband objects are removed, the clothing can be returned to the resident.

iv. Room Searches – the resident's room and furniture/belongings in the room, including assistive devices such as canes and wheelchairs, shall be inspected by designated staff.

v. Food Searches – inspecting packaging of food intended for residents

vi. Belongings Search – belongings such as purses, bags, backpacks, and packages brought in by visitor or via mail/delivery shall be inspected by staff for contraband.

vii. Unit-Wide Search – Nurse manager or designee shall call for a team huddle. The team shall identify the type of search and which rooms will be searched up to and including the great room and common areas.

3. Unit Searches of the Resident Rooms and Common Areas

a. Preparation

i. Staff shall notify SFSO of the search and request stand-by support if the resident has a history of aggressive behavior or has exhibited aggressive behavior previously during a clinical search. On such instances, at least one LHH SFSO deputy shall be stationed outside the entrance/exit of the resident's room to provide support in the event:

- the resident threatens or becomes verbally or physically aggressive toward staff, or other residents;
- staff observe that the resident has a dangerous object in their possession;
- staff observe that the resident has illicit or illegal drugs in their possession.

ii. Staff shall review basic safety search procedures before proceeding, including nonviolent safety management and prevention of challenging behavior principles as needed.

iii. Search teams shall be identified (at least 2 staff per room search) by the nurse manager or designee.

iv. One staff shall be assigned to monitor the unit entrance/exit.

v. Staff may request canine search assistance as needed from SFSO (refer to procedure 4).

vi. A mandatory community meeting shall be called to announce the safety search and instruct the residents to wait in the Great Room until called to their bedside for the search.

b. During the Search

i. Two staff shall provide support for each neighborhood being searched. The duties shall include escorting residents from the Great Room to the residents' rooms, working with agitated residents, collecting confiscated substances and paraphernalia, communicating with staff at entrance/exit, etc.

ii. At least one staff shall observe the residents in the Great Room. If available, Activity Therapy may run an activity group during the wait.

iii. Residents who have been searched may leave the unit, however, shall not be able to return until the search is concluded, or may be asked to wait in a separate dining room.

iv. All confiscated substances and paraphernalia shall be bagged and labeled. The Transfer Form for Contraband Items must be completed for all confiscated items.

v. Staff shall help with de-escalation and provide support as needed.

vi. SFSO shall provide support:

- When a resident becomes verbally or physically aggressive toward staff or other residents;
- exhibits behavior that threatens the safety or well-being of other residents or staff;
- staff observes that the resident has a dangerous object in their possession; and/or
- staff observes that the resident has illicit or illegal drugs in their possession.

c. After the Search

i. All confiscated contraband shall be catalogued by the staff member that conducts the clinical search, have a completed corresponding Transfer Form,

be disposed of in the manner described below, and documented in the resident's medical record:

- Confiscated illicit substances and/or drug paraphernalia, including cannabis, shall be bagged, labeled, and transferred to SFSO within the same shift.

- Confiscated alcohol shall be bagged, labeled, and transferred to SFSO within the same shift.

- Cigarettes confiscated from unsafe smokers shall be held or disposed of based upon the resident's care plan for smoking.

- E-cigarettes, lighters, matches, and other devices that ignite, light, or fuel a flame shall be bagged, labeled by nursing staff and secured by Social Services for safekeeping.

- Dangerous objects (including, but not limited to, box cutter, scissors, guns, or objects with a blade regardless of length) require immediate notification to SFSO. Items shall be bagged, labeled, and transferred to SFSO.

    - Should the resident or a surrogate decision-maker indicate that the dangerous object(s) are of sentimental value, then said item(s) shall be bagged and labeled by nursing staff, and secured by SFSO for safekeeping.

        - Said items shall be stored in a secured and locked location on LHH property for safekeeping.

        - Dangerous object(s) shall be transported to and from the secured and locked location by SFSO only.

        - The dangerous object may be released to the resident by SFSO upon discharge or to a person identified by the resident or the resident's surrogate decision-maker or personal representative.

        - Only SFSO shall retrieve the dangerous object from the storage location on the LHH campus.

        - Dangerous objects shall not be released to the resident, person identified by the resident, resident's surrogate decision-maker, or personal representative if the attending physician or SFSO reasonably determines that the person would be a safety threat to themselves or to others if the dangerous object was released to them.

- LHH shall keep any such confiscated dangerous objects for a maximum period of ninety (90) days after discharge.

- Any confiscated substances in pill, patch, or capsule form that cannot be identified shall be transferred to the pharmacy for identification and proper disposal.

  - If the pharmacy is closed: transfer the confiscated substances to SFSO.

- Any other confiscated substances that cannot be identified shall be given to SFSO.

- Confiscated sharps shall be disposed in the sharps container by nursing staff, witnessed by at least two staff members, and indicated on the Transfer Form for Contraband Items.

d. Documentation

i. When a clinical safety search is conducted it shall be documented in the resident's electronic health record using the Clinical Safety Search SmartPhrase.

ii. Staff shall submit a UO describing:

- The facts constituting a reasonable suspicion to conduct the search
- Resident consent or refusal
- Staff who conducted the clinical safety search and witnesses
- The results of the search
- Items found and seized
- Disposition of confiscated items
- Completion of Transfer Form of Contraband Items
- If the Sheriff issues a citation ticket number, include in the UO description

iii. The Resident Care Team (RCT) shall be informed when searches were conducted. The RCT shall review the incident and assess if the resident's care plan shall be modified.

e. Additional Clinical Safety Searches

i. An additional clinical safety search shall be conducted within 3 to 5 days after the first clinical safety search only if the resident or their representative provides consent for each separate search, when:

- A resident is found with illicit substances during the first clinical search
- A resident's urine confirmation (not screening) toxicology result is positive for amphetamine, methamphetamine, cocaine, heroin, cannabinoid, or fentanyl

ii. If during the additional clinical safety search another illicit substance is found, another search shall be conducted within 3-5 days. This shall continue until no illicit substances are found.

4. Canine Searches

a. LHH has access to canine assistance for drug searches when needed.
   i. A request by LHH administrative staff can be made to the SFSD for unit-wide or hospital-wide searches.

   ii. The search dog shall be handled by a professional handler only.

   iii. Staff shall be sensitive to those residents who may have negative reactions when they are around dogs.

   iv. Staff and residents shall be instructed about proper ways to interact with the dog, such as no petting or feeding.

5. Visitors

All visitors shall be informed that LHH strives to be a safe, drug-free healing environment, and that all contraband and illegal activities are prohibited. All items brought for residents ~~are~~ may be subject to search by staff. If contraband, paraphernalia, and/or illicit substances are found, they shall be disposed of per facility policy. If a visitor is suspected of bringing in contraband, staff may implement interventions, including but not limited to: inspection of packages the visitor brings to the unit, restricting or prohibiting visits, and/or calling SFSD for support.

ATTACHMENT:
Attachment A: Standard Work for Contraband Item Handling, Storage and Disposal
Attachment B: Standard Work for Clinical Safety Search

REFERENCE:
LHHPP 20-06 Leave of Absence (Out on Pass)
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-10 Management of Resident Aggression
LHHPP 75-05 Illicit or Prohibited Drugs or Paraphernalia Possession/Use by Residents or Visitors
LHHPP 75-10 Security Services Standard Operating Procedures
LHHPP 76-02 Smoke and Tobacco Free Environment
Check-In Form – Resident Returning from an Out on Pass

Revised: 19/09/10, 22/07/14 (Year/Month/Day)
Original adoption: 19/03/12

BED RAIL USE

POLICY:

1. Prior to bed rail use, must consider the use of appropriate alternatives (see policy 7) ~~Attachment A).~~ The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. Bed rails may only be used after careful assessment by the Resident Care Team (RCT) reviewing the risks and benefits of bed rail use.

2. Safety assessments shall be completed for residents who use bed rail(s).

3. A new safety assessment, order, and consent shall be completed when:

   a. the resident uses a different type of bed;
   b. there is a change in condition or functional status; and/or
   c. there are safety concerns with the quarterly assessment and the RCT has discussed continued use of bed rails after reviewing risks and benefits.

4. When the bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. They fall under the definition of a physical restraint. If they are not necessary to treat medical symptoms, and less restrictive interventions have not been attempted and determined to be ineffective, bed rails used as restraints should be avoided. If the bed rail meets the definition of a physical restraint, the hospital-wide policy and procedures outlined in LHHPP 22-07 Physical Restraints shall be followed.

5. Continued bed rail use requires at a minimum, a quarterly bed rail safety assessment by the RCT.

6. Facility Services staff is responsible for the proper installation of bed rails and tracking completion of annual preventive maintenance on the bed used by the resident.

~~6.~~7. Appropriate Alternatives: Facilities must attempt to use appropriate alternatives prior to installing or using bed rails. "Alternatives include roll guards, foam bumpers, lowering the bed and using concave mattresses that can help reduce rolling off the bed." Additionally, alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms, or behavioral patterns for which a bed rail was considered. For example, a low bed or concave mattress may not be an appropriate alternative to enable movement in bed for a resident receiving therapy for hip-replacement. If no appropriate alternative was identified, the medical record would have to include evidence of the following: • purpose for which the bed rail was intended and evidence that

alternatives were tried and were not successful • assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight), and • risks and benefits were reviewed with the resident or resident representative, and informed consent was given before installation or use.

~~7. Resident or representative may choose to use bed rails per preference.~~

PURPOSE:

To ensure safe and appropriate use of bed rails.

DEFINITIONS:

1. Entrapment: is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail.

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

~~3. Bed rails are considered restraints when:~~

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

~~b.~~a. ~~The use of a bed rail restricts freedom of movement~~.

PROCEDURE:

1. A safety assessment shall be completed by the RCT and documented via electronic health record (EHR) by the Registered Nurse taking into consideration the resident's current medical diagnosis, physical condition (size and weight), functional ability (bed mobility, transfer, ability to toilet self), cognition, communication, sleep habits, medication(s), physical and/or behavioral symptoms.
2. For beds with rails that are incorporated or pre-installed, the facility must determine whether or not disabling the bed rail poses a risk for the resident. Some considerations would include, but are not limited to • Could the rail simply be moved to the down position and tucked under the bed • When in the down position, does it pose a tripping or entrapment hazard? • Would it have to be physically removed to eliminate a tripping or entrapment hazard?

~~1.~~3. Facilities should follow manufacturers' recommendations/instructions regarding disabling or tying rails down. If bed rails are not appropriate for the resident and the facility chooses to keep the bed rail on the bed, but in the down position, raising the rail even for episodic use during care would be considered noncompliance if all of the

requirements (assessment, informed consent, appropriateness of bed, and inspection and maintenance) are not met prior to the episodic bedrail use for the resident.

~~2.~~4. The safety assessment takes into consideration the following:

a. Risk of entrapment,

b. Bed's dimensions are appropriate for the resident's size and weight,

c. Fall risk,

d. Physical restraint assessment,

e. Potential negative physical outcomes such as decline in function for activities of daily living and skin integrity issues, and

f. Potential negative psycho-social outcomes such as an undignified self-image, low self-esteem, and feelings of isolation, anxiety or agitation.

5. Use of bed rails shall be ordered by the physician via EHR. Physician will complete consent ~~and nursing staff will scan consent copy to EHR.~~
~~3.~~ . • What assessed medical needs would be addressed by the use of bed rails; • The resident's benefits from the use of bed rails and the likelihood of these benefits; • The resident's risks from the use of bed rails and how these risks will be mitigated.

~~4.~~6. The Resident or Resident Representative shall consent to bed rail use by signing the informed consent.

~~5.~~7. Nursing staff is responsible for notifying Facility Services when they find a bed that is past due for preventive maintenance.

~~6.~~8. The RCT is responsible for on-going monitoring and supervision of residents who use bed rails and for conducting a quarterly safety assessment and documenting the assessment in the RCT meeting notes.

~~7.~~9. For new admissions, the RCT shall review and consider the alternatives listed under Appendix A and determine if any of the suggested interventions are appropriate as an alternative to bed rail use.

~~**ATTACHMENT:**~~
~~Attachment A: Table for Alternatives to Bed Rail Suggestions~~

REFERENCE:

LHHPP 22-07 Physical Restraints
MR 820 Non-Restrictive Bed Rail Consent Form (revised 10/2019)
~~Barclays Official California Code of Regulations: §72319. Nursing Service - Restraints and Postural Supports~~
https://www.fda.gov/medical-devices/bed-rail-safety/recommendations-consumers-and-caregivers-about-bed-rails
https://www.fda.gov/media/71460/download
https://www.fda.gov/media/88765/download
Centers for Medicaid and Medicare Services: 42 CFR Part 482 Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule
http://www.cms.hhs.gov/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf

Revised: 10/11/10, 16/09/13, 18/03/13, 19/03/12, 20/10/13, 21/10/12 (Year/Month/Day)
Original adoption: 08/21/09

COMPLETION OF RESIDENT ASSESSMENT INSTRUMENT/MINIMUM DATA SET (RAI/MDS)

POLICY:

1. The assessments of the Resident Care Team (RCT) members are the primary data sources used by the RAI/MDS coordinator to complete the RAI/MDS assessments.

2. Respective members of the RCT are responsible for the timely completion of MDS assessments i.e. Admission, Quarterly, Annual, Significant Changes, Medicare and other required assessments.

3. The RCT shall utilize the RAI/MDS assessments to develop, review and revise each resident's comprehensive plan of care.

PURPOSE:

To successfully use the RAI/MDS process to enhance resident care, increase resident's active participation in care, and to promote the quality of life of the resident(s).

To utilize the RAI/MDS during care planning process.

To ensure accurate and timely completion of the Resident Assessment Instrument/ Minimum Data Set.

BACKGROUND:

The RAI/MDS is a tool used to identify resident problems, strengths, weaknesses and preferences and provides information for the development of an individualized plan of care.

PROCEDURE:

1. RAI/MDS Accuracy and Completion

a. The MDS Coordinator notifies Resident Care Team members by the end of each month~~every 21st of the month through e-mail~~ identifying those residents who are scheduled for assessments the following month. ~~If the 21st of the month falls on a weekend or holiday, the schedule shall be sent on the following business day~~. The MDS Coordinators may send an updated list after the initial notification~~e-mail~~ to reflect schedule revisions and additions.

b. The RAI/MDS Coordinator shall approve changes to the individual resident's schedule of RAI/MDS completion.

c. The Resident Care Team and the Department of Admissions and Eligibility are responsible for completing respective MDS sections as specified in Attachment C.

d. The team member whose area of assessment is triggered shall complete the Care Area Assessments (CAA). CAA that are triggered during completion of the comprehensive MDS shall be evaluated and discussed during RCC whether or not a comprehensive care plan needs to be developed for the triggered care areas (See LHHPP 23- 01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC).

e. The MDS Coordinator shall access the MDS in the electronic health record (EHR) during the scheduled Resident Care Conference for final review.

f. The MDS Coordinator shall facilitate discussion of the MDS, care areas (CAA) triggered and prompt the care planning process during the RCC and/or individual RCT members prior to the scheduled RCC.

g. All staff who complete any portion of the MDS shall enter their signatures, titles, sections or portion(s) of section(s) they completed, and the completion date in the EHR.

2. The RAI/MDS Assessments

A RAI/MDS assessment (CAA process and utilization guidelines) shall be completed for all residents at LHH.

Assessment Types:

a. Tracking Records

i. Entry- completion of an Entry tracking Record during admission and reentry.

ii. Death in facility- refers to when a resident dies in the facility or dies while on leave of absence (LOA).

b. OBRA Assessments

i. Admission- comprehensive assessment for a new resident or a returning resident.

ii. Annual- comprehensive assessment completed on an annual basis (at least every 366 days).

iii. Significant Change in Status Assessment- comprehensive assessment is completed if RCT determined that a resident meets the significant change

guidelines for either improvement or decline (see Standard Work for Significant Change in Status Assessment)

iv. Quarterly- an OBRA non-comprehensive assessment completed every 92 days following the previous OBRA and is used to track resident's status between comprehensive assessments.

v. Significant Correction to Prior Comprehensive Assessment- completed when the RCT determines that a resident's prior Comprehensive assessment contains a significant error.

vi. Significant Correction to Prior Quarterly Assessment- completed when the RCT determines that a resident's prior Quarterly assessment contains a significant error.

vii. Discharge (return not anticipated or return anticipated)- must be completed within 30 days when resident is discharged from the facility either return anticipated or return not anticipated.

c. Medicare Assessment- assessment of clinical condition of the resident receiving Part A SNF- level care.

Submission of required data to Centers for Medicare and Medicaid Services (CMS)

a. The facility must report data to meet the SNF Quality Reporting Program (QRP). The MDS 3.0 is transmitted to CMS through the Assessment Submission and Processing (ASAP) system to the Quality Improvement Evaluation System (QIES).
    a. The MDS 3.0 data is generated for the Certification and Survey Provider Enhanced Reporting system (CASPER) which provides the quality measures indicating the facility's star rating.
        i. List of Quality Measures
            1. High-Risk/Unstageable Pressure Ulcers (L) • Physical Restraints (L) • Falls (L) • Falls with Major Injury (L) 09/2020 v1.05 Certification And Survey Provider Enhanced Reports MDS 3.0 QM 11-4 CASPER Reporting MDS Provider User's Guide • Residents Who Newly Received an Antipsychotic Medication (S) • Residents Who Received an Antipsychotic Medication (L) • Prevalence of Antianxiety/Hypnotic Medication Use (L) • Antianxiety/Hypnotic Medication Use % (L) • Behavior Symptoms Affecting Others (L) • Depressive Symptoms (L) • Urinary Tract Infection (L) • Catheter Inserted and Left in Bladder (L)* • Low-Risk Residents Who Lose Bowel/Bladder Control (L) • Excessive Weight Loss (L) • Need for Help with ADLs Has Increased (L) • Percent of Residents Whose Ability to Move Independently Worsened (L)* • Percent of Residents Who Made Improvements in Function (S)* •

Changes in Skin Integrity Post-Acute Care Pressure Ulcer/Injury* (SNF Only)

b. The facility is required to submit staffing information through the Payroll Based Journal (PBJ) on a quarterly basis.

ATTACHMENT:
Attachment A: Required OBRA Assessment Schedule for the MDS
Attachment B: Medicare MDS Assessment Schedule
Attachment C: MDS 3.0 Section by Section

REFERENCE:
LHHPP 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
MDS 3.0 User's Manual, MED-Pass
Standard Work for Timely Submission and Accuracy of MDS
Standard Work for Significant Change in Status Assessment RCC

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

Attachment A: Required OBRA Assessment Schedule for the MDS

ADMISSION	Refer to RAI Manual page 2 - 8
~~Annual~~ANNUAL	Refer to RAI Manual page 2 - 19
SIGNIFICANT CHANGE IN STATUS	Refer to RAI Manual page 2 - 22 to 2- 27
SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT	Refer to RAI Manual page 2 - 30
QUARTERLY	Refer to RAI Manual page 2 - 31 to 2- 33
SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT	Refer to RAI Manual page 2 - 34
ENTRY	Refer to RAI Manual page 2 - 34 to 2 - 35
DEATH IN FACILITY	Refer to RAI Manual page 2 - 36
DISCHARGE	Refer to RAI Manual page 2 - 36 to 2 - 37

Attachment B: MEDICARE MDS Assessment Schedule

5 Day NPE (Medicare Last Covered Day) IPA (Interim Payment Assessment) Interrupted Stay ~~14 Day~~ ~~30 Day~~ ~~60 Day~~ ~~90 Day~~	Refer to RAI Manual ~~Page 2 - 29~~

Attachment C: MDS 3.0 Section by Section

SECTION	RESPONSIBLE DISCIPLINE(S)
A	
A0050	MDS
A0100 - A0200	IS
A0200	MDS
A0300~~10~~ – A0410	MDS
A0500 – A0900	A&E - autoflow
A1000	MDS - SS autoflow
A1100 - A1300	SOCIAL SERVICES -
A1200 – A1550	SOCIAL SERVICES and MDS
A1600 – A1700	MDS
A1800 – A2400	MDS
B	
B0100 – B1200	LICENSED NURSE
C	
C0100 – C0500	LICENSED NURSE
C0600 – C1000	LICENSED NURSE
C1310	LICENSED NURSE
D	
D0100 – D0350	LICENSED NURSE
D0500 – D0600~~50~~	LICENSED NURSE
E	
E0100 – E600	LICENSED NURSE
E800 – E1100	
F	
F0300 – F0400	ACTIVITIES
F0500 – F0700	ACTIVITIES
F0800	ACTIVITIES
G	
G0110 – G0120A	MDS
- G0300 – G0900	LICENSED NURSE
GG GG0100-GG0170	MDS
H	
H0100 – H0600	MDS
I	
I 0100 – I 8000	MDS
J	
J0120 – J2000	MDS
J2100 - J500	MDS
K	
K0100 – K0710	DIETITIAN (RD)

L	
L0200	MDS
M	
M0100 – M1200	LICENSED NURSE
N	
N0300 – N2005 0450	MDS
O	
O 0100 - O 0300	MDS
O 0400 - O0430 ~~A thru C~~	MDS (in collaboration with Rehab)
O 0400 D & E	MDS
O 0400 F	ACTIVITIES
O 0500 – O 0700	MDS
P	
P0100- P0200	MDS
S	
S9040A- S9040H	MDS
Q	
Q0100	MDS
Q0300 – Q0600	SOCIAL SERVICES
V	
V0100	MDS
V0200	RCT
V0200 B&C	MDS
X	
X0100 – X1100	RAI
Z0100	SOFTWARE CALCULATION
Z0400	RCT
Z0500 A&B	MDS COORDINATOR

RESIDENT/PATIENT AND VISITOR COMPLAINTS/GRIEVANCES

POLICY:

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

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

~~2.~~3. LHH encourages patients on the acute medial unit to raise concerns for resolution with the care providers on the acute unit without discrimination or fear of reprisal.

~~3.~~4. LHH shall make prompt efforts to resolve grievances ~~-~~residents/patients/visitors may have by actively working toward a resolution.

~~4.~~5. Individual resident/patient concerns that are addressed by the RCT or acute medical care team shall be documented in the medical record. Concerns raised during Residents Council and Community meetings shall be reflected in meeting minutes and or notes of those meetings respectively.

~~5.~~6. When methods for resolving concerns have not been successful and residents/patients/visitors choose~~s~~ not to use any of the above methods, LHH has a Complaint/Grievance form that can be submitted to the Administration Department (Administration) to address unresolved complaints/grievances in equitable and inclusive ~~a culturally sensitive~~ manner.

~~6.~~7. The neighborhood bulletin board shall display necessary information, consistent with federal requirements, on the residents/patients/visitors right to file complaints/grievances orally and in writing, including anonymously, and the process for submitting complaints/grievances.

PURPOSE:

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

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

DEFINITION:

Complaint/Grievance: A verbal or written communication about a problem and/or concern signed or anonymous, presented via resident drop boxes, included in resident satisfaction

surveys, or given directly to staff. Examples of complaints/grievances may include those about treatment, care, management of funds, lost clothing, or violation of rights.

PROCEDURE:

1. On admission, each resident receives the Resident Guidebook and the social worker orients him/her to the Resident Complaints/Grievance policy.
   ~~1.~~a. If admitted to the acute medical unit at Laguna Honda, the admitting nurse will remind the patient of their right to file a grievance.

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

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

4. The Resident Care Team in the Skilled Nursing Facility, and/or the care team on the medical acute unit, shall encourage a resident to complete the Residen/Patient/Visitor Complaint/Grievance form when methods for resolving concerns are not successful despite interventions by the Team and the resident's concerns continue to be unresolved.

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

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

7. Contents from Suggestion boxes shall be picked up Monday through Friday, excluding holidays by a designee from Administration. Complaint/Grievance forms and Suggestion forms shall be routed to ~~Assistant Hospital Administrator~~the Administrative Director or their designee.

~~8.~~ The ~~Assistant Hospital Administrator~~Administrative Director shall triage the complaint/grievance. ~~and create an Unusual Occurrence (UO) report.~~

8.

9. The ~~Assistant Hospital Administrator~~Administrative Director shall act as the Grievance Official and is responsible for managing the grievance process; receiving and tracking grievances through to their conclusions; leading/directing any necessary investigations; maintaining confidentiality of information compiled; issuing written grievance decisions on behalf of department/unit managers; and coordinating with state and federal agencies as necessary.

10. The appropriate department/unit manager shall acknowledge the complaint/grievance and or make contact the resident/patient in 5 business days. The resident/patient's right to confidentiality and privacy will be respected at all times.

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

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

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

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

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

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

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 22-03 Residents' Rights
Appendix PP/Guidance to Surveyors for Long Term Care Facilities ~~F165 - F166~~F585/Sections 483.10(j) (1) – (4)

Revised: 09/10/01, 10/04/27, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 22/08/17, 22/08/30
(Year/Month/Day)
Original adoption: 92/03/01

RESIDENT VISITATION

POLICY:

1. Residents' visitors shall be accommodated, without compromising the safety of the facility, residents, and staff, or the care or the well-being of residents at the facility.

2. Every resident has the right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable and in a manner that does not impose on the rights of another resident.

3. The facility shall provide access to a resident by individual(s) that provides health, social, legal, or other services to the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time. This includes the following individuals:

   a. Treating physician(s);

   b. Immediate family, other relatives and friends of the resident;

   c. Resident representative;

   d. Representative(s) of the Health and Human Services Secretary;

   e. Representative(s) of the State;

   f. Representative(s) of the Office of the State long term care ombudsman,

      a. Any representative of the protection and advocacy systems, as designated by the state, ~~and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000~~; and Any representative of the agency responsible for the protection and advocacy system for the developmentally disabled individuals;

      ~~a.~~b. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder as established under the Protection and Advocacy for the Mentally Ill Individuals Act of 2000. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder.~~;~~

~~4.~~ Residents (or the resident representative, where appropriate) shall be informed of their visitation rights through review of the Resident Handbook on admission and periodically thereafter as necessary.

4.

~~5.~~ The facility will inform each resident and/or resident representative of his or her visitation rights and related facility policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner he or she understands.

5.

6. The facility will inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates as well as deny visitation, including but not limited to:
    a. A spouse, including a same-sex spouse
    b. A domestic partner, including a same-sex domestic partner
    c. Another family member
    d. Adoptive/foster family members
    ~~—~~A friend
    ~~a.~~e.

~~6.~~7. Visitation privileges shall not be denied ~~on the basis of~~based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

PURPOSE:

To encourage visitation of residents while protecting resident rights and health needs.

PROCEDURE:

1. The facility will provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at the time. Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident, ~~with the exception of~~except for reasonable clinical and safety restrictions, placed by the facility based on recommendations of CMS, CDC, or the local health department.

    a. Recommended visiting hours are daily, from 10:00 a.m. to 9:00 p.m. Visits outside of the recommended visiting hours can be arranged with the Care Team.

~~1.~~2. The facility will provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.

~~2.~~3.

~~3.~~ The facility will provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. Facility staff will provide space and privacy for these visits.

4. All visitors must check in and sign in at the lobby and the nursing neighborhood upon arrival. (Cross Reference: LHHPP 75-02 Public Access and Night Security).

5. Visitors are not allowed personal items. Visitors may have a phone or wallet but cannot enter with a bag, purse, or any other personal item. Visitors are advised to leave personal belongings in their vehicles. If the visitor does not have a vehicle, staff will provide a secure locker for their belongings.

    a. If a visitor has personal medications that must be on their person, (such as blood pressure medication, allergy medication, seizure medication, etc.), they are permitted to carry this on their person.

6. All items and packages brought for residents are subject to search. Searches shall be conducted by trained staff and follow standard protocol. If inappropriate items are found, they will be disposed of per facility policy.

7. If a resident's physician has determined that having visitors would not be in a resident's best interest on a given day, this shall be explained to the family. When only family visits are permitted (as determined/requested by the resident), friends shall be so advised and not given entrance. (Cross Reference: LHHPP 75-03 Disorderly or Disruptive Visitors and LHHPP 75-10 Security Services Standard Operating Procedures Appendix H)

8. If isolation precautions are required in a resident's room or the care unit, visitors shall be advised of this by the unit's nursing personnel and instructed as to the necessary precautions. (Cross Reference: LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines for Infection Prevention)

9. If visitors object to any general restrictions or specific ones imposed on the resident's behalf, they should be referred to the Nursing Office for special consideration.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-10 Security Services Standard Operating Procedures Appendix H
Appendix PP/Guidance to Surveyors for Long Term Care Facilities, F172 Section 483.10 (f) (4) (vii) – (xi)

Revised: 92/05/20, 12/09/25, 16/11/08, 17/09/12, 22/06/14 (Year/Month/Day)
Original adoption: 88/01/22

~~Visitation will be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.~~

- ~~Residents have the right to define their family. During the admissions process, facility staff will discuss this issue with the resident. If the resident is unable to express or communicate whom they identify as family, facility staff will discuss this with the resident's representative.~~
- ~~The Office of the State Long-Term Care Ombudsman will be given access to examine a resident's medical, social, and administrative records in accordance with State law.~~
- ~~The facility will ensure all visitors enjoy full and equal visitation privileges consistent with resident preferences.~~

- ~~Reasonable clinical and safety restrictions that protect the health and security of all residents and staff, which may include, but are not limited to:~~
  - ~~Placing visitation restrictions to prevent community-associated infection or communicable disease transmission to one or more residents. A residents risk factors for infection (e.g. immunocompromised) or current health state (e.g. end of life care) will be considered when restricting visitors.~~
  - ~~Visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) will be asked to defer visitation until they are no longer potentially infectious (e.g., 24 hours after resolution outbreak of fever without antipyretic medication), or according to CMS or CDC guidelines, and/or local health department recommendations.~~
  - ~~Keeping the facility locked at night with a system in place for allowing visitors approved by the resident.~~
  - ~~Denying access or providing limited and supervised access to a visitor if that individual has been found to be abusing, exploiting, or coercing a resident until an investigation into the allegation has been completed or has been found to be abusing, exploiting, or coercing a resident.~~
  - ~~Denying access to a visitor who has been found to have been committing criminal acts such as theft.~~

- ~~Denying access to visitors who are inebriated and disruptive.~~
- ~~Denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility which places residents' health and safety at risk.~~
  - ~~If the facility determines illegal substances have been brought into the facility by a visitor, the facility will not act as an arm of law enforcement. Rather, in accordance with state laws, these cases will be referred to local law enforcement.~~
  - ~~Facility staff will not conduct searches of a resident or their personal belongings, unless the resident or resident representative agrees to a voluntary search and understands the reason for the search.~~

COACH USE FOR CLOSE OBSERVATION

POLICY:

1. Nursing Services at Laguna Honda Hospital and Rehabilitation Center (LHH) is responsible for providing close observation of residents when needed. The nurse manager/charge nurse in collaboration with Nursing Operations staff are responsible for allocating staff for coach assignment to provide the appropriate level of supervision.

2. Resident behaviors that may require close observation include but are not limited to the following:

    a. High risk for falls

    b. Impulsive behavior

    c. Risk for aggression

    d. Elopement risk

    e. Intrusive behavior

    f. Harm to self or others (See Policy #3)

    g. Other extenuating needs as determined by Resident Care Team (RCT) and with the approval of Nursing Director/Nursing Operations

3. Close observation measures are not intended for residents who are actively suicidal (defined as someone who is verbalizing an intent to harm self and has a plan and means to do so) or in imminent danger of harm to themselves or others, except while awaiting urgent evaluation and/or transfer to a higher level of care setting.

4. The need of a coach is a nursing decision and is intended as a short-term intervention while developing a long-term plan for resident safety.

5. The RCT is responsible for the initial assessment and ongoing evaluation/need for close observation measures.

6. Nurse Director/Supervisor shall approve all coach assignments based upon the RCT assessment.

7. Coaches shall provide continuous close observation of the resident and engage the resident as appropriate and provide all care needs within the scope of their licensure or certification while avoiding any distractions as follows:

a. Speaking in a non-business language or a language the resident does not understand,

b. Using personal cell phone,

c. Reading,

d. Sleeping on the job.

8. LHH Patient Care Assistant (PCA)/ Certified Nursing Assistant (CNA)/Home Health Aide (HHA) are expected to contribute to the electronic health record (EHR) documentation each hour for a resident who is provided with a coach.

9. The team leader/charge nurse is responsible for checking the resident's condition frequently and as needed.

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

PURPOSE:

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

PROCEDURE:

1. Role of the RCT

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

i. Assess the need

- The RCT (at a minimum, the MD and RN) shall review the resident's condition, the specific behaviors that need intervention, and the close observation measures needed to ensure resident safety.

ii. Develop an observation and intervention plan as follows:

- Possible close observation measures may include, but are not limited to:
- Increasing/decreasing the frequency of observation time periods
- Assignment of staff to provide close observation/cohort residents needing close observation

- Develop measurable goal/s related to the use of close observation. iii. Implement the plan
- The nurse manager/charge nurse shall assign staff as permitted, preferably unit staff who have received coach training and know the resident, to promote resident safety while providing direct care needs. The charge nurse/team leader shall round frequently to check on the resident's condition and for updates.

- Any request for additional staff used as coach shall be made through the Nursing Office.

- When a resident's family member or significant other assists with the resident's care and observation, the care plan shall reflect their participation and education. Nursing staff shall maintain overall responsibility for the care provided to the resident, including appropriate education on safety measures to be given to the resident, family and/or staff providing close observation of the resident.

v. Evaluate the plan (Focused Review)

- While close observation is implemented, the RCT shall meet regularlyweekly and at least quarterly to:
    - Review any changes in resident's condition.
    - Assess effectiveness of current interventions.
    - Evaluate resident goals and the need for ongoing close observation.
- The RCT shall summarize each meeting via EHR.
    - The RCT and other consultants which may include Nursing Directors, Quality Management, Clinical Nurse Specialists, Rehab, Psych and Pharmacy staff shall may conduct a Focused Review if a resident has required a coach to provide close observation greater than 30 days.
    - If no progress is made, after 60 days of close observation, resident case shall may be referred to clinical leadership for long term placement.

- If after 60 day **s, the resident continues to require close observation the RCT may decrease focused reviews to monthly while continuing efforts in seeking long term placement.**

vi. **Documentation** (See Attachment A for table reference)

- The coach providing the close observation shall document their observations of the resident's behavior and any interventions each shift via EHR.
- LHH PCA/CNA are expected to complete EHR documentation.
- Observations documented via EHR shall be incorporated in the Weekly or Monthly Summary by the licensed nurse.
- The behavior monitoring flowsheet shall be completed every shift by nursing and other clinical staff as appropriate. Weekly behavior summary shall be completed by the LN via EHR.
- The care plan shall be updated on an ongoing basis and include interventions for addressing the safety needs of the resident, including the need for close observation as an intervention.
- Each RCT meeting shall be documented via EHR and include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.
- Education provided to the resident, resident's family or significant other as related to safety measures shall be documented.

2. Role/Expectations of the Coach Providing Close Observation

a. A coach should be made aware of three important aspects of their assignment:

i. Why they are assigned to the resident.

ii. What goals are identified for this resident.

iii. What interventions can be employed with the resident.

b. The coach may provides close observation for one or more residents (cohort). All coach staff that are LHH employees are expected to perform the duties within their scope of practice specific to LHH for their assigned resident unless specified otherwise. The coach's responsibilities include but are not limited to the following:

i. Reporting to the charge nurse at the start/end of their shift for endorsements and obtaining shift endorsement from outgoing coach.

ii. Close monitoring of assigned resident(s) to prevent resident(s) from injury to self or injury to others.

iii. Engaging the resident with goal-focused resident-centered interventions and ongoing activities.

iv. Observingation, reporting and documentation of resident behavior, including observation of factors that contribute to improving resident's behavior and/or contributes to agitating the resident.antecedants the agitate or improve resident behavior.

v. Provision Providing of nursing care as normally expected of a coachwithin their scope, including which may include feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, skin care and 1 person pivot transfers as ordered..

vi. Ensuring environment is clean and free of clutter, which includes but is not limited to bed making, replenishing of pitcher, and bedside cleaning.

vii. May contributeContributing to the weekly focused reviewsRCT discussions and/or plan of care.

v.

vii. Transporti/ng/escorting residents to internal/external scheduled appointments.

vii.

viii. Other duties as assigned, including specific responses to certain needs of the resident.

ix. Ensure environment is clean and free of clutter, which includes but is not limited to bed making, replenishing of pitcher, and bedside cleaning.

x. c Coaches shall not leave residents unattended under any circumstances and are to use call light to summon for help/breaks/etc..

d Registry coaches shall perform all the duties as outlined in procedure 2above. Registry coaches may assist the LHH nursing assistant or licensed nurse but may not perform the following tasks independently:

xi. with the following, but may not perform independently:

- Feeding residents on a Specialized Feeding Plan
- Showering/bathing

- Use of any equipment or assistive devices for which they have not been trained.

Documentation (See Attachment A for table reference)

- The coach providing the close observation shall document their observations of the resident's behavior and any interventions each shift via EHR.

- LHH PCA/CNA are expected to complete EHR documentation.

- Observations documented via EHR shall be incorporated in the LHH Nursing Weekly Summary by the licensed nurse.

- The behavior monitoring flowsheet shall be completed every shift by nursing and other clinical staff as appropriate. LHH Nursing Weekly Summary shall be completed by the LN via EHR.

- The care plan shall be updated by LN on an ongoing basis and include interventions for addressing the safety needs of the resident, including the need for close observation as an intervention.

- Each RCT meeting shall be documented via EHR and include the reason for the resident's close observation, attempts to wean the resident from close observation by exploring alternative interventions to address resident behaviors, and progress towards meeting goals.

- Education provided to the resident, resident's family or significant other as related to safety measures shall be documented.

ATTACHMENT:
Attachment A: Coach Use for Close Observation Roles and Responsibilities

REFERENCE:
None.

Revised: 21/07/29,00/03/28, 00/11/22, 01/05/10, 01/05/18, 09/06/09, 13/01/29, 16/11/08, 17/11/14, 19/07/09, 19/09/10, 21/10/12 (Year/Month/Day) Original adoption: 98/11/16

Attachment A: Coach Use for Close Observation

Roles and Responsibilities

Role	Responsibility
LHH PCA/CNA	• Responsible for all duties within their scope of practice for assigned resident. • Documents via EHR and communicates resident behaviors to regular CNA and or team. • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet
Registry Coach	Responsible for all CNA dDuties except showering and using equipment without assistance. those listed below. • May assist LHH nursing assistant or licensed nurse but not perform independently: feeding residents on a specialized feeding plan showering/bathing • use any equipment or assistive devices for which they have not been trained Documents via EHR hourly.and • Ccommunicates resident behaviors to regular CNA and or team. • May assist LHH nursing assistant or licensed nurse but not perform independently: o feeding residents on a specialized feeding plan o showering/bathing o use any equipment or assistive devices for which they have not been trained
Regular CNA	• Completes EHR documentation with input from Coach • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet
Charge Nurse/LNs	• Assigns coach based upon available nursing staff. • Gives report to oncoming coach • Completes rounds frequently for updates • • Documents any behaviors in EHR behavior monitoring flowsheet LN will review EHR coach documentation for their shift and • • determine was the coach status initiated, continued or discontinued.
Resident Care Team	• Assesses need for Close Observation • ConductsWeekly: fFocused review to evaluate continued coach needd • May 30 days: pProvides Special focused rReview with consultants •

	• 60 days: May refer to Clinical Leadership for placement
LHH Home Health Aide	• May be assigned to be a coach but may only provide care with in their scope of practice. • Communicates resident behaviors to regular CNA and/ or team members for documentation.

CODE BLUE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide all residents/patients with cardiopulmonary resuscitation (CPR) in the event of an acute cardiac or respiratory arrest if appropriate, including clinic, pavilion acute and rehabilitation department.~~.~~

2. The Code Blue process shall also be utilized for choking events, unless specific directive has been expressed in the resident's/patient's Advanced Directive, stating otherwise. Refer to the NPP L 1.0 Emergency Intervention for Choking Policy and Procedure.

3. The Code Blue process shall be utilized in the event of a resident/patient~~.~~ experiencing Autonomic Dysreflexia (AD), seizure, signs and symptoms of a stroke or when staff feels that the medical emergency could be life threatening.

~~3.~~4. The Code Blue process can be used for residents/patients who are DNR/DNI for emergent, reversible situations and the DNR/DNI status will be confirmed immediately and reported to staff and providers at the bedside, unless Advanced Directive states otherwise and/or resident/patient is on comfort care

~~4.~~5. CPR and interventions for choking and possible opioid overdose shall conform to the American Heart Association's standards approved for Advanced Cardiac Life Support (ACLS) and Basic Life Support (BLS).

~~5.~~6. All licensed nurses and patient care assistants (PCA) ~~and Certified Nursing Asistancts (CNA)~~ shall be trained and remain current in BLS.

~~6.~~7. All physicians with primary care or general on-call duties shall be trained and maintain current ACLS certification.

~~7.~~8. All LHH staff are responsible for initiating Code Blue activities when cardiac or respiratory arrest occurs for residents/patients who do not show obvious clinical signs of irreversible death and:

   a. Who have requested CPR in their advance directives or declared CPR in their code status; or

   b. Who have not formulated an advance directive, or declared a code status; or

   c. Who do not have a valid DNR order.

9. Personnel responding to code blue calls will follow current LHH infection prevention guidelines for resident/patient isolation status.

~~8.~~10. LHH shall maintain staff preparedness by conducting periodic Code Blue drills.

a. Code Blue Drills will be conducted quarterly.
   a. All disciplines that respond to code blue situations will be required to participate in code blue drills, including physicians, nurse managers, nurse directors~~otrs~~, pharmacist, Licensed Nurses (LNs), Respiratory Therapists (RTs) & PCAs/Certified Nursing Assistants (CNAs).
b. The Code Blue Committee, in collaboration with Education & Training, shall develop and implement a schedule identifying the location, shift, and time of the drills and scenarios.

~~9.~~11. Each resident/patient with a documented cardiac arrest who has been resuscitated shall be discharged for further care, unless otherwise expressed via their surrogate decision maker (SDM) or physician. If discharge to another acute hospital is planned, 9-1-1 shall be called for emergency transport. Refer to Appendix 3: 9-1-1 Code Blue Activation Information.

~~10.~~12. A Code Blue Record and Code Blue Checklist shall be completed for every Code Blue event (i.e., whether or not the event is full cardiac or respiratory arrest) and shall be reviewed by the Code Blue Committee.

~~11.~~13. A Code Blue "All Clear" will be called when the resident/patient has either been transferred by EMS, or the medical condition has been stabilized and resident/patient will remain at LHH, or resident/patient has expired and MD has declared death.

~~12.~~14. Any medical emergency which occurs outside the LHH building, or in the Administration building (except Serenity Park, the Chapel, and Gerald Simon Theater), will be a 9-1-1 call (See Attachment 1).

~~13.~~15. A code blue that has been called and is a false alarm, such as resident/patient has been determined to be DNR/DNI and resuscitation efforts will not be performed, alarm was called/pushed in error, or resident/patient does not require emergency intervention. A code blue "cancelled" will be announced overhead.

PURPOSE:

1. To provide clinical care during a medical emergency.

2. To establish guidelines for LHH staff members to respond to a Code Blue event in a rapid, competent, and coordinated manner.

DEFINITION:

Code Blue: Rescue efforts including activating the emergency response system (chain of survival) and CPR activities in the event of a cardiopulmonary arrest or choking.

CPR: An emergency procedure that shall be done without delay to attempt to restore or maintain circulation or respirations during cardiac and/or respiratory arrest.

PROCEDURE:

1. Equipment

a. Crash Carts

~~a.~~i. Crash Carts on units will be plugged into red outlets.

~~i.~~ii. Locations

- South Tower: ~~Marina Suite storage room~~Nurse Station 1 with exception of South 4 where it is located in Nurse Station 2.
- North Tower: ~~Cypress Suite storage room~~Nurse Station 1
- Pavilion Mezzanine SNF: ~~Clean utility room~~Nursing Station
- Pavilion Mezzanine Acute: ~~Medication room~~Nursing Station
- Clinics: Behind the medical nurses' station
- Pavilion Ground Floor: Rehabilitation Department exam room
- Central Supply: Spare crash cart

~~ii.~~iii. Maintenance

- The crash carts on each SNF neighborhoods, acute units, ~~and~~ clinic, and rehab dur~~ru~~ing open hours shall be checked daily by a licensed nurse and maintained in operational condition.

If the crash cart seal is broken, or the cart has been used, the cart shall be returned to Central Supply (Materials Management), and a new crash cart shall be provided.

~~When a crash cart is opened during an emergency, if a pharmacist has responded to the code blue, the pharmacist will return the medication tray to pharmacy.~~

- When a crash cart is opened during an emergency, if a pharmacist has responded to the code blue, the pharmacist will return the medication tray to pharmacy.
- If a crash cart lock is found unsecured, or if a pharmacist is not present at the code blue, nursing will remove the medication tray

and return the tray to pharmacy if pharmacy is open, or place in supplemental drug room if pharmacy is not open.

b. Automated External Defibrillator (AED)

i. Locations

- Respiratory Department (Esplanade Level 1)
- Wellness Center: behind the front desk
- Sheriff's Desk – Main Lobby, Pavilion
- Moran Hall
- Gerald Simon Theater (Hallway)
- Cafeteria (Hallway)
- Kanaley Center

ii. Maintenance

- The AEDs are checked, at a minimum~~, Monday through Friday~~weekly, excluding holidays, by designated department staff.

c. AD Kit (see Appendix 1)

i. Location

- The AD Kit is located in the bottom drawer of the crash cart.
- AD emergency medications shall be placed in the medication drawer of the crash cart in a labeled plastic bag.

d. Magill Forceps (8" and 10"): Stored in the respiratory drawer of the crash cart.

e. Intraosseous access (EZ-IO) and supplies: Stored in the intravenous section of the crash cart.

f. EKG Machine: Stored in Pavilion Mezzanine Acute across from nurses' station.

g. Cervical spine immobilizer board and collar are stored in Pavilion Mezzanine SNF.

2. Initial Code Blue Response

a. Initiating a Code Blue

i. Activating the Emergency Response:

- If in the resident's/patient's room or clinic exam room, activate the Code Blue by pressing the Code Blue button behind the head of the bed or on the wall in the clinic room. After pressing the Code Blue button, call 4-2999.

- The ceiling dome lights in front of the resident's/patient's room and zone lights located at the end of each household shall illuminate flashing lights (scrolling of all bulbs).

ii. If the location of the Code Blue is not in the resident's/patient's room, or occurs in Moran Hall, the Chapel, ~~or~~ Gerald Simon Theater or~~,~~ other areas of the hospital, or ~~areas of~~ the Clinic, call 4-2999.

iii. Accessing 9-1-1 for Code Blue (see Appendix 3)

- Activate 9-1-1 call from the unit where the emergency is occurring.

- Once the 9-1-1 operator answers, follow the operator's instructions.

- Stay calm and speak clearly.

- State your name and your role.
"My name is _____ and I am a nurse on (state your location) at Laguna Honda Hospital".

- State the nature of the emergency.
"We have a medical emergency. A patient is in cardiac arrest and is not breathing".

- State the location of the emergency.
"The patient is located in room _____ or location _____".

- State what interventions are in process.

"A Code Blue has been called and the nurses are starting CPR".

- Wait for further instructions or questions from the 9-1-1 operator. Have the EHR open with this patients chart to provide other demographic information.

- If additional information is asked by the 9-1-1 operator, and you do not

have the information, it is okay to tell the operator "I do not have that information right now". Ask the operator if she/he would like you to try to get the information.

- DO NOT HANG UP OR DISCONNECT THE CALL. Wait for further instructions from the 9-1-1 operator.

b. Nursing and Medical Staff Response

i. If emergency medical assistance is needed the first responder (personnel who first arrives on scene, or witnesses the change in condition) shall initiate a code.

ii. Staff shall assess for resident's/patient's responsiveness, breathing and pulse per BLS Guidelines.

iii. If no pulse, begin Chest **C**ompression, open **A**irway, and assist **B**reathing using the bag/valve/mask connected to oxygen (**C-A-B**).

iv. Apply the defibrillation/STAT pads and use AED function on Zoll Defibrillator.

v. Check for patient's advanced directive code status. If the resident's /patient's code status is designated a Do Not Resuscitate (DNR), notify the physician.

vi. Resuscitation efforts shall be initiated for all persons experiencing a medical emergency in the Wellness Center.

c. Nursing Office Response

i. Once a Code Blue activation call is received, the Nursing Office personnel shall:

- Announce the overhead "Code Blue" page three times.
- Send a text to the Code Blue pagers with the location of the Code Blue.
- Two staff shall be assigned by the supervising nurse to guide the emergency response team to the location of the emergency.
  - 1 – One to wait near the elevator at the site of the emergency
  - 2 – One to wait at the Pavilion Ground Floor Lobby entrance

- Announce the overhead page "Code Blue All Clear" when notified by the neighborhood or location that the Code Blue has been cancelled.

3. Physician Response/Coverage for the Sity of Emergency

a. Physician Staff Response during daytime 0800 to 1700, Monday through Friday

i. Both physicians carrying urgent care pagers will respond to all emergencies throughout the hospital.

~~i.~~

ii. All physicians in the tower with emergency.

- For Pavilion Mezzanine SNF, Pavilion Mezzanine Acute,~~e and~~ Pavilion Mezzanine Acute Rehab and Wellness Center, all Pavilion Mezzanine physicians and South 2 physicians will respond to emergencies.

~~•~~iii. Code Blue Committee Physicians

b. Physician Staff Response Nights/Weekends

~~b.~~i. All in house physicians

4. Nursing Response/Coverage for the Site of Emergency

a. North and South Building

i. Nursing staff from the unit are required to respond to all emergencies on their resp~~o~~ective unit/floor, including elevator and hallway areas.

ii.

North Tower: One licensed nurse ~~from each~~ from North 2 and North 4 ~~neighborhood in the North and South Tower~~ shall respond to~~ the~~ emergenc~~ies~~y ~~in with~~ the North Tower.~~in~~ ~~that building~~the ~~(i.e., South Tower staff RNs/LVNs shall respond to their own tower).~~

~~i.~~ South Tower: One license nurse from South 2 and South 4 shall respond to the emergencies ~~with~~in the South Tower and all other hospital areas.

~~ii.~~iii. A licensed nurse from Pavilion Mezzanine SNF shall respond~~se~~ to each code., ~~and bring the 12-lead EKG machine (located in Pavilion Mezzanine Acute).~~

b. Pavilion [~~(~~including Pavilion Mezzanine SNF, Pavilion Acute Medical and Acute Rehabilitation (also known as the Inpatient Rehabilitation Facility "IRF"), Rehabilitation Department ~~Wellness Center)~~

i. Nursing staff from Pavilion the unit are required to respond to all emergencies on Pavilion.

~~i.~~ii. One licensed nurse from each neighborhood on ~~North 1,~~ North 2, and South 2 shall respond to the emergency.

~~ii.~~iii. ~~When a Code Blue occurs in the Wellness Center, the Pavilion Mezzanine licensed nurses, or Rehabilitation Department personnel shall bring the crash cart to the site.~~

c. **Wellness Center**

i. A licenses nurse from Pavilion Mezzanine SNF, North 2 and South 2 shall respond

ii. When a Code Blue occurs in the Wellness Center, the Pavilion Mezzanine licensed nurses, or Rehabilitation Department personnel shall bring the crash cart to the site.

d. Clinic

i. Nursing staff from the clinic will be required to respond to all emergencies in the clinic.

ii. A licensed nurse from Pavilion Mezzanine SNF, South 2 and South 4 shall respond to the emergency in the clinic.

~~c.~~e. Serenity Park (previously known as Harmony Park)

i. One licensed nurse ~~on each floor of the~~ from North 2 and North 4 ~~Tower~~ and Pavilion Mezzanine SNF shall respond to the emergency.

ii. The Pavilion Mezzanine SNF licensed nurse shall bring the crash cart to the site.

f. ~~3. e.~~ The Chapel, ~~or~~ Gerald Simon and all other indoor areas of main hospital building not addressed above

i. One licensed nurse from ~~each neighborhood in the South Tower~~South 2, ~~and~~ South 4 and Pavilion Mezzanine SNF shall respond to the emergency.

ii. The South 2 licensed nurse shall bring the crash cart to the site.

~~d.~~g. Outside the building (see attachment 9)

i. One licensed nurse from Pavilion Mezzanine SNF and licensed nurses from each neighborhood carrying code blue pagers will respond to the emergency.

ii. If enough staff are present, licensed nurse staff will confirm with supervisor if they may return to their assignment. If determined the person in distress is a resident/patient on your unit, remain at emergency to assist and provide any available information.

h. Calls requiring additional assistance

i. a. When additional assistance is required, unit staff will call the nursing office to page overhead "additional nursing and/or physician support is needed for Code Blue 'at location'."

ii. i. Nurses within the tower should go to the unit and assess if they are needed.

5. Roles and Responsibilities

a. Physician: The first ACLS physician to arrive shall:

i. Be the command physician of the code.

ii. Announce that they have assumed command of the Code Blue.

iii. Coordinate the resuscitation efforts.

iv. Confer with the unit physician, if available, regarding treatment of the patient.

v. Prescribe mode of treatment and medication.

vi. If present, a second physician shall assist the command physician.

vii. Insertion of intraosseous access ~~or central line access~~, when appropriate if unable to obtain IV access or as determined to be the most effective route for rapid treatment. Refer to LHHPP 24-21 Insertion and Maintenance of Intraosseous Device.

b. Nursing:

i. Performs standard roles, including chest compressions, airway, breathing, obtaining intravenous supplies and insertion of IV by RN, preparing medications, administering medications, applying STAT pads to prepare for defibrillation, recording Code Blue events.

ii. Management of the EZ-IO once access is established and placement verified by the physician.

iii. See Appendix 2: Guideline for Code Blue for Nursing Response for further description of nursing roles and responsibilities.

iv. The licensed nurse from the neighborhood with the Code Blue is responsible for ensuring that the crash cart, ~~and~~ emergency box, Workstation on Wheels (WOW) and glucometer is brought to the site of the emergency.

c. Pharmacy:

i. If present during Monday through Friday (non-holidays), a pharmacist shall assist the RN in preparing medications as ordered by the physician.

d. Respiratory Therapy:

i. If present, the Respiratory Therapist shall assist in maintenance of airway, ventilation, 12-lead EKG, and arterial puncture to obtain arterial blood gas as appropriate.

e. Elevator Access

i. Code Blue team members have keys to call for and to override the elevator in a code blue response.

ii. To use the key to the elevator:

- From outside the elevator, insert key and turn key to the right to the "ON" position. A period of 90 seconds is given to override the elevator. Remove the key before entering.

- Once inside the elevator, insert the same key and turn right to the "ON" position. Press "CLOSE DOOR". Wait until the doors are completely closed, then press the desired floor number, while continuously pressing the button for the desired floor (i.e., hold your finger on the button). Leave key in the switch until the desired floor is reached. Turn key to left to the "OFF" position and remove key.

6. Post-Code Blue Activities

a. Unit Charge Nurse & Nursing Operations

i. Notify Central Supply (CSR) at 759-3349 or 4-2760 that a used crash cart is being exchanged for a fully stocked crash cart.
- During off shift hours, nursing operations or designee will bring opened crash cart to Central Supply and retrieve back-up cart and bring to unit.
- Crash cart clip boards remain on unit.

ii. If the emergency drug box was used, the Charge Nurse, or licensed nurse designated by the Charge Nurse, shall return it to the pharmacy to be restocked. If the pharmacy is closed, the nursing supervisor shall sign out a replacement emergency drug box from the supplemental drug room.

iii. Gather staff involved in the Code Blue for a Post Code Huddle (debrief), to discuss what went well during the Code Blue and what areas need improvement.

b. Central Processing and Distribution (CPD)

i. CPD shall fax a notification to the pharmacy to replace the used medication tray and to lock the cart. If the pharmacy is closed, CPD shall notify the nursing supervisor to sign out a sealed complete tray of crash cart medications from the supplemental drug room to replace the used tray. CPD shall then lock the cart with a temporary lock and fax a notification to the pharmacy to check the cart and relock. (See Appendix 4-A: Crash Cart Supplies and Equipment and Appendix 4-B: Crash Carts Medications)

c. Team Physician

i. Notifies the family or legal representative, or delegates this responsibility to the attending physician, and shall document this notification/delegation in the medical record.

ii. If the resident/patient ~~–~~is to be transferred to the acute care hospital, the physician shall notify the emergency department physician regarding the resident's/patient's status.

7. Documentation

a. Designated Recorder (Preferably Registered Nurse):

i. Complete the Code Blue Record (see Appendix 5: Code Blue Record – MR317).

ii. If available, o~~O~~btain a printout of the rhythm strip during the Code Blue, place name and MR # on strip and attach to Code Blue Record. Place Code Blue Record with rhythm strip in box for scanning to medical record.

b. Physician:

i. Reviews and signs the Code Blue Record and the Post Code Blue Checklist.

ii. Writes summary of the Code Blue in the Physician Progress Notes.

c. The Nursing Supervisor, Nurse Manager, or Charge Nurse:

i. Ensures that a designated ~~Registered~~Licensed Nurse is recording the Code Blue events in the Code Blue Record.

ii. Ensures that the Code Blue Record is complete ~~(with EKG strip)~~ and signed by the recording nurse and the command physician.

iii. Ensure that the code blue huddle has occurred, then completes the Post Code Blue Checklist (See Appendix 7).

iv. ~~Bring a copy of the Code Blue Record to Nursing Office and place in Code Blue Committee Mailbox.~~Places original copy in HIM scanning bin and sends a copy of code blue record and post code checklist to DPH-LHHCodeBlueCommittee@sfdph.org.

d. Unit Licensed Nurse:

i. Documents the events leading up to the Code Blue, interventions, and resident/patient outcome in the EHR using the significant event nursing note.

8. Code Blue Drills

a. Each shift shall have a quarterly Code Blue Drill coordinated by Nursing Education.

b. At the beginning of the drill, the Nursing Office Personnel shall announce three times “Code Blue Drill” identifying the location and, at the same time, shall activate pagers of the Code Blue team members.

c. After completion of the drill the Nursing Office Personnel shall be notified to announce “Code Blue drill all clear” three times.

d. A nursing educator or other designated observer shall use two checklists developed by the Code Blue Committee to monitor the Code Blue Drill process.

i. One checklist shall be used to monitor the initial neighborhood response.

ii. The Post-Code Checklist / Medical Quality Assurance (see Appendix 7) shall be used to monitor the process after the Code Blue responder arrive.

e. The Code Blue Drill Record (see Appendix 6), along with comments from the staff, shall be used by the Code Blue Committee to evaluate the drill.

9. Quality Review

a. Nursing Education shall summarize the Code Blue drill records and post-code checklists to review the events, analyze trends, identify problem areas, develop corrective plans, and submit to the Code Blue Committee.

b. The Code Blue Committee shall receive copies of Code Blue drill records and post-code checklists to review during the Code Blue Committee meeting to analyze trends, identify problem areas, and develop corrective plans.

c. The Code Blue Committee Chair shall refer Code Blue events that need additional review to Medical and Nursing QI Committees, Medical Executive Committee, and Performance Improvement and Patient Safety Committee regarding the drills and Code Blue events.

ATTACHMENT:
Appendix 1: Automatic Dysreflexia Protocol
Appendix 2: Guideline for Code Blue for Nursing Response: Roles and Responsibilities
Appendix 3: Accessing 9-1-1 for Code Blue (Script)
Appendix 4-A: Crash Cart Supplies and Equipment (PDF format)
Appendix 4-B: Crash Carts Medications
Appendix 5: Code Blue Record (MR317)
Appendix 6: Code Blue Drill Record
Appendix 7: Post Code Blue Checklist
Appendix 8: Crash Cart Injection Reference Sheet
Appendix 9: Code Blue Outside the LHH Building
Appendix 10: Resident Code Blue Events – Quick Reference
Appendix 11: Emergency Box Contents
Appendix 12: Crash Cart Medication Drawer Contents
~~Appendix 13: Addendum to Code Blue Policy During Pandemic and Protective Quarantine (Approved by LHH HICS COVID-19 Response, May 2020)~~

REFERENCE:
AHA BLS
ACLS Manuals 2015
Code Blue Record MR317 (3/86; 4/09)
LHHPP 24-21 Insertion and Maintenance of Intraosseous Device
NPP L 1.0: Emergency Intervention for Choking
LHH Pharmacy P&P: 02.03.00 Emergency and Supplemental Medication Supplies
MSPP 001-01 Primary Care Procedures & Policies - Physician Services

Revised: 97/06/01, 00/12/14, 02/10/24, 03/11/04, 10/11/09, 11/11/29, 13/01/29, 13/09/24, 15/01/13, 17/05/09, 17/11/14, 19/03/12, 19/05/14, 22/01/11, 22/11/02 (Year/Month/Day)
Original adoption: 97/06/01 as MSPP Code Blue; 98/11/16 as LHHPP Code Blue Drill

Appendix 8:

Crash Cart Injectable Medication Reference
MEDICATION DOSING: IV = IO

Adenosine 6 mg/2ml syringe x 1 syringe/vial; 12 mg/4ml syringe x 2 syringes/vials
- Initial Adenosine dose 6mg (undiluted) IV push over 1-2 seconds
- May repeat 12mg x 2 if needed, follow each dose with 20mL of NS flush

Amiodarone 150mg/3 ml syringe x 3 syringes OR 3 vials
- Amiodarone 300 mg IV push over 2-3 minutes, flush with 20ml of NS
- May give an additional 150mg dose IV push in 3-5 minutes

Atropine 1mg/10ml syringe x 3 syringes
- Atropine is given 0.5-1 mg (undiluted) IV push over 1-2 minutes
- Dose may be repeated at 3-5 minute intervals until desired rate

10% Calcium Cl 1000mg/10ml syringe x 2 syringes
- Calcium chloride 2-4mg/kg (undiluted) IV slow push (<1ml/min)
- May repeat in 10 minutes if necessary

50% Dextrose 25g/50ml syringe x 1 syringe
- Dextrose injection (undiluted) of 20-50ml IV slowly (eg 3ml/minute)

Diphenhydramine 50mg/1ml vial x 1 vial
- Diphenhydramine 25-50mg (undiluted) IV push not to exceed 25mg/min

Epinephrine (1:10,000) 1mg/10ml syringe x 5 syringes or Epinephrine Kit x 5
- Epinephrine 1mg/10ml IV push over 1 minute
- May repeat IV dose every 3-5 minutes as needed
- Epinephrine Kit: Epinephrine 1mg/ml vial, 0.9% Sodium Chloride 10ml, 10ml or 12mL syringe and blunt fill needles - Dilute 1mg/mL of Epinephrine in 10mL of 0.9% Normal Saline. For IV or IO administration.

Furosemide 40mg/4ml vial x 5 vials
- Furosemide 0.5-1mg/kg (undiluted) IV push over 1-2 minutes (maximum rate 20 mg/min)
- If no response, increase dose to 2mg/kg slowly over 1-2 minutes

Lidocaine 2% 100mg/5ml syringe x 4 syringes **FOR LOADING DOSE**
- Lidocaine 1-1.5mg/kg (undiluted) IV push
- May give 0.5-0.75mg/kg every 5-10 minutes as needed up to maximum total loading dose of 3mg/kg

Lidocaine 2% 100mg/5ml VIAL x 1 **FOR IO USE ONLY**
- Infuse 1-2 ml slowly over 30-45 seconds to prevent discomfort in alert patients
- Allow at least 30 seconds after infusing Lidocaine before administering the normal saline flush

Crash Cart Injectable Medication Reference
MEDICATION DOSING: IV = IO

Lorazepam 2mg/ml vial x 2 vials (available in Omnicell **REFRIGERATORS**, and extra vials are available in N2, S2, and Acute Medicine Omnicell **REFRIGERATORS**)

- Lorazepam 4mg IV diluted in 4 ml of NS or D5W given over 2 minutes. Do not exceed 2mg/minute. May be given IM (undiluted) deep into the muscle mass.

Magnesium Sulfate 1g/2ml vial x 2 vials + 0.9% sodium chloride 10 ml x 2

- 1-2g diluted in 10ml of D5W or NS over 1-2 minutes, if ineffective, may repeat immediately

Methylprednisolone 125 mg/2ml vial x 1 vial

- Methylprednisolone125mg (undiluted) IV push slowly over 3-5 minutes

Midazolam Intranasal Kit 5 mg/1ml vial x 2 vial (available in Omnicell)

- 5mg (1 spray) as a single dose in 1 nostril; may repeat same dose in 10 minutes in alternate nostril based on response and tolerability
- Intranasal Midazolam Kit: Midazolam 5mg/mL vial, 3ml syringe, blunt fill needle, atomizer.

Naloxone 0.4mg/1ml vial x 5 vials

- Naloxone 0.4-2mg (undiluted) IV/IM/SQ/IO every 2-3 minutes till response
- Naloxone duration of action limited to 20-60 minutes, repeat doses may be necessary
- After 10mg of Naloxone has been given with no response, stop Naloxone

8.4% Sodium Bicarbonate 50meq/50ml syringe x 1 syringe or vial

- Sodium Bicarbonate 1meq/kg (undiluted) IV push

Verapamil 5mg/2ml vial x 2 vials

- Verapamil 5-10mg (undiluted) IV push over 2 minutes
- Dose may be repeated after 15-30 minutes

References:

1. Lexicomp
2. UptoDate ACLS Algorithm for Adults, updated 4-8-22
3. American Heart Association – ACLS Cardiac Arrest Treatment Algorithm 2015
4. SFGH EZ-IO Administration Policy and Procedure 7/2013

Revised 9/23/13, 9/18/14, 10/2017, 4/2019, 7/2020, 12/2020, 2/2021, 10/2022, 12/2022

Emergency Drug Supply from Pharmacy

Drug	Qty	Exp. Date
Albuterol nebulizer solution unit dose	3	
ASA 81mg chewable tablet	4	
Dextrose 50% 50ml Syr.	2	
Diphenhydramine 50mg/ml 1ml vial	1	
Epinephrine 1mg/ml 1ml vial	3	
Furosemide 40mg/4ml 4ml vial	2	
Glucagon 1mg inj.	1	
Glucose tablet	10	
Methylprednisolone 125mg/2ml vial	2	
Naloxone 0.4mg/ml 1ml amp	2	
Nitroglycerin 0.4mg S.L. tab	25	
Nitroglycerin Oint. 2% 1gm foil pack	3	

Drug	Qty	Exp.Date
Lorazapem 2mg/ml vials	**In Omnicell Refrigerator**	
Midazolam 5mg/ml (intranasal kit)	**In Omnicell**	

Supplies	Qty	Exp.Date
Blunt Needles	5	
6ml Luer Lok syringe	2	
3ml Vanishpoint syringe with 1.5 inch x 22 G needle	2	
3ml Vanishpoint syringe with 1 inch x 25 G needle	2	

L:\SEN\Code Blue\Inspection Cards\ER Box FRONT

Crash Cart Medication Drawer Contents

Item	Quantity
Adenosine 6mg (3 mg/ml 2 ml syringe or vial)	1
Adenosine 12mg (3 mg/ml 4 ml syringe or vial)	2
Amiodarone 150 mg (50 mg/ml 3ml syringe or vial)	3
Aspirin Chewable 81mg	4
Atropine 1 mg (1 mg/10 ml syringe or vial)	3
Calcium Cl 10% 1gm (1 gm/10 ml syringe)	2
Dextrose 50% 25gm (25 gm/ 50 mL syringe or vial)	1
Diphenhydramine 50mg (50 mg/ ml vial)	1
Epinephrine Inj. 1:10,000 (1 mg/ 10 ml syringe) **OR** Epinephrine Kits (Each kit has the following items:)	**5**
Epinephrine Inj 1mg/mL vial	**5**
0.9% Sodium Chloride 10ml	**5**
10 or 12 mL Syringe	**5**
Blunt Fill Needles	**5**
Furosemide 40mg (10 mg/ml 4 ml vial)	5
Lidocaine 2% 100mg (100 mg/5 ml syringe or vial)	3
Lidocaine 2% 100mg/5ml vial (**IO USE ONLY**)	1
Lorazepam 2mg* (2 mg/ml 1 ml vial)	5
Magnesium Sulfate 1gm (1gm/ 2 ml vial) + 0.9% Sodium Chloride 10ml x 2	2
0.9% Sodium Chloride 10ml vial	2
Methylprednisolone 125mg (125 mg/2ml vial)	1
Midazolam Intranasal Kit 5mg** (5mg/ml vial + atomizer)	2
Naloxone 0.4mg (0.4 mg/ml 1 ml vial/ampule)	5
Nitroglycerin SL tablets 0.4mg (25 tablets/vial)	1
Sodium Bicarbonate 50mEq (50 meq/ 50 ml syringe or vial)	1
Verapamil 5mg (2.5 mg/ml 2 ml vial)	2
Medication For Autonomic Dysreflexia	Quantity
Clonidine Tablet 0.1mg	4
Lidocaine Jelly 2% 100mg/5ml	4
Nitroglycerin Ointment 2% 1g foil pack	3

* In Omnicell Refrigerators on Every Unit

** In Omnicell on Every Unit

Supplies	Quantity
Blunt Fill Needles	10
Syringes without needles 3mL	3
Syringes without needles 6ml	3
Syringes without needles 10 or 12ml	3
Syringes without needles 60 mL	1
Alcohol Pads	10
Tourniquet	1
Sharpie Pen	1

HARM REDUCTION

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that provision of services is consistent with the San Francisco Department of Public Health's harm reduction philosophy, and state and federal standards for the provision of person-centered care.

PURPOSE:

To provide strategies that promote healthy behavior and decrease the short/~~ and~~ long-t~~t~~erm adverse consequences of risk behavior, even for those residents who continue to engage in unsafe practices.

SCOPE:

Harm reduction methods and treatment goals shall be used by LHH providers (including contractors), who deliver substance use treatment, mental health treatment, sexually transmitted disease (STD), and HIV/AIDS treatment and prevention services, and/or who serve residents who use drugs or alcohol.

DEFINITION:

Harm Reduction: It is a public health philosophy, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals, their family and community. The Harm Reduction model is person-centered and attempts to reach residents "where they are at," to assist them in making choices that lead toward better health. Harm reduction methods and treatment goals are free of judgment or blame and directly involve the resident in setting their own goals. There is growing evidence in literature to indicate that harm reduction approaches greatly reduce morbidity and mortality associated with risky health behaviors.

Unhealthy practices: Habits or practices that negatively impact one's health. Some examples include: 1) A resident continues to eat an excessive amount of sweets despite having unstable diabetes; 2) A resident continues to smoke despite having a history of stroke but is doing so off campus; 3) A resident continues to drink alcohol despite having liver failure but is not disturbing others.

Unsafe practices: Behaviors that negatively impact the healing environment and recovery of self or others but are not imminently dangerous. Some examples include: 1) A resident who is HIV positive brings used needles to the unit, increasing the risk of needle

stick to others around them; 2) A resident attempts to smoke inside their room; 3) A resident (who is not ~~being~~ aggressive) brings alcohol/drugs or other contraband to the unit and secretly ~~gives it~~provides to ~~another~~ other residents.

Imminently dangerous behavior: Behaviors that if not intervened upon immediately, would cause immediate harm to self or others. For example: 1) A resident attempts to smoke, or use lighters, matches, e-cigarettes, and/or other devices that ignite or fuel a flame, in the presence of or near devices that deliver oxygen to persons; 2) a resident is agitated and waving around a broken bottle while intoxicated).

Trauma informed System: A service system in which all parties involved recognize the widespread impact of trauma on the clients they serve and makes an effort to avoid re-traumatization while providing services. This approach includes the principals of safety, choice, collaboration, trustworthiness and empowerment. Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing Trauma-Informed Care.

Motivational Interviewing: A counseling technique that uses the stages ~~cycle~~ of change to determine readiness, focuses on exploring and resolving ambivalence (sometimes you just have to live with ambivalence and accept it and move on), and centers on motivational processes within the individual that facilitate change

~~Cycle~~**Stages of Change:** The transtheoretical model posits that health behavior change involves progress through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and relapse.

RATIONALE:

Harm reduction is a public health strategy that was developed initially for adults with substance ~~ab~~use problems for whom abstinence was not feasible. People are more responsive to culturally competent, non-judgmental services, delivered in a manner that demonstrates respect for individual dignity, personal strengths, and self-determination.

Service providers are responsible to the wider community for delivering interventions, which attempt to reduce the economic, social, and physical consequences of drug and alcohol related harm and harms associated with other behaviors or practices that put individuals at risk.

Those engaged in unhealthy or unsafe practices are often difficult to reach by offering 'traditional services', (e.g. abstinence-oriented treatment) therefore, the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with those individuals who are unable or not yet willing to engage

in treatment services. At LHH, this means that comprehensive treatments need to include strategies that reduce harm for residents who come for medical treatment but may be unable or not yet willing to modify their unsafe practices.

Relapse or periods of return to unsafe health practices are an expected part~~stage~~ in the stages~~cycle~~ of change and shall not be equated with or conceptualized as "failure of treatment", nor as "failure of resident."

Each service area within the system of comprehensive services at LHH can be strengthened by working collaboratively with other areas in the system. Harm Reduction methods are most effective when applied consistently across all services and providers.

People change in incremental ways and must be offered a range of treatment outcomes in a continuum of care from reducing unsafe practices (including but not limited to: changes in routes of administration, decrease in frequency of practices, use of alternative substances, or reduction of medical risks from practices) ~~to~~to the ultimate goal of abstaining from unsafe practices.

PROCEDURE:

1. Provision of Services

a. Service goals shall be determined through collaboration between the resident and resident representatives, the staff, and the program, establishing realistic measurements of success, for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care[42 CFR § 483.40].

b. Providers shall expand service options within existing programs or collaborate with other service agencies to be able to respond to residents and their ~~special~~ individualized needs.

c. As LHH is part of the San Francisco Health Network and a safety net institution, access to LHH services is allowed even for residents who are unable or not yet willing to abstain from unsafe practices on the LHH campus including the designated smoking area, provided that LHH can provide safe and adequate care for the resident.

d. Providers shall not deny services to individuals for exhibiting behaviors for which they seek or need help.

e. Residents shall not be denied access to, restricted from participation in, or terminated from, services on the basis of their use of ~~prescribed medications~~illicit substances.

f. Provider language shall not reflect bias toward personal behaviors, experiences, ethnicity, sexual orientation, or personal choices.

g. Programs shall broaden their treatment philosophies in order to provide quality, comprehensive care and coordinate care with other health care service providers.

2. Interventions

a. Initiation and Resident Education

i. Clinical interventions shall be individualized based on the safety risk assessment, differentiating approaches for unhealthy practices and unsafe practices.

ii. The provider shall:

- Meet with the resident to acknowledge and address the resident's unsafe practice(s), assess where the resident is in relation to the stages ~~cycle~~ of change, as well as how their current behavior ~~it~~ relates to the ~~resident's~~ir recovery goal(s) and goal(s) for that session in particular.

- Provide and document resident education regarding risk of unsafe practice(s) to increase resident awareness, reduce the risk of negative consequences, and help resident in making an informed decision regarding unhealthy and unsafe habits. Education and training opportunities shall include reference to LHH's harm reduction philosophy as appropriate to the education and training content/topic. Education provided shall be documented in electronic health record by the discipline providing the education.

- Utilize the principles in Trauma Informed System through mindfulness and awareness, and recognize personal trauma and triggers, and its impact to present behavior and coping skills. Use a "~~what~~ What has happened to you?" rather than, "What's wrong with you?", perspective in developing plan of care to our residents.

- ~~I~~Include motivational strategies (e.g. motivational interviewing) to explore residents' ambivalence regarding their willingness to change,.meanwhile~~that~~ ~~reduce~~

reducing the harm for those residents who are unable to or not yet willing to stop unsafe practices~~. To explore their ambivalence regarding the possibility of change.~~

- Along with the Resident Care Team (RCT), ensure that clinical interventions and initiated care plans are person-centered and shall take the resident's own goals and values into consideration.

b. Monitoring and Follow Up

i. Providers shall make a reasonable attempt, within the context of their programs, to follow-up with residents who demonstrate an inability or unwillingness to participate in treatment, and prior to discharge, make a reasonable attempt to find additional or alternative treatment.

ii. Providers shall recognize relapse, or a return to unsafe practices as part of the recovery process, not as a "failure of treatment" or "failure of resident." but an anticipated stage in the stage~~cycle~~ of change.

iii. Successes shall be measured to include incremental improvement in housing, physical and mental health, finance, employment and family and social support system.

iv. In the event that a resident is so impaired and/or uncooperative to present imminent danger to self or others, the provider shall follow LHHPP 22-10 Management of Resident Aggression in managing the situation.

v. The RCT will conduct a regular evaluation of the resident risk factors~~Evaluation of risk factors shall be completed by the RCT at a minimum every quarter, and shall be~~ and discuss~~ed~~ with the resident or representative during the Resident Care Conference.

~~**Quality Assurance**~~

~~Performance measures shall be established to assure implementation, compliance, and continuous improvement in adopting harm reduction approach.~~

~~Documentation audits shall include a monthly neighborhood review of residents undergoing a harm reduction program to verify that:~~

~~c. Harm reduction education was provided to the resident and documented.~~

~~d. Care plan was initiated and updated as needed.~~

~~e. Monthly neighborhood review of harm reduction plans shall be reported to Nursing Quality Improvement Committee.~~

ATTACHMENT:
None.

REFERENCE:
42 CFR Section 483.40 Behavioral Health Services
San Francisco Health Commission Resolution No. 10-00: Adopting a Harm Reduction Policy for Substance Abuse, STD and HIV
https://www.sfdph.org/dph/files/hc/HCRes/Resolutions/2000Res/HCRes10-00.shtml
LHHPP 01-00 Value, Mission and Vision Statement
https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.
https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/iecmhc-cog1.pdf.
LHHPP 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units
LHHPP 22-03 Resident Rights
LHHPP 22-10 Management of Resident Aggression

Revised: 19/03/12, 19/07/09 (Year/Month/Day)
Original adoption: 18/01/09

BEHAVIORAL HEALTH CARE AND SERVICES

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to ensure all residents receive necessary behavioral health care and services to assist them in reaching and maintaining their highest level of physicial, mental and psychosocial functioning.

PURPOSE:

To establish Policies and Procedures to ensure that LHH provides necessary behavioral health care and services which include[CMS DHHS SOM (§483.40)]:

a. Ensuring that the necessary care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;
b. Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being;
c. Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests, preferences, etc. and enhance the resident's well-being;
d. Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;
e. Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated.

DEFINITIONS:

1. **Highest practicable physical, mental, and psychosocial well-being**
   This is defined as the highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

2. **Mental Disorder**

   Mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

3. **Substance Use Disorder (SUD)**

Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability and failure to meet major responsibilities at work, school, or home. (Adapted from: Substance Abuse and Mental Health Services Administration (SAMHSA) definition found at http://www.samhsa.gov/disorders/substance-use).

4. **Trauma**
   Trauma is defined as results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

5. **Post-traumatic stress disorder (PTSD)**
   Post-traumatic stress disorder occurs in some individuals who have encountered a shocking, scary, or dangerous situation. Symptoms usually begin early, within three months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD.

6. **Depression:**
   Depression (major depressive disorder) is a common and serious medical illness that negatively affects how an individual feels, the way they think and act. Depression causes feelings of sadness and/or a loss of interest in activities once enjoyed. It can lead to a variety of emotional and physical problems and can decrease a person's ability to function at work and at home.

   Although people experience losses, it does not necessarily mean that they will become depressed. Depression is not a natural part of aging, however, older adults are at an increased risk. Symptoms may include fatigue, sleep and appetite disturbances, agitation, expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation. Late life depression may be harder to identify due to a resident's cognitive impairment, loss of functional ability, the complexity of multiple chronic medical problems that compound the problem, and the loss of significant relationships and roles in their life. Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established.

7. **Anxiety and Anxiety Disorders**
   Anxiety is a common reaction to stress that involves occasional worry about circumstantial events. Anxiety disorders, however, include symptoms such as excessive fear and intense anxiety and can cause significant distress. Anxiety disorders are prevalent among older adults and may cause debilitating symptoms. The distinction between general anxiety and an anxiety disorder is subtle and can be difficult to identify. Accurate diagnosis by a qualified professional is essential. Anxiety can be triggered by loss of function, changes in relationships, relocation, or medical illness. Importantly, anxiety may also be a symptom of other disorders, such as dementia, and care must be taken to ensure that other disorders are not inadvertently misdiagnosed as an anxiety disorder (or vice versa).

6 . Non-pharmacological Intervention:
Non-pharmacological intervention refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being.

BACKGROUND:

Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment.
3. The facility will ensure that necessary behavioral health care and services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.
4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.
5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports based upon residents' individual needs, include, but are not limited to:
   a. Depression – It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.
   b. Anxiety and Anxiety Disorders – There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-Traumatic Stress Disorder.
   c. Schizophrenia – It is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.
   d. Bipolar Disorder – It is a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly.

6. All LHH staff have the responsibility to help residents meeting their behavioral health care needs.

PROCEDURE:

1. Assessment and Reassessment

a. LHH utilizes the comprehensive assessment and reassessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes, but is not limited to:
   i. PASARR screening.
   ii. Obtaining history and prior level of functioning from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health.
   iii. Ongoing monitoring of mood and behavior, including identifying individual resident responses to stressors
   iv. Care plan development and implementation.
   v. Evaluation.

b. The resident, and as appropriate the resident's family, are included in the comprehensive assessment and reassessment process along with the interdisciplinary team and outside sources, as indicated.

2. Care Planning

The care plan shall:

a. Have interventions that are person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.

b. Provide for meaningful activities which promote engagement and positive, meaningful relationships. Residents living with mental health and SUDs may require different activities than other nursing home residents. The facility will ensure that activities are provided to meet the needs of these residents.

c. Reflect the resident's goals for care.

d. Account for the resident's experiences and preferences.

e. Maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.

f. Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated.

g. Address any other individualized needs the resident may have related to the mental disorder or the SUD. This includes incorporating behavioral plan recommendations (if any) from LHH Psychiatry providers working with the resident.

h. Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.

3. Interventions, Monitoring and Documentation

a. LHH Resident Care Teams (RCT) shall implement person-centered care approaches designed to meet the individual goals and needs of each resident. These may include achieving expected improvements or maintaining the expected stable rate of decline based on the progression of the resident's diagnosed condition.

b. Individualized, person-centered approaches to care should be implemented based upon the comprehensive assessment, in accordance with the resident's customary daily routine, life-long patterns, interests, preferences, and choices. These shall be implemented to address expressions or indications of distress. Feedback from the the resident, resident's family, and/or representative(s) shall be included when possible.

c. The RCT shall be aware of potential underlying causes and/or triggers that may lead to expressions or indications of distress. Identifying the frequency, intensity, duration, and impact of a resident's expressions or indications of distress, as well as the location, surroundings or situation in which they occur, may help the RCT identify individualized interventions or approaches to care to support the resident's needs.

d. Individualized, non-pharmacological interventions shall be developed and implemented to help meet behavioral health needs of all ages. These may include, but are not limited to:
   i. Ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite);
   ii. Encouraging exercise;
   iii. Providing pain relief;
   iv. Individualizing sleep and dining routines;
   v. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation;
   vi. Adjusting the environment to be more individually preferred or homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);
   vii. Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment when possible);
   viii. Supporting the resident through meaningful activities that match his/her individual abilities, interests and needs, based upon the comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns;
   ix. Assisting the resident outdoors in the sunshine and fresh air (e.g. in a non-smoking area for a non-smoking resident);

x. Providing access to pets or animals for the resident who enjoys pets (e.g. a cat for a resident who used to have a cat of their own);
xi. Assisting the resident to participate in activities that support their spiritual needs;
xii. Assisting with the opportunity for meditation and associated physical activity (e.g. chair yoga);
xiii. Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident's experience is real to her/him;
xiv. Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing;
xv. Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible (see MSPP D08-07 LHH Substance Treatment and Recovery Services).
xvi. Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy (see MSPP D08-03 Access to LHH Psychiatry services); and
xvii. Providing support with skills related to verbal de-escalation, coping skills, and stress management.

e. RCT shall monitor the effectiveness of the interventions, changing those approaches, if needed, in accordance with current standards of practice. Additionally, staff shall accurately document these actions in the resident's medical record and provide ongoing assessment as to whether they are improving or stabilizing the resident's status or causing adverse consequences.

f. If indicated, referrals for LHH Psychiatry services can be made (see MSPP D08-02 LHH Psychiatry Scope of Services and Organization; MSPP D08-03 Access to LHH Psychiatry Services).
   i. Services by LHH Psychiatry providers (and related policies) include:
      - psychotropic medication management (MSPP D01-05)
      - mental health services (MSPP D08-09)
      - substance treatment and recovery services (STARS, including Non-specialty outreach and engagement of resident with SUDs and specialty substance treatment, MSPP D08-07)
      - neuropsychological and psychological testing services (MSPP D08-08)
      - behavioral management services (including behavioral consultation, behavioral planning, and Health and Behavior Services, MSPP D08-10)

   ii. Recommendations from and interventions by LHH Psychiatry providers shall be incorporated into the resident's care plan through collaboration between the RCT and LHH Psychiatry providers.

g. The Therapeutic Care Team (TCT) under the Behavioral Response Team Department helps create and maintain a safe, equitable, and therapeutic care

environment for LHH residents and assist staff to recognize early signs and symptoms of escalation and other at-risk behaviors. TCT provides culturally appropriate, non-violent crisis intervention training, and individualized de-escalation techniques while collaborating with multidisciplinary staff to ensure consistent response from resident care team. TCT collaborates with RCT and LHH Psychiatry team to problem solve around incorporating behavioral management recommendations from Psychiatry providers into care plans as well as intervention implementation.

h. Residents who exhibit behaviors which could endanger themselves, other residents, or staff may benefit from a behavioral plan to ensure they are receiving appropriate services and interventions to meet their needs.

   i. Upon admission of a new resident, the Unit Nurse Manager or designee will determine if the resident's behaviors may benefit from a behavioral plan.

   ii. Within twenty-four hours of admission, the Unit Nurse Manager or designee should develop an interim behavioral plan, until the comprehensive assessment and care plan are developed. Any behavioral interventions should also be included in the baseline care plan.

   iii. The interdisciplinary team, including the resident, and as appropriate the resident's family, should develop a behavioral plan with identified behaviors through the RAI (Resident Assessment Instrument) process.

   iv. Information regarding the resident's usual routine may be gathered from the pre-screening application tool, from the resident and family members, and/or the comprehensive assessment.

   v. Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions.

   vi. Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care.

   vii. The care plan and behavioral plan should be reviewed at least quarterly for continued need of behavior management and appropriate interventions.

i. A behavioral plan may include a behavioral contract. If a behavioral contract is used, it will only be used with residents who have the capacity to understand it. A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract will not conflict with resident rights or other requirements of participation.

   i. Resident refusal to accept, or non-adherence to the terms of a behavioral contract, will not be the sole basis for a denial of admission, transfer or discharge.

   ii. A behavioral contract can include a schedule of daily life events, which addresses the individuality of the resident. The contract should reflect the resident's personal preferences and usual routine, to the extent possible. The

contract should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet the resident's highest practicable well-being.

iii. If a contract is used, it may also address:
   1) The resident's right to have a leave of absence and the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA).
   2) Facility efforts to help residents with mental disorder and/or SUD, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable.
   3) Steps the facility may take if substance use is suspected, which may include:
      - Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents.
      - Restricted or supervised visitation, if the resident's visitor(s) are deemed to be a danger to the resident, other residents, and/or staff.
      - Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident's condition.
      - Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others.
   4) Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons.

j. For psychiatric emergencies, refer to 22-09 Psychiatric Emergencies. For other behavioral management related practices, refer to relevant hospital policies, such as: HWPP 24-25 Harm Reduction, HWPP 24-26 Dementia Care, HWPP 24-12 Laguna Premier Club: A Neurobehavioral Day Program, HWPP 22-09 Resident Activities, HWPP 22-10 Management of Resident Aggression, HWPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use By Residents or Visitors.

k. All assessment, care plans, interventions, revisions and referrals shall be documented in the electronic health record (EHR).

4. Staff Training

All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment. Behavioral health training as determined by the facility assessment will include, but is not limited to, the competencies and skills necessary to provide the following:

a. Person-centered care and services that reflect the resident's goals for care.
b. Interpersonal communication that promotes mental and psychosocial well-being.
c. Meaningful activities which promote engagement and positive meaningful relationships.

d. An environment and atmosphere that is conducive to mental and psychosocial well-being.
e. Individualized, non-pharmacological approaches to care.
f. Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, substance use disorder, or other behavioral health conditions.
g. Care specific to the individual needs of residents that are diagnosed with dementia.
h. Care specific to residents with ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care.

ATTACHMENT:

REFERENCES:

1. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F740 – Behavioral Health Services. 42 C.F.R. §483.40.
2. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F741 – Sufficient/Competent Staff - Behavioral Health Needs. 42 C.F.R. §483.40.
3. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F742 – Treatment for Mental/Psychosocial Concerns. 42 C.F.R. §483.40.
4. Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F949 – Behavioral Health Training. 42 C.F.R. §483.95.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013
6. HWPP 24-25 Harm Reduction
7. HWPP 24-26 Dementia Care
8. HWPP 24-12 Laguna Premier Club: A Neurobehavioral Day Program
9. HWPP 22-09 Resident Activities
10. HWPP 22-10 Management of Resident Aggression
11. HWPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use By Residents or Visitors.
12. HWPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) and Resident Care Conference (RCC)
13. MSPP D08-02 LHH Psychiatry Scope of Services and Organization
14. MSPP D08-03 Access to LHH Psychiatry Services
15. MSPP D01-05 Psychotropic Medication Management
16. MSPP D08-09 Mental Health Services

17. MSPP D08-07 Subtance Treatment and Recovery Servicies
18. 22-09 Psychiatric Emergencies
19. Therapeutic Activity Programming policies

Most recent review: 2022/12/01 (Year/Month/Day)
Revised:
Original adoption: 2022/12/13

PAIN RECOGNITION, ASSESSMENT, AND MANAGEMENT

POLICY:

1. LHH must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. [CMS §483.25]
2. Pain is regularly assessed and reassessed per the RAI process, as clinically determined by the Licensed Nurse (LN) (see procedure section), and according to the resident's/patient's treatment modalities (see Pain Assessment/Pain Reassessment section).
3. CNAs/PCAs, under the direction of the LN, may assist to monitor the resident's/patient's self-report of pain intensity and possible pain behaviors, and will report these findings to the LN for further pain assessment and management.
4. When pain is identified, an interdisciplinary and individualized pain management plan will be developed as part of the resident's/patient's Pain Care Plan.
5. The Verbal Descriptor Scale is the preferred method for assessing and reassessing pain intensity for residents/patients able to self-report pain and who have the cognitive ability to understand instructions of how to report their pain.
6. LHH utilizes the Pain Assessment IN Advanced Dementia (PAINAD) scale which is the preferred method for assessing and reassessing pain in residents/patients who do not have the functional ability to verbally report their pain, and for residents/patients who do not have the cognitive ability to verbally report their pain.
7. LHH continuously monitors and improves its performance in managing residents'/patients' pain through its Pain Committee and via Performance Improvement activities through its reporting structure up to the PIPS Committee at a minimum of quarterly.

~~1. Residents have the right to appropriate assessment and management of pain.~~

~~2. Pain is regularly (re)assessed assessed and reassessed at a minimum of every shift at a minimum and as clinically indicated (see procedure section) by the Licensed Nurse (see procedure section).~~

~~3. When pain is identified, an interdisciplinary and individualized pain management plan is will be developed as part of the resident's Pain care Care planPlan. Complementary therapies will be implemented first for chronic pain.~~

~~The Verbal Descriptor Scale is the preferred method for (re)assessing assessing and reassessing pain intensity for residents/patients able to self-report pain and who have the cognitive ability to understand instructions of how to report their pain.~~

~~4. The Pain Assessment IN Advanced Dementia (PAINAD) scale is the preferred method for assessing and reassessing pain in residents who do not have the functional ability~~

to verbally report their pain and for resident who do not have the cognitive ability to verbally report their pain.

5. For residents receiving opioid therapy for chronic pain, see see MSPP XXXX Prescribing Controlled Substances for Chronic Pain Management.

6. Laguna Honda Hospital and Rehabilitation Center (LHH) continuously monitors and improves its performance in managing residents' pain through its Pain Committee and via Performance Improvement activities.

PURPOSE:

To describe a systematic approach for recognition, assessment, treatment, and monitoring of pain in order for LHH residents/patients to effectively manage their pain and promote the resident's/patient's quality of life and functional ability. [CMS §483.25]

To describe the assessment, management, and performance improvement monitoring processes for LHH residents/patients to effectively manage their pain in order to promote the resident's quality of life and functional ability, and to ensure that care is provided in a manner that is consistent with regulatory requirements

1. To enhance the resident's functional ability and quality of life.

2. To identify and eliminate barriers to effective pain management.

3. To comply with licensing and certification requirements.

TABLE OF CONTENTS

~~DEFINITION AND OTHER RELEVANT INFORMATION:~~

~~1. Pain:~~

~~a. An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (APS, 1999; IASP1994).~~

~~b. There are no biological markers of pain.~~

~~2. Acute Pain:~~

~~a. Follows injury or procedures and generally disappears when the injury heals.~~

~~b. Generally associated with autonomic nervous system activation (i.e. tachycardia, hypertension, diaphoresis, pallor and mydriasis).~~

~~c. To defer analgesia until the etiology of acute pain is diagnosed is rarely justifiable (APS, 1999).~~

~~3. Chronic Or Persistent Pain (AGS, 2009):~~

~~a. Pain lasting more than 3 months or beyond the expected time for healing which may or may not have an easily identifiable pathologic basis.~~

~~4. Addiction:~~

~~a. Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, compulsive use despite harm, and craving (Consensus statement American Academy of Pain Management, American Pain Society and American Society of Addiction Medicine, 2001).~~

~~5. Physical Dependence:~~

~~a. Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist. (Consensus statement American Academy of Pain Management, American Pain Society and American Society of Addiction Medicine, 2001).~~

~~6. Tolerance:~~

~~a. Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time (Consensus~~

~~statement American Academy of Pain Management, American Pain Society and American Society of Addiction Medicine, 2001).~~

PROCEDURE:

A. Pain Recognition ~~Assessment~~

1. In order to help the resident/patient attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being, and to prevent or manage pain, the facility will:
   a. Recognize when the resident/patient is experiencing pain and identify circumstances when the pain can be anticipated.
   b. Evaluate the resident/patient for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g., after a fall, change in behavior or mental status, new pain or an exacerbation of pain).
   c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's/patient's goals and preferences.

2. RCT staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to:
   a. Change in gait (e.g., limping), skin color, vital signs (e.g., increased heart rate, respirations, and/or blood pressure), perspiration
   b. Loss of function or inability to perform activities of daily living (ADLs) (e.g., rubbing a specific location of the body, or guarding a limb or other body parts)
   c. Fidgeting, increased or recurring restlessness
   d. Facial expressions (e.g., grimacing, frowning, fright, or clenching of the jaw)
   e. Behaviors such as: resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities
   f. Difficulty eating or loss of appetite
   g. Weight loss
   h. Difficulty sleeping (insomnia)
   i. Negative vocalizations (e.g., yelling, groaning, crying, whimpering, or screaming)
   j. Decline in activity level
   k. Skin conditions

~~1.~~

B. Pain Assessment and Reassessment:

1. LHH will use a pain assessment tool which is appropriate for the resident's/patient's cognitive status, to assist staff in consistent assessment/reassessment of the resident's/patient's pain.
   a. For residents/patients able to self-report pain intensity, the Verbal Descriptor Scale is the preferred method, however, the staff may use the Numerical Rating Scale when the resident/patient can more easily report their pain

through that method (See Appendix A).

b. The LN will utilize the PAINAD to assess possible pain behaviors for cognitively impaired residents/patients who cannot reliably report pain or for residents who do not have verbal function to be able to report pain (e.g., severe receptive or expressive aphasia) (See Appendix B).

2. For non-English speaking residents/patients who read in their native language, use the appropriate translated Laguna Honda Pain Intensity Scales (see Appendix A for English, Spanish and Chinese versions).
   a. Additional assessment information may require an interpreter to interview the resident.
3. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate member of the interdisciplinary team may necessitate gathering the following information, as applicable to the resident/patient.
   a. Pain intensity
   b. Duration of pain
   c. Frequency
   d. Location
   e. Timing
   f. Pattern (e.g., constant, or intermittent)
   g. Radiation of pain
   h. Descriptors (e.g., stabbing, aching, pressure, dull, etc.)
   i. Impact of pain on quality of life
   j. The resident's/patient's goals for pain management
   k. Physical or psychosocial issues that might be causing or exacerbating the pain
   l. Additional symptoms associated with the pain (e.g., nausea, anxiety)
   m. Treatment modalities that have been effective in managing the pain in the past

~~1.~~ **LN Role-Frequency of Pain Assessment (SNF/Long-Term Care Areas)**

4.

~~Licensed Nursing staff~~

For all Skilled Nursing Facility (SNF) admissions, the ~~nurse~~ LN will complete the SNF Nursing Admission Pain Assessment ~~within the Admission Navigator~~.

a.

b. As part of the RAI process, the ~~nursing~~ LN ~~N staff screens/~~assesses for pain by completing the MDS pain interview for residents able to communicate verbally, and with the following frequency;
   i. ~~, at~~ On admission,~~;~~
   ii. Q~~q~~uarterly,
   iii. A~~a~~nnually,
   iv. ~~and w~~With a ~~condition~~ change in condition.
   v. For residents unable to self-report pain during the RAI process, staff observation of possible pain-related behaviors ~~are~~is ~~recorded~~assessed

and documented.

c. Upon resident readmission

d. Prior to administering routine medication ordered to treat pain

e. Before and within 1 hour after PRN medication to treat pain

f. Anticipatory Pain: The LN will assess the resident/patient for the potential for pain prior to treatments/interventions that may induce discomfort, and administer pharmacologic treatment per physician order prior to such treatments as appropriate (e.g., wound care, rehabilitation therapies, range of motion, etc.).

~~a.~~

~~For acute units, the nurse will complete the Comprehensive Pain Assessment Form.~~

5. **LN Role-Frequency of Pain Reassessment (SNF/Long-Term Care Areas)**

a. The LN will reassess and document the pain location and pain intensity within one-hour after each PRN medication to treat pain.

b. The LN will reassess the resident's/patient's pain during treatments that might cause discomfort, assessing whether the pharmacologic treatment has been effective, and consult with the RCT when treatment modalities may need modification.

6. **LN Role-Frequency of Pain Assessment and Reassessment (Acute Unit)**

a. Pain Assessment/Reassessment will be completed;

~~At a minimum every shift on Acute Rehab, every 4 hours on Acute Medical, and admission~~

i. Prior to administering routine and prn medication to treat pain

- The LN will reassess and document the pain location and pain intensity within one-hour after each PRN medication to treat pain.

~~Before and within 1 hour after PRN medication to treat pain~~

ii. When clinically indicated (e.g., if patient exhibits behaviors that may indicate pain, with any change in condition with onset of pain, with treatments/procedures when pain is anticipated to occur, after pain interventions, etc.)

iii. For pain documentation in the LHH Acute Unit, refer to the Nursing Policy, Documentation of Care – Acute Unit.

7. **CNA/PCA Role in Monitoring Pain**

a. CNAs/PCAs, under the direction of the LN, may assist to monitor the resident's/patient's self-report of pain intensity (e.g., Verbal Descriptor Scale or Numerical Rating Scale) and possible pain behaviors observed during care, and report these findings to the LN for further pain assessment and management.

~~a.~~8. **Medical Staff Role~~Medical staff~~ ~~Physicians~~**

a. Perform a complete past medical history and physical examination which includes review of conditions commonly associated with pain~~:~~.

~~i.~~

~~ii.~~b. Review medication ~~regimen;~~regimen.

~~iii. Evaluate past medical history for conditions commonly associated with pain (e.g., arthritis, orthopedic injuries, peripheral vascular disease, advanced cancer, AIDS etc.); and~~

~~iv.~~c. Obtain tests to guide diagnosis and treatment of painful conditions as appropriate~~indicated~~.

d. Determine if the resident/patient has a history of substance use disorder (SUD)~~and~~ if known, opioid diversion~~,~~ and any considerations that the SUD might have on the resident's/patient's pain management plan.

~~2.~~ **Other ~~Resident~~ Care Team ~~(RCT)~~ Members**

~~9.~~

~~1.~~ In addition to the LN and physician, ~~O~~other ~~RCT~~ care team members ~~such as the Certified Nursing Assistant/Patient Care Assistance (CNA/PCA), sSocial Wworker (SW), Aactivity Ttherapist (AT), dietitian, and rehabilitation therapists~~ and staff may recognize the presence of pain as part of their initial and ongoing assessment process using some of the following strategies:

a.

~~v.~~i. Interviewing the resident's/patient's or family ~~caregiver;~~caregiver.

~~vi.~~ Inquiring of family caregivers how they recognize the resident/patient is in pain~~;~~. ~~and~~

ii.

iii. Observing the resident/patient in recreational or therapeutic activities.~~:~~

~~vii.~~iv. Observing whether the resident/patient might be experiencing any pain-related behaviors during care and treatment.

~~2.~~ **~~C. Pain Reassessment~~**

~~a. Monitor pain intensity at a minimum of every shift utilizing the appropriate pain assessment scale for the resident's/patient's functional and cognitive ability. (Verbal Descriptor Scale is preferred) each time vital signs are measured except as noted below.~~

i. Exceptions: If resident requires frequent V.S. measurement for a procedure (e.g. blood transfusion) or post injury (e.g. post fall with neuro checks), pain is assessed at the beginning and completion of the assessment process.

For non-English speaking residents who read in their native language, use the appropriate translated Laguna Honda Pain Intensity Scales (see Appendix A for English, Spanish and Chinese versions).

b. Additional assessment information may require an interpreter to interview the resident.

c. Reassess and document pain location and pain intensity before as needed (PRN) medications, PRN, and record pain intensity only within theone hour after each PRN medication administered.

d. Nursing assistantsCNAs/PCAs may monitor/record the residents' self-reports of pain intensity and report increased pain scores and possible pain behaviors to the licensed nurseLN for further assessment and management.

e. For residents able to self-report pain intensity, either the Verbal Descriptor Scale or Numeric Rating Scale, may be used. (Refer to Appendix A.)

Use the PAINAD to compute assess possible pain behaviors score for severely cognitively impaired residents who cannot reliably report pain or for residents who do not have verbal function to be able to report pain (e.g., severe receptive or expressive aphasia). (See Appendix B.)

Anticipatory Pain

The LN will assess the resident for the potential for pain prior to treatment interventions that may induce discomfort, and will administer pharmacologic treatment per physician order prior to such treatments as indicated (e.g., wound care, rehabilitation therapies, mobilization, etc.),

The LN will assess during such treatments whether the pharmacologic treatment has been effective to proceed with the treatment.

f. If the pharmacologic treatment has not been successful in managing the resident's pain, the LN will cease the treatment until discussing with the physician an alternate or additional pharmacologic therapy.

3. **Pain Management**

1. Resident-Centered/Patient-Centered pain management Principles of Pain Managementinterventions will be incorporated into the components of the Pain Care Plan, addressing conditions or situations that may be associated with pain, and which may include a specific pain management need or goal.

1. The RCT and resident/patient and/or resident's/patient's representative will collaborate to arrive at a pertinent realistic and measurable goal for pain treatment.

2.

~~i.~~a. The goals and interventions developed to manage pain are based on:

- v. The nature of the pain
- vi. The underlying pathophysiologic mechanism
- vii. Past interventions used
- viii. The resident's treatment preferences
- ix. Available resources
- x. Side effect profile and tolerance
- xi. Medical contraindications to specific interventions
- xii. Functional impact of pain and its treatment

~~ii.~~ A combination of complementary and pharmacological interventions shall be attempted to manage chronic pain.

b.

~~iii.~~c. The ~~RCT develops a P~~pain ~~management~~ Care Plan ~~plan whose~~ goal is to help the resident/patient achieve a level of pain relief tolerable, ~~to him/her~~ while maximizing the resident's/patient's functional ability and quality of life.

~~iv.~~d. If the resident~~/patient~~ has pain that is not amenable to routine interventions, pain management consultants, such as the Pain ~~and Healing Center~~ Clinic, may be considered ~~are available~~ to assist ~~the RCT to~~in managinge the resident's pain.

~~v.~~e. Risks and benefits of opioid therapy for non-cancer pain will be discussed with the resident/patient and/or surrogate decision-~~-~~maker. Providers may use the opioid informed consent~~.~~ (See MSPP D15 ~~XXXX~~).

~~vi.~~f. A treatment agreement may be used to clarify roles and responsibilities of the resident/patient and the care team and consequences for misuse of opioids. (See MSPP D15~~XXXX~~.)

~~vii. For recognizing/ treating pain in special populations see Appendices B, C, and D.~~

~~2.~~ Pharmacological Interventions: Refer to ~~General~~ Pain Management Guidelines~~s – refer to pain guidelines from:~~

3.

~~viii. American Pain Society (http://americanpainsociety.org/education/guidelines/overview)~~

~~ix. Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 (see Appendix E Summary) (https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm)~~

x. Non-Pharmacological/~~American Medical Directors Association (https://www.guidelinecentral.com/summaries/pain-management-in-the-long-term-care-setting/#section-420)~~

~~xi. AGS Panel. (2009) Pharmacological Management of Persistent Pain in Older Adults. Journal of American Geriatric Society (JAGS), 57; 1331-1346.~~

~~3.~~ Complementary ~~Therapies~~Interventions: ~~General Guidelines~~

4.

~~xii.~~ Complementary ~~i~~Interventions are defined ~~here~~ as therapeutic activities that holistically address the human suffering and distress associated with living with chronic pain that includes psychological, spiritual, ~~social~~social, and emotional and physical pain, and do not include analgesics.

a.

~~xiii.~~b. Complementary interventions include caring relationships, support, resident education, animal assisted therapy, movement groups, as well as physical, rehabilitative and ~~psychologically-oriented~~psychologically oriented interventions.

~~xiv.~~c. Complementary interventions may include individual and or group psychotherapy to assist the resident/patient in the development of cognitive behavioral skills to improve the resident's/patient's management of the pain experience.

~~xv. See Appendix F: LHH Resources/Services for Residents with Pain.~~

d. Resident/family education related to pain includes individual and group activities and ~~includes:~~includes the importance of reporting uncontrolled pain, self-care complementary techniques, safe use of medications, and reasonable expectations regarding amount of relief possible with chronic pain.

e. For additional Complementary Interventions, refer to the Pain Management Guidelines

~~xvi.~~Guidelines for Managing Pain in Residents with Substance Use Disorders: Refer to Pain Management Guidelines

5.

~~b. **Discharge Planning**~~

~~i. If a resident is being discharged to the community or to another care program on an opioid or other controlled substance for pain:~~

~~• LHH physician must consult with community primary care provider to discuss regimen and problem solve any concerns to ensure that the resident's continuing care needs are addressed.~~

~~• LHH Pharmacy may provide a limited supply of analgesics and co-analgesics, including controlled substances to manage the resident's pain, until appointment with community primary care provider is scheduled for ongoing prescriptions.~~

~~• Provide information to the resident and/or caregiver about the pain management plan including non-pharmacologic interventions.~~

~~• Prescribe Naloxone Nasal Spray for residents discharged with opioid doses > 50 morphine milligram equivalents (MME) per day or at risk for overdose.~~

4.**D. Documentation**

1. The ~~licensed nurse~~LN completes the SNF Nursing Admission Pain Assessment in the EHR.

2. Pain intensity scores are documented in the Pain Assessment section of the flowsheet in the EHR.

3. The PAINAD is documented in the Pain Assessment section of the flowsheet in the EHR.

~~a.~~

~~b. For acute care patients, the licensed nurse completes the Comprehensive Pain Assessment.~~

~~c. Pain intensity is recorded with each set of vital signs except as noted in Pain Reassessment Section.~~

~~d. Pain intensity scores are documented electronically in the EHR.~~

4. Breakthrough pain scores may be ~~are~~ recorded on the MAR, or in the Pain Assessment section of the ~~and~~flowsheet, and include the pain location and intensity (reason for PRN).

5. If the resident/patient is asleep or “off unit” when the pain reassessment is

attempted, the LN should ~~and change in intensity (as response to PRN). I~~indicate "asleep" or "off unit" in the Pain Assessment section of the flowsheet~~if unable to evaluate response to PRN medication~~.

~~e.~~6. With each pain assessment, the LN documents the location/orientation of the pain and any pain descriptors/characteristics conveyed by the resident/patient.

7. The LN ~~nurse~~ evaluates how pain effects the resident's functional status and progress towards the Pain Care Plan goals, ~~resident's response to pain management care plan~~ side effects of pharmacological treatments, ~~analgesic~~ pharmacological pain treatment effectiveness,~~use~~ non-pharmacological interventions, and other pertinent data ~~and progress toward goals~~ (e.g., impact of pain on ~~ADLs or~~ sleep, appetite, mobility, mood), on the weekly ~~and monthly~~ summary~~ies~~ and ~~on~~ within the Resident Care Plan ~~progress notes~~Notes ~~when~~ as appropriate.~~.~~
~~f.~~

8. The ~~-~~Pain C~~c~~are ~~p~~Plan will include the location (or site) of pain, pain associated diagnoses, and the method use to assess/reassess pain (~~NRS, VRS~~Verbal Descriptor Scale, Numerical Rating Scale, or ~~-or~~ PAINAD), pharmacological pain treatment interventions, non-pharmacological pain treatment interventions, alleviating and aggravating factors, and any pain-related behaviors that the staff should monitor for.

9. LHH Acute Unit:
   a. Complete pain assessment documentation as outlined in the Documentation section above.
   b. Complete pain care plan documentation as outlined in the Documentation section above. Care plans are evaluated every shift.
   c. Refer to the Nursing Policy, Documentation of Care-Acute Unit.

E. Discharge Planning

1. If a resident is being discharged to the community on an opioid or other controlled substance for pain:

   a. The LHH Pharmacy may provide a limited supply of analgesics and co-analgesics, including controlled substances to manage the resident's pain, until an appointment with a community primary care provider is scheduled for ongoing prescriptions.

2. LNs may provide information to the resident and/or caregiver about the pain management regimen including non-pharmacologic interventions.

3. The provider may prescribe Naloxone Nasal Spray for residents discharged with opioid doses > 50 morphine milligram equivalents (MME) per day or who are at risk for overdose.

~~g.~~

~~5.~~**F. Organizational Performance/Quality Improvement Efforts**

~~a.~~1. LHH c~~C~~onvenes a Pain Management Performance Improvement Committee (Pain PIP) to oversee QI efforts and to identify/address barriers to pain recognition, pain ~~assessment~~assessment, and pain management as indicated, and meets quarterly at a minimum.~~.~~

~~b.~~2. LHH ~~i~~incorporates pain assessment and management policies and procedures in clinical staff orientation and continuing education programs.

~~c. The~~ The LHH Pain PIP ~~Analyze MDS indicators related to pain management at least annually to determine patterns and prevalence of pain at LHH. Compare LHH data with national benchmarks.~~

~~d.~~3. ~~C~~collaborates with the RCTs of neighborhoods to examine care processes and/or resident population variations.

4. LHH ~~P~~provides access to pain consultants or pain clinics, and complementary therapies for residents with complex pain problems.

~~e.~~

ATTACHMENT~~S~~S:

Appendix A: Laguna Honda Pain Intensity Scales: Verbal Descriptor and Numeric Rating Scale and Verbal Rating Scale in English, Spanish and Chinese versions

Appendix B: Guidelines for Assessing and Managing Pain in Residents with Severe Cognitive Impairments & PAINAD
~~Appendix C: Guidelines for Managing Pain in Residents with Substance Use Disorders~~
~~Appendix D: Guidelines for Managing Pain in Residents who are Actively Dying~~
~~Appendix E: CDC Recommendations for Opioid Prescribing for Chronic Pain~~
~~Appendix F: LHH Resources/Services for Pain Management~~

CROSS REFERENCE:
MSPP ~~XXXX~~ D15 Prescribing Controlled Substances for Chronic Pain Management

REFERENCE~~S~~S:

American Geriatrics Society ~~GS~~ Panel ~~.~~ (2009). ~~P~~Pharmacological Management of Persistent Pain in Older Adults. *Journal of American Geriatric Society (JAGS), 57*; 1331-1346.

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Department of Health and Human Services, Centers for Medicare & Medicaid Services (10/2022). Pain recognition and management critical element pathway.

Dowell, D., Ragan, K.R., Jones, C.M., Baldwin, G.T., & Chou, R. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recommendations and Reports, November 4, 2022;71(3)*:1–95.

~~California Health and Safety Code1254.7. Pain as the 5th Vital Sign.~~
~~LHH Diversion Prevention Plan~~

Revised: 92/05/20; 00/10/05; 01/08/23, 10/10/26, 11/11/29, 12/05/22, 17/11/14, 19/03/12, 21/09/14, 22/30/11 (Year/Month/Day)
Original adoption: 88/01/22

Appendix A: (English version)

Laguna Honda Self-Reported Pain Intensity Scales:

Verbal Descriptor Scale*		Numeric Rating Scale
Very severe, horrible		10
Severe		9
		8
		7
Moderate		6
		5
		4
Mild		3
		2
		1
None		0

***Preferred**

Appendix A: (Chinese version)

拉古纳醫院疼痛强度自我报告量表

(Laguna Honda Self-Reported Pain Intensity Scales)

疼痛强度文字表達 **首　選** **Verbal Descriptor Scale** **(*Preferred)**	**疼痛强度數字表達** **Numeric Rating Scale**
非常劇烈可怕的疼痛 *(Very severe, horrible)*	10
劇烈疼痛 *(Severe)*	9
	8
	7
中度疼痛 *(Moderate)*	6
	5
	4
輕微疼痛 *(Mild)*	3
	2
	1
沒有痛 *(None)*	0

Appendix A: (Spanish version)

Escala de LHH para medir intensidad del dolor
¿Por favor díganos como y cuanto es su dolor para poderle ayudar?

***Preferred**

Intolerable **Insoportable** **Peor, horrible** *(Very severe, horrible)*		10
Fuerte **Mucho, severo** *(Severe)*		9
		8
		7
Moderado *(Moderate)*		6
		5
		4
Leve, poco, **un poquito** *(Mild)*		3
		2
		1
Ninguno *(None)*		0

Appendix B:

Guidelines for Assessing and Managing Pain in Residents With Severe Cognitive Impairments

1. Use PAINAD (see below) to detect pain related behaviors and record pain scores in EHR or TAR as per downtime procedures.
2. Rule out other non-pain causes of behaviors and intervene appropriately.
3. If a resident is sometimes able to self-report pain intensity, use self-report rather than PAINAD.
4. For residents with painful chronic conditions, such as arthritis, assume resident has pain and provide around the clock analgesia, (not PRN) before using psychotropics.
5. Maximize the use of complementary therapies (tub baths, massage, movement activities, and distraction) in addition to pharmacological interventions.
6. Carefully evaluate for medication side effects and adverse effects since resident's ability to notice/report these may be compromised.

Pain Assessment IN Advanced Dementia (PAINAD)

	0	1	2	Score
Breathing (independent of vocalizations)	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes	
Negative Vocalization	None	Occasional moan or groan. Low level speech with negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling, or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or	Unable to console, distract or reassure.	
			Total Score	

REFERENCE:

Warden V, Hurley AC, Volicer L. (2003). Development and Psychometric Evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. JAMDA, 4(10): 9-15.

~~Appendix C:~~

~~Guidelines for Managing Pain in Residents with Substance Use Disorders~~

~~1. Residents with Pain Who Are Actively Using Non-prescribed substances or alcohol:~~

~~a. Understand that many patients who use substances do so to feel good or to feel better. Undertreated pain may be a trigger to substance use relapse.~~

~~b. If patient consents, refer patient to STARS for assessment, treatment, and/or medication-assisted treatment (eg. buprenorphine/methadone/etc.)~~

~~c. Educate the resident that the goals of pain treatment are to manage pain and improve functioning, while maintaining safety.~~

~~d. Residents who frequently use opioids (e.g., heroin) often require higher than expected doses because of pre-existing tolerance.~~

~~e. Dose analgesics on a scheduled or an around-the-clock basis for residents with chronic pain.~~

~~f. Minimize PRN dosing for chronic, non-acute, non-cancer pain as this may lead to confrontation with staff about when it is time for medication, how much is needed etc.~~

~~g. Monitor for signs of diversion and develop plan with RCT to address if signs are discovered (this applies to all residents even those without known substance disorder history).~~

~~h. Recognize that many individuals with substance use disorders have: low pain thresholds, possible atypical pathophysiologic pain mechanisms, and increased anxiety related to the adequacy of pain management because of past negative experiences with the healthcare system and providers. Therefore they may be untrusting of your intentions.~~

~~i. Maximize use of non-pharmacologic and complementary interventions (e.g., heat/cold; massage; acupuncture; cognitive-behavioral approaches; etc.).~~

~~j. Be aware of drug-drug interactions (e.g., with antiretrovirals, Rifampin-Methadone, benzodiazepines, etc.) that may influence dose of opioid required to control pain and to prevent withdrawal or overdose.~~

~~k. If opiate medications are being decreased, monitor for signs of withdrawal and provide treatment, as withdrawal may increase the resident's experience of pain and may trigger an increase in substance use.~~

~~l. If the resident has acute pain, begin tapering opioids as the underlying condition is healing and counsel resident beforehand regarding this plan.~~

~~m. In general, believe the resident's complaints of pain unless you have compelling evidence otherwise. Recall that pain is subjective experience without reliable biological markers.~~

~~n. Closely monitor the interaction between pain management plan and substance use disorders.~~

~~**2. Residents in Remission/Recovery from Substance Use Disorders**~~

~~a. Recognize that some residents may deny pain or refuse treatment for pain because of fear of relapse.~~

~~b. Maximize use of non-opioid analgesics and adjuvant agents.~~

~~c. Educate resident on the risks, benefits and alternatives for opioid pain medications if these medications are indicated.~~

~~d. Maximize use of non-pharmacologic/complementary interventions (e.g., heat/cold; massage; acupuncture; cognitive-behavioral approaches etc.)~~

~~e. Closely monitor the effect of the pain management plan on the resident's disease of addiction.~~

~~f. Residents on daily methadone maintenance (for opioid dependence) may require more frequent dosing, or additional analgesics for pain control.~~

Appendix D:
Guidelines for Recognizing/Managing Pain and Other Sources of Distress in Residents who are Actively Dying

1. When the resident is able to report symptoms:

a. Inquire about pain/hurt

b. Ask about other uncomfortable symptoms: shortness of breath, anxiety, mental confusion, sadness, regret, nausea etc.

2. When resident is non-verbal, observe for behaviors suggestive of discomfort including but not limited to: moaning, groaning, facial grimacing, tense body language, restlessness, confusion, difficulty breathing, etc. Consider family/friend reports of discomfort.

3. If signs or symptoms are present, conduct a comprehensive assessment to understand:

a. Onset of sign/symptom

b. Duration (constant, intermittent, related to care procedures, etc.)

c. Non-pharmacological interventions (repositioning, calm and reassurance, etc.) used.

d. Pharmacological interventions to be used to relieve distress.

e. Evaluate effectiveness of the interventions and revise plan as necessary.

4. Assessing/addressing physical symptoms and other sources of suffering provides support and comfort for family, friends and volunteers providing support.

5. For physical symptoms:

a. Review current medication regimen for PRN medications.

b. If resident is no longer able to swallow medications consult with MD and pharmacist for alternative routes of administrations and formulations, e.g. parenteral (SQ or IV), suppository, concentrated liquid formulation for sublingual administration.

c. New medication orders should be obtained STAT to relieve terminal symptoms.

d. Evaluate effectiveness of medication in relieving symptoms/behaviors
e. For persistent symptoms, scheduled dosing is often necessary rather than PRN.

f. Provide regular oral care to moisten/refresh mouth and lips.

6. For residents being treated for pain orally, who are approaching the end of life, the attending physician may include additional orders with alternate route of administration in advance so there is no delay in obtaining the medication or controlling the symptoms, *e.g, If unable to take PO Morphine dose, may give Morphine ___ mg SQ/IV every ___ hours (ATC or PRN) pain/SOB.*

7. For evenings, nights, weekends and holidays, when necessary contact on call physician for unrelieved symptoms requiring evaluation/treatment.

~~Appendix E: CDC Recommendations for Opioid Prescribing in Chronic Pain~~

BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

BOX 2. Interpretation of recommendation categories and evidence type

Recommendation Categories

Based on evidence type, balance between desirable and undesirable effects, values and preferences, and resource allocation (cost).

Category A recommendation: Applies to all persons; most patients should receive the recommended course of action.

Category B recommendation: Individual decision making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

Evidence Type

Based on study design as well as a function of limitations in study design or implementation, imprecision of estimates, variability in findings, indirectness of evidence, publication bias, magnitude of treatment effects, dose-response gradient, and constellation of plausible biases that could change effects.

Type 1 evidence: Randomized clinical trials or overwhelming evidence from observational studies.

Type 2 evidence: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.

Type 3 evidence: Observational studies or randomized clinical trials with notable limitations.

Type 4 evidence: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

Determining When to Initiate or Continue Opioids for Chronic Pain

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3).**

Patients with pain should receive treatment that provides the greatest benefits relative to risks. The contextual evidence review found that many nonpharmacologic therapies, including physical therapy, weight loss for knee osteoarthritis, psychological therapies such as CBT, and certain interventional procedures can ameliorate chronic pain. There is high-quality evidence that exercise therapy (a prominent modality in physical therapy) for hip (*100*) or knee (*99*) osteoarthritis reduces pain and improves function immediately after treatment and that the improvements are sustained for at least 2–6 months. Previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip (*176*). Exercise therapy also can help reduce pain and improve function in low back pain and can improve global well-being and physical function in fibromyalgia (*98,101*). Multimodal therapies and multidisciplinary biopsychosocial rehabilitation-combining approaches (e.g., psychological therapies with exercise) can reduce long-term pain and disability compared with usual care and compared with physical treatments (e.g., exercise) alone. Multimodal therapies are not always available or reimbursed by insurance and can be time-consuming and costly for patients. Interventional approaches such as arthrocentesis and intraarticular glucocorticoid injection for pain associated with rheumatoid arthritis (*117*) or osteoarthritis (*118*) and subacromial corticosteroid injection for rotator cuff disease (*119*) can provide short-term improvement in pain and function. Evidence is insufficient to determine the extent to which repeated glucocorticoid injection increases potential risks such as articular cartilage changes (in osteoarthritis) and sepsis (*118*). Serious adverse events are rare but have been reported with epidural injection (*120*).

Several nonopioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are effective for chronic pain. In particular, acetaminophen and NSAIDs can be useful for arthritis and low back pain. Selected anticonvulsants such as pregabalin and gabapentin can improve pain in diabetic neuropathy and post-herpetic neuralgia (contextual evidence review). Pregabalin, gabapentin, and carbamazepine are FDA-approved for treatment of certain neuropathic pain conditions, and pregabalin is FDA approved for fibromyalgia management. In patients with or without depression, tricyclic antidepressants and SNRIs provide effective analgesia for neuropathic pain conditions including diabetic neuropathy and post-herpetic neuralgia, often at lower dosages and with a shorter time to onset of effect than for treatment of depression (see contextual evidence review). Tricyclics and SNRIs can also relieve fibromyalgia symptoms. The SNRI duloxetine is FDA-approved for the treatment of diabetic neuropathy and fibromyalgia. Because patients with chronic pain often suffer from concurrent depression (*144*), and depression can exacerbate physical symptoms including pain (*177*), patients with co-occurring pain and depression are especially likely to benefit from antidepressant medication (see Recommendation 8). Nonopioid pharmacologic therapies

~~Reference~~

~~Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: http://dx.doi.org/10.15585/mmwr.rr6501e1external icon. Accessed 7/20/2021.~~

Appendix F: LHH Resources/Services for Pain Management

Specific Pain Management Resources	Department	Hours of Service	Evening Hrs. (Y=yes; N=no)	Weekend Hrs. (Y or N)	Referral Process	Comments
Complementary Therapies (acupuncture, massage, meditation, music therapy/acutonics, reiki, Medical Qi Gong, hypnotherapy)	Pain and Healing Clinic/ Medicine Service	Thursdays only 9-12PM and 1-3:30PM	N #	N	E-Referral by MD	# Clinic Team has trained some PM nurses re. simple complementary therapy techniques
Heat or Cold Applications	Nursing	24 hours/day	Y	Y	NA	Refer to NPP for contraindications
Resident Education	Nursing	24 hours/day	Y	Y	NA	
Bedside Pain Assessment & Management Consultation	Nursing	Monday-Friday Days	N	N	Contact Clinical Nurse Specialist	Anyone may contact CNS; if medication related, MD agreement for referral is required
Medication Consultation	Pharmacy	Monday-Friday Days	N	N	Contact pharmacy	
Medication Management	Medicine	Monday-Friday Days (Primary Care MD)	Y - On Call MD for Acute Pain only	Y - On Call MD for Acute Pain only	Physician Monthly Calendar for Coverage	**Note:** Primary Care MD manages routine pain management regimen; On Call MD should be contacted by

Specific Pain Management Resources	Department	Hours of Service	Evening Hrs. (Y=yes; N=no)	Weekend Hrs. (Y or N)	Referral Process	Comments
						nursing only for acute or severe pain unrelieved by available medications; not for adjustment of routine regimen (to avoid splitting)
• Assessment • Medication Support, Psychotherapy • Mental Health Counseling (for co-morbid psychiatric conditions) • Health and Behavior (adjustment to disability, psychological factors related to pain/medical conditions) • Neuropsychological Services	Psychiatry	Monday to Friday 8:30A to 5PM	Y - On-call psychiatrist for psychiatric emergencies only	Y - On-call psychiatrist for psychiatric emergencies only	E-referral by PMD. Patients may also self-refer by notifying PMD.	See psychiatry department P+P's for further details regarding services.
• Assessment,	STARS/Psychiatr	Monday to	Y - On-call	Y - On-call	E-referral by	See STARS P+P

Specific Pain Management Resources	Department	Hours of Service	Evening Hrs. (Y=yes; N=no)	Weekend Hrs. (Y or N)	Referral Process	Comments
• Medication Support (including methadone/buprenorphine) • Individual/Group Counseling for co-morbid substance use disorders.	y	Friday 8:30A to 5PM	psychiatrist for psychiatric emergencies only	psychiatrist for psychiatric emergencies only	PMD. Patients may also self-refer by notifying PMD.	for further details regarding services.
• Therapeutic exercise • Stretching / ROM • Cryotherapy • Superficial heat • Deep heat (U/S) • Therapeutic bracing • Kinesio taping • Therapeutic massage • Soft tissue mobilization • E- stim • TENS • Traction • Aquatherapy	Rehabilitation Service (PT/OT)	Mon- Fri 8am-5pm	N	Y (limited & varies)	Referral per MD	
• Trigger Point Injection	Physiatrist and/or	Weekday	N	N	Consultation	

Specific Pain Management Resources	Department	Hours of Service	Evening Hrs. (Y=yes; N=no)	Weekend Hrs. (Y or N)	Referral Process	Comments
• Therapeutic Arthrocentesis • Therapeutic Joint Injection • Botox Injection	Orthopedic Surgeon	Clinic hours			per MD	
• Neighborhood's Group activities • Neighborhood's 1:1 activities • Wellness Land Programs • Wellness Aquatic Program • Hospital Wide Programs • Farm Program	Activity Therapy	7 days a week Activity Schedule 8:30AM-5PM	Y Monday Evening Program 7:30-8:30	Y (Unit and House wide Activity Schedules Posted on Unit)	Contact Neighborhood's Activity Therapist; For Aquatics Program - MD Referral required	
• 1:1 Chaplain Visits • Guided or Silent Meditation • Spirituality Groups • Prayer • Spiritual Support	Spiritual Care	7 days/week 8:30-5PM	Y if needed	Y	Call Spiritual Care Office ➢ Tues-Sat x43034 ➢ Sun-Mon x 43022	

Specific Pain Management Resources	Department	Hours of Service	Evening Hrs. (Y=yes; N=no)	Weekend Hrs. (Y or N)	Referral Process	Comments
• Religious Services						
• Provide emotional support • 1:1 counseling regarding pain and mood • Research community resources	Social Services	5 days/week 8- 4:30 PM	N	N	Contact unit MSW on RCT	
LPC • Therapeutic group and 1:1 activities addressing target symptoms. • Social interaction • Behavioral Interventions • Life Skills	Neurobehavioral program Nursing/ Psychiatry	7 days/wk 9-4:40 PM	N	Y	Referral by RCT	Distraction from pain by providing therapeutic and healing environment for neurocognitive residents with behavioral expressions including SAMHSA based modules.
Medical Cannabis	Resident	7 days/wk	Y	Y	Resident must	Edibles, tinctures,

~~Specific Pain Management Resources~~	~~Department~~	~~Hours of Service~~	~~Evening Hrs. (Y=yes; N=no)~~	~~Weekend Hrs. (Y or N)~~	~~Referral Process~~	~~Comments~~
					~~be in possession of valid medical cannabis card which has been obtained by a recommendation of an outside physician~~	~~topicals only are permitted. Resident must store product in locked bedside cabinet and may not share with others. LHH staff are not permitted to provide support for resident's ingestion/ maintenance.~~

ANTIMICROBIAL STEWARDSHIP PROGRAM

PURPOSE:

The purpose of this policy is to provide for an antimicrobial stewardship program (ASP) which aims to optimize appropriate selection of antibiotics, improve patient outcomes, reduce health care costs and antimicrobial resistance, and minimize adverse effects of antimicrobial use.

POLICY:

1. The hospital shall support a robust antimicrobial stewardship program for both acute and skilled nursing units.

2. T~~T~~he antimicrobial stewardship program shall evaluate all antimicrobial prescriptions in the acute care unit and targeted antimicrobial prescriptions on the skilled nursing units.

~~2.~~3. The CDC Core Elements of Antibiotic Stewardship for hospitals and nursing home settings are used as the program framework.

~~3. The ASP shall adopt standards of antimicrobial stewardship when evaluating antimicrobial use (See Appendix A).~~

PROCEDURE:

1. Antimicrobial Stewardship Program Members

a. The ASP Team is comprised of ~~a~~ physicians (infectious disease consultant, medical ~~doctor~~staff representative), clinical pharmacists, a representative from nursing, and the infection prevention and control officer.

~~a.~~b. The ASP team meets regularly with a minimum of 6 meetings/year

~~**2. ACUTE**~~

~~a.~~2. ~~Acute~~ Physician:

i. Assesses clinical signs and symptoms and laboratory reports to help guide antibiotic(s) choice

ii.

~~i.~~iii. Orders antibiotic(s) ~~giving~~ with an appropriate indication ~~for use~~, dosage, and duration of use.

~~ii.~~iv. Obtains necessary cultures and labs if indicated (e.g., urine, blood, sputum, creatinine clearance) prior to first dose of antibiotic(s).

v. Documents in the medical record rationale for antibiotic therapy and selection of agent(s).

~~iii.~~

~~b.~~3. Pharmacist:

a. Reviews antibiotic(s) ordered regardless of acute, SNF, or initiated at outside hospital prior to admission.

~~Performs a medication reconciliation to ensure appropriate medications are being used (this includes review of previous medication list and allergy history).~~

b. Monitors and evaluates antimicrobial prescribing for documentation of infection, and rationale for antibiotic(s) ordered

c. Contacts prescribers to recommend alternative therapy, dosage and/or duration of therapy when appropriate to optimize treatment.

~~i.~~

~~ii. Contacts physician to recommend alternative therapy, if appropriate (e.g., due to renal dysfunction or drug-drug interactions).~~

~~c.~~4. Both the physician and the pharmacist are responsible for the following:

i. Appropriate dosing of antimicrobials based on the patient's age, weight, renal function, clinical signs and symptoms, site of infection, causative organism, pharmacokinetics and pharmacodynamics of the drug.

ii. Routine monitoring of all appropriate laboratory studies, which may include CBC, renal and liver function tests, and drug concentrations.

iii. Refer to treatment guidelines to ~~D~~determin~~eation of the~~ appropriate length of antimicrobial therapy~~,~~ based on the patient's clinical status, the site of infection, and the causative agent.

~~3. SNF~~

~~a. Physician:~~

~~Assesses clinical signs and symptoms and laboratory reports to help guide antibiotic(s) choice~~

~~i. Orders antibiotic(s) giving with an appropriate indication, dosage, and duration of use for use.~~

~~ii. Obtains necessary cultures and labs if indicated (e.g., urine, blood, sputum, creatinine clearance) prior to first dose of antibiotic(s).~~

~~iii. Documents in the medical record rationale for antibiotic therapy and selection of agent(s).~~

~~4.~~5. Antimicrobial Stewardship Team:

a. Shall utilize the most recent standards for antimicrobial stewardship when ~~evaluating~~ performing review of antimicrobial use, including but not limited to review of lab results, culture findings, medication orders, progress notes, and medication administration records.

b. Develops criteria and protocols for monitoring and intervention.

~~b. Reviews antibiotic(s) ordered regardless of acute, SNF, or outside hospital admission.~~

c. Communicates protocols to medical staff and provides ~~education regarding antimicrobial stewardship~~ feedback on antibiotic use and antibiotic resistance patterns based on laboratory data to help guide prescribing practices~~.~~

~~d.~~ Reviews prescribing patterns ~~Monitors and evaluates antimicrobial prescribing for documentation of infection, and rationale for antibiotic(s) ordered.~~

~~e. Contacts prescribers to recommend alternative therapy, dosage and/or duration of therapy when appropriate to optimize treatment.~~

~~f.~~d. Reports results of ~~monitoring~~ antibiotic use and prescribing practices to Infection Control Committee, Pharmacy and Therapeutics Committee and Performance Improvement Patient Safety (PIPS) Committee.

ATTACHMENT:
Appendix A: Standards for Evaluating Antimicrobial Use

REFERENCE:
CDC. 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**

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American Society of Health-System Pharmacists' (ASHP). A Hospital pharmacist's Guide to Antimicrobial Stewardship programs.2010.
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Centers for Medicare and Medicaid Services. Infection Prevention, Control, and Immunizations CE Pathway 20054, 10/2022.

Rybak M, Lomaestro B, Rotschafer J et al. Therapeutic monitoring of Vancomycin in adult patients: A consensus review of the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacists. Am J Health-Syst Pharm. 2009; 66:82-98

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University of California, San Francisco. Antibiotic Management for Critically Ill patients. 2005. http://clinicalpharmacy.ucsf.edu/idmp/guide_home.htm

Revised: 16/11/08, 22/09/07 (Year/Month/Day)
Original adoption: 10/12/03

APPENDIX A
Standards for Evaluating Antimicrobial Use

1. Empiric broad-spectrum antibiotics (e.g. carbapenems, fluoroquinolones) are reserved for situations in which narrower-spectrum drugs are likely to fail. Empiric therapy should continue for no more than 3-4 days to prevent adverse effects and resistance.

2. Combination ~~therapy~~therapies are used for patients who have multi-drug resistant pathogens.

3. Antibiotics are narrowed based on antibiogram, formulary selection, culture results and sensitivities to minimize drug resistance.

4. Serum antibiotic drug levels are drawn to optimize efficacy and prevent toxicities for some antibiotics, including: vancomycin, aminoglycosides.

5. With improvement of the patient's medical condition, IV antibiotics are converted to oral agents to decrease health care costs and length of acute hospital stay. Patients will be discharged back to their previous ward with appropriate oral antimicrobials, if needed.

HERBAL SUPPLEMENTS: FORMULARY AND NON-FORMULARY

POLICY:

1. Herbal supplements are products derived from plants and/or their oils, roots, seeds, berries or flowers. The contents and purity of herbal supplements are not regulated and may contain undeclared contaminants. A limited number of herbal supplements are on the hospital formulary and may be ordered by the provider.

2. Non-formulary herbal supplements not on formulary may be patient/surrogate supplied but will be limited to USP verified supplements

3. Any requests for a non-formulary supplement will be evaluated on a case-by-case basis using the non-formulary order process, which will include a review by pharmacy and prescriber before approval.

~~3. A physician order will be required for use of patient/surrogate personally supplied supplements.~~

4. All herbal supplements, require a physician's order which includes:

    a. Supplement name
    b. Dose
    c. Frequency
    d. Route of administration
    e. Indication for use.

5. A pharmacist will review orders for all herbal supplements.
    a. Formulary supplements will be provided by pharmacy.
    b. Non-formulary herbal supplements that cannot be provided by pharmacy may be patient-supplied. Any supplement brought from outside will be sent to pharmacy for verification and labeling prior to administering to resident

6. All herbal supplements will be reviewed by pharmacy for potential interactions with the resident's medication regimen and the findings will be documented in the 30-day medication review note.

7. Any herbal supplement ordered and approved for administration will appear in the Medication Administration Record (MAR) in the Electronic Health Record (EHR) where administration will be documented by the Licensed Nurse (LN).
    a. Although herbal supplements are not medications, the "6 Rights" for nursing safe medication administration process will be followed. (See Medication Administration Nursing Policy and procedure).

8. Resident's personal supply of supplements will be securely stored by nursing.

9. Residents who request to self-administer herbal supplements must be assessed by Resident Care Team (RCT) to ~~and~~ determined ability to to be able to safely self-administer herbal supplements. The process for self-administration approval will follow the steps outlined in the Self-Administration section of policy NPP J 1.0.

PURPOSE:

To support resident choice and ensure resident safety.

PROCEDURE:

1. Any request by a Resident for a supplement will be reviewed by the prescriber.

2. The prescriber should review the request to balance resident right and patient safety, and ensure the requested supplement is a USP-verified product.

3. If product is already on formulary, the prescriber will order in Epic per current practice and hospital supply will be used.

4. If product is not on formulary, the prescriber will submit a non-formulary order in Epic.

5. Pharmacy will review the order for appropriateness and determine if the specific product can be ordered through the database in Epic.
    a. If the product was obtained by the Resident or by other on the behalf of the resident, pharmacy, the product will be sent to pharmacy for review prior to the order being entered into Epic.
    b. Pharmacy will label with resident name.
    c. If the product is not available, pharmacy will work with prescriber to explore other products or options that are appropriate and available.

6. Pharmacy will confirm the product is USP-verified
    a. Verification can be seen by identifying the "USP-Verified" logo on the label
    b. A list of USP-verified product is available online.
    ~~b.~~c. Any supplement that is not USP-verified is considered an exception to this policy and must be reviewed on a case-by-case basis by physician, nursing, and pharmacy and documented in the EHR.

7. Once verified and labeled, nursing will administer herbal supplements according to standard procedure for medication administration, including use of scanning for bar code medication administration.

ATTACHMENT:
NONE

REFERENCE:
Personal Medications and/or supplements: Pharmacy Policy 01.03.00
Medication Administration: Nursing Policy J.1.0

Original adoption: 22/11/08 (Year/Month/Day)

TRIPLE CHECK PROCESS

POLICY:

1. All billing claims submitted shall have the proper supporting documentation.

2. Claims submitted for SNF Medicare shall be reviewed in Triple Check.

3. Claims submitted for other SNF level of care (including PM Acute SNF/AOU), Acute Rehab, and Acute (including PM Shadow Acute) shall also be reviewed as necessary in Triple Check.

PURPOSE:

1. To ensure compliance with billing requirements.

2. To ensure timely billing for maximum allowable reimbursement.

GOAL:

To ensure timely claims submission by the Billing Department during the monthly bill drop process and appropriate documentation that reflects the level of care and the actual services rendered are in place.

PROCEDURE:

1. A monthly Triple Check meeting shall be conducted for purposes of verifying the accuracy of billing information.
    a. During the meeting, the following data will be reviewed:
        i. Copies of the billing forms (i.e. UB-04)
        ii. Medical records such as MDS payment items of residents with claims
        iii. MDS validation reports
        iv. Therapy logs
        v. Medical certifications
        vi. Census data

~~1.~~2. Participants of the Triple Check meeting shall comprise of the following staff: Resident Assessment Instrument (RAI) Coordinator and/or designee, Billing Manager/designee, Admission and Eligibility (A&E) Manager and/or designee, Utilization Manager (UM) Nurse Manager and/or UM Nurses, Compliance and Privacy Officer, Rehabilitation Services Manager and/or designee, and HIMS/HIS Manager and/or ~~/~~designee.

3. The UM ~~Nurse~~ shall start the list of Monthly Triple Check Files before or on the 1st working day of the month. The following are the Triple Check Files in the shared drive:

Medicare Part A SNF List; Anthem Blue Cross Medi-Cal Managed Care Patient List; Log of PMR Admission; Log of PMA Admission; SFHP Patient List; Other Payor List. [LHH-Compliance (\\IN-FI222)(R:):Triple Check Files folder:Year folder:Month Year Triple Check folder]

~~2.~~a. UM will review claims for accuracy of items such as qualifying hospital stay, type of bill, dates of service, status code, full and coinsurance days, and Medicare Beneficiary Identifier.

~~3.~~4. The Resident Assessment Instrument (RAI) Coordinator and/or designee, Billing Manager/designee, Utilization Manager (UM) Nurse Manager, and UM Nurses shall update the Triple Check Files.

~~4.~~5. The Billing Manager and/or ~~/~~designee informs the team of the meeting date, time and place.

6. During the Triple Check Meeting

~~5.~~

a. Using the Triple Check list, the RAI Coordinator/designee reports the patient's admission date, Assessment Reference Date (ARD) of MDS, the Payment Category and the last covered day of Medicare during the review of the Medicare Part A SNF List.

b. For the patient who participated in the rehabilitation program, the RAI Coordinator and/or ~~/~~designee shall also report on the number of Rehab minutes and the distinct number of therapy days. The Rehabilitation Services Manager and/or ~~/~~designee verifies the therapy minutes and days (start and end dates of therapy) entered on the MDS match the documentation in the medical records. The Rehabilitation Services Manager and/or ~~/~~designee shall be available for issues on rehabilitation services or need for clarification.

c. The RAI Coordinator and/or ~~/~~designee will review PDS validation reports to verify MDS assessments have been accepted into the QIES/ASAP repository. RAI Coordinator also reports which case is on-hold (MDS assessment incomplete), and the needed follow-up.

d. The A & E Manager or Supervisor shall be available for issues on insurance or need of clarification.

e. List of items for Triple Check discussion:
   a. Medicare Number and Name as listed.
   b. Dates of Admission/Readmission and Discharge are accurate, as applicable if discharge has occurred (last covered date or no longer meets skilled nursing level care for Medicare).
   c. UB04 Field 6, From and Through dates are accurately recorded.

d. Payment MDS A1600=UB04, Field 12.
e. Correct pay status evidenced by balancing of census.
f. Claim from and through billing dates, listed on the UB04 Field 6 are accurate.
g. HIPPS code on payment MDS @Z0100A=UB04, Field 44 and billed for correct number of days, Field 46.
h. Occurrence code and date are correct and payment MDS @A2300 =UB04, Field 31, date and as applicable for Fields 31-34.
i. Revenue Codes and corresponding fields are accurate in the UB04 Field 42.
j. Number of therapy days listed on the UB04, Field 46 = number of therapy days coded in Section O0425A, B, and C when an end of the Medicare A stay started and ended in the month for which days are billed on this claim.
k. ICD-10 listed in UB04, Fields 67 and 69=I0020B on the payment MDS.
l. ICD-10 codes listed on the UB04, Fields 67A-Q are also coded in sections I0100-I7900 and I8000A-J of the payment MDS.
m. Section GG scores on the payment MDS are supported by documentation in the medical record.
n. MDS is transmitted and accepted into the QIES ASAP.
o. Therapy treatment evaluations and plans of care are signed by the physician within 30 days of the first treatment delivery date.
p. Medical certifications are completed and signed by medical staff timely.
q. Physician's orders are present for the stay.
r. Payment MDS is signed at Z0400 as required.
s. Payment MDS is signed by the RNAC at Z0500 as required.
t. No non-fatal message on validation report indicating "group therapy >25% was provided".

7. After the Triple Check meeting:
   a. Medicare billing coordinator will correct any discrepancies on the UB-04 as discussed in the meeting.
   RAI/PPS coordinator: modify any assessments as needed, transmit, and communicate when completed to the Medicare billing coordinator.
   ~~a.~~

8. .Based from the previous month's Triple Check Files, the Billing Manager/designee reports on the outstanding issues that resulted in the delay of claims submission.

9. ~~I~~ssues identified based on payor source (Medicare, Managed Care, and Private Payor) shall be reported and the group shall agree on what follow-up is needed and/or resolution.

~~d.~~10. Issues identified shall be reported to Compliance Committee twice a year.

ATTACHMENT:
None.

REFERENCE:
None.

Revised:11/21/19, 20/01/14, 21/03/19 (Year, Month, Day)
Original adoption: 16/03/

UNUSUAL OCCURRENCES

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that staff primarily utilize the electronic Hospital-wide Unusual Occurrence (UO) reporting system to report investigations, communicate with relevant personnel and document corrective actions related to unusual occurrence events.

2. An Unusual Occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student.

3. UO reports shall be completed and submitted timely by any LHH employee who witnesses or becomes aware of an unusual occurrence. The initial report shall be completed by the first staff member responding to the event and those who are most knowledgeable about the occurrence.

4. UOs are confidential under Evidence Code 1156/1157. No copies are to be made except by Quality Management (QM) staff.

5. The QM Department shall maintain the UOs as part of Performance Improvement Patient Safety (PIPS) Committee records.

6. Access to the PIPS Committee records and reports shall be strictly limited to QM staff, Departmental and Hospital Performance Improvement Committees, Medical Executive Committee (MEC), and Joint Conference Committee (JCC).

PURPOSE:

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

PROCEDURE:

1. General Provisions

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

b. Malicious reports or reports with punitive intent are not appropriate. Interdepartmental conflict are to be discussed by the departments involved and reported on a UO only when not resolved in a timely manner.

c. PIPS Committee, a Committee of the Medical Staff, is responsible for reviewing and evaluating UO Reports as part of the Hospital Quality Assurance and Performance Improvement (QAPI) Program.

2. Reporting, Investigation and Follow-up

a. Before the end of the work shift, the Charge Nurse, reporting employee, or designee shall:

i. Complete the on-line UO which is directly transmitted to the QM Department.

- Necessary information for completing the UO:
  - Include the name of patient/resident (if applicable), unit, date of occurrence, time of occurrence, description of incident and person(s) notified.
  - Include the name(s) of staff, visitors, volunteers, students and other residents who were involved in the incident or witnesses to the incident.
  - Specifically identify who said what and/or who witnessed what part of the incident.
  - List what led up to the incident, other pertinent events occurring at the time, and any contributing acts of friends, relatives, or residents that may have led to the event.
  - Describe any equipment involved.
  - Note any injuries and state what medical care has been provided or is planned.

ii. Informs the supervisor on the shift of the occurrence. Follow the reporting protocol as described in LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response.

iii. Notify the attending physician if the incident involves the clinical care of a resident.

iv. Notify the resident's family or surrogate decision-maker of the incident as appropriate.

v. Submit other necessary documents to QM Department.

b. The supervisor or Operations Nurse Manager on duty shall determine whether immediate additional follow-up or action is required and whether notification of the Chief Medical Officer, Division Head, and Administrator on Duty is warranted.

c. If the incident involves a resident, documentation of the event, clinical response, and monitoring activities must be noted in the medical record according to the Hospital-wide Policies and Procedures. Do not document in the medical record the fact that a UO has been completed.

d. A unique log number shall be assigned to each submitted UO. Risk Management shall triage the UOs within 24 hours or the next business day and request for follow-up information as necessary using the on-line UO system:

i. Follow-up and investigation of UO reports:

- UO notification shall be sent to managers, supervisors and other relevant staff. UO follow-up and or investigation report(s) are requested from managers as necessary to determine contributing factors, corrective actions taken and/or referrals for follow-up actions.

- The manager and or other relevant staff assigned shall log in to the on-line UO system daily, review their respective worklist and read the UO report and or messages no later than the next business day.

- Completed follow-up and/or on-line investigation reports are to be submitted to the QM Department within four business days of the UO report.

- Risk Management shall be responsible for tracking the return of follow-up and or investigation reports.

- Staff shall use the on-line UO system and not use the email system to address case specific UO issues.

ii. Follow-up of reportable UOs (refer to LHHPP 60-03 Incidents Reportable to the State of California):

- Regulatory Affairs may direct further staff actions on reportable occurrences.

- Completed follow-up and/or investigation reports are to be submitted to the QM Regulatory Affairs team no later than the 4th calendar day following the incident.

- Telephone notification of reportable UOs to California Department of Public Health (CDPH) shall be made by the mandated reporter.

e. Risk Management shall aggregate UO data to identify patterns/trends. UO summary reports shall be brought to the PIPS committee for further review, evaluation, and recommendations (e.g., if patterns/trends are identified, the PIPS Committee may work with the involved departments to institute further studies and develop a plan of correction, which may include a mechanism for ongoing monitoring).

f. The UO report may be classified as closed by Risk Management or designee after sufficient essential information is gathered and corrective action(s) implemented to minimize risk of occurrence.

g. UO summary reports shall be submitted to the MEC through the PIPS committee and to the Joint Conference Committee. Recommendations from these Committees shall be forwarded to the MEC.

3. Downtime procedure for reporting an Unusual Occurrence

a. Before the end of the work shift, the charge nurse, reporting employee, or designee shall:

i. Complete the UO form F-821A “Confidential Report of Unusual Occurrence”:

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

- Complete Part 3 by stating the facts as outlined in Section 2 above.

ATTACHMENT:
Attachment 1: Confidential Report of Unusual Occurrence.

REFERENCE:
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 24-06 Resident and Visitor Complaints/Grievances
LHHPP 60-03 Incidents Reportable to the State of California
LHHPP 60-05 Review of Serious Adverse Events in D/P Skilled Nursing Facility
LHHPP 60-08 Risk Management Program
LHHPP 60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)
Laguna Honda Form SOC 341
Laguna Honda On-line UO Pocket Guide

Revised: 96/07/15, 98/08/10, 00/03/09, 08/01/08, 11/09/27, 15/09/08, 18/11/13, 20/01/14, 22/05/09, 22/11/15 (Year/Month/Day)
Original adoption: 94/08/15

LAGUNA HONDA HOSPITAL
QUALITY MANAGEMENT DEPARTMENT

CONFIDENTIAL REPORT
OF UNUSUAL OCCURRENCE
(NOT A PART OF THE MEDICAL RECORD)
This incident involves (check applicable box):
❑ RESIDENT ❑ STUDENT
❑ VISITOR ❑ VOLUNTEER ❑ OTHER

NOTE: Report employee injury on Industrial Accident Report form, not on UO.

PART 2 -

UNIT:
IF NO STAMP,
WRITE

NAME:
ADDRESS:
TELEPHONE:
D.O.B.: ↑ STAMP ADDRESSOGRAPH HERE↑

GENDER ❑ M ❑ F	AGE	UNIT	INCIDENT LOCATION
DATE OCCURRED	TIME OCCURRED AM / PM		TODAY'S DATE
M.D. NOTIFIED	TIME CALLED AM / PM		TIME RESP'D AM / PM

PART 1 - TO BE COMPLETED BY QM DEPT:

____ 1a. Missing Resident (off post / with adverse effect)
____ 1b. Missing Resident (on post & no adverse effect)
____ 2. Death from Unnatural Causes
____ 3. Disease Outbreak
____ 4. Major Accident / Injury
____ 5a. Assault
____ 5b. Abuse
____ 6. Fire
____ 7. Resident Burns
____ 8. Suicide Attempt
____ 9. AMA / AWOL
____10. Suspected Adverse Drug Reaction
____11. Visitor Fall, Injury
____12. Resident Fall
____13. Resident or Family Complaint
____14a. Problem Behavior (aggressive)
____14b. Problem Behavior (non-aggressive)
____15. Delay In Service
____16. Medication or IV Fluid Error
____17. Hazardous, Unsanitary Condition
____18. Narcotic Count / Keys
____19. Non-Adherence to Policy
____20. Substance Abuse
____21. Unavailable Supplies, Equipment Malfunction
____22. Property Loss, Destruction
____23. Resident Altercation
____24. Fracture, Dislocation, Sprain
____25. Laceration, Bruise, Skin Tear
____26. Pressure Sore Upon Admission
____27. Pressure Sore Facility Acquired
____28. Other_____

PART 3 - *DESCRIBE OCCURRENCES SEQUENTIALLY. STATE FACTS: NAME INDIVIDUALS, CONTRIBUTING FACTORS & EXTENT OF INJURY. NOTE ANY INTERVENTIONS AND FOLLOW-UP, IF KNOWN.*

Reported by_____Location_____

Position/Title_____Tel._____

If applicable, notified ❑ Supervisor_____ ❑ Admin on Duty_____ ❑ IP_____
Time Time Time

	Name:	Location	Telephone
Other persons with knowledge of this occurrence.	Name:	Location	Telephone
	Name:	Location	Telephone

PART 4 – FOR QM USE ONLY:
Referred to:
❍ **For Investigation**
❍ **For Information only**

POSITION		LOCATION	TELEPHONE	**LOG NUMBER**
LOGGED BY	DATE	TRIAGED BY	DATE	

HAND DELIVER TO LOCKED PERFORMANCE IMPROVEMENT MAILBOX – DO NOT PHOTOCOPY

FORM F-821 – A (REV 03/00) ALSO LHPP 96-06

RESIDENT EVACUATION PLAN

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. Decision to Evacuate

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

a. Residents whose emergency plan indicates that evacuation may be harmful shall be evaluated by their physicians to determine the best course of action for the individual resident's well-being.

b. All residents for whom evacuation is indicated shall be moved out of the unsafe area(s) and into an alternate care site.

c. Alternate care sites shall be selected by the HICS Team using the information in Appendix A.

d. A binder that includes a list of equipment and supplies and standard work instructions for the setup of each alternate care location is located in the emergency command center.

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

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

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

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

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

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

2. Horizontal Evacuation

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

a. Move ambulatory residents.

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

c. Move residents who are bed-ridden using evacuation devices or emergency carriers.

d. Check the area to ensure that all residents have been moved out of the unsafe area.

e. Account for all residents, staff, and visitors.

f. If anyone is missing, attempt to locate them and notify the command center, the Nursing Office, and the Sheriff's Department.

3. Vertical Evacuation

a. If horizontal evacuation is insufficient to locate residents in an area that is safe for their care, vertical evacuation shall be initiated. If elevators are operational and safe to use, vertical evacuation shall be completed using a combination of stairs

and elevators. In the event of a fire, earthquake, or other disaster that may compromise the safety of the elevators, elevators shall not be used and the procedures for stair evacuation shall be followed.

b. Upon making the decision to evacuate, the command center shall designate a destination location(s) within the facility to which residents will be relocated and staff from the labor pool shall be used to set up the area for resident care.

4. Vertical Evacuation Using Elevators

a. Elevators shall be controlled by staff from the labor pool with a key to override the elevators. These staff members shall remain in the elevators and use each elevator to clear one floor at a time. The order in which neighborhoods will be evacuated shall be determined by the Incident Commander and shall depend on the type and specific location of the emergency.

b. Ambulatory Residents

i. Ambulatory residents who are able to walk up and down stairs shall be escorted to an exit stairwell by a member of the Nursing staff, who shall walk up or down the stairs with groups of 3-5 residents.

ii. The Nursing staff shall go back to the neighborhood to continue evacuation.

iii. Additional staff members from the labor pool will be waiting in the stairwell on the same floor as the designated relocation area and shall escort residents in groups of 5-10 from the stairwell to the relocation area.

c. Residents in Wheelchairs

i. Residents in wheelchairs shall be brought to the great room and then to the elevator in groups of 4-6. The Charge Nurse shall coordinate this process.

ii. If time is of the essence, some of the non-ambulatory residents may be taken down the stairs after the ambulatory residents using evacuation devices, such as Stretchairs. They shall then be carried by waiting staff to the relocation area.

iii. Additional staff shall be available on the same floor as the designated relocation area and shall direct/escort residents to the relocation area as needed.

d. Bed-bound Residents

i. After the residents in wheelchairs have been evacuated, residents in beds may be brought to the elevators. This shall be coordinated by the charge nurse.

ii. If time is of the essence, bed-bound residents may be brought down the stairs using evacuation devices or carriers.

iii. Labor pool staff shall bring residents to the designated care area.

e. Wheelchair Retrieval

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

5. Vertical Evacuation Using Stairs Only

a. Ambulatory Residents

i. Ambulatory residents who are able to walk up and down stairs shall be escorted to the exit stairwell by a member of the Nursing staff, who shall walk up or down the stairs with groups of 3-5 residents.

ii. The Nursing staff shall go back to the neighborhood to continue evacuation.

iii. Additional staff members from the labor pool shall be waiting in the stairwell on the same floor as the designated relocation area and shall escort residents in groups of 5-10 from the stairwell to the relocation area.

b. Non-ambulatory Residents

i. Non-ambulatory residents shall be brought down the stairs using evacuation devices such as Stretchairs, Stryker chairs, and Paraslydes after the ambulatory residents have evacuated. See Appendix B for information about available devices.

ii. If time is of the essence or there are not enough evacuation devices, staff shall use blanket carries to bring residents down the stairs and to the relocation area. See Appendix C for instructions on make-shift evacuation devices.

iii. As many staff members as possible shall be provided from the labor pool for this task, which shall be coordinated by the Nurse Manager and/or Charge Nurse.

c. Wheelchair Retrieval

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

6. Shelter in Place Plan

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

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

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

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

Response Measure
Identify nature of incident and determine necessary level of response and protection.
Coordinate safety and security with law enforcement entities as appropriate.
Implement the following activities: • Close air vents, windows, and doors. • Facilities department to shut down hospital Vacuum and Air Conditioning Unit. (HVAC)
Notify employees, visitors and vendors as to nature of the danger and reason for the shelter-in-place.
Assess capabilities and identify personnel resource requirements and staff availability.
Develop and implement public-information plans for employees and the media to provide information on disease recognition, necessary infection-control measures, treatments, and home-care/after-care instructions.

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

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

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

7. Communication and Coordination

a. Each department shall assign a representative to the Emergency Preparedness Committee who is responsible for continuously enhancing and sustaining emergency preparedness.

b. Coordination of meetings and related activities is achieved through the Emergency Preparedness Coordinator under the direction of the Department of Workplace Safety and Emergency Management.

c. Residents are apprised of emergency preparedness and response procedures in the resident handbook, which is reviewed with the resident on admission by a social worker.

d. The department manager shall facilitate continuous updates for the emergency call back lists. The confidential call back lists are kept securely in the HICS Command Center.

e. Emergency preparedness updates are communicated to the leadership forum, executive committee, neighborhood and departmental meetings, community meetings, and residents' council as necessary.

f. LHH participates in a city-wide emergency preparedness healthcare coalition to support the goal of interoperability and coordination of planning, mitigation, response, and recovery activities.

g. Multiple communication systems are available and practiced to achieve redundancy in the event of technology downtime and to achieve coordination city-wide.

i. Primary methods of communication include regular telephone services.

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

8. Accounting for Residents and Resident Tracking

a. Labor pool staff shall greet residents at the designated relocation area and account for all residents arriving in the area and report to the Command Center.

b. The Command Center shall work with Nurse Managers to account for any missing residents.

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

c. For any resident who is evacuated, continuity of care document (CCD) shall be made available to providers at the receiving facility via the health information exchange. The document shall contain key information including problem list, allergies, medications, recent lab results.

9. Non-Compliant Residents

a. Utilize staff members who are familiar with the non-compliant resident to help persuade cooperation.

b. Speak calmly to the resident using simple, slow language to help them understand the dire need to evacuate the area or facility.

c. Speak in a warm, friendly manner that inspires them to act without fear or panic.

d. Reframe the situation in a way that highlights the benefits of leaving and emphasizes the emergent nature of the situation.

e. Clearly explain to the non-compliant resident the process for evacuation and offer reassurance about the safety and security of evacuation relocation sites.

f. Engage other staff members who are familiar with the non-compliant resident that can demonstrate official authority in a compassionate manner to help coax the resident to cooperate in the evacuation process.

g. Request the assistance of family members or responsible parties to help persuade the resident to cooperate in the evacuation process.

h. Offer snacks or some other type of accommodation (i.e. enhanced level of comfort, change of scenery, etc.) that may incentivize non-compliant residents with behavioral health issues.

i. Enlist the help of local law enforcement if the resident is defiant and non-compliant in the evacuation process.

~~c.~~j. When the urgency of the situation requires, consider physically removing the resident with standard techniques like a blanket-carry or drag, two-person seat carry or utilization of evacuation equipment (evacuation chair, evacuation sled, etc.) to remove and protect the resident from imminent danger.

~~9.~~10. Employee Training

a. All LHH staff shall be made aware of general evacuation procedures in orientation and annual emergency preparedness in-services.

b. A team of staff from Nursing, Rehab, and Activity Therapy shall be trained on the use of evacuation devices annually. This training shall include hands on practice using the equipment.

ATTACHMENT:
Appendix A: Alternate Care Sites
Appendix B: Evacuation Devices
Appendix C: Emergency Carriers

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

Revised: 18/09/11, 19/03/12, 19/09/10, 20/03/17 (Year/Month/Day)
Original Adoption: 14/07/29

APPENDIX A: Alternate Care Sites

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

APPENDIX B: Evacuation Devices

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

a. **Reeves Stretchairs** (approximately 60) are stored in the emergency storage room in H2 and can be made available by request from the Command Center. Each Stretchair has a cover with a shoulder strap to facilitate easy transport of several devices at once. Open the Stretchair and place under the victim either on a flat surface (bed or floor) or on a chair. To use on a flat surface, roll the victim to one side and place the Stretchair beneath them, with the top aligned with the victims shoulder. Roll the victim to the opposite side and ease the Stretchair beneath them. Secure the shoulder and crotch/ hip straps. To use on a chair, place on a chair with the crotch strap near the edge of the seat and place the victim on the device by having the victim stand up momentarily and then sit down on the Stretchair or transfer the victim via a standing pivot with 1 or 2 assistants or via a mechanical lifting device. Assure that the top of the Stretchair is level with the victims' shoulders. Lift on the count of three ("1-2-3 lift") with 2-4 rescuers each firmly grasping one or two handles, depending upon the weight of the victim and the strength of the rescuers. The Reeves Stretchair is rated up to 1000 lbs.; however you must never lift more than you can easily manage

b. **Medivac chairs** (approximately 30) are also stored in the emergency storage room in H2 and can be made available by request from the Command Center. They are rated at 450 lbs and they do not have a strap. Place under the victim as described above.

c. **Paraslydes** (15) are available through the Command Center and can be used to evacuate down stairs. Pictoral directions appear on the device. Place the victim (500 lb weight limit) on the stair litter by rolling them to the side and placing the device beneath them. Roll the victim onto the device and center them on the device by sliding their shoulders, then legs, then hips to the middle of the litter. Fold the device around the victim and secure the straps, criss-crossing the chest straps. Use 2-4 rescuers to slide the Paraslyde to the stairwell and ease the device safely and slowly down the stairs. An additional harness is provided if needed for added control for lighter rescuers to ease a heavy victim down stairs.

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

APPENDIX C: Emergency Carriers

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

a. Cradle drop and blanket pull – 1 person (heavy resident)

   i. Double a blanket lengthwise on floor parallel to bed. Slide arm nearest resident's head under the neck and grasp shoulder. Slide free arm under knees and grasp firmly. Place knee or thigh, depending on height of bed, against bed close to resident's thigh. Keep both feet flat on floor about six (6) inches from bed. Pull resident from bed; no lifting is necessary. Pull with both hands, push with knee or thigh against bed. The moment resident starts to leave bed, drop on knee nearest the head. When the resident is clear of bed, the extended knee supports knees of resident and the arm under neck supports arm and shoulders of resident. The cradle formed by the knee and arm protects the back. Let the resident slide gently to the blanket and pull blanket from the room.
   ii. Rescuer cannot maintain the balance necessary if rescuer pulls the resident's buttocks instead of the knees or thighs out on rescuer's knee. This removal is for residents too heavy for one person to carry, for low beds and for bed fires.

b. Swing – 2 persons

   i. Carriers grasp wrists under the resident's knees and behind the resident's back. Resident's arms are along the two carriers' shoulders. Carry resident from room to safe place.

c. Extremity – 2 persons

   i. (To carry a person through a burning exit). One carrier grabs resident around knees (carrier's body between the resident's knees). Second carrier grabs resident under the arms and across upper abdomen. Carry resident from room. Use wet cover if possible.

d. Using a gurney – 3 persons

   i. Gurney placed parallel to bed. Three carriers to lift, one at shoulder level and upper back, one below waist and below hip, one at knee and at ankle. Lift resident and place on gurney. Wheel to safety.

e. Without a gurney, using a blanket – 3 persons

   i. First person spreads blanket on floor at right angles to bed. Resident is placed on blanket. First person positions at the head of the resident, placing own hands on blanket above the resident's elbows. Second and third persons position on the sides of the resident, placing their hands above and below the resident's knees.

FIRE DRILL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center shall conduct a minimum of one Fire Drill per building or zone occupied by residents (e.g. in the North, South and Pavilion buildings) each month on rotating shifts for a total of 3 drills per month to reach each shift at least quarterly.

2. Fire Drills will be scheduled by the hospital's Fire Safety Officer (FSO), in cooperation with appropriate department managers, however the drills will be randomly conducted and unannounced to staff prior to the drill.

3. It shall be each department manager's responsibility to understand and comply with Fire Drill procedures, and to require staff participation in all Fire Drills.

4. Department managers are responsible for assuring that their employees receive Fire Safety Training as part of new employee orientation and annually thereafter. The Fire Safety Officer (FSO) is available as a resource to provide training as necessary.

PURPOSE:

Fire drills are conducted regularly so that staff are familiar with Code Red procedures and can readily respond in case of an actual fire in the facility.

PROCEDURE:

1. The FSO or designee will prepare a quarterly drill schedule identifying the locations and times of the drills. This schedule will be submitted to the Executive Administrator and Chief Operations Officer (COO).

2. The FSO will advise the Nursing Operations Officer (NOO) of the time and location of the Code Red Drill, will call DTIS (monitoring service) to notify them that the City Tie will be deactivated during a drill, and will deactivate the City Tie, allowing for drill participants to activate a manual pull station without sending an actual alarm to the Fire Department.

3. Upon notification of a Code Red Drill by the FSO or designee, hospital staff are to take the following actions:

   Follow the R.A.C.E. acronym below for basic fire response steps:

   i. **R**escue persons in immediate danger while announcing "Code Red" to nearby staff.

ii. **A**larm by pulling the lever on the nearest manual pull station and Dial 4-2999. Provide the following information:

- Location of fire
- What is burning
- Your name
- Nursing Office shall:
  - Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: "Attention, Attention, May I have your Attention Please." "CODE RED DRILL (location)"
  - Page the Emergency Response Group (Stationary Engineers, SFSD, Emergency Management Coordinator, Nursing Program Directors, Nursing Operations Managers).

iii. **C**ontain the smoke and/or fire by closing all windows and doors and direct others to assist you.

- State that you would move residents needing oxygen to a safe area to administer it.
- Licensed staff simulates turning off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.
- State that you would turn off electrical equipment in the area.

iv. **E**xtinguish: Extinguishers are located in corridors and units throughout the facility. Extinguishers are used according to the P.A.S.S. acronym (Simulate):

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

b. Department managers and Nurse Managers are responsible for ensuring that employees have knowledge of the fire extinguisher locations.

c. North Mezzanine (NM) exception: North 1, 2, 3 and 4 will send one staff member to North Mezzanine to monitor the fire stairwell doors to assure resident safety as follows:

i. **N1:** send staff to monitor NM **Cypress** household door

ii. **N2:** send staff to monitor NM **Redwood** household door

iii. **N3:** send staff to monitor NM **Cedar** household door

iv. **N4:** send staff to monitor NM **Juniper** household door

Staff must proceed via stairs to NM with caution: Do Not open door if warm/ hot to touch or if smoke is seeping through.

4. Staff in areas of the hospital other than the drill location shall simulate a Code Red Drill in their department. The department supervisor will complete the Fire Drill Participation form, include signatures of staff, and will forward it to the Fire Safety Officer. For night shift drills, National Fire Protection Administration Life Safety code permits silencing of chimes; staff are alerted to the drill by overhead announcement.

5. The FSO or designee will advise the NOO when the fire drill is concluded. The NOO ~~r~~will announce "Code Red Drill All Clear" three times over the public address system ~~and will transmit the same message via radio to all radio units~~. The FSO may disable the chimes for night shift drills, however, the overhead announcement will still be made.

6. All Department Managers, Nurse Managers or designees shall complete the Fire Drill Participation form, and fax it to the Fire Safety Officer in Facility Services at 759-2330 within one hour of the drill. The FSO shall notify the Nurse Manager and Nursing Supervisor of any neighborhoods that fail to submit a Fire Drill Participation Form within an hour of completion of a fire drill. The FSO shall submit an Unusual Occurrence to Quality Management if there are any neighborhoods that have failed to submit a Fire Drill Participation Form 24 hours after completion of a fire drill. The FSO will record departmental/ward participation and report results to Division Heads and to the Safety Committee. The FSO will complete a separate form for the drill location. All forms will be placed on file for annual review by the State Fire Marshal.

7. The FSO will advise the Nursing Office that the Code Red Drill is clear, will call DTIS to notify them that the City Tie is being reactivated, and will reactivate the City Tie.

ATTACHMENT:
Appendix A: Laguna Honda Hospital Fire Drill Fire Safety Officer's Drill Record
Appendix B: Laguna Honda Hospital Fire Drill Participation Form

REFERENCE:
CCR, Title 22, Sections 70743, 70745 and 72553
CCR, Title 19, Section 3.09. San Francisco Fire Code, Sections 12.201 through 12.204
NFPA Life Safety Code 101 2012 edition), Chapter 19, paragraph 19.7.1.7.

Revised: 13/01/29, 16/01/12, 19/07/09, 22/10/5 (Year/Month/Day)
Original adoption: 11/09/27 (Content derived from 71-02 Fire Response Plan)

Appendix A
LAGUNA HONDA HOSPITAL FIRE DRILL
FIRE SAFETY OFFICER'S DRILL RECORD

1. Drill Location: _____ Date: _____

2. Time: _____AM/PM Shift: Day _____ Swing _____ Night _____

3. Procedures Implemented:

   a. Declare Code Red Drill? Yes ( ) No ( ) Time _____ AM/PM
   b. Activate the fire alarm? Yes ( ) No ( )
   c. Call operator 4-2999? Yes ( ) No ( )
   d. Operator announce "Code Red Drill (location)"? Yes ( ) No ( )
   e. Operator simulated call to 911? Yes ( ) No ( )
   f. Close doors and windows? Yes ( ) No ( )
   g. Take extinguisher to fire? Yes ( ) No ( )
   h. Simulate evacuating individuals from danger? Yes ( ) No ( )
   i. Staff from adjacent wards reported for assistance? Yes ( ) No ( )

4. Watch Engineer respond? Yes ( ) No ( ) Time _____ AM/PM

   a. Simulate securing ventilation? (If applicable) Yes ( ) No ( )

5. SF Sheriff respond? Yes ( ) No ( ) Time _____ AM/PM

6. Time drill terminated. Time _____ AM/PM

7. Rating of drill (check one). Explain basis for rating in comment section below. Drills are rated on how well staff performs.

   Excellent _____Fair _____ Good _____ Poor _____

8. Comments:

9. If performance on drill is fair or poor, please submit your plan of correction to the Executive Administrator's office for review within 1 week of drill date.

10. Fire Safety Officer_____ Date:_____

Safety Committee Chairperson

Appendix B

LAGUNA HONDA HOSPITAL
FIRE DRILL PARTICIPATION FORM

Instructions: This form must be completed by **ALL** Units and faxed to the Fire Safety Officer at 759-2330 in Facility Services, **within one hour of completion of the drill.** This form should be completed even if the fire drill is not conducted in your work area. Your staff should actively participate in every fire drill.

1. Your Department/Location:_____
   Date:_____
   (NOT the location of drill)

2. Time:_____(AM/PM) Shift: Day_____ Evening _____
   Night_____

3. Procedures implemented.
   Chimes and strobes are not activated for fire drills between the hours of 9pm-6am.

	Review Criteria	YES	NO	N/A
a.	Was Code Red Drill announcement heard over paging system?			
b.	Were the chimes audible?			
c.	Were the Strobe lights visible?			
d.	Did fire smoke doors held by electromagnets close?			
e.	Did staff simulate closing doors and windows?			
f.	Did staff simulate turning off oxygen and any electrical equipment?			
g.	Did staff simulate controlling a fire?			
h.	Are staff familiar with patient and visitor evacuation procedures including those residents with oxygen?			

4. Comments:

5. Participants are to PRINT own name and classification:

EMPLOYEE NAME	CLASSIFICATION

----------PLEASE DO NOT WRITE BELOW ---- FOR FACILITIES USE ONLY----------

6. _____

_____ Facilities Review by: Date: Signature

7. Problems identified from **a** thru **d** to be followed up by facilities:

8. Problems from **e** thru **h** to be followed up by Nurse Managers:

INFECTION SURVEILLANCE PROGRAM

POLICY:

1. Laguna Honda Hospital (LHH) will implement an ongoing infection prevention and control (IPC) surveillance program that provides for a systematic collection, analysis, and interpretation of healthcare-related data essential to planning, implementation, and evaluation of the resident care services to identify trends and inform decisions for care in an effort to reduce transmission of disease in this population.

2. An annual risk evaluation that includes IPC trends and findings will provide the baseline to guide care, treatment and services to this population.

3. LHH will utilize ~~McGeer~~NHSN criteria for long-term care/skilled nursing facilities (SNF) and National Healthcare Safety Network (NHSN) criteria for acute care facilities to define surveillance criteria, identify specific data collection methods, as well as determine what qualifies as in an infection to use consistently and accurately.

4. LHH recognizes that surveillance definitions are not the same as clinical definitions and that ~~McGeer and~~ NHSN criteria do not define clinical diagnosis or treatment. Ultimately, only the medical provider will provide the medical/clinical diagnosis and treat accordingly. LHH will consistently use ~~McGeer and~~ NHSN criteria for NHSN, local, and state reporting requirements.

~~5. To provide an accurate risk evaluation for the LHH population, the annual IPC program risk assessment will include but is not limited to the following elements/data:~~

~~a. Demographics and needs of the resident population~~

~~b. Infection rates~~

~~c. Changing pathogens and antimicrobial resistance~~

~~d. Community health events and emerging infectious disease~~

~~e. Change in technology, procedures and standards of practice~~

~~**PURPOSE:**~~

~~The objectives of the program include the following:~~

~~1. Monitor the occurrence of healthcare-associated infections (HAIs) and develop intervention strategies to reduce such infections;~~

~~2. Detect and investigate clusters of HAIs or outbreaks and emerging infectious diseases;~~

3. Evaluate infection prevention and control measures;

4. Observe staff compliance with infection control standards and facility policies and procedures;

5. Identify potential risk factors for infection;

6. Gather and compile HAI data, observe trends and patterns, and determine rates of occurrence;

7. Identify organisms of epidemiologic significance such as tuberculosis and antibiotic-resistant bacteria;

8. Utilize surveillance information to conduct communicable disease contact and exposure investigations (e.g. positive tuberculosis screens); and

9. Meet mandated city, state, and federal reporting requirements based on surveillance data.

PROCEDURE:

1. The responsibility of infection control surveillance is carried out by the Infection Control Nurse (ICN). Electronic information may be gathered from, but not limited to, the following sources:

    a. Microbiology department for culture results

    b. Pharmacy department for antibiotic orders

    c. Radiology department for chest x-ray results

    d. Respiratory care department for nasal swab results

    e. Nursing department change of shift reports

    f. Resident/patient health records

2. Suspected infections that occur on LHH SNF neighborhoods are reviewed by the ICN based on McGeer criteria to determine if the infection is an HAI or community-acquired infection (CAI).

3. Suspected infections that occur on the acute care units are reviewed by the ICN based on NHSN criteria. NHSN reporting of acute care HAIs and CAIs includes the submission of a monitoring plan and ongoing surveillance of antibiotic resistant organisms as well as annual influenza vaccination rates for staff.

4. Confirmed cases of HAIs and CAIs are listed on the monthly neighborhood infection control surveillance log and are available for review by the clinical care team members.

5. Monthly surveillance data is aggregated quarterly and submitted for review by the Infection Control Committee for trends and patterns.

6. Surveillance data on antibiotic resistant organisms such as *Methicillin-resistant Staphylococcus aureus* (MRSA), *Vancomycin-resistant Enterococcus* (VRE) species, *Carbapenem-resistant Enterobacteriaceae* (CRE), Extended Spectrum *Beta Lactamase* (ESBL) organisms, and *Clostridioides difficile* (*C. diff*) are specially tracked for trends, new incidence, recurrence, colonization, and appropriate treatment.

7. An annual infection control report is prepared based on surveillance data gathered, observation findings, and other infection control activities performed during the past fiscal year. The report is submitted annually to the Performance Improvement and Patient Safety Committee and to the Joint Conference Committee for their review and evaluation of the facility's infection prevention and control program.

8. The ICN conducts quarterly and as needed infection control rounds, which include hand hygiene, specialized precautions, and general infection prevention and control standards wherever resident care activities are carried out and in food preparation areas.

9. Findings from infection rounds are shared with the manager of the respective department for follow-up as necessary.

10. Based on infection control surveillance data gathered, the ICN is responsible for submitting and or preparing the following reports:

    a. Monthly NHSN reporting for infections occurring on the acute care units.

    a. Cases of reportable

Definitions:

"Infection surveillance" refers to an ongoing systematic collection, analysis, interpretation, and dissemination of infection-related data.

"Outcome measure" is a mechanism for evaluating outcomes or results, such as tracking specific infection events.

"Process measure" is a mechanism for evaluating specific steps in a process that lead, either positively or negatively, to a particular outcome metric. Also known as performance monitoring, a process measure is used to evaluate whether infection prevention and control practices are being followed.

Policy Explanation and Compliance Guidelines:

1. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required.
2. The staff participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. Examples of notification triggers include, but are not limited to:
    a. Resident develops signs and symptoms of infection.
    b. A resident is started on an antibiotic.
    c. A microbiology test is ordered.
    d. A resident is placed on isolation precautions, whether empirically or by physician order.
    e. Microbiology test results show drug resistance.
3. An annual infection control risk assessment will be used to prioritize surveillance efforts, as documented in the facility's *Infection Surveillance Action Plan*. In turn, surveillance data will provide information for subsequent infection control risk assessments.
4. The CDC's National Healthcare Safety Network (NHSN) Long Term Care Criteria will be used to define infections. For MDS purposes, specific guidance in the RAI manual will be followed when coding for infections (i.e. UTI).
5. Surveillance activities will be monitored facility-wide, and may be broken down by department or unit, depending on the measure being observed. A combination of process and outcome measures will be utilized.

~~b.~~6. The facility will collect data to properly identify possible communicable diseases ~~to the local health department.~~ or infections before they spread by identifying:

~~c. Outbreaks to the local and state health departments.~~

a. Data to be collected, including how often and the type of data to be documented, including:
    i. The infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections:
    ii. Observations of staff including the identification of ineffective practices, if any; and
    iii. The identification of unusual or unexpected outcomes, infection trends and patterns.
b. How the data will be used and shared and with appropriate individuals (e.g., staff, medical director, director of nursing, QAA committee) when applicable, to ensure that staff minimize spread of the infection or disease.

7. The facility will communicate via email communications, the Daily Situational Stat (DSS report) and clinical huddles to staff and/or prescribing practitioners information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical interventions as indicated.
8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends.
9. All resident infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated.
10. Employee, volunteer, and contract employee infections will be tracked, as appropriate and as known, such as influenza or gastrointestinal infection outbreaks.
11. Data to be used in the surveillance activities may include, but are not limited to:
    a. 24-hour shift reports
    b. Lab reports
    c. Antibiograms obtained from lab
    d. Antibiotic use reports from pharmacy
    e. Medication regimen review reports
    f. Skills validations for hand hygiene, PPE, and/or high risk procedures
    g. Rounding observation data
    h. Self-reported concerns
    i. Resident and employee immunization data
    j. Documentation of signs and symptoms in clinical record
    k. Transfer/discharge summaries for new or readmitted residents for infections.
12. Formulas used in calculating infection rates will remain constant for a minimum of one calendar year, and will require discussion in QAA meetings before changes in the formulas are made.

ATTACHMENT:
None.

REFERENCE:
Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria available at:
https://www.jstor.org/stable/10.1086/667743#metadata_info_tab_contents
CDC/NHSN Surveillance Definitions for Specific Types of Infections available at:
https://www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf
Association for Professionals in Infection Control & Epidemiology (APIC).
(2013). *Infection Preventionist's Guide to Long-Term Care*. Washington DC, WA: APIC Association for Professionals in Infection Control & Epidemiology.

Revised: 14/03/17, 15/07/30, 15/11/09, 18/11/13, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

TRANSMISSION-BASED PRECAUTIONS ~~INCLUDING~~AND RESIDENT ROOM PLACEMENT

POLICY:

The ~~LHH procedures for~~ facility uses a coordinated process of standard and transmission~~-~~ based precautions ~~(TBP) will align with the Centers for Disease Control & Prevention (CDC) guidance for patient care and safe room placement based on five (5) criteria:~~

~~1. appropriate room placement~~

~~2. appropriate use of personal protective equipment (PPE)~~

~~3. limiting the movement/transport for those in TBP~~

~~4. use of dedicated patient-care equipment and~~

~~5. proper cleaning and disinfection of rooms.~~

~~1. Resident room placement will meet the resident care infection prevention and control needs by providing the most appropriate room and bed assignment for the resident, as determined by the physician in collaboration with the resident care team and infection prevention and control.~~

~~2. Most diagnoses allow placement of residents into shared rooms and priority for single room placement will be based upon needs, including infection prevention and control requirements for~~ to reduce the risk of transmission~~-based precautions.~~

~~3.~~ ~~Residents with~~ of communicable diseases~~, whether suspect or confirmed, will be assigned rooms according to the resident care precautions adopted by Laguna Honda Hospital (LHH) and referenced in LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions~~ to patients, employees, and visitors.

~~4. Daily cleaning and disinfecting of rooms with residents in transmission-based precautions will be in effect until the precautions are discontinued or until the resident is discharged. This includes enhanced cleaning processes for high-touch areas, horizontal surfaces, and use of specific cleaning products, if required.~~

~~PURPOSE:~~

~~The purpose of this policy is to provide effective practice measures to staff to safely care for patients with~~ **RESPONSIBILITES:**

A. This policy applies to all employees of Laguna Honda Hospital and Rehabilitation and to all medical staff, volunteers, contract workers and students.
B. Supervisors, managers, and directors are required to enforce the provisions of this policy in their areas. Employees who do not follow the contents of this plan may be subject to disciplinary action.
C. The Infection Prevention Department is available to provide consultation regarding transmission based precautions.

Any patient known or suspected ~~infections that represent an increased risk to others. These measures usually temporary, serve to control and/or mitigate risk to staff, visitors and other patients based upon the individuals specific care needs.~~

~~**DEFINITIONS:**~~

~~**Transmission-based precautions:** Standard Precautions is considered the first tier of preventing infections from occurring or being transmitted~~ to ~~others and includes such practices as hand hygiene and respiratory hygiene. Transmission-based Precautions (TBP) is regarded as the second tier of precautions once an infection is known or suspected to be present. The aim of TBP is to slow or stop the spread of that infection to others by using specific measures known to be effective based upon the mechanisms of~~have a disease or condition that warrants transmission ~~of the specific organism(s). The CDC recognizes three (3) classifications of~~ based precautions will be placed in the appropriate transmission ~~for all disease-causing organisms with specific actions to utilize to reduce transmission. The three TBP categories are:~~

~~1. Contact~~

~~2. Droplet~~

~~3. Airborne (respiratory)~~

D. ~~Enhanced Barrier Precautions (EBP) is not a~~ precautions upon admission. Physicians and/or nurses will promptly order the precautions category ~~of TBP but an additional intervention for use in skilled nursing homes where there is common colonization of multi-drug resistant organisms (MDROs) in a residential setting. EBP is a targeted aim of gowns and gloves where MDROs are present or likely to be present including wounds, indwelling urinary or IV catheters. EBP's may be used alone or in conjunction with other TBPs. EBP require signage, point of care PPE availability, and are usually in effect for the duration of the stay. Standard Precautions will be observed with each resident interaction. EBP precautions are found at the end of this document~~for newly diagnosed or suspected cases.

~~It is important to keep in mind that a person may be infected with one or more organisms simultaneously and may require a combination of controls to reduce transmission. For example, combining influenza (droplet) and a wound infection (contact).~~

~~Transmission-based precautions does not require the use of disposable food trays or utensils. Routine dietary cleaning procedures are effective at cleaning and disinfecting food utensils for re-use.~~

~~**Colonization:** disease causing organisms found on the body but there is no evidence that the organism is causing an infection~~

1. The nurse is responsible for ensuring that the precautions are initiated and maintained according to the specified protocol.
2. The infection prevention staff or the patient's nurse may initiate transmission based precautions without the physician's order based upon a lab report, or patient's changing status (e.g., diarrhea) or based on a prior known admission infectious status. In those instances, the physician will be notified that the patient was placed on transmission based precautions, and a note for the rationale will be entered in the nurse's notes.

E. PPE will be located in each Resident unit and care location/department.

PROCEDURE:

~~1. As an immediate intervention, whenever a patient is suspected of having an active infection based upon signs and/or symptoms, it is important not to delay taking measures to institute transmission-based precautions including on holidays, weekends or afterhours, even before lab confirmation is available. Delay can result in transmission and illness to others. TBP can be terminated if not warranted based on lab or other confirmation when available.~~

~~2. Nursing staff will contact the physician if available or Infection control nurse (ICN) for consideration whether the infection may represent Contact, Droplet or Airborne transmission and take immediate appropriate actions including but not limited to:~~

~~a. Close privacy curtain to reduce air movement if sneezing, coughing~~

~~b. Communicate with patient and family why the steps are necessary to prevent others from becoming infected.~~

~~c. Move patient a to private room, if available (ask patient to wear mask during transfer if respiratory)~~

~~d. Provide tissues and disposal bags for expectorant as appropriate~~

~~e. Provide isolation cart with PPE including patient specific equipment~~

f. Place signage identifying the type of isolation and required PPE for patient care

g. Have patient remain in room until lab confirmation has been made including meals and activities

h. Nursing staff will confer with the physician for lab confirmation orders

i. Cover any drainage from wounds or openings with absorbable dressings

j. Follow intravenous protocols for decannulation of IV's catheters if suspected peripheral line infection or sepsis (may be required to retain catheter tips for culture)

k. Restrict entrance of staff and other personnel in the room until lab confirmation is made

l. Visitation can resume after TBP measures are in place and visitors are able and willing to adhere to the precautions based upon their own risk and ability to comply with precaution measures (e.g. masking)

m. The resident's electronic health record must contain the rationale for the selected transmission-based precautions. This should also be document in the care plan.

n. Once the resident is no longer at-risk for transmitting the infection, the removal of transmission-based precautions is required in order to provide the highest level of emotional well-being, support residents rights and to avoid unnecessary involuntary seclusion. The physician in collaboration with ICN and accepted best practices will determine when TBP may be terminated.

3. Upon admission or relocation, the physician and clinical staff will:

a. Identify residents who may require transmission-based precautions prior to admission or relocation

b. When a patient under a TBP is transported, the facility will provide communication to the receiving institution of the TBP type including emergency response, transport vehicles, dialysis or other clinics, and receiving acute care facility/other.

c. Pre-Admitting/pre-screening staff will be alerted to residents who may require transmission-based precautions prior to transport in collaboration with the Infection Control Nurse and Patient Flow Nurse Manager prior to admission to the facility.

4. To the extent possible, notification of the resident and responsible party will be made prior to admission or shortly thereafter for the potential of transmission-based precaution requirements based upon diagnosis.

5. The physician order for transmission-based precautions will be followed by placing the appropriate signage on the door to alert staff and visitors of proper precautions to take when entering the room. No reference is to be made regarding the site or the illness/microorganism. Signage is to indicate the type of TBP only and the required PPE. Signage is available inside the isolation carts and on the LHH SharePoint page.

6. Order the appropriate isolation cart from Central Processing Department (CPD) and ensure that the cart remains stocked with appropriate PPE available to all staff for the entire period of the transmission-based precautions. Refer to LHHPP 72-01 B25 Isolation Carts.

7. Provide visitors with appropriate PPE and assist visitors to follow precautions

8. Airborne Precautions are to prevent the transmission of suspected or confirmed organisms that are transmitted by the inhalation of infectious particles that remain suspended in air for long periods of time, such as measles, chickenpox, disseminated herpes zoster or active pulmonary *Mycobacterium tuberculosis*

    a. ROOM PLACEMENT: An airborne infection isolation room (AIIR), sometimes referred to a negative-pressure room, is required for Airborne Precautions. If an AIIR room is not immediately available, place the patient in a private room, close the door, limit susceptible staff inside the room (immunocompromised), cover any infectious skin lesions, and transfer to a facility with AIIR availability.
    b. Cohorting in a centralized location or neighborhood of multiple residents with the same organism may be utilized for some disease processes/illness in alignment with local, state and federal guidelines (Covid-19 for example).

    c. For transport: the patient should wear an isolation mask, observe cough etiquette and hand hygiene. Do not allow the patient to remain in a hallway or other waiting area. Transport out of the room when the receiving vehicle is ready to receive them.

    d. STAFF PPE: A fit-tested respirator (e.g. N95) is worn by staff providing care in addition to PPE required for Standard Precautions, such as eye protection. Fit testing is required annually and as needed.

    e. MEDICAL EQUIPMENT: Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs) to avoid excessive movement in/out of room. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.

f. CLEANING / DISINFECTING: Clean using the facility schedule using EPA approved disinfectant for specific organism

9. Droplet Precautions are to prevent the transmission of suspected or confirmed organisms that are transmitted by droplets generated by coughing and sneezing that are too large to become suspended and travel in air and inhaled, but may be deposited on mucous membranes such as rhinovirus or influenza. The Sars CoV-2 virus (Covid-19) is transmitted primarily by droplet but additional precautions may be required including use of N95 respirator when community transmission is high or there is an outbreak. See the Covid-19 management protocol for specific details for management of Covid-19 infections.

a. ROOM PLACEMENT: decisions regarding patient placement is made on a case-by-case basis considering infection risks to other patients in the room and available alternatives.

i. The door should remain closed as long as it does not represent a safety concern for the patient (i.e., frequent falls)

ii. The patient should remain in the room, leaving for only medically necessary purposes. The patient should don a mask when leaving the room, and follow hand hygiene and respiratory hygiene

b. STAFF PPE: don a mask upon entry to the room. If expected to go within 6 feet of patient, don a gown in addition to a mask at room entry.

c. MEDICAL EQUIPMENT: Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs) to avoid excessive movement in/out of room. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient

d. CLEANING/DISINFECTING: Clean using the facility schedule using EPA approved disinfectant for specific organism

10. Contact Precautions are to prevent the transmission of suspected or confirmed organisms that are transmitted by direct or indirect contact with the resident or environment such as uncontainable drainage from a multi-drug resistance organism (MDRO) like *methicillin-resistant Staphylococcus aureus* (MRSA) or extended spectrum beta-lactamases (ESBL).

a. ROOM PLACEMENT: is based upon a clinical and IP review for risk of transmitting the disease to others. Consideration is given to type of infection, drainage, cooperation of patient to comply with restrictions, patient mobility and activity level, severity of illness as well as the morbidities (immunocompromised for example) of potential roommates. Ideally, a private

room is preferred but not required. Care plan the room needs, expected duration and provide instruction by communicating with patient and family. Consideration must be given to whether a private bathroom is also needed.

b. STAFF PPE: An isolation gown and gloves are worn by staff in addition to PPE required for Standard Precautions, such as eye protection.

c. MEDICAL EQUIPMENT: Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patients

d. CLEANING/ DISINFECTION: **Prioritize cleaning and disinfection of the rooms** of patients on contact precautions ensuring rooms are frequently cleaned and disinfected (e.g., at least daily or prior to use by another patient if outpatient setting) focusing on frequently-touched surfaces and equipment in the immediate vicinity of the patient.

11. Enhanced Barrier Precautions (EBP) is an infection control intervention and not a separate category of TBPs, used for patients with multi-drug resistant organisms (MDROs) in skilled nursing facilities (SNFs) due to the high prevalence of MDRO colonization which is common in this setting.

a. The CDC has expanded EBP for any SNF resident with an indwelling device or wound regardless of MDRO colonization or infection status

b. In the majority of situations, EBP will be in effect for the duration of the patient's admission; door signage should be posted with PPE located at the point of care; care plan EBP for individualized care needs

c. EBP is an intervention designed to reduce transmission of resistant organism that employees the use of targeted glove and gown use during high contact resident care activities

d. EBP may be indicated when Contact Precautions do not apply, for resident with any of the following regardless of MDRO colonization status:

i. Wounds

ii. Indwelling devices (urinary catheters, IV's, feeding tubes etc.)

iii. Infection or colonization with an MDRO

e. ROOM PLACEMENT: is based upon a clinical and IP review for risk of transmitting the disease to others. Consideration is given to type of infection,

~~drainage, cooperation of patient to comply with restrictions, patient mobility and activity level, severity of illness as well as the morbidities (immunocompromised for example) of potential roommates. Ideally, a private room is preferred but not required. Care plan the room needs, expected duration and provide instruction by communicating with patient and family. Consideration must be given to whether a private bathroom is also needed.~~

~~f. STAFF PPE: An isolation gown and gloves are worn by staff for high contact activities (e.g. bathing, toileting, changing incontinence pads or devices)~~

~~g. MEDICAL EQUIPEMENT: Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient~~

~~h. CLEANING/ DISINFECTION: Cleaning and disinfection of the resident's environment will be accomplished using an Environmental Protection Agency (EPA) approved disinfectant that is effective against spore forming organisms or the specific confirmed organism .~~

TRANSMISSION Based Precautions are designed for patients documented or suspected to be infected/ colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission. The three categories of Transmission Based Precautions include: Contact, Droplet, and Airborne.

A. Signs. Signs will be placed either on the outer room doors for patients placed on transmission based precautions. The sign shall be limited to the type of precautions.

B. Patient Transport. If a patient placed on transmission precautions requires transport, notify the area prior to transport about the patient's condition and the requirement for transmission based precautions.

C. Room Selection. Patients placed under transmission based precautions will be placed in a private room if possible or cohorted with another patient infected with the same pathogen. If this is not possible, the patient may be placed with a patient who has low risk of infection. Consult Infection Prevention Department. place the tray on a clean barrier instead of on a contaminated environmental surface.

D. Linen. All soiled linen will be handled in the same manner regardless of the patient's specific diagnosis. Although the risk of disease transmission from soiled linen is minimal, the following infection prevention guidelines apply to the management of linen and laundry.

1. Handle soiled linen as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen.

2. Linen will not be sorted or rinsed in patient care areas.
3. Place all linen in the designated leak-proof, laundry bags. It is not necessary to put any linen in a red bag.
4. Caution must be exercised to help prevent laundry bags from being OVERFILLED. Do not drag the linen bag on the floor while transporting to soiled utility room.
5. Filled linen bags will be closed securely.
6. Linen should not be stockpiled in rooms.
7. Double bagging will be utilized only when the original linen bag is torn, punctured, or visibly contaminated on the outside; or if the linen contains such a large amount of fluid that the original bag may leak.

E. Foodservice. Disposable trays and utensils for foodservice are not necessary for patients under transmission based precautions. Dietary carts are cleaned per hospital-approved policy.

F. Visitors

- **Airborne**: Visitation should be limited to only those who Nursing agrees will support patient's safety/wellbeing. Visitors should wear a tight fitting mask (N95 - perform seal check) if visitor is unable to tolerate a surgical mask can be used (Sfeir, 2018).
- **Droplet:** Visitation should be limited to only those who Nursing agrees will support patient's safety/well -being. Visitors wear a surgical mask. Visitors are reminded to keep their hands off of their face and perform hand hygiene upon leaving the room.
- **Enhanced Droplet**: Visitation should be limited to only those who Nursing agrees will support patient's safety/well -being. Visitors wear a tight-fitting mask.
- **Contact**: Visitors are not required to wear PPE for contact precautions unless the visitor is going to participate in direct resident care or visit another patient in the hospital. An information sheet is available to educate families of patients on contact precautions to determine if the visitor is at risk for infection (e.g., visitor has an open wound, catheter, etc.).

G. Terminal Room Cleaning

1. When patients are discharged or transferred, the precaution sign must stay in place utthe designated employee has cleaned the room.
2. All room surfaces and equipment are terminally cleaned according to EnvironmentalServices cleaning procedures. Privacy curtains are removed and sent to the laundry.

H. Education. The nurse will educate the patient and/or visitors about hand hygiene, respiratory hygiene (if applicable) and the type of transmission precautions.

I. Environmental Services. EPIC notification automatically populates on the EVS bed board patients on transmission based precautions. EVS staff shall follow TBP signage posted outside rooms and seek guidance from nursing for any question.

CATEGORIES OF PRECAUTIONS

AIRBORNE Precautions are designed to reduce the risk or eliminate the airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei (small particle residue - 5um or smaller sized evaporated droplets which remain suspended in the air of long periods of time) or dust particles containing the infectious agent.

All patients who are:
a) diagnosed with confirmed active TB and are infectious, or b) under clinical suspicion of active pulmonary TB or who show signs or symptoms indicative of a possible TB infection should be placed in airborne precautions (i.e., negative pressure, private room with the door kept closed, N-95 particulate respirator for those entering the room).

Patients who have signs and symptoms compatible with tuberculosis, and who have a diagnostic test for TB (i.e., AFB sputum smear or culture shall be placed under airborne precautions until TB has been ruled out as a diagnosis).

A. Patients will be placed in an airborne infections transmission (negative pressure) room with a minimum of 6 – 12 air exchanges per hour with ventilation either outside or through a high efficiency particulate air filter.

B. When a patient is placed in an Airborne Precaution room, Plant Facilities must be notified, as these rooms must be tested daily using a physical test. Nursing will notify on-call engineer upon admission or transfer of a patient requiring air negative pressure. If the patient is currently in a room that is air negative pressure and then the patient's status changes to need air negative pressure, the nurse needs to notify on-call engineer to check the room for correct pressure daily.

C. Patients diagnosed with tuberculosis or rule out tuberculosis will be placed in the following respiratory isolation rooms:

Location	Room(s)
South 4	28, 48
South 5	28, 48
South 6	28, 48
Pavilion Mezzanine	48

D. Doors must remain closed for the airborne negative pressure rooms to work. This includes doors to ante rooms.

E. An N-95 particulate respirator must be worn when entering the room of a patient in Airborne Precautions. Personnel will have a qualitative fit test prior to being assigned duties requiring the use of an N-95 particulate respirator and will perform a fit check (put mask on and make sure that no air escapes while exhaling) prior to each use. NOTE: Gloves and gowns are not required for airborne precautions unless standard precautions require them.

F. Susceptible persons will not enter the room of patients known or suspected to have measles (rubeola) or varicella (chickenpox). Employees who do not know their status may contact the Employee Health Department.

G. Only transport the patient to other areas if it is essential. If transport is necessary, schedule a time slot to avoid other patients (e.g., last patient of the day) if possible and notify the area regarding patient's precautions prior to patient transport.

H. Patient will wear a surgical or procedural mask during transport and any time he/she is out of the airborne negative pressure room.

DROPLET Precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large particle droplets (larger than 5 um in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated by the source person during coughing, sneezing, or talking and/or during the performance of certain procedures such as suctioning and bronchoscopy. Transmission via large particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 6 feet or less.

A. A surgical or procedural mask must be worn when working within a 6 foot diameter of the patient. The healthcare worker may choose to put on the mask prior to entering the room. An airborne transmission negative pressure room is unnecessary. NOTE: Gloves and gowns are not required for droplet precautions unless standard precautions require them.

B. Patients will be transported only when medically necessary. Inform the receiving area that the patient is under droplet precautions. Patient will wear a surgical mask during transport.

ENHANCED DROPLET Precautions are used when patients with suspected novel pathogens (such as COVID-19) are placed in rooms that are not AIIRs.
Patients in Enhanced Droplet precautions require:

A. Private room if available

B. A portable HEPA filter unit may be added to the room.

C. Care providers must wear a fit-tested N-95 respirator, ~~and~~ eye protection, ~~a~~ powered air purifying respirator (PAPR), gown and gloves.

D. Patients should stay in their room except for essential purposes, in which case, a regular mask (surgical) is worn by the patient at all times outside their room.

E. Visitors will be instructed to wear a tight fitting mask (if N-95 mask, no fit testing required for visitors). They should be instructed on how to don the mask and how to form a good seal. (See Appendix B: Donning and Doffing Mask)

F. Discontinuing Precautions:

1. Enhanced Droplet precautions for COVID-19 positive patients may be discontinued following current CDC and regulatory guidance. Consultation with infection control is encouraged if questions arise.

CONTACT Precautions are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient care activities that require physical contact. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment. Contact precautions are issued for patients infected or colonized with:

A. Gloves will be worn when having contact with patient care equipment that has been used by a patient on contact precautions (e.g., cleaning a wheelchair).

B. Staff will wear a clean, non-sterile gown when entering the patient room for any reason. The HALLWAY PPE cart will remain stocked; nursing personnel caring for the patient shall ensure that items on the cart remain stocked including Regular and XL sized gowns.

C. ANY reusable patient equipment must be cleaned after use with hospital approved disinfectant products.

D. Linen will be stored in a regular linen bag. When the bag is filled, the bag will be closed securely and put in the soiled utility room.

E. Solid waste generated by isolation procedures (e.g., gowns and gloves) shall be disposed of in a regular waste bag inside the patient's room.

F. Immediately prior to exiting the patient room, PPE will be removed. Gowns will be taken off prior to gloves, rolling inwards. Gloves will be taken off taking care to avoid contamination of the hands. At that time, hands will be immediately washed with soap and water, or an alcohol antiseptic gel will be used. Avoid recontamination of hands from environmental surfaces.

G. Transport of patients under contact precautions requires that the patient must be wearing a fresh contact transmission gown outside of the patients' room. The accepting department will implement contact precautions according to policy when the patient arrives in their department.

H. Patients under contact precautions will be allowed outside of the room at the discretion of the unit supervisor. Acceptable behavior might include walks in the hallway of their unit for exercise.

ENHANCED CONTACT Precautions are designed to reduce the risk of transmission of C.difficile by direct or indirect contact spread throughout the healthcare environment. Enhanced contact precautions are issued for patients with active infectious colitis not colonization.

A. Private room if available.

B. Follow and adhere to PPE usage as outlined under contact precautions.

C. Perform hand hygiene preferably with soap and water. Alcohol based hand rubs are an alternative substitute when hand washing sinks are not in close proximity to patient care locations.

D. Use hospital-approved **sporicidal** (bleach) disinfecting wipes on surfaces and equipment.

E. Patients should stay in their room except for essential purposes, in which case, patient should be continent and ability to contain liquid stool is possible. Patient shall wash hands with soap and water and place a clean gown prior to leaving room.

ENHANCED BARRIER Precautions- Long Term Care for residents with wounds or indwelling medical devices during specific high-contact resident care activities commonly associated with MDRO transmission.

A. Private room if available or cohort with compatible roommate based on MDRO status.

B. Wear gowns and gloves while performing high-risk tasks:
1. Morning and evening care
2. Device care (Urinary, Feeding tube, etc.)

3. Close contact resident care (Bathing, peri-care, toileting, changing briefs, respiratory care).
4. Changing bed linens

C. In multi bedrooms, consider each bed space as a separate room and change gowns, gloves and perform hand hygiene when moving from contact with on resident to contact with another resident.

D. Gowns and Gloves should always be removed inside the room when care activity is complete. Gowns and Gloves should not be worn outside the room when resident care is not being performed.

E. Visitors do not need to routinely wear gown and gloves when visiting a resident on EBP. However, visitors who participate in close resident care activity, should wear gowns and gloves when providing care.

DISCONTINUATION of TRANSMISSION BASED PRECAUTIONS: Transmission based precautions remain in effect for a limited periods (while risk of transmission of infectious agent persists during the period of infectivity).

A. Empirically initiated transmission based precautions may be adjusted or discontinued when additional clinical information becomes available (confirmatory laboratory results).

B. Strategies for determining when to discontinue precautions are organism specific and summarized in Appendix A

ATTACHMENT:
~~Attachment 1: Standard Work for Disposable Isolation Meal Trays~~
Appendix A: Type and Duration of Transmission Based Precautions Recommended for Selected Infections and Conditions

Appendix B: Donning and Doffing Mask

REFERENCE:
~~LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units~~
~~LHHPP 72-01 B1 Standard Precautions~~
~~LHHPP 72-01 B2 Hand Hygiene~~
~~LHHPP 72-01 B25 Isolation Carts~~
~~LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions~~
~~LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment~~

~~LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan~~
~~LHHPP 73-09 Respiratory Protection Program (RPP)~~

CDC ~~2007~~ Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings~~, retrieved October 1, 2015~~ (2007)

~~CMS State Operations Manual (2017, November 22). Appendix PP Guidance to Surveyors for Long Term Care Facilities. 42 CFR §483.65 Infection Control (Tag F880). Rev 173~~

CDC ~~(July 2022). .~~gov/COVID in Healthcare ~~associated infections.~~settings (updated 2022)

Minnesota Department of Health (CDPH cited) **Isolation Precautions in LTCF for CDI** health.state.mn,us

CDC: Implementation of ~~*personal protective equipment*~~Personal Protective Equipment (PPE) ~~*use*~~Use in ~~*nursing homes*~~Nursing Homes to ~~*prevent the spread*~~Prevent Spread of ~~*multi-drug*~~ Multidrug-resistant ~~*organisms (MDROs).*~~Organisms (MDRO) July 12,2022

~~https://www.cdc.gov/hai/containment/PPE-Nursing Homes.html#:~:text=Enhanced%20Barrier%20Precautions%20(EBP)%20are,high%20contact%20resident%20care%20activities.&text=Infection%20or%20colonization%20with%20an%20MDRO.~~

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Revised: ~~2022/08/04,~~ 18/11/13, 20/10/13, 22/10/13 (Year/Month/Day)
Original adoption: 16/01/12

Appendix A:
Type and Duration of Transmission Based Precautions Recommended for Selected Infections and Conditions

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Standard Precautions are to be used on every patient. These precautions protect you from exposure to body fluids that could potentially be infectious. ALWAYS protect yourself and wear a mask, eye shield, gloves, and gown when anticipating contact with body fluids.

Some of the organism/syndromes below require a higher level of protection above Standard. This is because of contamination of the environment (making transmission extremely easy), the mode of transmission (contact, droplet, airborne), or the epidemiological significance of the organism (i.e. antibiotic resistance, high virulence). Noted in this table transmission based precautions (Enhanced Contact, Contact, Droplet, Airborne) are always in addition to Standard Precautions.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Acquired immunodeficiency syndrome (AIDS), Human Immunodeficiency Virus (HIV)	**Standard**		
***Acinetobacter baumannii*:**			
Multi-drug resistant	**Contact**	Duration of illness	Place patient in a private room. Epidemiologically significant organism.
Antibiotic sensitive	**Standard***		

Aspergillosis (*Aspergillus sp.*)	**Standard**		Consult IPC if massive soft tissue infection with copious drainage may consider higher level of TBP.
Botulism	**Standard**		Not transmitted from person to person.
Organism/Syndrome	**Precautions**	**Duration of Precautions**	**Comment**
Campylobacter gastroenteritis (See gastroenteritis)			
Candida auris (C. auris)	**Contact**	Duration of Illness*	*For colonization or infection: 1. Contact Infection Control/Nursing Operations Immediately. 2. Private room required. DO NOT COHORT unless cleared though infection control. 3. Hand washing with soap and water as alcohol-based hand rubs are ineffective against C. auris. 4. Clean resident environment daily with Bleach or hospital approved disinfectant effective against C. auris and throughout after interacting with resident or environment. 5. Assume indefinite colonization. 6. Notify receiving facility of C. auris status on transfer or discharge. 7. Consult with Infection Control with questions.
Candidiasis (*Candida sp.*), all forms including mucocutaneous	**Standard**		

Carbapenem-resistant Enterobacteriaceae (CRE)	**Contact**	Duration of Stay*	*For colonization or infection: 1. Contact Infection Control/ Nursing Operations Immediately. 2. Place patient in private room, private bathroom, and dedicated medical equipment. Do not cohort until cleared through infection control. 3. Assume indefinite colonization. 4. Hand hygiene and environmental cleaning are key. 5. Notify receiving facility of CRE status on discharge or transfer. 6. Requires serial surveillance cultures 3-6 months after initial positive to consider discontinuation of precautions.

Organism/Syndrome	**Precautions**	**Duration of Precautions**	**Comment**
Clostridium:			
***C. difficile* gastroenteritis,** enterocolitis (Clostridioides difficile – C. diff - Acute Infection e.g., active colitis).	**Enhanced Contact**	Remain on Enhanced Contact Precautions until 2 days after last unformed stools.	• Private room: door may remain open • Dedicated equipment • Soap and water for hand hygiene • DISINFECT all high touch surfaces with hospital approved BLEACH wipes/sporicidal cleaner/disinfectant once per shift. *Consult Infection Control for questions related to room placement/cohorting guidance following active infection.
Conjunctivitis:			
Acute bacterial	**Standard**		
Chlamydia	**Standard**		

Gonococcal (including gonococcal opthalmia) neonatorum)	**Standard**		
Viral	**Standard**		
COVID-19 (Novel Coronavirus 2019) (SARS-CoV2)	**Airborne/Contact with eye protection**	refer to current LHH COVID-19 prevention and management protocol.	N-95/PAPR + gown + gloves + eye protection, Private Room with door closed.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Cytomegalovirus (CMV) or immunosuppressed	**Standard**		Standard precautions for contact with all body fluids. No additional precautions necessary for pregnant HCWs.
Diarrhea, acute, of unknown etiology, infective etiology suspected *(see gastroenteritis)*			
Endometritis	**Standard**		
Enterococcus sp, vancomycin resistant (VRE)	**Standard***		*Depending on transmission risk- addition of transmission based precautions might be necessary. Consult Infection Control with questions.
Epstein-Barr virus (including infectious mononucleosis)	**Standard**		
Food poisoning:			
Botulism	**Standard**		Not transmitted from person to person
Clostridium perfringens or *welchii*	**Standard**		Not transmitted from person to person

Staphylococcal (*Staphylococcus aureus*)	**Standard**		Not transmitted from person to person
Gastroenteritis (*C. difficile see Clostridium; Norovirus- see Norovirus)*			
Adenovirus	**Contact**	Duration of illness (until diarrhea resolves)	Place patient in private room. Hand Hygiene with soap and water (***not alcohol gel***) is recommended until diarrhea resolves.
Campylobacter sp.			
Cholera (Vibrio cholerae)			
Cryotosporidiosis (*Cryptosporidium sp.*)			

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Gastroenteritis cont. (*C. difficile see Clostridium; Norovirus- see Norovirus)*			
Escherichia. Coli (Enterohemorrhagic O157:H7)			
Escherichia. Coli Other species	**Contact**	Duration of illness (until diarrhea resolves) *Rotavirus: Duration of illness (until diarrhea resolves) **AND** one negative rotavirus test is obtained	Place patient in private room. Hand Hygiene with soap and water (***not alcohol gel***) is recommended until diarrhea resolves.
Giardiasis *(Giardia lamblia)*			
Rotavirus*			
Salmonella (including S. typhi)			
Shigella species			
Vibrio parahaemolyticus			
Yersinia enterocolitica			
Gonorrhea (*Neisseria gonorrhea*)	**Standard**		
Guillain-Barre syndrome	**Standard**		Not an infectious condition.
Helicobacter pylori	**Standard**		

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Hepatitis, viral:			
Type A, chronic	**Standard**		
Type B (HBsAg positive)	**Standard**		
Type C and other unspecified non-A, non-	**Standard**		
Type E	**Standard**		
Herpes simplex (*herpesvirus hominis*):			
Mucocutaneous, disseminated or primary, severe	**Contact**	Until lesions dry and crusted	Place patient in a private room.
Mucocutaneous, recurrent (skin, oral, genital)	**Standard**		
Herpes zoster (see varicella zoster)			
Human Metapneumovirus	**Droplet/Contact**	8 Days from symptom onset or until symptoms resolve regardless of test result	Place patient in a private room if possible.
Impetigo, diffuse	**Contact**	Until 24 hours after initiation of effective therapy	Place patient in a private room if possible.

Influenza:			
Human (seasonal influenza)	**Droplet**	7 days after onset of symptoms and fever free >24 hours	Place patient in a private room or cohort (with verified same viral strain).
Legionnaires' disease (*Legionella sp.*)	**Standard**		Not transmitted from person to person.
Leprosy (*Mycobacterium leprae*)	**Standard**		
Lice (pediculosis)	**Contact**	Until 24 hours after initiation of effective therapy. One treatment is usually sufficient.	Place patient in a private room.
Molluscum contagiosum	**Standard**		
Monkeypox	**Enhanced Droplet**	Until all lesions have crusted, and crusts have separated, and a fresh layer of healthy skin has formed.	Place patient in a private room. Dedicated equipment.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Multidrug resistant organisms (MDRO) infection and colonization:			
Enterococcus, vancomycin resistant (VRE)	**Standard***		*Depending on transmission risk (uncontained wounds/urine)- addition of transmission based precautions might be necessary. Consult Infection Control with questions.
Gram negative organisms, MDR (also see *Acinetobacter baumannii*)	**Standard***		
Staphylococcus aureus, nafcillin/methicillin resistant	**Standard***		
Carbapenem Resistant Enterobacterales (CRE)	**Contact**		

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Noroviruses	**Enhanced Contact Precautions**	Patient remains on precautions until discharge. Consult with Infection Control for extended inpatient stays at hospital, SNF, or Subacute units.	• Gloves and gowns for all persons entering the patient's room for any reason • Private room; door may remain open • Dedicated equipment • Soap and water for hand hygiene • DISINFECT all high touch surfaces with BLEACH once per shift
Pediculosis (Lice)	**Contact**	Until 24 hours after initiation of effective therapy	
Pressure ulcer (decubitus, pressure sore) Infected Major	**Enhanced Barrier**	Until drainage stops or can be contained by dressing.	

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Respiratory Viruses:			
Coronavirus (Seasonal)	**Droplet (See comment)**	Until symptoms resolve regardless of test result	Place patient in a private room if possible. Add Contact Precautions if copious moist secretions and close contact likely to occur.
Human Metapneumovirus	**Droplet/Contact**	Until symptoms resolve regardless of test result	Place patient in a private room if possible.
Influenza (Human/seasonal influenza)	**Droplet**	7 days after onset of symptoms and fever free >24 hours	Place patient in a private room or cohort (with verified same viral strain). See Appendix B for additional Postpartum instructions
Parainfluenza	**Droplet/Contact**	Until symptoms resolve regardless of test result	Place patient in a private room if possible.
Respiratory syncytial virus (RSV)	**Droplet/Contact**	8 Days from symptom onset or until symptoms resolve regardless of test result	Place patient in a private room if possible.
Rhinovirus	**Droplet (see comment)**	Until symptoms resolve regardless of test result	Place patient in a private room if possible. Add Contact Precautions if copious moist secretions and close contact likely to occur.
Scabies	**Contact**	Until 24 hours after initiation of effective therapy	
Syphilis:			
Skin and mucous membrane, including congenital, primary, secondary	**Standard**		
Latent (tertiary) and seropositivity without lesions	**Standard**		

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Tuberculosis (*M. tuberculosis*):			
Skin-test (PPD) positive with no evidence of current pulmonary disease	**Standard**		
Pulmonary (suspected or confirmed) OR laryngeal disease	**Airborne**	Discontinue precautions only when TB patient is: 1. On effective therapy x14 days 2. Improving clinically 3. Has 3 consecutive negative sputum smears collected on different days or when TB is ruled out	Place patient in a negative air pressure room, staff to wear N95 or PAPR.
Varicella (chickenpox)	**Airborne/Contact**	Until ALL lesions are crusted over	Place patient in a negative air pressure room. Susceptible HCWs should NOT enter the room if other, immune caregivers are available.
Wound Infections	**Enhanced Barrier Precautions**	Until healed	
Varicella zoster (herpes zoster, shingles):			HCWs susceptible to varicella are also at risk for developing varicella when exposed to patients with herpes zoster lesions; therefore, susceptible HCWs should not enter the room if other immune caregivers are available.
Disseminated (across multiple dermatomes) disease in any patient.	**Airborne/Contact**	Place patient in a negative air pressure room until ALL lesions are crusted over	

Localized in normal patient and lesions can be contained/covered	**Standard**		

Appendix: Donning and Doffing Mask

Putting on a mask with head straps

Inspect the mask. Before putting on a mask, first inspect it for damage. Do not use a mask that appears damaged.

1. **Wash your hands** or use hand sanitizer before putting on your mask.

2. **Position the mask in your hand with the nose pieces at your fingertips.** (Most masks designed to seal to the face have a thin metal or plastic bar at the top of the device)

3. **Cup the mask in your hand** allowing the headbands to hang below your hand. Hold the respirator under your chin with the nosepiece up.

4. **The top strap (on single or double strap respirators) goes over and rests at the back of your head near the crown.** The bottom strap is then positioned around the neck and below the ears. Do not crisscross the straps.

5. **Place your fingertips from both hands at the top of the nose clip. Slide down both sides of the strip to mold the nose area to the shape of your nose.**

Check the Seal. Check the seal of the mask to the face. Place both hands over the mask, take a quick breath in to check the seal. Breathe out. If you feel a leak when breathing in or breathing out, there is not a proper seal.

Image credit: The CDC (https://blogs.cdc.gov/publichealthmatters/2019/05/using-a-respirator/)

Taking off a mask with head straps

Do NOT TOUCH the front of the mask!
It may be contaminated.

1. **Wash your hands** or use hand sanitizer before taking off your mask.

2. **Remove by pulling the bottom strap over the back of your head,** followed by the top strap. Remember, do not touch the facepiece of the mask.

3. **For reusable masks wash and safely store after use.** For single use masks, safely discard after removal.

4. **Wash your hands** or use hand sanitizer after taking off your mask.

Image credit: The CDC (https://blogs.cdc.gov/publichealthmatters/2019/05/using-a-respirator/)

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GENERAL INFECTION CONTROL VISITOR GUIDELINES

POLICY:

~~1. Visitors shall be provided with infection prevention and control instructions and or written materials by Nursing staff or other disciplines when visiting residents.~~

1. This facility will implement heightened surveillance activities for communicable disease during periods of transmission in the community, an outbreak in the facility, and/or during a declared public health emergency for the illness. The facility may modify visitation practices when there are infectious outbreaks or pandemics to align with current CMS guidance and CDC guidelines. Visitors will be expected to follow general infection control practices to protect a vulnerable population when visiting the facility. Visitation will be permitted at all times with very limited exceptions to ensure that resident's rights are respected and prioritized.

PURPOSE:

~~To~~ The purpose of this policy is to provide information to minimize the transmission risk of infection from the community to the patients by using general control measures including hand hygiene, respiratory hygiene, vaccinations and masking to reduce the risk of disease transmission. When in the facility, visitors ~~to residents or staff and to assist staff in educating visitors on~~are expected to adhere to the core principles of infection prevention and ~~control recommendations to reduce transmission of infections.~~follow the local, state, and federal requirements when outbreaks occur.

DEFINITION:

- **Visitor**: ~~Anyone~~For the purpose of this policy a visitor is defined as anyone who is not ~~a healthcare worker,~~performing work in the facility at the request of the facility, whether paid or unpaid~~; who comes on the Laguna Honda Hospital (LHH) campus to meet, visit, or comes within 6 feet of a resident~~.

PROCEDURE:

1. ~~Visitors~~Visitors that are Ill: Signage will be posted at entrances that indicate that visitors with a fever, respiratory, or gastrointestinal symptoms shall be asked to refrain from visiting LHH until they are afebrile for at least 24 hours (without the use of fever-reducing medication) and symptoms have resolved for at least 24 hours.

2. Practice Hand Hygiene: Visitors shall be encouraged to practice proper hand hygiene by staff and through signage placed throughout the facility and on neighborhoods conveying the importance of hand hygiene, how to do it correctly, and to perform hand hygiene frequently. Refer to LHHPP 72-01 B2 Hand Hygiene.

3. Transmission-based Precautions: A resident on additional transmission-based precautions will have signage placed outside the room alerting individuals prior to

entering. Nursing shall explain the transmission-based precautions to the visitor before they enter the room for the first time and if further education and clarification is needed. Visitors will be ~~strongly encouraged~~asked to follow the personal protective equipment (PPE) requirements for the transmission-based precautions indicated by the signage~~,~~ when providing or assisting with patient care and reminded to practice hand hygiene upon entering and exiting resident rooms. Visitors who fail to follow infection control requirement may be asked to leave the facility.

4. Annual Influenza Vaccine: Visitors shall be encouraged to get an annual influenza vaccine, which is recommended by Centers for Disease Control and Prevention (CDC) annually for everyone 6 months and older to protect against the influenza virus. Signage regarding the importance of a flu vaccine, respiratory/cough etiquette, and the mandatory masking period during the influenza season shall be visible throughout the facility and on neighborhoods.

   a. ~~During this time, visitors~~Masking: Visitors who have not received the current year's flu vaccine OR visitors vaccinated with the live attenuated influenza vaccine (LAIV) within 7 days shall be asked to wear a mask anytime s/he is within 6 feet of a resident. ~~Masking by visitors is voluntary.~~ California requires masking by al individuals entering high risk settings. CDC has determined that those who receive the LAIV or "nasal spray" should avoid contact with immunocompromised persons for 7 days after getting the nasal spray vaccine.

   b. Practice Respiratory Hygiene: Visitors shall be asked to cover coughs and sneezes with a tissue. If tissues are not available, cover coughs and sneezes with the sleeve. Clean hands by using an alcohol-based hand rub or washing hands with soap and water immediately after.

~~Respiratory stands that are stocked with masks~~Rare Exceptions and ~~tissues~~Limitations:

   1 Visitation Alternatives: visitors may be asked and LHH will provide other forms of visitation including tele-visits, video visits, or outdoor visits for specific needs during a limited time to control disease transmission.

   ~~c.~~2. Holiday/High Volume Visitation: every effort will be made ~~available during the influenza season.~~ to provide a safe space for visitation during periods of high volume such as holidays. However, some accommodations may be required including staggering visiting hours to ensure physical distancing during outbreaks.

   3. Compassionate Care Visitation: considerations will be made on a case-by-case basis to provide for a safe and compassionate visitation for all residents based upon their individual needs.

   ~~5.~~4. Outbreak Guidance: In the event of an outbreak/epidemic in the facility or community, ~~notices shall be posted outside of affected neighborhoods and/or at facility entrances to provide information on restrictions and guidelines for~~

~~visitors~~more restrictive guidance may be implemented including but not limited to severe respiratory outbreaks such as Covid-19. Specific protocol management will be provided during pandemics.

ATTACHMENT:
~~None.~~
Screening Signage

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
CDC Influenza (Flu) available at: https://www.cdc.gov/flu/index.htm
CDC Live Attenuated Influenza Vaccine [LAIV] (The Nasal Spray Flu Vaccine) available at: https://www.cdc.gov/flu/about/qa/nasalspray.htm

CMS: QSO-20-39-NH (revised 09/23/22). Nursing Home Visitation COVID-19 Revised

Revised: 16/09/13, 19/03/12, 20/10/13 22/09/29 (Year/Month/Day)
Original adoption: 05/11/01

ILLICIT OR DIVERTED DRUGS AND/OR PARAPHERNALIA POSSESSION/USE BY RESIDENTS OR VISITORS

POLICY:

1. As in the greater community, the use, possession, solicitation and/or distribution of illicit or diverted drugs and/or paraphernalia at Laguna Honda Hospital and Rehabilitation Center (LHH) is prohibited.

2. ~~Facility~~LHH staff ~~will~~shall have knowledge of signs, symptoms, and triggers of possible ~~illegal~~ substance use, which includes but is not limited to:

   a. Changes in resident behavior

   b. Increased, unexplained drowsiness

   c. Lack of coordination

   d. Slurred speech

   e. Mood changes

   f. Loss of consciousness

3. Staff shall take steps to prevent illicit or diverted drugs and/or paraphernalia use or access~~,~~ and shall promote and support resident efforts to minimize the health consequences of illicit or diverted drug and/or paraphernalia use.

~~2.~~4. If ~~the facility~~LHH determines through observation that a resident may have access to ~~illegal~~ substances that they brought into the facility or secured from an outside source, the facility will not act as an arm of law enforcement.

~~3.~~5. The San Francisco Department of Public Health promotes Harm Reduction methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals, their family and community. Harm reduction methods and treatment goals are free of judgement or blame and directly involve the client in setting their own goals.

PURPOSE:

1. To ensure LHH's capability to deliver effective health care to its residents by:

   a. Minimizing the presence and use of illicit or diverted drugs at LHH;

   b. Eliminating the presence of illicit or diverted drugs and /or drug paraphernalia;

c. Minimizing disease progression related to illicit or diverted drug use;

d. Maximizing therapeutic impact and safety of prescribed medication;

e. Maximizing the safety of the resident and other residents, staff, volunteers, and visitors; and

f. Complying with State and City laws and regulations.

g. Including strategies that reduce harm for those clients who are unable or unwilling to modify their unsafe behavior.

DEFINITIONS

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

2. **Diverted drug**: Any drug that is intentionally and without proper authorization, used or taken possession of that is not prescribed for the resident. Examples of drug diversion include, but are not limited to, the following:

    - Medication theft, from other patients or organizations.
    - Using or taking possession of a medication without a valid order or prescription
    - Forging or inappropriately modifying a prescription.

3. **Paraphernalia**: Medical apparatus or over-the-counter items that are commonly used in illicit drug activity such as syringes, needles, drug pipes, hemostats, and so forth.

4. **STARS:** Substance Treatment and Recovery Services offered at LHH.

5. **MAT**: Medication Assisted Treatment for the use of substance abuse (specifically opioids).

6. **Harm Reduction**: SFDPH philosophy promoting methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community by reducing unsafe practices rather than abstaining from dangerous behavior.

PROCEDURE:

1. Illicit or Diverted Drug Possession/Use by Residents

a. On admission to LHH, the Admissions and Eligibility Department representative shall inform the resident of this Illicit or Diverted Drug and/or Paraphernalia Possession/Use policy and shall request that the resident acknowledge notification. The resident, or the resident's legal representative, affirms by his/her signature on the House Rules and Responsibilities that s/he understands and agrees to abide by the policy and procedure.

b. If the resident has a substance use disorder or a history of substance use, the admitting or attending physician shall recommend to the resident that s/he receives an assessment by a STARS clinician in addition to medical management. The referral for STARS can be made through LHH Psychiatry e-referral. STARS providers shall offer specialized services including group therapy, individual counseling, and recommendations about Medication Assisted Treatment (MAT) for substance use. For details on STARS service, see MSPP D08-07 LHH Substance Treatment and Recovery Services.

c. The Resident Care Team (RCT) shall identify the team member who shall address safety issues around substance use, once identified, with the resident whose behaviors related to substance use are negatively impacting their own care and/or affecting others. This is to ensure safety for all. Intervention options shall be reflected in the resident's care plan, which may include (but are not limited to) MAT, participation in STARS treatment, peer counseling, 12 Step groups, other psychosocial treatment and interventions, and San Francisco Sheriff's ~~Department~~ Office (SFSO~~D~~) assistance in case of safety crisis.

   i. The attending physician shall offer STARS, as indicated.

   ii. STARS and/or other LHH Psychiatry providers shall offer behavioral intervention recommendations. For details on LHH Psychiatry service on behavioral management, see MSPP D08-10 Behavioral Management Services by LHH Psychiatry.

   iii. RCT team members shall orient the resident to LHH safety rules, and address issues related to substance use through the care planning process. Clinical interventions may include limiting access to medications and/or illicit drugs (passes, access, visitors, etc.).

   iv. When any LHH staff member has reasonable grounds to conclude a resident is using illicit or diverted drugs in violation of LHH policy, s/he shall inform the resident's attending physician or assigned physician coverage and the RCT.

      - If the physician determines reasonable grounds exist, comprehensive drug screens shall be obtained, consistent with the signed Conditions of Admission.

- If the resident refuses testing and is competent to refuse, (a) the refusal shall be considered the same as a positive result, and (b) further hospitalization may be conditional upon the resident's desire to comply with LHH policy.

2. **Resident symptoms indicating a change of condition requiring a possible urine toxicology screen (UTOX)**

a. Resident symptoms indicating a change of condition requiring a possible urine toxicology screen (UTOX) would include an altered level of conscious ness, abnormal vital signs (RR<12), somnolence. Observable signs of intoxication as well as sign of overdose (not breathing, unresponsive, lips and fingers turning blue/grey, gurgling sounds, rigid limbs), for which a code must be called.

i. Provider to evaluate resident exhibiting a change of condition based upon signs and symptoms communicated by staff.

ii. A urine toxicology (UTOX) screen shall be requested from the ED by provider any time a resident is determined to require an ED visit.

iii. The Charge Nurse shall complete Unusual Occurrence and submit to Quality Management (QM) any time a resident is determined to require an ED visit.

iv. If resident does NOT require ED visit the provider shall order comprehensive urine toxicology (UTOX) screen and await results.

v. Staff shall immediately send residents requiring Narcan to Emergency Department (ED);

- Provider shall request urine toxicology (UTOX) screen from ED and await results.

3. **Urine toxicology (UTOX) Results**

a. If UTOX results are negative and/or contain the residents prescribed medications – no follow up required;

b. If UTOX results are positive:

i. Charge Nurse to complete Unusual Occurrence Report, AND

ii. Nurse Manager/ Nursing Operations or Quality Management shall report Facility Reported Incident (FRI) to CDPH within 24 hours per Title 22.

iii. Pharmacy shall review results of any non-prescribed medications identified in UTOX with provider and notify QM.

4. If the RCT determines reasonable grounds exist, a designated team member may conduct a clinical safety check of the resident's person, room, bed and belongings for the safety of the resident, other residents, and staff as outlined in LHHPP 22-12 Clinical Safety Search Protocol. All contraband found during a clinical safety check shall be turned over to the ~~SFSD~~SFSO for appropriate legal disposition. If the resident becomes aggressive or poses a safety risk, unit staff shall request the ~~SFSD~~SFSO to standby during the clinical safety check.

   a. The employee who discovers or suspects the illegal use, possession, solicitation and/or distribution shall complete an Unusual Occurrence report.

   b. LHH staff may request the ~~SFSD~~SFSO to consider a legal search.

      i. If warranted, the ~~SFSD~~SFSO shall evaluate the circumstance and shall determine if legal "probable cause" exists to permit a deputy to conduct a legal search.

      ii. If probable cause exists, LHH staff shall inform the resident of the need for the ~~SFSD~~SFSO to search in order to protect the resident, as well as others from the health/safety implications of substance use in LHH.

      iii. The ~~SFSD~~SFSO shall conduct the legal search.

      iv. The ~~SFSD~~SFSO shall seize all contraband found during a legal search and shall proceed with appropriate and legal disposition.

      v. Any resident or visitor in possession of illegal substances is subject to detention and possible citation or physical arrest by the ~~SFSD~~SFSO.

   c. Substance use (lab documented and/or reasonable grounds), possession, solicitation and/or distribution shall result in progressive interventions for the resident.

      i. A determination shall be made of the resident's decision-making capacity to enter into a treatment plan.

      ii. If resident has no decision-making capacity regarding substance treatment:

      iii. The RCT, in conjunction with the surrogate decision maker (if any), shall initiate or increase behavioral interventions intended to limit resident access to illicit or diverted drugs; and

iv. Staff shall document reason(s) for treatment decision(s).

v. If resident has decision-making capacity regarding substance treatment:

vi. Further treatment at LHH shall require that the resident adhere to a substance use related behavior plan developed by the RCT.

vii. The behavioral plan may include (but not be limited to) interventions such as: random laboratory (preferably urine) toxicology testing, attendance at substance use treatment groups, restricted community or LHH access, room observation and visitor check-in.

viii. Refusal to enter into a treatment contract or violation of the predetermined terms of the behavior plan shall be considered a decision by the resident to end the treatment and may result in discharge.

ix. In the event of discharge, the resident shall be offered a referral to community outpatient services.

x. In the event that discharge from LHH would constitute a medical emergency (risk to life, limb or function within 48 hours), the RCT shall initiate or increase behavioral interventions intended to limit resident access to illicit or diverted drugs and may implement other behavior plan conditions.

d. Upon presentation to LHH of a resident previously discharged for violation of policies or contract(s), a readmission to LHH shall require the resident to reengage in a substance use treatment plan. If two LHH admissions have resulted in substance use-related discharges, the resident shall be considered to have refused LHH services and, in conjunction with LHH Screening Committee, the resident shall not be readmitted without review and demonstration of change from the resident (for example, successful completion of community residential substance treatment program).

5. Paraphernalia Possession/Use by Residents

a. When any LHH staff member has reasonable grounds to conclude a resident may have possession and/or use of drug paraphernalia, the RCT shall be informed.

i. Assigned nursing staff and other available members of the RCT may initiate a clinical safety check of the resident's person, room, bed and belongings for the safety of the resident, other residents, and staff as outlined in LHHPP 22-12 Clinical Safety Search Protocol. If the resident becomes aggressive or poses a safety risk, unit staff shall request the ~~SFSD~~SFSO to standby during the clinical safety check.

ii. The RCT may request the ~~SFSD~~SFSO to consider a legal search, and to proceed, if warranted, as outlined in paragraph 1.C.IV.

b. If staff find illicit or diverted drugs and/ or paraphernalia in a resident's possession and/or use:

i. Staff shall confiscate the illegal or diverted drugs and/or paraphernalia and turn it over to the ~~SFSD~~SFSO. Paraphernalia not placed into evidence by the ~~SFSD~~SFSO shall be disposed of in accordance with appropriate disposal procedures.

ii. The staff person who directly observed the drug paraphernalia shall report the incident to the ~~SFSD~~SFSO.

iii. The clinical staff person who directly observed the drug paraphernalia, or her/his immediate supervisor, shall document the incident in the resident's medical record and complete an Unusual Occurrence report.

iv. If the staff member who directly observed the drug paraphernalia is not a clinician, s/he should report to an RCT member and also complete an Unusual Occurrence report.

v. Depending on the type of intervention (legal search or clinical safety check), the ~~SFSD~~SFSO or assigned nursing staff with other available members of the RCT, may perform further checks of the resident's person, room, bed, and belongings.

vi. If the resident remains at LHH and the physician determines reasonable grounds exist, the physician may order comprehensive drug screens which shall be obtained from the patient, consistent with the signed Conditions of Admission.

vii. Residents who are found with illegal or diverted drugs may be subject to detention and/or citation or physical arrest by the ~~SFSD~~SFSO.

viii. Found illicit or diverted drug or paraphernalia, including unauthorized syringes, may be grounds for discharge.

ix. If the RCT determines that the resident is unable to be immediately discharged because such discharge might constitute a medical emergency (i.e., risk to life, limb or function within 48 hours), the resident shall not be discharged. In lieu of discharge, LHH staff shall take appropriate steps to limit resident access to drug paraphernalia by creating a behavior plan that may include:

- Restriction to room and/or neighborhood.

- Restriction of visitors.
- Transfer of room assignment for increased safety.
- Removal of other personal containers where syringes could be stored (e.g., toothbrush holder).
- Search and removal of contraband as outlined in LHHPP 22-12 (Clinical Safety Search Protocol-).
- Close observation by staff (refer to LHHPP 24-10 Close Observation).
- Limitations of pass privileges.
- Toxicology screens and resident clinical safety checks shall be performed upon return to care unit from pass, as indicated.

c. A resident who was previously discharged for drugs or paraphernalia possession who then requests readmission to LHH and agrees to abide by LHH policies:

   i. Shall be screened and may be considered for readmission based on his/her current condition.

   ii. May be asked to sign a behavioral plan as a condition of admission.

6. Illicit or Diverted Drugs and/or Paraphernalia Possession/Use by Visitors

a. If a visitor is observed, or reasonably suspected, to be in possession and/or use of illegal or diverted drugs and/or paraphernalia, the staff who directly observed the event shall immediately report the incident to the ~~SFSD~~SFSO for immediate response and investigation.

b. A visitor found to be in possession and/or use of illicit or diverted drugs and/or paraphernalia may be referred by the RCT or LHH staff to Administration for administrative review, which may include restriction or removal of visitation privileges at LHH.

c. A visitor found to be in possession and/or use of illegal or diverted drugs and/or paraphernalia is subject to detention, removal from LHH grounds and/or possible citation or physical arrest by the ~~SFSD~~SFSO.

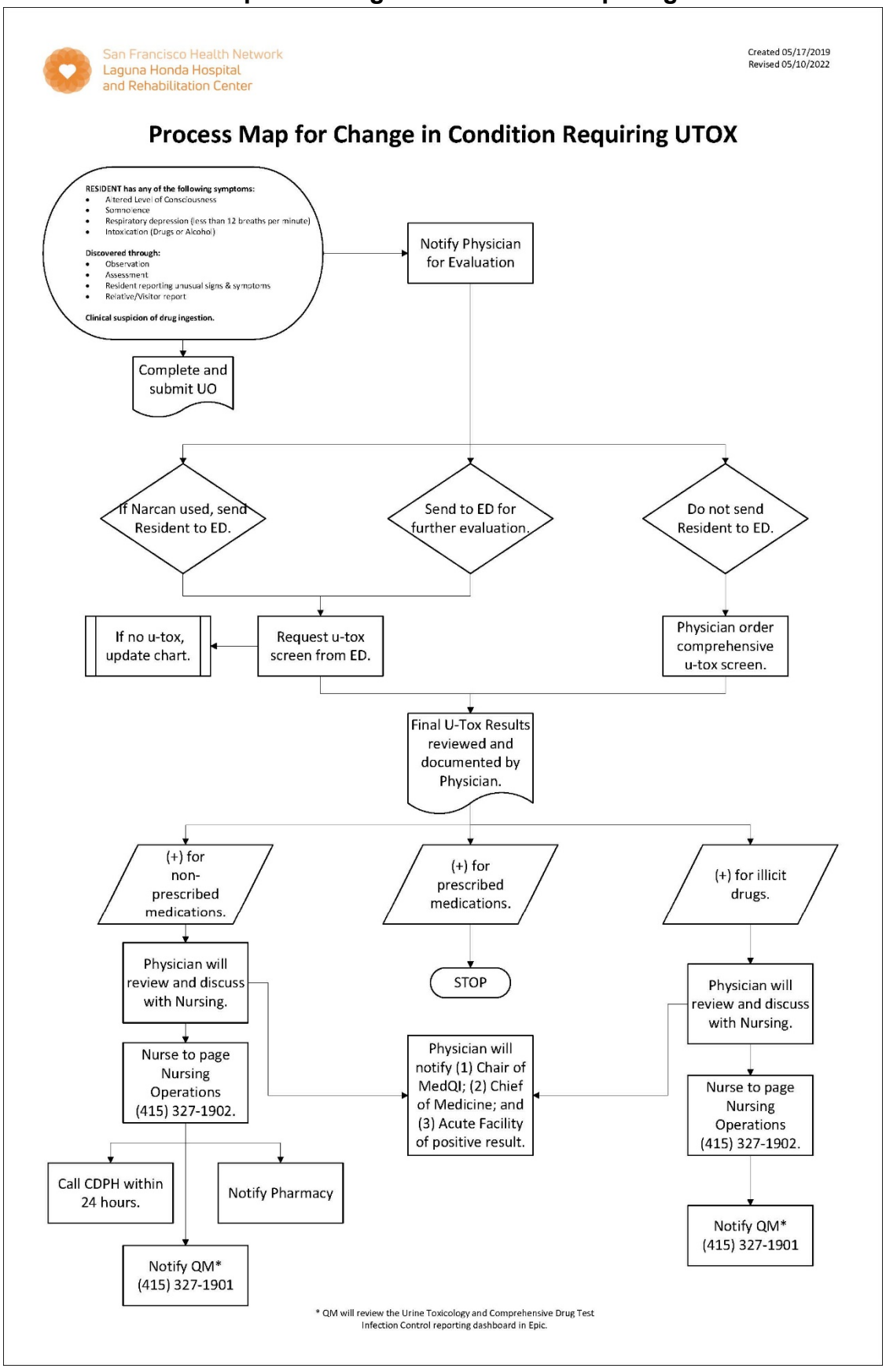
ATTACHMENT:
Appendix I: Process Map for Change in Condition Requiring UTOX

REFERENCE:

LHHPP 20-01 Admission to LHH and Relocation Between LHH SNF Units
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-03 Resident Rights
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 22-12 Clinical Safety Search Protocol
LHHPP 24-10 Close Observation
LHHPP 24-25 Harm Reduction
LHHPP 60-04 Unusual Occurrences
LHHPP 75-03 Disorderly or Disruptive Visitors
MSPP D08-07 LHH Substance Treatment and Recovery Services
MSPP D08-10 Behavioral Management Services by LHH Psychiatry

Revised: 98/04/01; 00/05/25, 12/09/25, 14/05/27, 17/06/01, 17/09/12, 19/03/12, 20/05/19 (Year/Month/Day)
Original adoption: 96/07/15 (drugs only)

Appendix I: Process Map for Change of Condition Requiring UTOX



SMOKE AND TOBACCO FREE ENVIRONMENT

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to maintain a smoke and tobacco free environment consistent with State laws and City regulations for the protection and preservation of the health of residents, employees, volunteers and visitors.

2. Smoking and tobacco products are prohibited on the LHH campus, with the exception of smoking in the designated smoking area as described below.

3. Lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame are not permitted and shall be collected from residents by staff for safekeeping.

4. Residents are not permitted to keep tobacco products on their person, in their personal belongings, or in their patient room. Tobacco products will be stored in a central location for safekeeping and usage only in Serenity Park, the designated smoking area. Patients will receive one smoking product at a time

5. Tobacco products brought by visitors, bought for residents, or purchased by residents while Out on Pass will be surrendered in the lobby and picked up by designated unit staff.

6. This policy applies to any tobacco product, any product that emits smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, including nicotine and non-nicotine e-cigarettes, cigarettes, cigars, pipes, pipe tobacco, or chewing tobacco.

7. Buying and selling of tobacco products, products that emit smoke, or any lighted, heated, ignited, electronic, or any other device that delivers nicotine or other substances to the user, between any individuals is prohibited.

8. The prohibition of smoking on the LHH campus applies to staff, vendors, volunteers, and visitors.

9. Residents may only smoke in the designated smoking area when on the LHH campus, in accordance with their individual care plan. Smoking or ingesting cannabis is not permitted in the designated smoking area.

10. Residents with an oxygen tank or concentrator are prohibited from smoking or being within 6 feet of the designated smoking area.

11. During off campus resident related activities:

a. Residents are expected to comply with this policy and according to their care plan.

b. Employees shall comply with this policy when on work time.

DEFINITION:

1. The LHH campus means the area owned, operated, maintained, or leased by the City, bordered by Laguna Honda Boulevard, Woodside, Idora and Clarendon and includes all buildings, grounds, parking spaces, and all vehicles owned or operated by LHH or the City.

2. Smoking means inhaling, exhaling, burning, or carrying any lighted, heated, or ignited cigar, cigarette, cigarillo, pipe, hookah, electronic device, or any other device that delivers nicotine or other substances to a person.

3. Tobacco Product means:
   a. any product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, snuff; or

   b. any electronic device that delivers nicotine or other substances to the person inhaling from the device, including, but not limited to, an electronic cigarette, electronic cigar, electronic pipe, or electronic hookah.

PURPOSE:

1. To promote a smoke and tobacco free environment;

2. To comply with state and/or local regulations which promote a smoke free work environment;

3. To ensure a healthy, comfortable and safe environment; and

4. To provide leadership, guidance and support in the promotion of a healthy lifestyle.

PROCEDURE:

1. Signage

a. Signs that advise that LHH is a smoke and tobacco free campus shall be posted at the hospital's entrances.

b. Signs that advise that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are prohibited shall be posted at the hospital's entrances.

c. A designated smoking area has been created for residents' use.

2. Applicability

a. Resident Notification, Assessment and Care Planning

i. Applicants and referral sources shall be informed by receipt of the referral packet that LHH is a smoke and tobacco free campus with a designated smoking area for LHH residents.

ii. New residents are given the Smoke and Tobacco Free Environment Policy by Admissions and Eligibility staff at the time of the resident's admission or as soon thereafter as is reasonable.

iii. The resident or surrogate decision-maker acknowledges receipt of the Smoke and Tobacco Free Environment policy and agrees to abide by its requirements by their signature on the House Rules and Responsibilities.

iv. The physician and/or the licensed nurse shall document the resident's smoking and tobacco use history.

v. When indicated, a designated member(s) of the Resident Care Team (RCT) shall provide the resident with smoking cessation education and therapies.

vi. The Smoking Assessment shall be completed by RCT members to determine if a resident has a desire to smoke and if the resident is a safe or unsafe smoker. Assessment and education about smoking and smoking cessation shall be documented in the resident's medical records.

- The frequency of Smoking Assessment shall be completed on admission, re-admission, quarterly, annually, when ~~there is a significant change in condition, when a resident is placed on oxygen, when a resident who smokes has delirium affecting cognition and understanding, and/or when a resident who did not smoke at admission begins to smoke.~~a resident experiences a cognitive change that affects their safety awareness and judgement.

- Any resident who is deemed safe to smoke, with or without supervision, shall be allowed to smoke in the designated smoking area, at designated times, and in accordance with his/her care plan.

vii. ~~Clinical care plan interventions shall be developed for those residents who are placed on oxygen~~If indicated (e.g., possession of an ignitor), ~~. This shall include a search of the resident's room and/or belongings, with the consent of the resident, to collect lighters, matches, e-cigarettes, and other devices that ignite,~~

~~light, or fuel a flame for safekeeping.~~refer to LHHPP #22-12 Clinical Search Protocol

viii. Clinical care plan interventions shall be developed for those residents who have violated the smoke and tobacco free environment policy, and may include,

- Search of a resident's belongings and room, with their consent, for, and safekeeping of, smoking or tobacco product materials.

- Meeting with RCT members to discuss the violation with resident and outline care plan to prevent further smoking or tobacco product violations, which may include repeat searches, engagement in smoking cessation activities, referral to Psychiatry for management of comorbid behavioral health conditions and/or MD.

ix. Those residents who are identified as smokers, who would like to quit smoking shall be offered smoking cessation education and will be evaluated for appropriate therapies with a goal of smoking cessation.

b. Employee and Volunteer Notification

i. Job posting announcements shall include a statement informing applicants that LHH is a smoke and tobacco free campus.

ii. Employees, volunteers, including trainees and students, shall be notified during orientation that smoking is not permitted on the LHH campus. Staff, vendors, volunteers and visitors will need to go off campus to smoke. The designated smoking area is only for resident use.

iii. To facilitate a smoke and tobacco free environment, designated staff shall periodically offer smoking cessation programs for employees.

iv. Volunteers shall be notified that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are not permitted at each visit when asked to sign-in with the volunteer kiosk.

c. Visitor Notification

i. Visitors, including contractors, vendors and outpatients, shall be informed that LHH is a smoke and tobacco free campus, and that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are not permitted through signage at entrances, applicable agreements, hospital brochures and staff. The designated smoking area is only for resident use.

3. Compliance & Safety

a. Employee Obligations

i. The entire LHH community is responsible for complying with the Smoke and Tobacco Free Environment policy, which may include respectfully informing the smoker that LHH is a smoke and tobacco free campus with a designated smoking area for resident use only.

ii. The Smoke and Tobacco Free Environment policy is part of the new employee orientation and annual in-service.

iii. An employee who observes a violation of this policy by a resident is to report the incident to the respective neighborhood nurse manager/charge nurse.

iv. An employee who observes a violation of this policy by a staff member is encouraged to report the incident to the responsible manager for corrective action.

v. An employee who violates this policy may be subject to disciplinary action.

vi. Sheriff Officers who observe noncompliance or are contacted to assist with notifying residents, visitors or employees to comply with this policy may cite the noncompliant individual for violation of municipal or state codes.

b. Safety Obligations

i. For residents who are identified as a smoker or have a desire to smoke, the RCT shall complete the smoking assessment on admission, re-admission, quarterly, annually, when there is a significant change in condition, when a resident is placed on oxygen, when a resident who smokes has delirium affecting cognition and understanding, and/or when a resident who did not smoke at admission begins to smoke.

ii. The RCT shall ensure that residents whose assessments or care plans indicate a need for assisted or supervised smoking have a written plan that assists, supervises, and monitors their smoking. The RCT shall also ensure that lighters, matches, e-cigarettes, and other devices that ignite, light, or fuel a flame are collected from such residents.

iii. The RCT shall review the care plan of residents who are not complying with the terms of this policy to determine if further interventions can be provided to assist the resident with compliance.

iv. The smoke patrol shall report smoking violations to the Nursing Office.

v. RCT will address resident's non-compliance by assessing and implementing appropriate interventions.

4. If at any time LHH changes its policy to prohibit smoking, it will allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents and takes into account non-smoking residents.

   ~~c.~~a. Residents admitted after the facility changes its policy will be informed of this policy at admission, along with their family members.

ATTACHMENT:
None.

REFERENCE:
LHHPP 22-12 Clinical Search Protocol
LHHPP 35-01 Guidelines for Sales, Distribution of Free Items, and Solicitation on the Campus
LHHPP 75-05 Illicit or Prohibited Drugs and Paraphernalia Possession/Use By Residents or Visitors
CDPH Program Flexibility, Requested 01/13/2014
Laguna Honda House Rules and Responsibilities
Smoking Cessation Assessment (MR 161T)
California Labor Code Sec. 6404.5
California Health and Safety Code Sec. 11362.3
San Francisco Health Code Art. 19F

Revised: 98/01/01, 08/10/01, 08/11/25, 10/04/13, 11/11/29, 14/01/28, 15/11/09, 18/09/11, 19/03/12, 20/10/13, 22/07/12 (Year/Month/Day)
Original adoption: 92/10/30

STUDENT, VOLUNTEER AND CONSULTANT ORIENTATION

POLICY:

New students, consultants and volunteers are required to attend an orientation training prior to rendering care and supportive services to residents at Laguna Honda Hospital.

PURPOSE:

To assure the delivery of ~~resident centered~~quality care according to Center for Medicare /Medicaid Services (CMS) guideline training of all new and existing contractors in order to meet the conditions of participation ~~standard Hospital operating procedures~~ and ensure a welcoming environment for all.~~.~~

PROCEDURE:

1. Prior to commencing of ancillary activity within the Hospital, all new persons will be scheduled to participate in a documented orientation training:

Orientation Target Group	Responsible Manager
Non-employees	
Volunteers	Manager/Coordinator, Volunteer Department
Students/Interns~~Volunteers~~	Manager/Coordinator responsible for respective student/intern~~Manager/Coordinator, Volunteer Department~~/DET School Affiliation Coordinator
Non-employee consultants~~Students/Interns~~	Manager/Coordinator responsible for contract/agreement~~Manager/Coordinator responsible for respective student/intern~~
~~Non-employee consultants~~	~~Manager/Coordinator responsible for contract/agreement~~

2. Failure to comply with this policy will result in appropriate action, including denial of ancillary participant's privileges.

3. Staff from Volunteer Services, Department of Education and Training (DET), ~~Nursing Education~~, or the responsible manager/coordinator shall provide a physical tour of the hospital and ~~-~~orientation in the following~~se~~ areas in accordance with CMS Regulations: ~~review definition of resident-centered care,~~ emergency response procedures, resident rights and civil rights, culture of humility, dementia and behavior, communication, trauma informed care, infection control, quality assurance and improvement, compliance and privacy. In addition to an introduction to the ~~a physical tour of the hospital,~~ resident population served, specific job duties, introduction of relevant personnel and/or ~~-~~hospital policies and procedures, including abuse reporting, ~~fire safety response, emergency preparedness, infection control,~~ hazard communication, smoke~~-~~free campus~~. and confidentiality of resident health information.~~

~~3.~~4. The responsible manager/coordinator will ensure completion of the initial training and annually thereafter to comply with CMS Regulations.

~~4.~~5. DET shall review departmental orientation materials for students, volunteers, and consultants for compliance with regulatory requirements at least annually.

ATTACHMENT:
None

REFERENCES:
LHHPP 80-02 Employee and Volunteer Identification
NPP A5.0 Nursing Educational Affiliations

Revised: 22/10/03, 22/06/29, 97/06/11, 02/11/14, 08/04/22, 15/03/10 (Year/Month/Day)
Original adoption: 92/05/20

STAFF EDUCATION PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall maintain an effective staff training, orientation, and education program to uphold and improve staff competencies in the provision of person-centered, culturally respectful and inclusive interdisciplinary services.

2. LHH education and training programs shall be consistent with LHH strategic goals and regulatory requirements.

3. LHH education programs shall support individual development and group needs identified through the performance improvement activities and performance appraisals.

4. DET shall conduct a biannual review and revision of the topics of its in-service training program for submission to CDPH. Prior to submission to CDPH, DET will present its proposed in-service training program to Nursing Executive Committee (NEC) for review. After approval from NEC, the proposed in-service training program will be sent to Performance Improvement and Patient Safety Committee for a final review. Thereafter it will be sent to CDPH for approval. This process is to ensure that topics are relevant to the facility and its needs.

5. Human Resources staff shall notify the Department of Education and Training (DET) of the names of new hires and their start dates; staff who have left and their separation dates; and staff who are on an extended leaves and their anticipated return dates.

PURPOSE:

The purpose of this policy is to delineate staff responsibilities related to the provision of staff education and development at LHH.

CORE PRINCIPLES OF LEARNING:

1. To promote learning that supports resident-centered care and improves outcomes at the bedside consistent with the hospital's mission and vision.

2. The model shall be integrated, partnership-oriented, collaborative, and supportive of all LHH staff, based in the hospital’s organizational development goals and linked to the neighborhoods.

3. Everyone learns and everyone teaches. All staff can participate in teaching opportunities. While the staff development team can provide the guidance, consultations and support in the delivery of training, all staff are engaged.

4. Compliance shall continue to be a high priority of our education program, and we shall exceed regulatory standards so that we can see long-lasting behavioral changes.

5. Education shall be dynamic, participatory and customized for the learners. The facilitator or instructor shall be able to apply teaching methods that the audience can relate to and find meaning which they can apply to their essential job functions and responsibilities.
6. Effective education supports all departments; clinical and non-clinical, and assesses interests and needs of staff and programs by identifying quality indicators in high risk, high volume, or problem-prone areas.

7. Education shall promote effective communication and positive interactions among peers. Teaching opportunities can include both residents and staff.

8. Education is focused on developing individual and collective capacities for high performance, with training that leads to individualized care.

9. Learning opportunities are used to develop leadership skills at all levels that promote accountability and are linked to the hospital's goals and objectives.

PROCEDURE:

1. Staff Training and In-services

a. Human Resources shall schedule new employees to attend New Employee Orientation (NEO) upon hire.

b. New employees shall receive a 2-day in-person and computer-based NEO training to the culture, strategic goals, safety and regulatory requirements of LHH.

c. The NEO program shall be scheduled at a minimum on monthly basis beginning the first business day of a pay period.

d. Annually, employees shall be provided with year-round mandatory in-services that meet State, Federal and City requirements.

e. A monthly calendar of scheduled educational in-services shall be sent electronically to staff with DPH email accounts and posted on the intranet.

f. DET shall provide live classes for CNAs, PCAs and HHAs to meet the 24-hour CNA certification requirements.

g. A variety of initial and annual health and safety classes shall be provided to specific classifications of employees in compliance with Cal OSHA regulations.

h. Live classes may also be provided for specific staff audiences.

i. Computer based or live training shall be provided to other employees at the discretion of department supervisors.

~~i.~~j. In-service training is provided by qualified personnel (in house or outside entities) in a variety of formats (e.g., facilitated training, computer-based training, self-directed learning, mentoring and/or coaching, etc.).

k. Mandatory live classes are open to all staff, students and volunteers.

l. Training content includes, at a minimum:
   i. Effective communication for direct care staff.
   ii. Resident rights and facility responsibilities for caring of residents.
   iii. Elements and goals of the facility's QAPI program.
   iv. Written standards, policies, and procedures for the facility's infection prevention and control program.
   v. Written standards, policies, and procedures for the facility's compliance and ethics program.
   vi. Behavioral health.
   vii. Dementia management and care of the cognitively impaired.
   viii. Abuse, neglect, and exploitation prevention.
   ix. Safety and emergency procedures.

m. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment.
   ~~j.~~

2. Employee Responsibilities

a. Every employee shall

   i. Be accountable and responsible for their own development, competency, and compliance with educational requirements for licensure or certification.

      - Be present and sign in when attending educational requirements.

      - Employees shall not have another person represent them or sign in for them in their absence.

   ii. Participate in formal and informal needs assessment processes to identify learning needs.

   iii. Participate in LHH orientation, mandatory in-service, and needs based training such as, Mandatory Plan of Correction – related trainings, unit based training, or individual training.

iv. Participate in professional educational activities, with supervisory approval as needed, during paid time or continuing education leave.

v. Report learning needs and knowledge or skill deficiencies to their supervisor or manager during orientation, annual performance appraisal, and on an ongoing basis.

vi. Collaborate with their supervisor and manager in meeting identified learning needs.

vii. Perform duties within their respective scopes of practice, according to LHH policies and procedures in a culturally effective manner.

viii. Maintain adequate continuing education hours to meet the requirements of their license or certification.

3. Manager Responsibilities

a. Department leaders: including directors, supervisors, and managers shall collaborate with DET educator(s) to perform the following functions:

i. Provide department and unit based orientation for employees new to the department or to a job within the department.

ii. Assess, plan, develop, implement, and evaluate unit based orientation and educational activities within their own area(s) or departments.

iii. Utilize pertinent data, including aggregate data, concerning resident satisfaction, quality indicators, competency findings and other outcome data to assist in the needs assessment process.

iv. Provide in-service education documentation including original sign-in sheets, outlines, evaluations or post-tests to the DET for inclusion into the LHH education database within 2 weeks of the training.

v. Monitor employee compliance with mandatory in-services by reviewing the monthly compliance report, following up with individual staff who have not completed their mandatory in-services within 30 days of assignment and addressing timely completion of mandatory in-services as part of the annual performance appraisal process.

vi. Oversee that the environment is inclusive of diversity (i.e. pictures, role-modeling inclusive behavior) and supports cultural humility.

vii. Collaborate with DET if any employee was placed on administrative leave for abuse or any disciplinary issue to identify training needs prior to returning to full duty.

4. Staff Development Steering Committee (SDSC)

a. The Staff Development Steering Committee was developed to increase staff awareness and support LHH's core principles of learning.

b. The Staff Development Steering Committee comprise of an interdisciplinary team of members from Administration, Nursing, Medicine, Social Services, Clinical Nutrition, Therapeutic Activities, Pharmacy, Information Services, Rehabilitation Services, Environmental Services, Human Resources and QM.

c. Additional members from other departments may join the Committee with approval from their Division head and the Chair.

d. Functions of Core Team Members:

i. Core team members shall meet, at a minimum quarterly, to discuss and collaborate on the development and implementation of the vision and strategic planning goals for learning for LHH.

ii. Participate in reviewing and developing hospital-wide education programs and their respective departmental education plans for current and new staff members, or assign this task to a staff member(s) within their division or department.

iii. Contribute to improving vertical and horizontal communications within the facility.

iv. Review and develop education policies and procedures.

v. Cultivate a culture of compliance to support the mission and vision of the organization.

vi. Promote continuous quality assurance and performance improvement (QAPI) approach to improve patient/resident outcomes and organizational effectiveness.

vii. Evaluate the effectiveness of education programs based on resident outcomes data and staff performance appraisal information.

viii. Establish annual hospital-wide educational priorities

e. Other Functions of a Sub-group of SDSC Members

i. Determine LHH's hospital-wide education and training needs by reviewing performance improvement data and reports:

- Resident outcome data, such as satisfaction surveys, quality indicators, State survey results, and demographics identifying the problems and needs of the resident population
- QAPI Team and committee educational recommendations. (e.g., Infection Control, Safety, Code Blue, Abuse Prevention, etc.)
- Risk management data
- Department of Public Health recommendations
- LHH strategic goals
- Current evidence based practice and healthcare research
- Competency and Performance Appraisal trends provided by Human Resources
- Educational needs surveys
- Class / Course evaluations

ii. Develop and implement an annual hospital-wide education and training program and orientation programs that address identified needs and meet or exceed healthcare industry standards and regulatory requirements.

iii. Collaborate to develop and maintain Program Approvals (HS279A and B) for annual in-service and C.N.A. orientation from the California Department of Public Health (CDPH), licensing and certification division in collaboration with DET and the Chief Nursing Officer.

iv. Provide assistance and consultation to facility leadership to determine educational needs and to enhance competency, cultural effectiveness and performance.

5. Documentation of Formal Educational Activities

a. Educational activities are documented to meet minimum requirements of the State Department of Health Services and California Board of Registered Nurses or other pertinent regulatory bodies.

b. Documentation of in-services shall include:

i. An in-service cover sheet containing the following information:

- Title of the program
- Date
- Instructor(s)
- Length (number of hours)
- Assessed need (or purpose)
- Performance
- Behavioral Objectives
- Equipment needed
- Materials needed
- Outline of content (with adequate detail to discern what was taught)
- Method of Evaluation (to assure that learning has occurred)

ii. Original sign-in sheets

iii. Course evaluations (a representative sample are kept on file after the end of the course)

iv. Posttests or other evidence of evaluation of learning (a representative sample are kept on file after the end of the course)

c. Documentation for continuing education credits under LHH's Board of Registered Nursing provider number shall comply with the current BRN CEU requirements including:

i. Title of Program

ii. Date(s)

iii. CE hours

iv. Objectives

v. Overview

vi. Course Outline

vii. Method of Evaluation

viii. Course evaluations and / or posttests (kept on file in DET)

ix. A brochure or flyer posted at least 30 days before the start of the class that includes the first 5 bullets, cost and refund policy if there is a fee, course cancellation policy and the required BRN CEU provider statement.

d. Transcripts of individual staff attendance are available to staff and managers.

e. Education compliance tracking reports are available through the computerized education database and can be accessed from the database by designated staff from DET or designees with administrative access to the database.

f. DET maintains files of educational programs submitted for a minimum period of 4 years for in-services and continuing education courses.

g. NEO records are maintained for a minimum of 10 years by Human Resources and DET departments.

ATTACHMENT:
None.

REFERENCE:
Visioning and Strategic Planning for Learning in the New Laguna Honda

Reviewed: 07/01/03, 08/11/25, 12/09/25, 15/03/10, 16/09/13, 19/07/09, 21/02/09 (Year/Month/Day)
Original adoption: 07/01/03

Revised Pharmacy Policies and Procedures

LAGUNA HONDA HOSPITAL **01.03.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PERSONAL MEDICATIONS AND/OR SUPPLEMENTS

Policy:

Medications and/or supplements brought into Laguna Honda Hospital with the resident are not to be used in the Hospital.

Purpose:

To ensure that the resident receives only medications and supplements ordered by their attending physician at Laguna Honda Hospital.

Procedures:

1) On admission, the nurse in charge will ascertain whether the resident has any medications and/or supplements on their person or in their possessions.

2) If there are relatives or a guardian, the nurse may return the medications and/or supplements to them on request.

3) If the medications are not returned to the family or guardian, the nurse will then send the medications and/or supplements to the pharmacy for destruction.

4) Medications and/or supplements will be disposed of in the manner described under "Disposition of Medications" (Policy and Procedure 02.01.02) after 30 days.

5) Medications brought into Laguna Honda Hospital will not be administered to the resident except in the event that the medication is not on the Formulary ,is additionally hard to obtain, quite expensive, or will only be used for a short period of time (e.g. a resident admitted for respite care). USP verified non-formulary supplements may be administered to resident after approval via the non-formulary process as outlined below.

   a) Prior to administration, medication brought into the Hospital for use as outlined by this Policy will be examined and positively identified by the pharmacist or physician, and labeled with a Laguna Honda Hospital Pharmacy label indicating the name of medication, strength, dose, and expiration date. ~~This does not apply to herbal supplements. Pharmacy will not identify, label or handle patient personal herbal supplements.~~

b) The amount of medication to be issued will be limited to a supply sufficient to allow the pharmacy to obtain the hospital's own supply, or in the case of a resident admitted for respite care, until the resident can be discharged.

6) Patient personal supply of supplements will be limited to USP verified supplements.
   a) A physician order will be required for use of patient personal supply of supplements.
   b) Patient personal supply of supplements will be stored by nursing
   c) Administration of patient personal supply of supplements will be documented on the medication administration record.
   ~~d)~~ Any supplement that is not USP-verified is considered an exception to this policy and must be reviewed on a case-by-case basis by physician, nursing, and pharmacy and documented in the EHR

Revision History: 12/97, ~~202208068~~8/22, 11/22

LAGUNA HONDA HOSPITAL **02.01.04**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PASS MEDICATION

Policy:

Residents on pass will receive sufficient medications for the duration of the pass.

Purpose:

To assure continuity of care.

Procedure:

1. **When the pharmacy is open**, the attending physician will enter a "Take-Home Med" order through EPIC. Controlled substances will be e-prescribed or hand-written on a controlled substance prescription with doctor's signature and date. The order shall include the name of the medication(s), strength, frequency, directions for use, quantity and start/end time and date of the pass

   a. The pharmacist will dispense the medications in properly labeled child-proof containers.

   ~~a.~~b. Bulk medications (topicals, eye/ear drops, inhalers, insulin) that are taken from the unit for use while on pass will be properly relabeled with an outpatient label

   ~~b.~~c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.

2. **When the pharmacy is closed**, the physician may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed in a progress note in the electronic health record.

   a. Controlled substances **may not** be dispensed by the physician from the ward's supply. When the pharmacy is closed, the Nursing Supervisor will contact the on-call pharmacist at home.

   b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Room for the physician to properly label the pass medications taken from the resident's own supply.

   c. The physician will counsel the resident on proper use of his/her medications.

Revision History: 2/96, 4/98, 12/98, 1/05, 2/19, 7/22

LAGUNA HONDA HOSPITAL **02.01.05**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY COMPUTER DOWN-TIME

Policy:

In the event of computer downtime, the pharmacist shall implement a manual system of pharmacy operation.

Purpose:

To assure that prescription orders are properly and uniformly processed during computer downtime periods.

Procedure:

I. Pharmacy staff will submit a helpdesk ticket in the event of suspected downtime. Request estimated length of downtime when submitting ticket.

The downtime procedures should be implemented if the system will be down for greater than 30 minutes during pharmacy operations or as advised by the Hospital Incident Command System (HICS).

A. The downtime computer will be used to- print patient medication profile and MAR summary reports for any patient with new orders to facilitate checking for drug interactions, appropriate dosing and allergies.

B. The downtime computer will be used to print batch fill lists

C. If the downtime is extended, the packaging machines may need to utilize the previous days file for filling the packager fill list. Decision to use the previous day's file will be made by the PIC in conjunction with additional hospital leadership and HICS.

II. ALL NEW ORDERS: Prescriptions will be filled directly from the written order. The labels will be typed manually using pharmacy typewriters or handwritten. The label (if greater than 48 hour supply of medication provided) and the pharmacy copy of the order will note the following:

1. Resident's name and unit
2. Medication and strength
3. Quantity dispensed
4. Administration instructions
5. Manufacturer
6. Physician's name
7. Date of expiration
8. Date of fill
9. Filling pharmacist's initials and pharmacy technician initials (as applicable)
10. Drug description (discharge and pass medications only).

III. ALL REFILL ORDERS: Fill lists will be printed from the downtime computer for scheduled batches. Prescriptions that are not part of the cart fill may be refilled from the printed medication profile.

A. Prescription labels and pharmacy copy of the order must contain all of the information noted in #2 above, in addition to marking the order as a "Refill".

IV. After dispensing, copies of all manually filled new and refill orders will be placed in a specially designated area for later inputting into the electronic system.

V. When the downtime is clear, all orders dispensed by the above procedures must be entered into the system by pharmacy. The correct written fill date must be used when entering the orders.

VI. For prolonged downtime, pharmacy may need to assist with bulk charging. See downtime binder for ~~step-by-step~~step-by-step instructions on the bulk charging process.

Reference:
HWP 21-21 Electronic Health Record (EHR) Downtime
DPH Wide Epic Admin 9.03 Electronic Health Record (Epic EHR) Downtime

Revision History: 3/97, 10/09, 7/20

LAGUNA HONDA HOSPITAL **02.01.09**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR REPACKAGING MEDICATIONS

Policy:

Pharmacy personnel shall repackage medications using standard procedures in individual packages for dispensing when it is either cost effective or unavailable from the manufacturer.

Purpose:

To ensure accuracy and documentation of all repackaging activities.

Procedure:

I. Technicians shall be responsible for repackaging medications under the supervision of a pharmacist.

II. The packaging shall be done in the manufacturing area of the Pharmacy.

III. The technician shall check the repackaging record of the drug to be packaged to determine if special instructions need to be followed, and check the quantity repackaged last time to serve as a guide as to the quantity that shall be repackaged this time.

A. If the drug has never been repackaged, a pharmacist shall investigate and identify any potential problems. The results shall be noted on the repackaging record, referenced and verified by the Supervising Pharmacist. Drugs with well-known stability problems (e.g. nitroglycerin) shall **NOT** be repackaged.

IV. Before packaging, the bulk drug shall be inspected to verify that it is the proper drug and checked for contamination or other deleterious effects. Determine that the expiration date on the original container allows an adequate shelf life for the repackaged product and enough drug of the same lot number is available to complete the operation. If a chemical is used for compounding and it does not have a manufacturer's expiration date, use the Pharmacy Department determined expiration date for repackaged medications in 5.e.. If different manufactured lots are used, each lot shall be handled as a separate procedure and different lot numbers assigned.

V. The labels on the individual packages shall be typed. Labels shall include the following information:

A. Full name of the drug (no abbreviations) and in the following order:

1. Generic name
2. Trade name if available, in parenthesis, or
3. Trade name only if it is a combination drug.
4. Manufacturer's name
5. If a hazardous drug, include the word "hazardous" next to the drug name

B. Strength and size, number of tablets or volume if applicable.
C. Dosage form. Example: tablet, capsule, elixir or syrup.
D. Units of measure shall be noted using the metric system.

E. Expiration date of the **repackaged drug.** The beyond use date for non-sterile products repackaged into single unit or unit dose containers ~~is one year or less~~ is 6 months from date of repackaging, unless stability data or the manufacturer's labeling indicates otherwise or manufacturer's expiration date is earlier. The beyond use date for multiple-use containers such as a ~~typical~~ prescription vial shall be ~~not~~ no later ~~then~~ than the manufacturer's expiration date ~~on the manufacturer's container~~ or one year from the date the drug is ~~dispensed~~ filled, whichever is earlier.

F. Pharmacy control number - This number will be the date plus a letter to identify the item packaged (See Policy & Procedure 02.01.07 Number Assignments).

G. NDC and barcode of medication

H. An extra label shall be printed which is to be attached to the backside of the packaging record.

Sample label: ACETAMINOPHEN AND CODEINE
300mg/15mg tabs #25
(for Tylenol with Codeine #2)
Control # 900515A Mfg: TE
Exp: 11/15/90 Initials:

I. Initials of the technician repackaging, the pharmacist who checked the label and the pharmacist checking the product shall be noted on the packaging record.

VI. Repackaging records of all packaging runs shall be kept (ATTACHMENT 1) and shall include:

A. Complete description of the product (name, strength, and dosage form of the drug).
B. Copy of the label that shall be affixed to the back of the control record.
C. Special packaging procedures/requirements.
D. Pharmacy control number.
E. Expiration dates – Pharmacy and manufacturer
F. Total quantity packaged.
G. Units packaged (total number and size).
H. Manufacturer's name
I. Manufacturer's ~~control~~ lot number.
J. Initials of the person who did the repackaging.
K. Initials of the pharmacist who checked the label
L. Initials of the pharmacist who checked the completed product.

VII. Adequate space shall be provided for repackaging, free from extraneous material. The repackaging area and the packaging material shall be clean. Cleanliness is essential for the personnel involved in the operation.

VIII. After repackaging, the item repackaged along with the bulk container (s) shall be set aside for a pharmacist to check with the records.

IX. It shall be the responsibility of the pharmacist to verify that the packaging system (drug, materials, machines and devices) is set up correctly and all procedures have been performed properly. The pharmacist shall verify that:

A. The drug matches the label (i.e. the correct drug was packaged).
B. Information on the label is correct.
C. Correct amount or volume is packaged.
D. Repackaged product is properly sealed.
E. Packaging record for the drug is completed.
F. Packaging lot number is logged.

X. After the pharmacist checks the product, it shall be ~~placed into stock in the appropriate location~~ put away in its assigned location for use

NOTE: All drugs should be packaged and stored in a temperature and humidity-controlled environment. Temperature shall not exceed 25°C (77°F). The applicable FDA and USP requirements concerning the type of package required for specific drug products shall be followed. It is the responsibility of the Supervising Pharmacist to ensure that all equipment, materials and procedures conform to legal requirements.

XI. There shall be two binders kept in the packaging area. One shall contain the repackaging records of individual drugs. The other shall contain a daily log of repackaging and manufacturing activity. All records shall be kept for 3 years after the expiration date.

XII. References:

A. The Script. California Board of Pharmacy, July 2001.
B. Revised USP Stds for Am J Health Syst Pharm 2000; 57:1441-5.

Revision History: 2/2002

Attachment 1 – Repackaging Record Log

LAGUNA HONDA HOSPITAL **02.01.10**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY OPERATIONS DURING THE TEMPORARY ABSENCE OF A PHARMACIST

Policy:

Pharmacists are able to have duty free breaks and meal periods to which they are entitled under Section 512 of the Labor Code and the orders of the Industrial Welfare Commission, without unreasonably impairing the ability of a pharmacy to remain open.

Purpose:

To comply with legal requirements and good clinical practice.

Procedure:

A. In situations where a single pharmacist staffs the pharmacy, the pharmacist may leave the pharmacy temporarily for breaks and meal periods without closing the pharmacy. Ancillary staff may remain in the pharmacy if the pharmacist reasonably believes that the security of the dangerous drugs and devices will be maintained in his or her absence. If in the professional judgement of the pharmacist, the pharmacist determines that the pharmacy should close during his or her absence, then the pharmacist will close the pharmacy and remove all ancillary staff from the pharmacy during his or her absence.
B. During the pharmacist's temporary absence, no prescription medication may be provided to a resident or to a resident's agent unless the prescription medication is a refill medication that the pharmacist has checked, released for furnishing to the resident and was determined not to require the consultation of a pharmacist.
C. During such times ~~that~~ when the pharmacist is temporarily absent from the pharmacy, the ancillary staff may continue to perform the non-discretionary duties authorized to them by pharmacy law. ~~However, a pharmacist upon his or her~~ Upon returning to the pharmacy, the pharmacist shall review ~~any duty~~ the duties performed by ~~any member of~~ the ancillary staff.
D. During the temporary absence of a pharmacist as authorized by this section, an intern pharmacist may not perform any discretionary duties nor otherwise act as a pharmacist.
E. The temporary absence authorized by this section is limited to the minimum period authorized for pharmacists by section 512 of Labor Code or orders of the Industrial Welfare Commission, and any meal is limited to 30 minutes. The pharmacist who is on break is not required to remain in the pharmacy area during the break period.

Authority cited: Sections 4005, 4115 and 4116, Business and Professions Code. Reference: Section 1714.1 of Title 16 of the California Code of Regulations.

Revision History: 08/05

02.01.03

LAGUNA HONDA HOSPITAL
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR BEDSIDE STORAGE OF MEDICATIONS

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

Purpose: To prevent unauthorized use or handling of bedside medications.

Procedure:

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

II. Only naloxone nasal spray~~-~~, rescue inhalers, or ~~any , and~~ other documented, approved rescue medications prescribed by physicians for bedside storage may be kept at bedside.

   a. Naloxone nasal spray prescribed for patient's at risk for unintentional opioid overdose emergency drugs shall be stored on the resident's person or in a locked cabinet or drawer.

III. No other medications or herbal supplements shall be kept at bedside.

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

V. The licensed nurse assigned to medication duty will supervise the use of self-administered medications and chart the medications used on the medication and treatment record.

   a. The medications used will be recorded in the resident's health record, based on observation of self-administration by nursing personnel and/or information supplied by the resident.

   b. The quantity supplied for bedside storage will be recorded by nursing staff in the resident's health record each time the medication is supplied.

Revision History: 10/91, 6/98, 2/19, 8/22, 11/22

LAGUNA HONDA HOSPITAL **02.02.02**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR FENTANYL TRANSDERMAL PATCHES

Policy:
The fentanyl transdermal patch is a Schedule II controlled substance that is a high risk drug. The medication shall be prescribed, dispensed, applied, monitored and disposed of appropriately to assure therapeutic efficacy, prevent adverse outcomes and to prevent diversion.

Purpose:
To outline the process for the proper prescribing, dispensing, application, monitoring, disposal and documentation of the fentanyl transdermal patch used for the treatment of severe pain.

Procedures:
1. Prescribing: Fentanyl transdermal patch is indicated for the management of persistent moderate-to-severe pain when around the clock pain control is needed for an extended time period. Fentantyl transdermal patch shall only be used in patients who are already receiving opioid therapy, are opioid tolerant, and who require a total daily dose equivalent to at least 25 mcg/hour transdermal patch. Fentanyl is contraindicated in patients who are not opioid tolerant, in the management of short-term analgesia, or in the management of postoperative pain. Only residents with physician orders will receive fentanyl patches as directed.

2. Order Processing/Dispensing:
   a) The pharmacist shall verify the resident's opioid intake in previous 7 days to assure adequate opioid tolerance (use of > 60mg oral morphine equivalents / 24 hours for previous week). This verification will be documented in an i-Vent (pharmacist intervention documentation section) in the electronic health record.
   b) Dose titration: The dosage should not be titrated more frequently than every 3 days after the initial dose or every 6 days thereafter. ~~Patients~~ Residents should wear a consistent fentanyl dosage through two applications (6 days) before dosage increase based on supplemental opiate dosages can be estimated. **Note:** Upon discontinuation, ~17 hours are required for a 50% decrease in fentanyl levels.
   c) The pharmacist shall assess fentanyl patch dose increases for appropriateness by evaluating supplemental opiate usage between dose adjustments. The US product labeling for fentanyl patch recommends using a ratio of at least 45mg oral morphine equivalents per 24 hours for each 12.5mcg/hr dose increase of fentanyl patch. The pharmacist shall document this assessment in an i-Vent in the electronic health record.
   d) If an order for fentanyl patch is part of a ~~patient's~~ resident's admission orders the pharmacist shall verify that the ~~patient~~ resident was receiving a fentanyl patch previously from a transfer summary or by verifying with nursing that the ~~patient~~ resident was wearing a fentanyl patch upon arrival. This verification will be documented in an i-Vent in the electronic health record.
   ~~d)~~e) Pharmacy will load fentanyl patches securely in the Omnicell on the units under patient specific orders for nurses to retrieve and administer to residents.
   ~~e)~~f) For outpatient prescriptions the pharmacist will confirm that naloxone has been made available consistent with ~~pharmacy~~ medical staff policy MSPP-D15~~02.02.00~~.

3. Application, verification, and disposal of the fentanyl transdermal patch see Nursing PP J1.0

Revision History: 11/01, 5/11, 4/14, 2/16, 3/19, 4/19, 08/22

LAGUNA HONDA HOSPITAL **02.03.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR EMERGENCY AND SUPPLEMENTAL MEDICATION SUPPLIES

Policy:

An emergency medication container will be kept on each unit and supplemental medication supplies will be kept in the Supplemental Medication Room.

Purpose:

To have medications available in case of need and to make sure that items are replaced when used.

Procedures:

A. **SUPPLEMENTAL MEDICATION AUTOMATED DISPENSING CABINET (ADC) –** ***Also see PHAR 09.00 Automated Dispensing Cabinets***

1. The Supplemental Medication ADC is to be used only on nights, weekends, and holidays when the pharmacy is closed.

2. The nursing supervisor is the only authorized person to have the key to the room containing the Supplemental Medication ADC.

3. Nursing supervisor will be notified by either MD or RN as to which emergency medication is needed.

4. Nursing supervisor will consult the supplemental medication list posted on the Omnicell Information Webpage SDR List or use OmniExplorer at a cabinet to see if the medication is available.

5. If the medication is available, the nursing supervisor and RN will proceed to the Supplemental Medication ADC.

6. Nursing supervisor will dispense requested medication to RN.

7. An electronic record will be maintained, which includes the medication issued, date, amount issued, resident's name, and name of the nurse supervisor.

8. Re-secure Supplemental Medication Room by checking door is locked when exiting.

9. Before dispensing to the unit, the nursing supervisor shall check the medication ordered against patient's listed drug allergies in the electronic health record. If an allergy is noted the physician should be contacted.

10. If the requested medication is not available from the Supplemental Medication ADC, the Nursing Supervisor will use the OmniExplorer feature to determine if the medication is available in another ADC within the facility. If the medication is not available in any ADC the Nursing Supervisor will check with the physician to see if an available medication can be substituted, or if therapy can wait until the Pharmacy reopens. If not, the nursing supervisor will call a pharmacist at home to come to the hospital and dispense the medication from the Pharmacy.

11. If a LHH pharmacist cannot be reached or is unavailable:

    a. The nursing supervisor will call ZSFG Inpatient Pharmacy at (415628) 206-8460 to check availability of the medication ordered. If available, the nursing supervisor will request the ZSFG Inpatient Pharmacy fill the prescription based on the order in the electronic health record.

    b. The amount dispensed will be limited to the amount necessary for doses to be administered until the LHH Pharmacy reopens.

    c. The nursing supervisor shall arrange for a taxi or other transport to be sent to ZSFG to pick up the medication and return it to LHH. The medication will be distributed to the unit.

    d. This procedure does not apply to any controlled substance.

12. Medications removed from the Supplemental Medication ADC after hours will be replenished as soon as the Pharmacy is open.

13. Pharmacy staff will restock the ADC using the procedures outlined in PHAR 09.00.

14. Those medications found in the Supplemental Medication Room are listed on the pharmacy intranet page and the list is updated by a pharmacist as items are added or deleted.

B. EMERGENCY MEDICATION CONTAINER ("Emergency Box"):

1. Emergency medication supplies will be kept in a separate, clearly labeled container in each medication room.

2. This container will be sealed with tamper-proof device that will show that it has been opened. Controlled substances shall not be stored in the emergency medication container ("emergency box"). Emergency medications that are controlled substances shall are stored in the automatic dispensing cabinet.

2.

4. Contents of the emergency medication container are determined by the code blue committee and are listed in hospital wide policy 24-16 Code blue appendix 11. A sign-out card will be placed on the container to record medication used. The person taking the medication will record:
   - Name, dose, and quantity of the medication
   - Name of resident.
   - Date and time of administration of the medication.

1. Signature of person administering the medication.

3.

5. Whenever the container is opened, the nurse on the unit should notify the Pharmacy. Nursing staff will

contact the pharmacy to stock and reseal the Emergency Container. Notification and replacement of used

2. medications must be done within 72 24hours.

4.

A pharmacist will inspect the Emergency Box monthly and document that the correct tamper proof seal is in place and that there are no expired medications by writing the date of inspection and staff initials on the card located on the outside of the container. In the acute care unit and medical clinic, this inspection will occur once every 30 days.

5.

3. Emergency boxes that contain medications that are nearing expiration date will be brought back to the pharmacy to be replenished and resealed with a new tamper proof device.

6.

4. A pharmacist will check the contents of the emergency box whenever it is opened or replenished and reseal it with a tamper proof device recording the date, seal number, and pharmacist initials on the card located on the outside of the container.

7.

6.8. When replacing an emergency box in the medication room on a nursing unit pharmacy staff will bring a new sealed emergency box to the nursing unit to exchange for the old box to decrease the amount of time that the unit would be without an emergency box.

C. CRASH CART

1. Crash carts will be located on each floor of the Main Buildings, and on each floor of the Pavilion, to be used in accordance with Hospital wide policy 24-16 Code Blue.

2. The contents of the crash cart are determined by the code blue committee and listed in hospital wide policy 24-16 appendix 12.

3. The Pharmacy will be responsible for keeping the crash carts properly stocked with drugs.

4. The pharmacist, or technician under pharmacist supervision, will fill a tray with crash cart medications and complete a contents sheet (Hospital wide policy 24-16 appendix 12)

   a. This contents sheet will include the expiration date of each drug.
   b. The earliest expiration date will be circled, and this information will be copied onto a sticker to be placed on the outside of the crash cart when the tray is exchanged. The pharmacist checking the tray will sign and date the bottom of the contents sheet and include the sheet on top of the tray.
   c. The pharmacist will place the tray with contents sheet situated for easy viewing in the tamper-evident plastic bag. Affix the sticker with the earliest expiration date information onto the sealed bag for later transfer to the outside of the crash cart when the tray is exchanged.
   d. Pharmacy staff, as assigned, will ensure 3 trays are pre-packaged and ready to exchange at all times.

5. When a crash cart is opened during an emergency, if a pharmacist has responded to the code blue, the pharmacist will return the medication tray to pharmacy. If a pharmacist is not at the code blue, nursing will

remove the medication tray and return to pharmacy if pharmacy is open, or place in supplemental drug room if pharmacy is not open.

6. When an emergency box is opened during an emergency the procedures for obtaining a new emergency box should be followed in hospital wide policy 24-16 code blue

4.7. A pharmacist will inspect the crash cart monthly.

5.

a. This contents sheet will include the expiration date of each drug
b. The earliest expiration date will be circled and this information will be copied onto a sticker to be placed on the outside of the crash cart when the tray is exchanged. The pharmacist checking the tray will sign and date the bottom of the contents sheet and include the sheet on top of the tray.
c. The pharmacist will place the tray with contents sheet situated for easy viewing in the tamper-evident plastic bag. Affix the sticker with the earliest expiration date information onto the sealed bag for later transfer to the outside of the crash cart when the tray is exchanged.
d. Pharmacy staff, as assigned, will ensure 3 trays are pre-packaged and ready to exchange at all times..

6. When a crash cart is opened, if a pharmacist has responded to the code blue, the pharmacist will return the medication tray to pharmacy. If a pharmacist is not at the code blue, nursing will remove the medication tray and return to pharmacy (pharmacy if open, place in supplemental drug room if pharmacy is not open). Central Supply will contact pharmacy for a pharmacist to inspect the medication tray.

a. If the tamper evident plastic bag sealing the medicine tray was opened then a pharmacist or pharmacy technician will replace it with a new pre-packaged and sealed medication tray that has already been checked by a pharmacist and lock the crash cart with a tamper evident lock. The pharmacist or pharmacy technician will document the date, staff initials, and the new lock number on the card attached to the outside of the crash cart. The pharmacist or pharmacy technician shall place a notification sticker on the medication tray drawer that identifies the medication in the tray with the earliest expiration date.

b. If the tamper evident plastic bag is still sealed then the pharmacist or pharmacy technician will verify that there are no expired medications in the tray and that the notification sticker on the outside of the medication drawer identifies the medication in the tray with the earliest expiration before locking the crash cart with a tamper evident lock. The pharmacist or pharmacy technician will document the date, staff initials, and the new lock number on the card attached to the outside of the crash cart.
c. When an emergency box is opened during an emergency the procedures for obtaining a new emergency box should be followed in hospital wide policy 24-16 code blue

46. A pharmacist will inspect the crash cart monthly.

a. A pharmacist will verify that the number on the tamper evident lock matches what was documented on the card attached to the outside of the crash cart and that the medication in the crash cart is not expired by checking the notification sticker on the medication drawer.

b. If the number on the tamper evident seal and the card do not match or the medication tray is expired, then a pharmacist will bring a new sealed medication tray to the crash cart to perform an exchange to minimize any time on the unit without a crash cart medication tray. During a medication tray exchange the crash cart will be opened and the medication tray returned to the pharmacy before being replaced with a new pre-packaged and sealed medication tray that has already been checked and sealed by a pharmacist. After the medication tray has been replaced the pharmacist will lock the crash cart with a tamper evident lock and document the date, staff initials, and the new lock number on the card attached to the outside of the crash cart. The pharmacist shall place a notification sticker on the medication tray drawer that identifies the medication in the tray with the earliest expiration

c. If the number on the tamper evident lock matches the card and the medication tray is not expired then the pharmacist will document the date, staff initials, and the existing lock number on the card attached to the outside of the crash cart. When a crash cart is opened during a code blue event the procedures for obtaining a new crash cart should be followed in hospital wide policy 24-16 code blue

References Policies

LHHPP 24-16 Code Blue appendices: 11,12;

Pharmacy Policy 03.02.00 Unit area inspections for labeling, storage, and suitability of medications

Revision History: 1995, 8/99, I/00, 2/28/02DY, 08/02, 05/03, 03/07, 02/10, 06/10, 2/15, 2/17, 4/19, 11/19, 089/22

LAGUNA HONDA HOSPITAL **02.05.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR INVESTIGATIONAL DRUGS

Policy:

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

Purpose:

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

Procedure:

I. Drugs used as part of an investigational research protocol at Laguna Honda Hospital shall comply with the Hospital-wide Policy and Procedure on Approval Process for Human Subject Research.

II. One set of copies of the approved research protocol and the informed consent signed by the resident or surrogate decision-maker shall be placed in the resident's chart. Another set of copies shall be forwarded to the Pharmacy Director.

III. All drugs used as part of a research protocol shall be forwarded to the Pharmacy Department for proper storage, labeling and dispensing.

IV. Record keeping for doses dispensed and received, as required by the research protocol, shall be the responsibility of the Pharmacy staff.

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

VI. The following drug information shall be communicated by the Principal Investigator or co-investigator(s) to nursing staff requested to administer research protocol drugs:
   a. drug action and uses
   b. side effects, signs and symptoms of toxicity
   c. dose
   d. strengths available
   e. any special cautions or warnings regarding handling or use

VII. Upon conclusion of the study or discharge of the resident(s) from the Hospital, the Principal Investigator or co-investigator(s) shall contact the Pharmacy Director to arrange for disposition of remaining study drug(s).

Revision History: 8/94, 8/14, 2/19

LAGUNA HONDA HOSPITAL **03.01.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY QUALITY ASSESSMENT AND IMPROVEMENT

Policy:

The Pharmacy Department shall participate in the overall Hospital quality assessment and improvement program. The Pharmacy Director shall coordinate this participation and ensure that the review and evaluation of quality for selected important aspects of care are reported to the hospital-wide Performance Improvement and Patient Safety Committee (PIPS) and/or the Pharmacy & Therapeutics Committee (P&T), and to the appropriate hospital administrators.

Purpose:

To provide high quality Pharmaceutical Services to all residents and staff, consistent with the Department's Mission.

MISSION STATEMENT:

The mission of Laguna Honda Hospital is to provide or ensure a continuum of health care services for senior and disabled residents of San Francisco.

"The mission of the Laguna Honda Hospital Pharmacy Department is to provide reliable, consistent, comprehensive and cost-effective pharmaceutical services to the residents and staff of the Hospital. These services shall be provided to promote safe and effective use of medications, and to advise, educate and offer a learning environment for students, volunteers and other health care providers. The Department is committed to assuring quality outcomes by emphasizing inter-disciplinary teamwork, continuous improvement, drug therapy expertise and sound financial management."

IMPORTANT ASPECTS OF CARE AND SERVICES PROVIDED:

1. Accurate dispensing of medications
2. Timely dispensing of medications
3. Providing counseling for residents discharged with medications
4. Providing drug information to residents and staff
5. Promoting safe and effective drug therapy

I. SPECIFIC PHARMACY QUALITY ASSESSMENT & IMPROVEMENT ACTIVITIES:

A. PHARMACY STOCK -- Pharmacy stock is checked monthly for outdated or expiring medications. Pharmacy Staff are responsible to check their assigned pharmacy stock section monthly for outdated or expiring medications.

1. Threshold: N/A
2. Reported to: Currently not reported

B. SUPPLEMENTAL DRUG ROOM -- Medications used from supplemental drug room are reconciled daily. Expiration dates are checked monthly by assigned pharmacy staff.

1. Threshold: N/A
2. Reported to: Currently not reported

C. NARCOTIC CII COUNTS PHARMACY NARCOTIC SUPPLY – CII-V reconciliation is done daily for all items that have been dispensed or added to stock at the end of the shift and documented by the technician's initials next to the line item. An audit of all controlled substances stored in the pharmacy is done monthly.

1. Threshold: 100%
2. Reported to: P&T (monthly)

D. MEDICATION STORAGE REFRIGERATOR TEMP – Medication Refrigerators are checked twice daily by nursing staff. The medication refrigerators in the pharmacy are checked a minimum of twice daily during pharmacy operating hours. All medication storage refrigerators and freezers are monitored continuously via wireless monitoring system. The first check each morning will include a review of the "Daily Sensor Report/ 12Hr" report for the previous 24 hours or longer if the department is not open 7 days/week. At the beginning of each month, the designated department will print a "TempTrak Equipment QA / Performance Report" for the preceding month and file with the temperature log.

1. Threshold: 100%
2. Reported to: ~~Results of nursing station refrigerators are reported monthly via DRR to head nurse and Director of Nursing.~~ Results of Pharmacy refrigerator temperatures are reported P&T (monthly).

E. EMERGENCY BOXES AND CRASH CARTS -- The emergency boxes and crash carts are checked monthly for completeness and freshness of stock. (or when box/cart has been opened)

1. Threshold: N/A
2. Reported to: P&T (monthly)

~~F. PHARMACY OMNICELL MEDICATION TRANSACTION AUDIT – Each month the omnicell transactions for 4 residents over a 5 day period is compared to the Medication Administration Record for accuracy in documentation.~~

~~1. Reported to: Results of activities are reported to nurse manager, nursing director, Medication Error Reduction Subcommittee,~~

~~G.~~F. NURSING STATION CHECKS -- Nursing stations are checked on a monthly basis for Title 22 regulatory compliance with proper storage of meds, expiration dates, absence of discontinued medications, cleanliness, presence of appropriate drug information sources and applicable written hospital policies.

1. Threshold: N/A
2. Reported to: Nurse Manager, Chief Nursing Officer & Hospital Administration (monthly), P&T(monthly and PIPS (quarterly).

~~H.~~G. MEDICATION REGIMEN REVIEWS (MRR) -- In accordance with State and Federal guidelines, the medical charts of all patients are reviewed every 30 days by a pharmacist (refer to Policy & Procedure 06.01.00).

1. Threshold: 100%
2. Reported to: Medication irregularities are ~~reported in writing to the unit physician and nurse manager monthly~~documented in the patient chart monthly as a 30 day med review note. MRR is available for viewing by members of the Resident Care Team ~~electronically in the MRR Database~~. Findings and recommendations are reported to the Chief Nursing Office, the attending physician, the Chief Medical Officer and if appropriate, the administrator.

~~I.~~H. MEDICATION PASS OBSERVATION – At least 4 units are selected per month for observation of medication administration.

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (monthly), applicable nursing unit managers and nursing administration (monthly)

~~J.~~I. IV PREPARATION OBSERVATION AND STERILITY TESTING - Pharmacy personnel shall be observed during sterile compounding and evaluated at least annually as part of competency assessments required to compound sterile preparations (refer to Policy & Procedure 07.01.00).. Preparations compounded during the media fill challenge and gloved fingertip samples will be incubated per the manufacturer's specifications to test for microbial growth

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (Annually)

~~K.~~J. PHARMACY COMPOUNDING –At least one sterile preparation and one non-sterile preparation compounded by the pharmacy will be sent to an outside analytical laboratory for potency and sterility testing annually. See pharmacy policy and procedure 7.01.00 for details regarding retesting and recall for unacceptable results.

1. Threshold: Potency 100% +/- 10% actual concentration vs. labeled concentration;
   No microbial growth 100%
2. Reported to: Medication Error Reduction Subcommittee, P&T (Annually),

~~L.~~K. MEDICATION RECALLS -- Medications recalled by the FDA, manufacturer, or at the discretion of the supervising pharmacist for a compounded preparation will be handled immediately upon notification. Recalled drugs are removed from stock as described in the Pharmacy Policy & Procedure for Drug Recall (02.04.00) and returned to wholesaler or manufacturer.

1. Threshold: 100%
2. Reported to: Medication Error Reduction Subcommittee and P&T, if recalled medication was in stock and nature of reason for recall poses potential risk or danger to residents

Revision History: 10/91, 1/94, 3/98, 3/99, 6/99, 8/01, 10/03, 11/10, 06/11, 11/2014, 10/15, 8/18, 10/18

LAGUNA HONDA HOSPITAL **03.01.02**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR MED PASS OBSERVATION

Policy:

The pharmacist shall perform observations of nursing medication administration passes.

Purpose:

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

Procedure:

1. ~~One or two p~~Pharmacist(s)/pharmacy student(s) will ~~be assigned by the Supervising Pharmacist to~~ perform monthly medication pass observations.

2. The location will be selected based on DRR assignments or ~~for observation~~ according to the Medication ~~Pass Observation~~ Administration Critical Element Pathway Schedule.

~~3. At minimum, four med passes will be observed every month. The goal is to observe med pass on each unit at least once during every calendar year.~~

~~4.~~3. The goal is to observe m~~M~~ed passes for a minimum of ~~20~~20 medications per unit ~~will be observed~~. Med passes done other than 9am may have less than 20 medications per unit.

~~5.~~4. Errors observed during med pass will be communicated to the licensed nurse involved, and/or the Nurse Manager.

~~6.~~5. All observation will be reported on the Medication Pass Observation Competency Assessment form ~~(attachment)~~

~~7.~~6. The Medication Pass Observation Competency Assessment form will be forwarded to the ~~Supervising~~ Designated Lead Pharmacist for review and follow-up.

~~8.~~7. Results of the med pass observations will be ~~part of the monthly Nursing Drug Regimen Review report forwarded~~ reported to ~~the~~ Quality Management, Nursing Director and Chief Nursing Officer.

~~9.~~8. Results will also be documented ~~monthly~~ in the Pharmacy Department Report to the Medication Error Reduction Subcommittee, ~~and~~ Pharmacy and Therapeutics Committee, and Performance Improvement Patient Safety Committee

Revision History: 9/93, 6/99, 2/06, 01/08, 10/09, 6/11, 8/18, 8/22, 9/22

LAGUNA HONDA HOSPITAL **03.03.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR INFECTION CONTROL

Policy:

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

Purpose:

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

Procedure:

1. Storage
   a. Medications, chemicals and other pharmaceutical products are stored in accordance with US Pharmacopeia, National Formulary and manufacturer's recommendations.

2. Dispensing Oral Medications
   a. The touching of medications by hands is prohibited.
   b. A counting tray and spatula will be used when dispensing tablets and capsules.
   c. Counting trays and spatulas will be cleaned daily with 70% ~~Ethyl~~ Isopropyl Alcohol.
   d. Tablets, capsules, or liquids will be dispensed in fresh clean containers with clean labels.

3. Medication Prepacking
   a. Disposable gloves shall be worn w~~W~~hen prepacking tablets and capsules into unit doses~~, disposable gloves shall be worn~~.

4. Compounding Ointments and Creams
   a. The compounding surface and utensils shall be cleaned with 70% ~~Ethyl~~ Isopropyl Alcohol prior to and after use.
   b. Compounding will be done in accordance with the standards of pharmaceutical practices. Refer to Pharm 02.01.08.

5. Compounding Topical Solutions
   a. Solutions will be compounded in accordance with the standards of pharmaceutical practices.
   b. Sterile water for irrigation U.S.P. is the water ~~to be~~ used ~~in the~~ for compounding ~~of~~ topical solutions.
   c. Refer to Pharm 02.01.0~~68~~ for a list of expiration dates for non-sterile compounding.

6. Expiration Dates
   a. No medications or pharmacy products will be dispensed beyond the manufacturer's recommended expiration date.
   b. Medications or pharmacy products that will expire within 30 days of the expiration date will be recalled from the wards and ~~will be~~ removed from pharmacy stock.

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

      Revision History: 10/91, 12/96, 05/97, 07/03, 08/18, 7/22

LAGUNA HONDA HOSPITAL
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY DEPARTMENT SAFETY & EMERGENCY PREPAREDNESS PLAN

Background:

The Safety & Emergency Preparedness Committee of Laguna Honda Hospital provides safety & disaster readiness leadership. The Committee plans, executes & evaluates Hospital-wide disaster preparedness drills so that staff will be trained & ready to respond in a major emergency. The Committee is also charged with examining safety issues & implementing programs to ensure the safety of all Hospital residents, staff & visitors.

Policy:

The pharmacy staff will be trained on current safety issues and emergency preparedness programs established by the Laguna Honda Hospital's Safety & Emergency Preparedness Committee. Knowledge of these issues and programs will aid the department to address ongoing safety & emergency preparedness items. Regular & routine monitoring & discussion of safety related issues will keep on-the-job accidents to a minimum & also prepare the staff to respond appropriately in an established Hospital emergency preparedness drill or in an actual incident such as an earthquake or fire.

Procedure:

1. The pharmacy staff will receive regular (annual) training on safety issues, accident/illness prevention programs, and disaster plans through hospital wide inservices and during regular departmental staff meetings. Special staff meetings shall be scheduled as needed to address urgent safety issues.

~~1.~~ Pharmacy staff will evacuate the pharmacy if a fire is in the pharmacy or an area immediately adjacent to the pharmacy and pharmacy is in immediate jeopardy. Evacuation will be horizontal. Direction of evacuation is determined by location of the fire.

~~2. A pharmacy staff member will conduct monthly safety inspections in pharmacy work areas & will complete the Departmental Safety Inspection form (attachment 1).~~

~~3. The Departmental Safety Inspection form shall be kept on file in the Director's Office.~~

~~4.~~2. In a disaster or disaster drill, the disaster call back plan shall be initiated ~~(04.01.01 attachment 1)~~.

~~5.~~3. If an individual on the pharmacy staff has a safety issue or emergency preparedness concern, he or she shall contact the Pharmacist In Charge (PIC) or the Pharmacy Director. The PIC or Pharmacy Director will determine the urgency of the issue & will take appropriate action for follow-up & review.

New: 3/94 ~~RF~~
~~Reviewed: 02/05dw, 02/06, 01/08, 04/09, 8/12, 8/13, 8/14~~
Revised: 10/09, 2/10, 6/11, 6/15, 9/22

LAGUNA HONDA HOSPITAL **04.01.01**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR DUTIES AND RESPONSIBILITES DURING DISASTERS AND DISASTER DRILLS

Policy:

The Pharmacy Department shall participate in Hospital-wide disaster drills. In an actual disaster Pharmacy Staff shall be available and prepared to assist the disaster team as required.

Purpose:

To assure the availability of appropriately trained and educated staff for the provision of pharmaceutical care during a disaster or disaster drill.

Procedure:

I. In an actual disaster, the call back of Pharmacy Staff as outlined in the Hospital wide disaster plan for the Department shall be initiated ~~(attachments 1 & 2)~~.

II. Pharmacy Staff shall coordinate procurement and delivery of any medication needed but not available at the treatment site(s).

III. Pharmacists shall provide drug information consultation to treatment physicians and nurses as requested.

IV. Upon request, Pharmacists shall assist physicians and nurses during an actual disaster by administering medications to residents and disaster patients.

V. Pharmacy Department staff shall receive annual inservice education and training on disaster procedures and responsibilities.

NEW: 12/94 SK
REVISED: 4/98 SK, 2/05 dw, 04/08, 10/09, 6/15
RETYPED: 10/03 BT
REVIEWED: 02/06, 04/09, 2/10, 4/11, 5/12, 8/13, 8/14

LAGUNA HONDA HOSPITAL **06.03.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR DISCHARGE COUNSELING

Policy:

The pharmacists at Laguna Honda Hospital will provide medication counseling for residents being discharged from Laguna Honda to the community.

Purpose:

To educate residents on proper use and storage of their medications, as well as to advise them of any pertinent precautions.

Procedure:

1. Upon completion of discharge orders by the physician, ~~a copy of~~ the orders will be e-prescribed to Pharmacy.

~~2.~~ Pharmacy will verify with nursing/social worker ~~Proposed~~ anticipated discharge date, time and location. ~~will be included in the discharge order.~~

3. Pharmacy staff will fill medications in the amounts specified by the physician. Prescriptions for discharge will be filled in childproof containers~~/ or~~ bottles *or bubble pack* and labeled in lay-language.

4. Prior to the time of discharge, a pharmacist or pharmacy student will arrange to visit the resident and/or resident's representative for discharge counseling. If necessary, the services of an interpreter will be sought. Pharmacy will consult ~~the head~~ nursing to arrange an appropriate time for the visit. ~~*See #8 for exceptions*~~*See #9 for exceptions*

5. Counseling sessions will include (but are not limited to) the following information:
~~5.~~

~~a.~~ Name of medication, indication, and directions of use~~Proper use and storage of the medication~~

a.

~~b. Importance of the directions~~

c. Relevant warnings

d. Proper use and storage of the medication

~~c.~~

Other information will be provided based on the professional discretion of the pharmacist. In appropriate cases, discussion of adverse effects and interactions may be a component of the counseling.

6. In conjunction with counseling, the pharmacist will fill out the discharge medication form (MR 313) using appropriate lay-language (Patient Discharge Information, copy attached) pharmacist will provide a form listing the medications, directions, and quantities given at discharge. The form will indicate that refills must be authorized by follow up providers and filled by community pharmacy. Also, will ensure the discharge instructions were understood by resident/family and all questions were answered. The form and medications will be kept by nursing staff until the actual time of discharge. Additional forms may be used if the space provided for discharge medication information is not sufficient. (Additional pages will be numbered; i.e., pg. 1 of 2, 2 of 2, etc.) The resident and Pharmacist will sign and date the form when counseling is complete. The Pharmacist will write a brief note in the integrated progress section of the chart indicating that discharge counseling was performed (or, if counseling not done, why it was not done. Pharmacist will leave the medications and form with nursing or return to pharmacy until the resident is ready to leave.)

6.

7. The Pharmacy Department will keep a log of counseling done. The log will include resident's name, number, unit, date of counseling and signature of pharmacist who performed counseling. Pharmacist will scan the signed form into WAMB under patient's profile. A short documentation of the consultation can be entered in WAMB.

7.8. Pharmacist will "sell" the medications in WAMB once medications are picked up or left with the wardunit nursing team.

8.9. Discharge counseling will not be required for the following residents or situations:

a. Residents who leave the hospital AMA or without medications
b. Respite residents (unless a new medication has been introduced to the regimen during the resident's stay, or dose/schedule changes have occurred, in which case counseling will be done)
c. Resident refuses discharge counseling
d. Resident is discharged to a facility that provides medication administration, including a Skilled Nursing Facility or Board and Care.

9.10. If a resident is discharged after regular pharmacy hours, the unit nurses are responsible for discharge counseling; however, every attempt will be made by pharmacy to complete discharge counseling during regular pharmacy working hours.

New: 1/92
Reviewed: 02/05dw, 02/06, 01/08, 04/09, 8/11, 5/12, 8/13, 8/14, 8/15,
7/22 Revised: 4/10, 8/31

Laguna Honda Hospital Department of Pharmacy Sterile IV compounding competency

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

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

Signature of Person Assessed Printed Name Date

Signature of Qualified Evaluator Printed Name Date

*The person assessed is immediately informed of all unacceptable activities, and shown and informed of specific corrections.

Laguna Honda Hospital Department of Pharmacy Sterile IV compounding competency

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

	Cleaning
	Selects appropriate cleaning agents based on the day of the week using the wall chart
	Sanitizes AND disinfects all ISO-5 surfaces in the CAI with appropriate cleaning agents including the ante-chamber before and after any compounding activities
	Changes the pad on the isolator cleaning tool and cleans starting with the ceiling, then walls, then main surface of the direct compounding area. Uses overlapping strokes from top to bottom when cleaning the walls and unidirectional overlapping strokes when cleaning the ceiling and main surface such as front to back. Sanitizes Gauntlets and Sleeves.
	Identifies the procedure for monthly deep cleaning as well as weekly cleaning of bins, carts, shelves
	Aseptic Technique
	Introduces only essential materials into the CAI and stages items to avoid creating turbulent airflow or impeding laminar flow of HEPA filtered first-air over critical sites
	Disinfects components/vials/supplies with an appropriate agent prior to placing into the ante chamber of the CAI
	Waits at least ~~10~~ 60seconds after placing items in the ante-chamber with the door closed before moving items into the work area of the CAI
	Ensures syringes, needles, and tubing remain in their individual packaging and are only opened in ISO Class 5 work area
	Disinfects stoppers, injection ports, and ampule necks by wiping with sterile 70% isopropyl alcohol and allows sufficient time to dry
	Affixes needles to syringes without contact contamination
	Punctures vial stoppers and spikes infusion ports without contact contamination entering with the bevel of the needle face up at an approximate 45 degree angle to minimize risk for coring
	Disinfects sterile gloves routinely with 70% sterile isopropyl alcohol between each compounded product, every time an item is transferred in or out of the work area to the ante-chamber, whenever there is a spill, whenever gloves are visibly soiled, or whenever compounder suspects contamination
	Disposes sharps and drug waste according to LHH pharmacy and procedure
	Documentation
	Identifies location of master compounding formulas on the pharmacy intranet and identifies the process for creating and editing
	Identifies the lot number compounding log located in the dispensing area of the pharmacy and can explain how new lot numbers are generated based on the date and the number of items compounded that day
	Identifies what information is required on the label for a compounded sterile product
	Defines "beyond use date" and explains how beyond use dates are assigned based on the master drug formula using manufacturer package insert, USP797, and reputable pharmacy literature sources.
	Accurately documents cleaning activities on the daily cleaning log
	Accurate documents air pressure differentials on the daily log
	Has read the most updated version of sterile compounding pharmacy policy THIS YEAR
	Labels any diluent bags removed from overwrap with appropriate expiration dating

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

Signature of Person Assessed Printed Name Date

Signature of Qualified Evaluator Printed Name Date

*The person assessed is immediately informed of all unacceptable activities, and shown and informed of specific corrections.

Laguna Honda Hospital Department of Pharmacy Sterile IV compounding competency

Initials of Evaluator														
Incubator temp (Celsius)														
Growth														

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

Signature of Person Assessed	Printed Name	Date
Signature of Qualified Evaluator	Printed Name	Date

*The person assessed is immediately informed of all unacceptable activities, and shown and informed of specific corrections.

Laguna Honda Hospital Department of Pharmacy

Assessment of hand hygiene, garbing, and cleaning of **EVS** personnel

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

Signature of Person Assessed Printed Name Date

Signature of Qualified Evaluator Printed Name Date

A passing score consists of the evaluator observing all of the activities above or soliciting the appropriate responses from the person being assessed as well as annual review of the standard work video for cleaning in the IV and hazardous drug rooms.

	Documents cleaning activities appropriately
Review the standard work video for cleaning (Enter Date)►	

Signature of Person Assessed	Printed Name	Date
Signature of Qualified Evaluator	Printed Name	Date

A passing score consists of the evaluator observing all of the activities above or soliciting the appropriate responses from the person being assessed as well as annual review of the standard work video for cleaning in the IV and hazardous drug rooms.

LAGUNA HONDA HOSPITAL **07.01.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR STERILE PRODUCT PREPARATION, HANDLING, AND DISPOSAL

Policy: The pharmacy shall ensure the sterility and integrity of sterile products prepared and used at Laguna Honda.
Purpose: To ensure the appropriate surveillance, prevention, and infection control procedures for sterile products.

Table of Contents

Definitions and Abbreviations

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

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

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

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

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

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

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

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

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

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

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

USP – United States Pharmacopoeia

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

CSP – Compounded sterile preparation

Pharmacy Areas for Preparing Sterile Products

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

Hand Hygiene and Garbing procedure for IV room

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

Environmental Controls in the IV room

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

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

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

Monitoring and Testing of Environmental Controls in the IV room

1. Pressure Differential Monitoring
    a. IV room relative to adjacent areas
        i. Measured wirelessly and continuously by engineering via the TEMPTRAK system.
        ii. If differential pressure becomes negative in the IV room engineering will be consulted to evaluate the potential causes and the supervising pharmacist will determine if any changes in workflow or beyond use dating are necessary until the desired pressure differential is restored.
        iii. Pressure differential will be manually documented on a daily basis when the pharmacy is open on the “air pressure differential log”
    b. CAI
        i. Pressure differential of the antechamber and main workspace within the CAI will be checked daily when the pharmacy is open by qualified personnel and recorded on the “air pressure differential log”
        ii. The CAI will sound an audible alarm in the event that pressure differentials fall out of the manufacturer specified operation ranges. When the alarm is sounded the supervising pharmacist will be informed to evaluate and troubleshoot before any sterile compounding activities are continued and will determine if any compounded preparations made at the time of the alarm were compromised.
2. Temperature monitoring
    a. Refrigerator temperature in the IV room is wirelessly monitored and documented per hospital wide policy 31-01 wireless refrigerator and freezer temperature monitoring system.
    b. The temperature of the IV room and hazardous drug room are continuously monitored wirelessly with limits set for operator comfort and manufacturer recommended storage conditions for IV drugs.
    c. Humidity gauges are present in the IV room to detect significant changes that would affect operator comfort.

3. Certification and testing of primary and secondary engineering controls shall be performed every six months and whenever a primary engineering control or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area.
    a. Certification will be performed by a qualified operator to meet test standards of CETA Certification Guide for Sterile Compounding Facilities under dynamic conditions to include viable particle counts, non-viable particle counts, and smoke pattern testing.
    b. Viable particle counts
        i. Viable surface sampling is performed every six months in the primary engineering controls and the surrounding areas by an outside qualified operator as part of routine certification testing
        ii. Viable particles in the air are tested by volumetric air sampling procedures by an outside qualified operator every six months as part of routine certification testing. Volumetric air sampling will test a sufficient volume of air (400 to 1,000 liters) at locations inside the PEC and surrounding area.

Cleaning and Sanitizing of the Workspaces

1. Procedure for cleaning of primary engineering controls (CAI in IV room)
    a. The cleaning, sanitizing and organizing of the direct compounding areas (DCA) is the responsibility of qualified pharmacists and pharmacy technicians and is performed prior to any compounding activities and at least daily when the pharmacy is open.
    b. Sanitize the gauntlets of the CAI with a germicidal detergent followed by sterile water and allow to dry.
    c. Disinfect the gauntlets of the CAI with sterile 70% isopropyl alcohol
    d. Replace the non-shedding pad on the isolator cleaning tool and utilize it during the following cleaning procedures to clean surfaces that would normally be out of reach.
    e. Sanitize all surfaces in the primary engineering control (including the gauntlets again) with a germicidal detergent followed by sterile water to remove gross filth. A pre-saturated non-shedding wipe or spray may be used with the isolator cleaning tool.
    f. Do not directly spray the ceiling towards the HEPA filter because it can cause damage and compromise its integrity. When cleaning surfaces use an overlapping horizontal motion in one direction starting at the top of the isolator working down. Clean the ceiling first, then the back, then the sides, the front panel, and finally the bottom surface inside the primary engineering control. Be sure to clean the antechamber last in addition to the direct compounding areas.
    g. After sanitizing with a germicidal detergent and sterile water then disinfect the surfaces of the primary engineering control (including the gauntlets/sleeves again) with sterile 70% isopropyl alcohol following the previous procedures.
    h. Once a week replace the germicidal detergent with a sporicidal detergent for sanitizing all surfaces including the gauntlets in the primary engineering control.
    i. After completing the cleaning process, document the activity in the “cleaning record for sterile compounding room”

j. Prior to donning sterile gloves and after the initial cleaning procedures for the surfaces of the CAI disinfect the gauntlets with sterile 70% isopropyl alcohol

k. If the primary engineering control has been turned off between aseptic procedures, it should be operated for at least 30 minutes to allow complete purging of room air from the direct compounding area, then cleaned with the above procedures before performing any compounding activities

l. Once a month the CAI will undergo a deep cleaning in which the front panel is opened and the bottom work tray is lifted out to clean area underneath, working in a horizontal unidirectional motion from right to left starting from the back and working forward with overlapping strokes. The deep clean will consist of sanitizing with a sporicidal detergent and sterile water followed by disinfecting with sterile 70% isopropyl alcohol.

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

Master Compounding Formula

1. Prior to any compounding activities a master formula approved by a pharmacist must be created or obtained from the library of master formulas stored on the pharmacy intranet.
2. A master formula must include the following:
    a. Active and inactive ingredients to be used
    b. Equipment to be used including the appropriate primary engineering control

c. The maximum allowable beyond use date for the preparation, and the rationale or reference source justifying its determination

d. Specific and essential compounding steps used to prepare the drug

e. Quality reviews required at each step in the preparation of the drug including:

   i. Review calculations on master formula to confirm that the measurement of each additives and diluent will result in the final labeled concentration

   ii. Visual inspection of all ingredients to be used for manufacturer expiration dating and integrity of manufacturer packaging such as broken seals on vials or punctures in a stopper or injection port.

   iii. Visual inspection of any reconstituted products for complete dissolution

   iv. Visual inspection of any vial stopper or injection port punctured for evidence of leaking or coring.

   v. Pharmacist to verify volume or measurement of any additive prior to final dilution and confirm it matches the master formula.

   vi. Visual inspection after final dilution against a well-lit contrasting background to detect the presence of impurities such as particulate matter, unexpected change in color, precipitation, or coring.

f. Instructions for storage or special handling requirements

g. An "update log" section shall be included on every master formula to include the date of creation with pharmacist initials. Any modifications to an existing master formula shall be documented in the "update log" sections with the description of changes as well as the date and pharmacist initials.

Aseptic Technique and Pharmacy Sterile Product Preparation

1. Sterile preparations shall be compounded in a primary engineering control that maintains an ISO class 5 environment under dynamic conditions using aseptic technique.
2. Aseptic technique refers to standardized compounding procedures intended to decrease the risk of contamination of a compounded sterile product. Talking should be minimized during aseptic preparation.
3. Ingredients used to compound sterile products should be determined to be stable, compatible, and appropriate for the product to be prepared, according to manufacturer or USP guidelines or appropriate scientific references. Ingredients and compounding process for each preparation is determined in writing and reviewed by a pharmacist on a master formula before compounding begins.
4. All ingredients should be inspected for defects, expiration date, and product integrity before use. Expired or defective products should not be used for compounding. Defective products should be reported to the FDA Med Watch Program, https://www.accessdata.fda.gov/scripts/medwatch/, or 1-800-FDA-1088.

5. Prior to performing any activities in the primary engineering control inspect the isolator gauntlets and sleeves for any defects or tears.
6. Any ingredient, equipment, or item required for sterile compounding shall be disinfected with sterile 70% isopropyl alcohol on all surfaces before placing inside the antechamber
7. Wait at least ~~10~~ 60 seconds after placing items into the antechamber before opening the divider and bringing items into the work area inside the primary engineering control.
8. During any sterile compounding in the CAI all of the surfaces and isolator gauntlets are disinfected frequently with sterile 70% isopropyl alcohol including:
    a. The beginning of each shift and before each lot
    b. At least every 30 minutes when continuously compounding
    c. After each spill or when surface contamination is suspected
9. All rubber stoppers of vials and bottles, the necks of ampoules, and injection ports into an IV bag are disinfected by wiping with sterile 70% isopropyl alcohol and waiting at least 10 seconds before they are used to prepare sterile products.
10. Only materials essential for preparing the sterile product should be placed in the primary engineering control. Products must be adequately separated so as not to disrupt the unidirectional airflow leaving the high efficiency particulate air (HEPA) filter. Overcrowding of materials should be avoided also to minimize disruption of clean airflow.
11. Extreme care must be taken to prevent obstruction of clean air across the critical area or site, defined as the area immediate to the point of entry area in to a container, including the needle or device used to enter the container. The pharmacist or technician must be aware about the relation of other objects within the cabinet so that these objects never become an obstacle between the HEPA filter and critical area, as this can cause contamination of the critical area. Avoid reaching directly over the critical area because contaminants from the person or clothing may fall on the critical area. Only the cleanest air should be allowed to flow over the critical area of all the materials within the hood.
12. Avoid touch contamination of sterile needles, syringe parts, and other critical sites.
13. Solutions from ampoules must be properly filtered to remove particles.
14. Solutions from reconstituted powders should be mixed carefully, ensuring complete dissolution of the drug with the appropriate diluents.
15. Needle entry into vials should be performed at a 45-60° angle with the beveled side facing upwards to avoid coring of the vial closure.
16. After completion of the product, an additive cap or seal should be placed over the stopper or additive portal, to signify completion of the product as well as protect the portal from contamination.
17. Before, during and after the preparation of sterile products, the pharmacist or technician should carefully check the identity and verify the amounts and sequence of the additives in the sterile preparations detailed in the master drug formula against the original prescription, medication order, or other appropriate documentation before the product is released or dispensed.

18. After the preparation of every compounded sterile product, the contents of the container are thoroughly mixed and then inspected for the presence of particulate matter, evidence of incompatibility, or other defects.
19. After procedures are completed, used syringes, bottles, vials, and other supplies are removed, but with a minimum of exit and re-entry into the direct compounding area so as to minimize the risk of introducing contamination into the aseptic workspace.

Beyond Use Dating

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

Qualifications of Personnel Who Prepare Sterile Products

1. Qualified personnel that compound sterile products for patient use shall pass the following competency assessments at least annually. (See Attachment 1)

    a. Hand hygiene

    b. Gowning and garbing

    c. Sterile compounding calculations and terminology exam

    d. Cleaning and disinfection of controlled compounding areas and equipment

    e. Accurate documentation of compounding activities, cleaning, and monitoring of environmental controls

f. Pharmacy calculations and terminology exam

g. Sterile compounding knowledge assessment

i. Shall include review of most current policy and procedure

ii. Contents to be determined and re-evaluated annually or more frequently at the discretion of the pharmacist in charge

h. Gloved fingertip testing (see attachment 1 assessment for results recording and incubation process)

i. Defined as a process whereby compounding personnel lightly press each fingertip and thumb onto appropriate growth media, which are then incubated at a temperature and period of time conducive to multiplication of microorganisms as determined by the manufacturer.

ii. Presence of any microbial growth is considered a failed gloved fingertip test and shall require remediation and reassessment before personnel can continue to compound sterile products

iii. Gloved fingertip testing shall be performed with sterile gloves donned over the gauntlets of the compounding aseptic isolator prior to a media fill challenge and after a media fill challenge for both the right and left hands.

iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.

i. Media fill challenge (see attachment 1 assessment for results recording and incubation process)

i. Shall consist of compounding procedures using a growth based media to mimic the most complex procedures performed by the pharmacy.

ii. The design of the media fill challenge shall be recorded in the IV competency binder located in the clinical pharmacist office and available on the pharmacy intranet.

iii. The design of the media fill challenge shall be re-assessed at least annually and any modifications recorded along with rationale.

iv. Incubation temperature and growth media evaluation will be recorded daily when the pharmacy is open on the associated competency assessment form.

v. Presence of any microbial growth in any of the growth media used in the media fill challenge is considered a failed media fill challenge and shall require remediation and reassessment before personnel can continue to compound sterile products

j. Hazardous drug compounding assessments including decontamination as defined in hazardous drug policy 07.02.00

2. New personnel shall be oriented with the policy and procedure of compounding sterile products and receive adequate training consisting of audio/visual materials, shadowing a qualified compounder, and hands on practice under the supervision of a qualified compounder prior to initial competency

assessment. The pharmacist in charge shall determine when new personnel have completed adequate training to begin competency assessment.

3. New personnel shall complete 3 sets of gloved fingertip assessments ~~on 3 separate occasions~~ prior to compounding sterile products for patient use.
4. Records of competency assessment shall be available for each individual qualified personnel and retained for three years.

Quality Assurance

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

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

    a. When action levels are exceeded during fingertip sampling the employee shall not compound sterile products until remediation and successful resampling
    b. When action levels are exceeded during environmental sampling the pharmacy shall investigate the possible sources of contamination and document interventions along with

results of resampling. The beyond use dating of sterile products compounded prior to successful resampling shall be evaluated and potentially adjusted as determined by the pharmacist-in-charge.

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

9. Quality reviews are required before, during, and after compounding sterile products and are described on the compounding master formula

Labeling

1. Finished products should be labeled with at least the following information:

- Resident's name
- Prescription number
- Patient or medical record number
- Directions including rate of administration for IV medications
- Name & concentration of all ingredients (including primary solution)
- Prescribing physician's name
- Date filled
- Expiration date
- Pharmacist's, technician's initials
- Pharmacy telephone number
- Instructions for storage & handling
- All hazardous or cytotoxic preparations shall bear a special label stating: "Chemotherapy – Dispose of Properly" or "Hazardous – Dispose of properly"

2. The label should be legible and affixed to the final container in a manner enabling it to be read while the sterile product is being administered.

Handling of Sterile Products Outside the Pharmacy

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

Administration of Sterile Products

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

Documentation and Recordkeeping

1. The following should be documented and maintained on file for an adequate period of time, according to organizational policies and state regulatory requirements:
    a. Records of training and demonstrated competence shall be available for each individual and retained for three years beyond the period of employment.
    b. Refrigerator and freezer temperatures,
    c. Certification of CAI.
    d. Master formula compounding sheets
    e. Lot number assignment log for compounded products
    f. Results of annual end product testing

Revision History: 8/03, 06/07, 01/08, 04/09, 2/10, 10/10, 08/11, 5/14, 10/15, 08/17, 7/19, 7/20, 9/22

Attachment 1: Pharmacy Staff IV competency
Attachment 2: Assessment of hand hygiene, garbing, and cleaning of EVS personnel

LAGUNA HONDA HOSPITAL **07.02.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

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

POLICY:

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

The pharmacy shall not compound sterile hazardous drug products.

PURPOSE:

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

DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

Receipt of Hazardous Drugs

1. Pharmacy Personnel shall inspect shipping containers for signs of damage or breakage such as visible stains from leakage or the sound of broken glass. If a shipping container appears to contain damaged products it shall be moved to the hazardous drug room for storage for evaluation by a pharmacist and the supplier contacted for potential return.
    a. If the unopened package is to be returned to the supplier then it shall be enclosed in an impervious container and labeled as hazardous.
    b. If the supplier refuses return then it shall be disposed of as hazardous waste
    c. If the pharmacist determines opening the container would not result in harmful exposure to hazardous drugs (such as in the case of just loose tablets in the container) it should be opened in the C-PEC and any products recovered deactivated and decontaminated prior to storage.
2. Pharmacy personnel wear a single pair of chemotherapy gloves when unpacking containers that may contain hazardous drugs.
3. Unpacking shipping containers that may contain hazardous drugs shall occur in an area with access to a spill kit.

Storage of Hazardous Drugs

1. Oral and topical cytotoxic drugs shall be stored in lidded? yellow bins separate from the non-hazardous drug supply. Any reusable equipment used to count or repackage cytotoxic drugs shall also be separated and clearly labeled to prevent any cross contamination. Refrigerated cytotoxic drugs shall be stored in a dedicated refrigerator in the hazardous drug room.
2. Hazardous drugs that are not cytotoxic shall be stored in red bins and may be stored with non-hazardous inventory.
3. Non-cytotoxic hazardous drugs may be stored with non-hazardous drugs in the same patient cassette.
4. Cytotoxic drugs should be separated from other drugs in a patient cassette with an appropriately labeled plastic bag.

Compounding and Manipulation of Non-sterile Hazardous Drugs

1. Any manipulation of hazardous drugs beyond repackaging whole dosage forms or counting (such as cutting tablets or compounding) shall be performed in a C-PEC in the hazardous rug room.
2. Compounding of non-sterile hazardous drugs shall occur in ~~in~~ the hazardous drug room in a C-PEC in accordance with USP757 and USP800.

Environmental Controls in Hazardous Drug Room

1. The C-PEC in the hazardous drug room is a containment ventilation enclosure (CVE) and it is only used for non-sterile compounding and manipulation of hazardous drugs by qualified personnel
    a. The C-PEC shall be externally vented and operate continuously under negative pressure greater than -0.01"WC.
    b. During a power outage or air handling maintenance that interferes with negative pressure in the room or C-PEC pharmacy personnel shall stop any compounding activities and exit the hazardous drug room after removing any PPE and performing hand hygiene. Once the C-PEC can be powered on it should be decontaminated and sanitized on all surfaces and wait the manufacturer-specified recovery time before resuming compounding activities.
2. Secondary engineering controls in the hazardous drug room include:
    a. A rigorous deactivation, decontamination, and sanitation program
    b. Negative pressure -0.01 and 0.03 inches water column relative to adjacent areas with at least 12 air exchanges per hour.
    c. Equipment used to compound or clean in the hazardous drug room remains dedicated to the hazardous drug room to prevent possible contamination of other areas of the pharmacy with hazardous drug residues
    d. Standardized gowning, garbing, and hand hygiene procedures including double shoe covers to help prevent tracking hazardous drug residues into other areas of the pharmacy

Testing and Monitoring of Environmental Controls in the Hazardous room

1. Pressure Differential Monitoring
    a. Hazardous drug room relative to adjacent areas
        i. Measured wirelessly and continuously by engineering via the TEMPTRAK system.
        ii. If differential pressure falls out of range in the hazardous drug room, engineering will be consulted to evaluate the potential causes and the supervising pharmacist will determine if any changes in workflow regarding personnel safety are needed until the desired pressure differential is restored.
        iii. Pressure differential will be manually documented on a daily basis when the pharmacy is open on the "air pressure differential log."
2. Temperature monitoring
    a. The temperature of the hazardous drug room is continuously monitored wirelessly with limits set for operator comfort and manufacturer recommended storage conditions for drugs.
    b. Humidity gauges are present in hazardous drug room to detect significant changes that would affect operator comfort.
3. Certification and testing of primary and secondary engineering controls shall be performed every six months and whenever a primary engineering control or area designated for compounding is relocated, altered or a service to the facility is performed that would impact the device or area.

Hand Hygiene and Garbing procedure

1. Remove any hand, wrist, finger, or other visible jewelry
2. Remove any neck lanyards, ties, or necklace jewelry
3. Don hair cover and face mask to cover bridge of nose down to the chin. Don additional facial hair cover if necessary.
4. Don shoe covers placing the first covered shoe over the line of demarcation to the clean side prior to donning the second shoe cover.

5. Don a second pair of shoe covers after crossing over the line of demarcation.
6. Perform hand hygiene for 30 seconds using soap and water up to the elbows and dry hands
7. Don a non-shedding splash resistant gown
8. Don 2 pairs of chemotherapy gloves
9. At the end of hazardous compounding:
    a. Remove and discard gloves, gown, facial hair cover, mask, hair cover, and first pair of shoe covers in the yellow hazardous drug waste container.
    b. Perform hand hygiene with soap and water for at least 30 seconds
    c. Remove second pair of shoe covers one at a time ensuring that the uncovered foot is placed over the line of demarcation.
    d. Discard second pair of shoe covers in the yellow hazardous waste container and disinfect hands prior to leaving the hazardous drug room.

Deactivation, Decontamination, and Cleaning of the Workspaces in the Hazardous Drug Room

1. Schedule for cleaning activities (Deactivation, Decontamination, Sanitizing)
    a. Trained environmental service personnel shall clean the hazardous drug room floors daily when the pharmacy is open and clean the ceilings, walls, and windows once a week.
    b. Pharmacy personnel shall clean the C-PEC daily when used for compounding and at least once a week regardless of use. Cleaning the C-PEC shall occur before and after compounding.
    c. Pharmacy personnel shall clean the carts, bins, and shelves once a week.
2. C-PEC
    a. Deactivate all the surfaces of the C-PEC with diluted bleach followed by decontamination and sanitization with a germicidal detergent using the isolator cleaning tool as needed, using overlapping wiping motion from the top of the workspace to the bottom and then in the same direction horizontally
    b. Avoid using sprays in the hazardous drug room since it can spread hazardous drug residues. Instead use pre-saturated wipes or pourable pull top bottles to wet a non-shedding wipe.
3. Hazardous drug room
    a. Floors shall be deactivated with diluted bleach followed by decontamination and sanitization with germicidal detergent daily when the pharmacy is open
    b. Walls, windows, carts, bins, and shelves are deactivated with diluted bleach followed by decontamination and sanitization with a germicidal detergent weekly.
4. After completing any cleaning activities document in the “cleaning record for hazardous drug room”
5. Dispose of all cleaning waste and PPE worn during cleaning in the yellow hazardous drug waste bin
6. All equipment used to clean the hazardous drug room is dedicated to the room and cannot be used for cleaning activities elsewhere.

Use of C-PEC for compounding non-sterile hazardous drugs

1. The C-PEC is run continuously, but if it is turned off then turn on the C-PEC and wait one minute before raising the sash to deactivate, decontaminate, and sanitize all of the surfaces inside the C-PEC
2. All of the surfaces in the C-PEC must be deactivated, decontaminated, and sanitized before and after compounding.
3. Place compounding equipment and ingredients in the C-PEC and lower the sash before starting to compound.

4. Prepare any compounds according to the master formula (See "Master compounding Formula in pharmacy policy 07.01.00), deactivate and decontaminate the container of the final product with diluted bleach and a germicidal detergent and place in a plastic bag to decrease the risk of spilling.
5. Deactivate and decontaminate any reusable compounding equipment with diluted bleach and a germicidal detergent and then place in a plastic bag for storage in the hazardous drug room.
6. A beyond use date shall be assigned based on the master formula and USP795 (See policy 07.01.00 "Beyond use dating").
7. Discard any waste in the yellow hazardous drug waste bin.

Transport of hazardous drugs

1. Hazardous drugs shall be transported in containers that minimize the risk of breakage or leakage.
2. Liquid and semi-solid formulations shall be transported in plastic bags and handled with chemotherapy gloves.
3. Non-cytotoxic hazardous drugs may be transported with non-hazardous drugs for the same patient in the same container.
4. Solid dosage form cytotoxic drugs shall be separated from other patient medications by a plastic bag with appropriate labeling.
5. Non-solid cytotoxic dosage forms shall be transported in a plastic bag with appropriate labeling by personnel wearing chemotherapy gloves with a spill kit readily available.

Hazardous Drug Identification

1. The pharmacy shall maintain a list of hazardous drugs on the pharmacy and nursing intranet which shall include medications ~~are~~ on the National Institute Occupational Safety and Health (NIOSH) list of "antineoplastic and other hazardous drugs" as well as drugs determined to be hazardous by the supervising pharmacist.
2. The hazardous drug list shall be evaluated annually by a clinical pharmacist and supervising pharmacist and shall include assessment of drugs added or removed from the NIOSH list that is updated bi-annually
3. Hazardous drugs shall be assessed for cytotoxic designation
    a. Cytotoxic drugs are handled with the same precautions as other hazardous drugs, but may have different storage and labeling requirements. In addition "chemoprecautions" shall be observed for patients receiving cytotoxic drugs per hospitalwide policy 25-05.
    b. Cytotoxic designation is determined through collaborative evaluation between the clinical pharmacists, pharmacy supervisor and oncology pharmacist at Zuckerberg San Francisco General Hospital.
    c. Evaluation of cytotoxic designation includes reviewing the mechanism of action, hazardous metabolites, American Hospital Formulary Service (AHFS) classification, relevant FDA and manufacturer warnings, NIOSH classification, and risk of adverse effects upon exposure.
    d. Hazardous drugs that destroy cells or inhibit their function with indiscrete or non-specific mechanisms of action that do not have any safe level of exposure are typically designated as cytotoxic.

Administration of Hazardous Drugs – See Hospitalwide policy 25-05

Training

1. All pharmacy personnel handling hazardous drugs in any capacity shall be trained based on their job function
2. Training for pharmacy personnel shall be documented and occur:
    a. Before a new employee independently handles hazardous drugs
    b. Whenever new equipment is introduced such as PPE or C-PEC
    c. Whenever there are significant changes in policy and procedure
    d. Reassessed at least every 12 months
3. Training for pharmacy personnel shall include the following:
    a. Identification of hazardous and cytotoxic drugs – location of the hazardous drug list
    b. Storage, labeling, and dispensing requirements for hazardous drugs
    c. Proper use of PPE
    d. Spill management
    e. Proper use and maintenance of environmental controls and compounding equipment
    f. Proper disposal of hazardous drug waste and trace-contaminated materials such as packaging
    g. Deactivation, decontamination, sanitization practices
    h. Appropriate documentation of cleaning, monitoring, and maintenance activities in the hazardous drug room
    i. Master formula and Beyond Use Dating (See Policy 07.01.00)
    j. Non-sterile compounding competency and practical
4. Training for environmental service personnel shall be documented and occur:
    a. Before a new employee cleans the hazardous drug room independently
    b. Whenever there is significant changed to policy and procedure
    c. Reassessed at least every 12 months
5. Training for environmental service personnel cleaning the hazardous drug room shall include:
    a. Deactivation, decontamination, and sanitization practices
    b. Proper use of PPE
6. Pharmacy personnel that handle hazardous drugs shall sign a hazardous drug acknowledgement form (Appendix 1)

Labeling and Dispensing

1. Hazardous drugs dispensed by the pharmacy shall be identified by the word HAZARDOUS printed on the packaging or with an auxiliary label and shall be identified on the medication administration record in the electronic health record
2. Cytotoxic drugs dispensed by the pharmacy shall be identified by an auxiliary label “Cytotoxic – Observe Chemo Precautions”
3. Hazardous drugs that are included in category 1 of the NIOSH list shall be dispensed as final dosage forms that do not require any manipulation prior to administration besides counting
4. Hazardous drugs shall not be crushed or cut outside of the C-PEC in the hazardous drug room (unless there has been a documented assessment of risk), but some dosage forms may be dispensed in an oral syringe to be dissolved in the oral syringe prior to administration. The medication administration record in the electronic health record shall include details on how to prepare a hazardous medication for administration and what PPE to utilize if needed.

Assessment of Risk

1. Hazardous drugs identified on the NIOSH list shall meet the containment strategies identified by USP800.
2. An assessment of risk shall be documented in cases where a hazardous drug does not meet the containment strategies in USP800.
3. Assessment of risk for alternative containment strategies must be approved by the pharmacy supervisor and re-evaluated every 12 months.
4. Assessment of Risk shall include:
    a. Type of hazardous drug
    b. Dosage form
    c. Risk of Exposure
    d. Packaging
    e. Manipulation

Hazardous Drug Waste

1. Unless identified as RCRA waste (see below) all hazardous drug waste including any supplies, PPE, or containers potentially contaminated with hazardous drug residues should be disposed of in the yellow hazardous drug waste bin.
2. Hazardous waste containers shall be puncture resistant and appropriate for sharps disposal
3. The yellow hazardous waste container shall be replaced by environmental services when it is ¾ full or has been used for 90 days. New yellow hazardous waste containers shall be dated when they start being used.
4. Resource Conservation and Recovery Act (RCRA) waste
    a. Some hazardous drugs need to be separated and disposed of in one of the black RCRA waste containers.
    b. RCRA waste containers shall be labeled with their contents and shall be replaced by environmental services when it is ¾ full or has been used for 90 days. New RCRA waste containers shall be dated when they start being used.
    c. Expired cytotoxic drugs or packaging/supplies contaminated with cytotoxic drug residue that have not been dispensed by the pharmacy shall be disposed of in the appropriate RCRA waste container
    d. Nicotine, Warfarin, Silver sulfadiazine, silver nitrate, and selenium sulfide are considered “Listed waste” and shall be disposed of in the appropriate RCRA container.
    e. All hazardous, cytotoxic, and listed waste dispensed by the pharmacy shall be considered “RCRA empty” and shall be disposed of in a yellow hazardous waste container.

Spill Management of Hazardous Drugs

1. Spill kits are located in the pharmacy and are available outside the pharmacy on the medical acute unit, the supplemental drug room, as well as the "chemo cart"
2. See hospital wide policy 25-05 for contents of the spill kit
3. Small spills of 5 ml or less or dropped pills may be wiped up with absorbent gauze while wearing chemotherapy gloves. Dispose of spill waste and chemotherapy gloves in the yellow hazardous drug container.
4. Spills larger than 5ml should be managed per hospital policy 25-05

Attachment:
Attachment 1: Hazardous Drug Risk Acknowledgement Form
Reference:
LHHPP 25-05 Hazardous drug Management
PPP 07.01.00 Sterile Product Preparation, Handling, and Disposal
United States Pharmacopeia and National Formulary (USP 800). Rockville, MD: United States Pharmacopeial Convention; 2017. https://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/general-chapter-800.pdf. Accessed July 15, 2019
USP795
CDC NIOSH (National Institute for Occupational Safety and Health). 2004- 165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings
American Society of Health System Pharmacists. 1/12/2006. ASHP Guidelines on Handling Hazardous Drugs

Revision History: 10/15, 7/19, 3/20

AUTOMATED MEDICATION DISPENSING CABINETS

POLICY:

Nursing, Pharmacy, Central Supply and Respiratory Therapy staff who have completed training and are authorized to perform these procedures will utilize the Automated Medication Dispensing Cabinet (ADC) for the control, dispensing, documentation, and charging of medications and supplies that are available in the ADC.

RELEVANT DATA:

1. The information technology pharmacist, or designee, is the ADC System Administrator and is responsible for the assignment of permanent login ID and password to authorized staff members of Nursing, Pharmacy, Central Supply and Respiratory Therapy departments.

2. Permanent access code will be issued within 5 business days of submission of: 1) a completed "*Omnicell User Account Request Form*," signed by the supervisor of employee needing an account, and 2) a signed *Omnicell Password Verification Statement*. An incomplete form or unauthorized approval signature will not be processed.

3. The ADC System Administrator or designee will inform the requesting person via email when account has been activated. The login ID assigned will be the same as the ~~INVISION~~ user's DSW ID number.

4. Generation of password will be prompted during initial login. Password will be valid for six months (180 days) and will have to be changed every six months (180 days) thereafter.

5. No permanent access codes will be assigned or released by telephone or e-mail.

6. Nursing Directors or designee will assign temporary access code to per diem, float, nursing instructors, or new nursing staff members pending permanent login access code. A temporary code expires after 24 hours.

7. The Nursing Education Department or designee provides orientation to new users for licensed nurses. CSR will train new staff to their department as needed, including respiratory department. Pharmacy will orient new pharmacy staff as needed.

8. The Nurse Manager/Unit Manager is responsible for the prompt notification of the activation or separation of any nursing employee with an ADC System access code. Following notification of separation of any user, the ADC System Administrator or designee must immediately de-activate the login ID password by deleting the user from the system.

9. Pharmacy is responsible for stocking medications in the ADC and maintenance of medication database. CSR will be responsible for maintaining the supplies database and stocking supplies in the ADC.

10. The nurse dispensing controlled substances from the ADC System Cabinet is responsible for security, accountability for and documentation of medication administration and wastage.

PROCEDURE:

I. **LOGIN**

A. Enter login ID

B. Enter password

C. Biometric Login

-require to login with password once a day

II. MAINTENANCE OF PATIENT LIST (ADT FUNCTIONS)

A. The ADC patient list is created by the Admissions, Discharge, and Transfer (ADT) interface with the ~~INVISION~~ EHR software.

B. ADD PATIENT FUNCTION

Generally not needed as census information is maintained by nursing staff on unit.

Please see *Computer /ADC Down Time* procedure ~~when~~ ~~INVISION~~ if the EHR is down. See V below.

C. EDIT PATIENT INFORMATION

1. The patient information cannot be edited in the ADC system.

III. PHARMACY PROCEDURES

A. STOCKING MEDICATIONS INTO THE AUTOMATED DISPENSING CABINET

1. Pharmacy will restock the ADC as scheduled (i.e. daily, every other day, etc.). The inventory levels will be determined using the Pharmacy Omnicell Server.

2. During restock on non-controlled medications, if inventory count is incorrect, the Pharmacy Technician adjusts the on-hand quantity.

B. CONTROLLED SUBSTANCES DISCREPANCIES

1. Pharmacy and Nursing will resolve discrepancies from restocking errors.

2. Pharmacy will run the Unresolved Discrepancy Report. Discrepancies which are unresolved for more than three days will be reported in writing to Nursing Administration for resolution and corrective action.

~~3. Pharmacy confirms that cycle counts of controlled substances are conducted and reports the % compliance, by nursing unit, to nursing and pharmacy administration quarterly.~~

C. UNIT INSPECTION

1. Pharmacy will check expiration dates~~ing~~ of ~~the~~ medications stocked in the ADC at least every 30 days.

D. SDR (Supplemental Drug Room)

1. Pharmacy will retrieve copies of orders from nursing office where SDR Omnicell cabinet is located every morning.

2. Cabinet will be restocked to maximum level every day.

E. ACUTE CARE UNITS with ADC

1. Pharmacy will dispense 24-~~-~~hour supply for all new orders for medications not routinely stocked in the ADC.

   Patient specific multi-dose medications will be dispensed per unit and have patient specific label; these will not be stocked in the ADC.

2. Cabinet will be stocked with 7-day supply of medications within 24 hours of new orders received by pharmacy

IV. DISPENSING MEDICATION

A. ALL MEDICATIONS

1. General Dispensing

   a. Dispense medications at the ADC by selecting the Patient Care menu. Follow the instructions which appear on the computer screen. Refer to the on screen quick reference guide on the ADC as needed.

   b. If medication is not in the resident's profile, needs to be restocked/destocked or is unavailable, use the Nursing-Pharmacy Communication Form to notify Pharmacy.

2. Emergency Override Medications

   a. Nursing supervisors will have override~~able~~ access to all medications. Evening and morning shifts RN and LVN staff will have override access only to overrideable medications.

   b. A list of overrideable drugs accessible to evening and morning RN and LVN is reviewed at least annually by the Pharmacy and Therapeutics Committee.

   c. If medications are needed and pharmacy is not open, select "Remove Items", then select "Stocked Items".

   d. A list of all available medications stocked in the cabinet will appear. Select the medications needed. The system will ~~then tell you~~show if the medication is overrideable or not.

   e. The nurse must check for correct dosage, allergies and drug interactions before administration of medications.

3. ~~Charge and Credit~~Item Return Responsibility

   a. The nurse, or respiratory therapist, is responsible for completing the dispensing and return procedures on units. ~~to insure proper charging and crediting.~~

4. Discrepancies Found While Stocking

   a. Pharmacy technician will fill out the Stocking Discrepancy Form when a discrepancy is found during stocking of narcotics. The form is to be signed by nurse on unit and pharmacy technician, and a copy is sent to the nurse manager. Pharmacy will keep the original.

b. Pharmacy technician will fill out the Return Bin Discrepancy Form when a discrepancy is found during destocking of narcotics from the External Return Bin (ERB). The form is to be signed by nurse on unit and pharmacy technician, and a copy is sent to the nurse manager. Pharmacy will keep the original.

B. CONTROLLED SUBSTANCES

1. Dispensing

a. Nurses must retrieve only the dose needed for resident, and not retrieve doses for multiple residents without going into their profile.

~~2. Multidose Vials/Bottles~~

~~a. Dispense the total amount in mL from the vial/bottle on screen (e.g. 20mg of Roxanol 20mg/mL will be 1mL). Remove individual patient dose.~~

~~b. Return remaining amount in mL in the vial/bottle that is shown on screen (e.g. 29mL of a 30mL bottle of Roxanol).~~

~~3.~~2. Returning Medication

a. Nurses must document the dispensing, disposal (wastage), and return of controlled substances. Only sealed, unused controlled substances can be returned to the cabinet via the ERB.

b. Small packages of controlled substances will be returned to the ERB. The *Return Medication* function is selected from the menu and the instructions followed to complete the return process. The patient will receive credit for all returned medications.

c. If the medication package is not intact, the user must follow the procedure for Wasting Medication.

~~c.~~d. If medication package is intact and eligible for returns, returns must be witnessed by at least one other licensed personnel (i.e. enter Witness Password). For shifts with one licensed staff in the unit, documentation of returns should be done as soon as a second licensed staff is available as a witness.

~~4.~~3. Wasting Medication

a. Nurses are required to waste all opened unused controlled substance.

b. If all or part of a controlled substance has been wasted, the wastage will be documented using the Waste Medication function at the time of the wastage. The instructions appearing on the screen are followed.

c. All wastage is to be documented at the time of the wastage and witnessed by two licensed personnel (i.e. enter Witness Password). For shifts with one licensed staff in the unit, documentation of wastage should be done as soon as a second licensed staff is available as a witness.

d. If the medication packaging is not intact, use the Waste Medication function for disposal.

~~5.~~4. End of Shift Verification - Cycle Count (i.e. Controlled Substance Count)

a. One licensed nurse each from the oncoming and off going shift will perform the end of shift verification procedure.

~~6.~~5. Discrepancy Report

a. A licensed nurse from each shift will print a discrepancy report before the end of each shift. The Charge Nurse is responsible for e~~i~~nsuring this task is completed. Information includes the medication, user who discovered the discrepancy, the users who last had access to the medication and description of the problem.

b. Discrepancies must be investigated and resolved at that time, before any staff member leaves the nursing unit (for scheduled 2-5 narcotics only). The Resolve Discrepancy function is selected and the screen instructions followed. A witness is required for controlled substances or other selected medications as determined by the ADC System Administrator. If a witness is required, use the Witness Function and complete as instructed. The Comment field must be completed with an acceptable statement regarding the resolution of the discrepancy.

c. Any unresolved discrepancy involving a controlled substance will be reported to the nurse manager/supervisor on duty. A narcotic discrepancy report will be completed and returned to the Pharmacy for investigation and disciplinary action, as necessary. And an Unusual Occurrence Report (UO) must be completed.

~~7.~~6. Obtaining new controlled substance when the pharmacy is closed.

a. If a new order for a controlled substance (CS) is received after pharmacy hours, the Nursing Supervisor will check a designated Omnicell unit, which provides information about medications stored in all Omnicell units, for the location of the newly ordered medication.

~~b. A copy of the new order will be faxed to pharmacy.~~

~~c. The licensed nurse will bring a copy of the new order to the unit where the needed medication is located, for double-check with the Nursing Supervisor.~~

~~d.~~b. With the Nursing Supervisor, the nurse will obtain the doses of controlled substance required until pharmacy re-opens.

~~e.~~c. The Nursing Supervisor and licensed nurse will verify the amount taken from Omnicell.

~~f.~~d. The nurse will create a CS log sheet which indicates amount and dose of CS removed from Omnicell.

~~g.~~e. Both the Nursing Supervisor and the licensed nurse will co-sign the CS log sheet.

~~h.~~f. Controlled substances dispensed from Omnicell for an individual resident's use, will be double-locked in the medication cart.

~~i.~~g. In inter-shift report, nurses will communicate the need to manually count the CS locked in the medication cart and may choose to place a notice on the Omnicell as a reminder about the need for manual count.

j.h. At change of shift, the CS log will be checked with the amount of CS remaining in the locked medication cart.

k.i. When pharmacy reopens, the pharmacist will ~~update the resident's medication profile to reflect the new CS order.~~reconcile any controlled substance overrides and orders placed in the HER. The CS log sheet will be sent to the Pharmacy for their record keeping including updating resident's medication profile so CS can be accessed from Omnicell.

C. NON-CONTROLLED MEDICATIONS

1. Dispensing -See ALL MEDICATIONS

2. Returning Medication

a. Medications removed from the ADC that are not administered and are in the original sealed package may be returned to the ERB.

b. The *Return* function is selected from the Patient Care screen after selecting a patient. Follow the instructions to complete the return process. The patient will receive credit for all returned medications.

c. External Return Bin is only for returning medications.

d. The pharmacy technician will retrieve medications in the ERB back to pharmacy. ~~reconcile medications expected in the ERB with medications found in the ERB. All discrepancies will be reported to the unit Nurse Manager and the Pharmacist in Charge. *See Return Bin Discrepancy Form.*~~

D. RESPIRATORY MEDICATIONS AND SUPPLIES

1. Respiratory therapists have access to compartments which contain only respiratory therapy items. No access to scheduled drugs or other medications has been authorized. The system software has been configured to display only those drugs to which the therapist/materials manager has been authorized access.

V. COMPUTER/ADC DOWN TIME

A. If ~~INVISION~~ the EHR is down, add patient manually from the Patient Care screen.

1. Nurse Managers may add patients at the Cabinet level. Before adding a patient manually, the nurse should check the Global List first. The Global List displays all patients in the hospital.

2. Select the "Add New Patient" function from the Patient Care Menu. Follow the instructions on the screen to complete the patient name using this format:

a. Enter the patient's First and Last name;

b. Enter the patient account number. **NOTE**: The account number MUST be entered correctly and cannot be modified after entry. If an error is made, delete or cancel the patient entry with the incorrect patient account number, and re-enter the patient and correct account number.

3. After entering the patient, the operator selects "Add New Patient" button.

4. Pharmacy will run the Temp Patient Billing Reconciliation daily. This function links the temporary patient added to actual patients on the server coming from ADT interface.

B. If ADC is down:

Nursing:

1. Notify pharmacy that the Omnicell cabinet is not working. Please do not call Facility Services.
2. Pharmacy will open ~~nn up~~ the non-narcotic drawers and transfer controlled substances to locked narcotic drawers in medication cart.
3. To get medication:
    i. look up the location of the medication on the inventory sheet by searching for the medication name
    ii. find the drawer that has the medication
    iii. retrieve the medication
    iv. sign out the medication on the *Omnicell Downtime Drug Usage Record (non-controlled substance)*
4. For controlled substances follow normal procedures for medications NOT stored in Omnicell (retrieve medications from locked narcotic drawer in the medication cart, logging them out on the CS log sheet, and record waste on the CS log sheet)
5. Keep the medication room locked at all times
6. Fax the *Downtime Drug Usage Record* and *CS log sheet* to pharmacy each morning before 08:00. This will be used by the pharmacy to re-stock the ADC.

Pharmacy:

1. Pharmacy technician or designee will open front of ADC unit which opens all drawers except controlled substances.
2. Pharmacy technician or designee will transfer controlled substances to locked narcotic drawer in medication cart. Dispensing will be documented manually on the Controlled Substance Record as outlined in P&P/Controlled Substances.
3. A pharmacy technician will go to the medication room and deliver:

    i. *Omnicell Downtime Drug Usage Records (non-controlled substance)*

    ii. A copy of the most recent inventory sheets for that cabinet
4. The pharmacist or technician will speak with the charge nurse/nurse manager to ascertain which controlled substances will need to be stocked there.

5. An adequate quantity of controlled substances will be delivered to the nursing unit with filled out Controlled Substance log sheet. The nurse will sign them in and lock them in their narcotic cabinet

6. When the cabinet is again up and running, the Omnicell Drug Usage Records will serve as an Inventory Below Par Report to restock the ADC.

Restocking of Omnicell Cabinets when Communication is Down (Pharmacy Technician Activity)

1. At the cabinet, log onto the cabinet and use the "Restock" function.

2. Start at the top left of the list and look at the quantity available. If there is not enough of the medication to last 24 hours, write the medication down and an adequate quantity to fill in order to bring the inventory up to a quantity that will last 24 hours.

3. Use the down arrow key to move to the next item. Check its quantity. If it is low, add to the fill list. Continue this process until all medications in the cabinet have been checked.

4. Fax the fill list to pharmacy

5. Pharmacy technician will use the fill list as if it were a computer generated inventory below par list

6. Pharmacist will initial the list after checking the medications against the fill list.

7. The medications will then be delivered to the Omnicell cabinet for restocking in the usual manner.

VI. OMNICELL SYSTEM CABINET PRINTER MAINTENANCE

A. Paper will be stored inside the ADC cabinets as an item to remove (using the Floor stock patient). Paper will be restocked by pharmacy personnel when the paper has reached its re-order level.

VII. TROUBLE SHOOTING

A. To reset password, please fill out the Omnicell User Account Request Form, and forward to pharmacy. For nursing department, please call nursing managers or supervisors. If further help is needed or if nurse manager or supervisor is unavailable, please contact pharmacy.

B. For software support, call Omnicell Service Center: 1-800-910-2220

C. For hardware support, call Omnicell Service Center: 1-800-910-2220

New: 04/09
Reviewed: 2/10, 08/11, 6/12, 8/13, 8/14, 8/15
Revised:

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

OMNICELL USER ACCOUNT REQUEST FORM

Date of request: _____

Person requesting (must be supervisor of employee needing an account):

Print Name: _____ Signature: _____

REQUEST IS FOR:

ρ New Account ρ Reset Password ρ Remove Account ρ Change Unit Location

(Please print clearly)

Last Name: _____

First Name: _____

Middle Name: _____

INVISION Username Login: _____

Unit Location(s): _____

Department:

- ρ NURSING
  - License Nurse Classification:
    - ρ Staff RN/LVN Float π Yes π No
    - ρ Nurse Manager Shift π Day π PM π AM
    - ρ Nursing Director
    - ρ PM/AM Shift Supervisor
- ρ PHARMACY
  - ρ Pharmacist
  - ρ Pharmacy Technician
- ρ RESPIRATORY THERAPIST
- ρ OTHER (please specify):

Employee to Read and Sign:

I am the only person who possesses a unique password that will allow me to access the Omnicell Cabinets under my name. I am the only person who will use this unique password to access the Omnicell cabinets. I will not disclose my password nor delegate my power to access the Omnicell cabinets to anyone for any reason.

I agree that upon my separation from Laguna Honda Hospital, I will immediately stop accessing Omnicell cabinets.

_____ _____

(Signature of Employee) (Date)

Please forward completed form to the pharmacy via fax: 759-6017. The request will be processed within 5 business days and the person requesting will be notified via email. Accounts will automatically delete after 90 days of inactivity.
Please call Lucy at x3302 (pager: 327-9074) for questions.

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

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

OMNICELL USER ACCOUNT REQUEST FORM

Date of request: _____

Person requesting (must be supervisor of employee needing an account):

Print Name:_____ Signature: _____

REQUEST IS FOR:

☐ New/Renew Account ☐ Remove Account ☐ Change Unit Location

(Please print clearly)

Last Name: _____

First Name: _____

Middle Name: _____

DSW/POI Number: _____

Unit Location(s): _____

Department:

☐ NURSING

License Nurse Classification:

☐ Staff RN/LVN
☐ Nurse Manager
☐ Nursing Director
☐ PM/AM Shift Supervisor

Float: ☐ Yes ☐ No

Shift: ☐ Day ☐ PM ☐ AM

☐ PHARMACY
- ☐ Pharmacist
- ☐ Pharmacy Technician

☐ RESPIRATORY THERAPIST

☐ OTHER (please specify):

Employee to Read and Sign:

I am the only person who possesses a unique password that will allow me to access the Omnicell Cabinets under my name. I am the only person who will use this unique password to access the Omnicell cabinets. I will not disclose my password nor delegate my power to access the Omnicell cabinets to anyone for any reason.

I agree that upon my separation from Laguna Honda Hospital, I will immediately stop accessing Omnicell cabinets.

_____ _____

(Signature of Employee) (Date)

Please forward completed form to the pharmacy via fax: 415-759-6017. The request will be processed within 5 business days and the person requesting will be notified via email. Accounts will automatically delete after 60 days of inactivity.
Please email Kien Vuong for questions.

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

OMNICELL PASSWORD VERIFICATION STATEMENT

I understand that my access code, which consists of an identification code, password and biometric login, is my electronic signature for all transactions in the Omnicell Medication Dispensing Cabinets. It will be used to track all of my transactions with a time and date stamp. These records will be maintained and archived in accordance with Laguna Honda Hospital policy and will be available for inspection by all regulatory bodies, such as the DEA and the State Board of Pharmacy.

Upon receipt of my user ID, it is my responsibility to immediately sign on to the Omnicell cabinet and enter a new password of my choice. I will not keep a hard copy record of this new password. If I forget my password, I must contact my supervisor.

I understand that I must not give this password to anyone. To maintain the integrity of my electronic signature, my password must remain confidential. This password is encrypted throughout the Omnicell system and cannot be accessed by others such as pharmacy, nursing, CSR, and Omnicell employees. If for any reason I feel anyone else has knowledge of my password, I must select a new password immediately and notify my nurse manager. A password can be reset by any member of nursing management on the unit and reentered by me at my convenience.

_____

Print Name Date

_____

User Signature

Rehabilitation Center

ursing-Pharmacy Communication Form

Date:__________________________

Unit:__________________________

Requested by:____________________________

Ext #:_________________________

g medication(s):

	Medication Name and Strength:	Check one of the following: ☐ Omnicell item used up…Please restock ☐ No one on unit uses medication…Please destock. ☐ Omnicell item and order are not listed on Omnicell Profile (Need to fax copy of order) ☐ Drug DC'ed…Please remove from patient's profile (Need to fax copy of DC order also)
	Medication Name and Strength:	Check one of the following: ☐ Omnicell item used up…Please restock ☐ No one on unit uses medication…Please destock. ☐ Omnicell item and order are not listed on Omnicell Profile (Need to fax copy of order) ☐ Drug DC'ed…Please remove from patient's profile (Need to fax copy of DC order also)
	Medication Name and Strength:	Check one of the following: ☐ Omnicell item used up…Please restock ☐ No one on unit uses medication…Please destock. ☐ Omnicell item and order are not listed on Omnicell Profile (Need to fax copy of order) ☐ Drug DC'ed…Please remove from patient's profile (Need to fax copy of DC order also)

STOCKING DISCREPANCY FORM

Ward: _____ Date: _____
Time: _____

Medication	**Quantity in Bin**	**Quantity Found**	**Comments**

Date_____Time_____RX TECH_____

Date_____Time_____LICENSED NURSE_____

Please make a copy and forward to nurse manager for follow-up.
Return the original to pharmacy.

RETURN BIN DISCREPANCY FORM

Ward: _____ Date: _____
Time: _____

Medication	Quantity in Bin	Quantity on Report	Comments

Date_____Time_____RX TECH_____

Date_____Time_____LICENSED NURSE_____

Please make a copy and forward to nurse manager for follow-up.
Return the original to pharmacy.

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

Omnicell Downtime Restock List

Date:
Ward:

MEDICATION	QTY ON HAND	PAR LEVEL	QTY TO ADD	RX TECH/RPH INITIAL

SHEET ISSUED:	ISSUED TO WARD:	SHEET RETURNED:

LAGUNA HONDA HOSPITAL PHARMACY
NARCOTIC-HYPNOTIC DRUG RECORD SHEET

Sheet No:_________

DRUG:	**AMOUNT ISSUED** (STARTING BALANCE):

DATE	TIME	RESIDENT NAME	RN/LVN Signature	Quantity Removed	Quantity Returned	Quantity Wasted (check)	Quantity Wasted & RN/LVN Co-Sign	BALANCE (number remaining)

Nurse's signature: ____________________________ Continue Next Page ☐Y ☐N

Second Page

DRUG:	BALANCE FROM PREVIOUS PAGE: ____________

DATE	TIME	RESIDENT NAME	RN/LVN Signature	Quantity Removed	Quantity Returned	Quantity Wasted (check)	Quantity Wasted & RN/LVN Co-Sign	BALANCE (number remaining)

SHEET ISSUED:	ISSUED TO WARD:	SHEET RETURNED:

LAGUNA HONDA HOSPITAL PHARMACY **Sheet No:____________**

1. NARCOTIC-HYPNOTIC DRUG RECORD SHEET

MULTIDOSE LIQUID & MULTIDOSE VIAL INJECTABLES

DRUG:	**VOLUME (ML) ISSUED** (STARTING BALANCE):

DATE	TIME	RESIDENT NAME	RN/LVN Signature	Quantity Removed		Quantity Wasted (check)	Quantity Wasted & RN/LVN Co-Sign	**BALANCE** (number remaining)
				MG	ML			

Nurse's signature: ______________________________ Continue Next Page ☐Y ☐N

Second Page

DRUG:	BALANCE FROM PREVIOUS PAGE VOLUME (ML): ______________

DATE	TIME	RESIDENT NAME	RN/LVN Signature	Quantity Removed		Quantity Wasted (check)	Quantity Wasted & RN/LVN Co-Sign	BALANCE (number remaining)
				MG	ML			

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

Omnicell Downtime Drug Usage Record
(non-controlled substance)

Medication:
Beginning Balance:

DATE	TIME	RESIDENT NAME	RN/LVN Signature	Quantity Removed	Quantity Returned	Quantity Wasted (check)	**BALANCE** (number remaining)

LAGUNA HONDA
HOSPITAL AND
REHABILITATION
CENTER

Omnicell System Competency Evaluation

Place a check next to each function that has been completed

Function	Completed
1. Overview	
System Functionality Overview	☐
Help Desk Support	☐
Help Screen & Assistance	☐
Serial Number Location	☐
Power Switch	☐
2. Using the System	
User IDs & Passwords	☐
Minimum Password Length and Password Expiration	☐
Local vs. Global Patient Lists	☐
Adding a Temporary Patient	☐
Dispensing a Medication	☐
Correct Bin Levels	☐
Overriding a Medication	☐
Dispensing a Partial Dose	☐
Returning a Medication	☐
Wasting a medication	☐
Refrigerated/Remote Medication	☐
Dispensing Supplies	☐
Returning Supplies	☐
3. Other Functions	
Performing a Cycle Count	☐
Discrepancy Resolution	☐
Pharmacy Reports	☐
4. Super User Functions	
Creating a Temporary User	☐
Resetting a Users Password	☐
Touch & Go Fingerprint Registration	☐
Deleting a Temporary Patient	☐

Name: _____ Date: _____
Unit: _____ Login ID: _____

Trainer: _____

AUTOMATED DISPENSING CABINET (ADC) REPORT REVIEW

POLICY:

The Nursing and Pharmacy Departments will monitor medication dispensing (including controlled substances) to ensure accountability of use.

PROCEDURE:

ACTIVITY	PROCEDURE
Override Report	A. All override orders will be reviewed within 48 hours to ensure: 1. There is a new order associated with the override a. if not found, pharmacy staff will follow-up to verify that there is an order b. if no order is found in patient's chart, the nurse manager will be notified 2. There was no existing order in the patient's profile that could have been used without requiring override 3. Ensure patient name associated with the override is correct. 4. Override reason is appropriate 5. Override occurs only when the pharmacy is closed B. If the override does not meet the above criteria, the nurse manager will be notified for follow-up and response within 48 hours. C. If the nurse manager does not provide an adequate response within 48 hours, pharmacy staff will complete and submit an Unusual Occurrence (UO) form.
Wastage Report	A. Dose Required Report identifies medications taken out for a partial dose order but without a corresponding waste. A unit-based report is emailed daily to the Nurse Manager. The unit-based report is also printed on the unit's printer for a charge nurse or covering Nurse Manager to follow-up. Follow-up should be completed daily. B. The Nurse Manager or delegated Charge Nurse shall investigate the incident with the nurse who did not record waste and will resolve based on their findings. C. If the Nurse Manager or Charge Nurse is not able to resolve the wastage issue, the Controlled Substance Pharmacist or Pharmacist In Charge shall be consulted to assist with the resolution. 1. When the wastage is resolved, resolution shall be documented in Omnicell 2. If the wastage is not resolved, document in Omnicell as such and generate a UO for the event.
Discrepancy Report	A. Nursing staff shall resolve discrepancies before the end of his/her shift. B. Nurse Managers will have discrepancy reports emailed to them for all discrepancies (resolved or not). C. Nurse Managers are expected to review and follow-up all unresolved or incorrectly resolved discrepancies within 24 hours. D. The Controlled Substance Pharmacist or designee will review the discrepancy reports within 72 hours, and follow-up with Nurse Managers on any unexplained/inappropriate reasons or inappropriate procedures. 1. Nurse Managers shall respond within 48 hours after being notified of issues identified by the pharmacist. 2. If no response is received from the Nurse Manager or if the reason for the discrepancy is unresolved after 72 hours, a UO will be generated. E. The Controlled Substance Pharmacist or designee will include the Pharmacy Director in email notifications of discrepancy that involves missing medications.

Temporary Patient	A. Daily, the Controlled Substance Pharmacist or designee will review manually added patient accounts generated from the Automated Dispensing Cabinet. B. If a corresponding computer generated patient account exists, no further action is needed. C. If a match cannot be found and a prescription medication was issued, the unit Nurse Manager will be notified via email to follow-up. D. If no response is received within 48 hours, the Controlled Substance Pharmacist or designee shall notify the Nursing Directors for follow-up with the Nurse Manager. The Pharmacy Director shall be notified also. E. Medications removed under temporary patient accounts are completed utilizing the override function. Appropriateness of overrides is reviewed per Override Report procedure.
Medication Order Reconciliation	A. Every order needs to be attached to a patient record in Omnicell. If there is no match between the patient ID in the order and the patient ID in the patient record, a pharmacist or designee needs to reconcile which patient the order belongs to. ~~B. The Patient Account Number customized report in QS/1 will be generated to find the patient name. Search the patient record in QS/1 to find the appropriate patient account number for the order.~~ ~~C.~~B. In Omnicenter, reconcile the order with the correct patient account number.

New: 01/10
Reviewed: 8/13, 8/14, 8/15
Revised: 06/12

LAGUNA HONDA HOSPITAL **09.03.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

Periodic Check of Quantity on Hand in ADC (Omnicell)

POLICY:

The Pharmacy will conduct periodic Automated Dispensing Cabinet (ADC/Omnicell) hand count inventories to ensure proper inventory and dispensing controls.

PROCEDURE:

All controlled substances stored in ADC (Omnicell) devices are accounted for at least daily. Nursing perform cycle counts for controlled substances during their nursing shift. For non-controlled substances stored in ADCs, the pharmacy department at LHH will reconcile drugs in each ADC with ADC inventory records during the restocking process. If the quantity of the expected inventory and stock on hand differ, the pharmacy technician will adjust the on-hand quantity data, thereby creating a record to track discrepancies of non-controlled substances.

~~a. Nurse Managers and the Director of Pharmacy will be notified quarterly of the results and of any discrepancy trends.~~
~~b. Nurse Manager is to review the data with their staff and potential reasons for such discrepancies.~~
~~c. Nurse Manager is to review appropriate dispensing procedure in Omnicell to prevent future discrepancies.~~

Pharmacy shall also conduct monthly inventory and expiration date audits of 5 randomly selected ~~controlled substances~~medications ~~per~~in each ADC (Omnicell) device. Audits will cover 1 OTC and 4 controlled substance items.

Reviewed: 8/13, 8/14, 8/15
Revised: 06/12

LAGUNA HONDA HOSPITAL **09.04.00**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PHARMACY OPERATION OF MEDICATION UNIT DOSE PACKAGER MACHINE (PARATA ATP ~~FASTPAK~~)

Policy:

Pharmacy Staff who are authorized to perform these procedures will utilize the Parata ATP ~~FastPak~~ machine to repackage bulk oral medications into unit dose preparations. Further, authorized staff will follow these procedures for proper maintenance and troubleshooting of the machine and system. Only select, designated users will have security to perform the admin functions as detailed in the admin procedures below.

Purpose:

To ensure a safe and effective process for repackaging unit dose oral medications by pharmacy for facility use.

Procedure:

1. Operation

~~Processing an Order~~

~~A. Select the **NEW ORDERS** Button~~
~~B. Select the order and press **PROCESS**~~
~~C. Select an **ORDER TYPE** (Default set to Repack)~~
~~D. Select a **CUT AFTER** Option (Default set to Order)~~
~~E. Select an **ORDER DISPENSE DIRECTION** (Default set to unit dose per patient)~~
~~F. Select **NEXT**~~
~~G. Select a **FACILITY** from the drop-down list. Select 'Labels' and 'Sort Group' if not populated~~
~~H. Select **FINISH**. The order will appear on the home screen with a status of ready to dispense~~

Dispensing an Order

A. Ensure communication has been established with the ATP machine. The **MANUAL** button in the lower right-hand corner of the screen should be green and the button text should display **AUTO**.
B. Select **HOME**.
C. Select an **ORDER** that has a status of **READY FOR DISPENSE**.
D. Select **DISPENSE**.

Dispensing an Order with Smart Canister

A. Follow steps 1-4 from section above.
B. Then, follow the prompts on the **ADD/REMOVE SMART CANISTERS** screen, selecting **NEXT** after adding or removing each canister.
C. The order starts dispensing when all required Smart Canisters are placed in the ATP

Creating a Range of Bags Order

A. Select **HOME**.
B. Select **SEARCH**.
C. Select a **FILTER** at the top of the screen.
D. Select the **ORDER**.
E. Select the **PATIENT**; the bag details will populate on the screen.
F. Select the **START BAG NUMBER** (or **REVERSE BAG NUMBER**).
G. Select the **END BAG NUMBER** (or **REVERSE BAG NUMBER**).
H. Select **CREATE ORDER** and dispense as usual.

Creating a Range of Bags Order

Note: use the following steps for any interrupted order mid-dispense

A. Follow steps 1-4 above.
B. Select the **PATIENT**; the bag details will populate on the screen.
C. Select the **START BAG NUMBER** (or reverse bag number). This is the bag after the last good bag dispensed.
D. Select the **END BAG NUMBER** (or reverse bag number). This is the last bag for the tray currently in ATP. It will be identified with its Tray number and the Cell number is 64 (the last cell of the tray; it may be on a different patient). Make a note of the End Bag Number; the bag number after this will be your Start Bag Number in step 6.
E. Select **CREATE ORDER**.
F. Follow the steps 1-8 above to create a range of bags for the remainder of the order.
G. Select **HOME**.
H. Select the first range of bags order and select **DISPENSE**.
I. When the order calls for the UTC tray, you will need to move the medications to the designated cells on the screen.
J. Select **HOME**.
K. Select the second range of bags order and select **DISPENSE**.
L. Note that when Dispense Manger calls for "Tray 001" it will be the tray that was next in the order.

Pharmacist Verification of dispensed products

A. The pharmacist will check and verify all medications dispensed from the machine.
    a. Validation of correct drug, package fill, labeling for packaged pouches.
    b. Rejection of incorrectly packaged product.

Refilling a Canister While Dispensing

A. The ATP stops dispensing and the **ATP REFILL NOTIFICATION** screen appears displaying the canister number that needs to be refilled. Touch the canister number on the screen.
B. The drawer will unlock. Open the drawer.
C. Remove the canister and check to confirm that it is empty. If the canister is not empty, replace the canister and select **RESUME**
D. If the canister is empty, select the **MANUAL** or **SCALE** as the count method.
E. Proceed to the manual or scale refill page for the next steps.

Refill a Canister using the Manual Method

A. Select **HOME** and then press the **MEDS** button
B. Enter the medication name, canister number, NDC or barcode into the search box
C. Select the medication from the list and select **REFILL**, from the bottom menu.
D. Remove the canister from the drawer.
E. Select **MANUAL** as the count method
F. Scan the canister label
G. Scan the medication bottle. The barcode must be found in Inventory Manager to Proceed.
H. If the canister is empty, select **EMPTY** on the screen to reset the quantity to zero
I. Select a **QUANTITY**, or enter a quantity; select **ADD**.
J. Select SCAN MORE BOTTLES if you have more than one bottle to add to the canister. Scan medication bottle and add quantity.
K. Update the manufacturer's lot number and expiration date.
L. Select **NEXT**. If an RPh CHECK button is visible on the bottom of the screen, a pharmacist must login and verify the refill. See two sections below for instructions.
M. Scan the canister and return it to its drawer location
N. Select **OK**.

Refilling a Canister Using the Scale Method

A. Press **HOME** and then select the **MEDS** button.

B. Enter the medication name, canister number, NDC or barcode in the search box.
C. Select the medication from the list and press **REFILL** on the lower menu.
D. Remove the canister from the drawer.
E. Select **SCALE** as the count method. (See note below) Scan the canister label.
F. Scan the medication bottle. The barcode must be found in Inventory Manager to proceed.
G. Place empty canister on the scale; press **TARE** in Dispense Manager (not on the scale).
H. Fill canister and press **COUNT**. (See note below) Select ADD on the Dispense screen.
I. Select **SCAN MORE BOTTLES** if you have more than one bottle to add to the canister. Repeat steps 7-10.
J. Update the manufacturers lot number and expiration date.
K. Select **NEXT**. If an RPh **CHECK** button is visible on the bottom of the screen, a pharmacist must log-in and verify the refill. See Section below for instructions.
L. Scan the canister and return it to its drawer location.
M. Select **OK**.

Updating a Canister Medication

A. Select **HOME**.
B. Select **MEDS**.
C. Select **CANISTER** for 'Location Types' (deselect Tray, Groups and External).
D. Search for the medication by Med Name, Canister, NDC Number or Barcode by selecting the appropriate button and typing in the search criteria.
E. Select the medication and select UPDATE.
F. Update the manufacturer's lot number, expiration date, and description (if required).
G. Select **SAVE**.

Note: the assigned expiration date is automatically calculated based on pharmacy specific settings

Slotting a Medication

Note: medications must be added to Inventory Manager before they can be slotted in Dispense Manager

A. Select **HOME**.
B. Select **MEDS**.
C. Search for the medication by med name, canister, NDC, or barcode.
D. For Location Types, select the **CURRENT LOCATION** (Canister, Tray or External) for the medication if you are re-slotting, Or **NEW MEDS** if it is a medication that was newly entered into Inventory Manager.
E. Enter in your search text using the touchscreen keyboard. Press **OK**.
F. Select the medication and select **SLOT**.
G. To slot the medication as **EXTERNAL** Or **TRAY**, select the appropriate button and select OK.
H. To slot the medication as a canister, select the **CANISTER** button and click the white rectangle under the Canister Number. This will display available canister locations.
I. Enter a **THREE DIGIT CANISTER NUMBER** or select from the **AVAILABLE CANISTER** list.
J. Select **OK**.
K. Select **ADD CANISTER**.
L. Be sure **ACTIVE** is selected.
M. Select **OK**.
N. Select **REFILL** to fill the canister and update the manufacturer's lot and expiration date.

Note: Do not delete a slotted cannister. Instead, **INACTIVATE** the slotted cannister.

Pharmacist Verification of a Filled Canister

A. Press **ADD** button
B. Confirm canister matches the details on the screen.
C. Confirm the canister is filled appropriately with the correct medication.
D. Verify the Canister #, Lot #, Expiration Date, and visually verify that items in the bulk bottle matches the tabs/caps placed in canister.
E. Press **RPH CHECK** button.
F. Use the biometric reader or manually type credentials to verify.
G. Press **NEXT**.

H. Scan the canister
I. Place the canister back into the correct location in the ~~FastPak~~ ATP machine
J. Press the **RESUME** button.

2. Maintenance

Cleaning

A. Cleaning will be completed by technicians assigned to the Parata machines. The technician will document completion in the Parata cleaning log. The following is the cleaning cadence. More detailed instructions can be found in the cleaning log.
B. Daily Cleaning (for every 8 operating hours)
    a. Sub Hopper Belt using the HEPA vacuum
    b. Sub Hopper Curtain using a dry cloth
    c. UTC Tray Buckets using alcohol wipes
    d. First Shutter Base & Curtain using dry cloth
    e. Second Shutter using a dry cloth
    f. Heater Bar using the Scotch Brite pad
    g. Heater Rubber using alcohol wipes
C. Weekly Cleaning (every Sunday)
    a. Drawer channels using a dry cloth
    b. Desiccant replacement
    c. Motor Bases using the HEPA vacuum
    d. Motor base Sensors using a dry cloth
    e. Interior of cannisters using a vacuum followed by a dry cloth
D. Monthly Cleaning (2nd Sunday of the month)
    a. UTC trays using a vacuum followed by a dry cloth
    b. Interior Cabinet using the HEPA vacuum
E. Quarterly (3rd Sunday of the month)
    a. Drawer Chutes using a dry cloth
    b. Middle Drawer using the HEPA vacuum
    c. Paper supply disk using a dry cloth
    d. Exterior Surface using a dry cloth
F. Bi-annually
    a. Pharmacy ~~staff~~ technician will coordinate with the pharmacy administrative assistant to reach out to Parata to schedule preventative maintenance.
    b. Preventative maintenance performed by Parata technician:
        i. Replace Heater Rubber
        ii. Replace Perforation Blade
        iii. Replace Wrinkle Preventer
G. As needed
    a. Replace the Cutter Blade
    b. Clean the ULT using the HEPA vacuum
H. Software (every Monday)
    a. Close the Parata application, followed by a reboot of the workstation.

Replacing the Paper

A. Open the ATP lower doors.
B. Pull out the lower packaging unit.
C. Remove the empty cardboard spool from the paper supply disk.
D. Place the new paper roll on the paper supply disk; ensure the smooth white side is facing outwards.
E. Lay the old paper inside the new with a ½ inch overlap; ensure serrated edges line up.
F. Using two small pieces of tape, tape the topside and underside of the overlapped paper together. Use a business card/employee ID to create a sturdy flat surface within the paper

G. Verify paper path is correct (compare to chart displayed on lower left door). Tighten the roll counterclockwise until the brake release roller clicks.
H. Push the LPU back into place and close the ATP lower doors.
I. Select **RESUME** in Dispense Manager.

Replacing the Ribbon

A. Open the ATP lower front doors.
B. Pull out the lower packaging unit.
C. Locate the printer assembly (silver box with white plastic handle on the front edge).
D. Pull the plastic handle towards you to release the assembly.
E. Open the printer assembly cover by pulling up on the black knob.
F. Remove both the empty and used ribbon spools simultaneously. Save the empty ribbon spool and discard used ribbon spool per HIPAA regulations.
G. Open a new spool of ribbon; adhere adhesive to empty spool.
H. It is important that the ribbon is in alignment with the empty spool. Roll the empty roll on the new ribbon until one rotation is made around the empty spool.
I. Insert both spools into the printer assembly; refer to the ribbon path diagram on the underside of the printer assembly cover. It is important that the ribbon is fed through the unit correctly and both spools are pressed all the way down. By hand, roll the empty spool clockwise until the black ribbon has reached the empty spool.
J. Close the printer unit and push it back into place.
K. Push the LPU back into place and close the ATP lower doors.
L. Select **RESUME** on Dispense Manager.

Changing the Cutter Blade

Note: Use extreme caution when changing the blade; cutter blade is very sharp!

A. To retract the blade for safe removal, loosen the white blade locking knob by turning it one full turn to the left
B. Use the locking knob to retract the blade putting it into "safe position"; re-tighten the locking knob.
C. Remove the metal safety guard from the blade assembly by lifting it off and to the left; set aside.
D. Remove the blade holder. The front end is held in by a pin and the back sits in a cut-out channel on the housing
E. Remove the white blade locking knob and carefully side the blade all the way out.
F. Insert the new blade into the blade holder, Replace and tighten the white blade locking knob in the "safe position"
G. Replace the cutter blade assembly and install the metal safety guard.
H. Use the white locking knob to extend the blade and make sure the cutter is in the "Home" position (the red arrows will line up).

Removing the Lower Packaging Unit

A. Open the ATP lower doors.
B. Use the power button to turn off power to the ATP.
    a. **NOTE**: Swapping out LPU's while the ATP is powered on will cause damage to the ATP, resulting in production downtime
C. Place the LPU cart in front of the ATP and extend positioning arm Lift the left and right lock levers on the front corners of the LPU.
D. If applicable, disconnect the USB at the back-right side before moving the LPU.
E. Secure LPU cart in place.
F. Lean forward and push the square metal latch on the LPU while pulling the LPU onto the cart.
G. Retract the positioning arm and lock the LP onto the cart by lifting the steel lock shaft found at the front of the cart.

Replacing the Lower Packaging Unit

A. Place the LP cart in front of the ATP and extend positioning arm.
B. Verify the left and right lock levers on the front corners of the LPU are in the up position.

C. Push LPU into the ATP until it stops; then lower left and right lock levers.
D. If applicable, re-connect the USB at the back-right side of the LPU.
E. Retract the positioning arm and remove cart.

For issues that cannot be resolved by pharmacy, contact the Parata Technical Assistance Center: 1-866-559-0968. Serial numbers and LP PO numbers are listed on the front of each machine.

3. Administrative Functions

Releasing an Order from the Universal Interface

A. Select the Universal Interface icon twice to open the application.
B. If the light next to the interface tab is red instead of green, check the box next to the interface name to turn the interface
C. Select the order.
D. Select **RELEASE**. When the order has been successfully released to Dispense Manager, the order's status will change to **ROUTED**. If the status is rejected, click the **ERROR VIEWER** in the lower right corner of the window to view details.

Note: if the "Auto Release New Orders" checkbox is selected, orders will automatically be routed to the Dispense Manager

Reset/Re-releasing an order from the Universal interface

A. Select the Universal Interface icon twice to open the application.
B. Select order to reset; then press **RESET** button.
C. The order status will change from Routed to Not Routed.
D. Select the order.
E. Select **RELEASE**. When the order has been successfully released to Dispense Manager, the order's status will change to Routed. If the status is rejected, click the **ERROR VIEWER** in the lower right corner of the window to view details.

Note: if you want to delete an order, follow the steps to reset the order, highlight the order, and then press **DELETE**

Adding a User to Security Manager

Note: User must have the rights to perform these steps.

A. Open and log-in to the Security Manager application.
B. Verify the Main tab is selected.
C. Select **VIEW BY** User.
D. Select **ADD**.
E. Enter the user's full name (First and Last Name).
F. Enter the desired user name (10 characters maximum).
G. Enter the employee id, if needed per pharmacy requirements.
H. Enter the initial password (it can be changed later; must be 4 characters long).
I. Retype the Password in the 'Verify Password' field.
J. In the 'Rights' section, select the user's permission level for each application. Or, Assign the user to a Group, if desired.
K. Verify the Active Box is checked and select **OK**.

Modifying, Activating and Deactivating Users

A. Open and log-in to the Security Manager application.
B. Verify the Main tab is selected.
C. Select View By User.
D. Select the user name from the list.
E. Select **MODIFY**.
F. EDIT the user details, rights or groups, as necessary.
    a. *To deactivate, uncheck the box next to Active Select OK.
G. Select **OK**.

Caution: You may also permanently delete a user from the system by selecting their name and clicking “Delete”. Use caution when deleting users. They will be removed from the system and all dispensing history for this user will also be deleted. They will not appear in any historical reports. It is recommended to inactivate users instead of deleting.

Enrolling a User for Biometrics

A. Open and log-in to the Security Manager application.
B. Verify the Main tab is selected.
C. Select View By user.
D. Select the user name from the list.
E. Select **BIOMETRICS**.
F. Select **ENROLL**.
G. Select the finger the user will use to log on each time they use the biometric scanner.
H. When the message **PLACE FINGER ON** appears, the user places their finger on the biometric scanner.
I. Follow the on-screen prompts to remove and place the enrolled finger on the biometric scanner.
J. The message **ENROLLMENT COMPLETE** will appear when the process is complete.
K. Select **VERIFY USER**.
L. Follow the on-screen prompts. When **VALID ID: MATCH** appears, enrollment is verified.
M. Select **CLOSE**.

Searching for a Medication in Inventory Manager

A. Open and log-in to Inventory Manager application.
B. Verify the Main tab is selected.
C. Select an option from the Search dropdown menu: NDC, Customer NDC, Primary Med Name, Secondary Med Name, Manufacturer, Barcode Description and Inventory Number.
D. Enter your search criteria,
E. Select **BEGINS WITH**, **CONTAINS**, or **ENDS WITH** for your search.
F. Select **SEARCH**,
G. Select the medication from the list to view the medication details.

Note: To sort the medication list, select an option from the "Sort by' drop- down menu: NDC, Customer NDC, Primary Med Name, Secondary Med Name, Manufacturer, Barcode, Description, and Inventory Number.

Open and log-in to the Inventory Manager application.

A. Verify the Main tab is selected.
B. Select **ADD FROM MED DB**.
C. Enter a barcode or an NDC to search for.
D. The **SEARCH RESULTS** window will populate.
E. Click the **PLUS SIGN** next to the medication name to expand the medication details. Verify that the medication details match the medication bottle.
F. Select the medication you want to add to Inventory Manager from the list.
G. Select **OK**.
H. Most medication detail fields will populate.
I. Verify all information and fill in any **REQUIRED FIELDS** (in red print) that are empty.
J. Select SAVE.

Note: After a medication is added to Inventory Manager, it must be slotted in Dispense Manager before it can be dispensed from the ATP. See Instructions from Section 1. Operations.

Selection of Qualified Medications for Canister

A. Medications must be NDC specific for each designated canister
B. Medications must be reviewed by designated pharmacist or Pharmacy Supervisor before ordering the canister from Parata.
C. Medication review must include utilization, exclusion criteria, supply chain availability, and cost. Exclusion criteria include:
    a. Controlled substances
    b. Hazardous medications

c. Allergenic medications, e.g., penicillin, sulfa-containing drugs as determined
d. Liquid medications

Adding a Medication to Inventory Manager

A. Open and log-in to the Inventory Manager application.
B. Verify the Main tab is selected.
C. Select **ADD**.
D. Enter the medication details. Required fields are in red and include: Primary Med Name, Control Level, Dose Form, Unit, NDC, Manufacturer, Customer NDC and Barcode. ~~Inventory Number may also be required based on pharmacy requirements.~~
    a. The medication primary name listed is based off the brand vs. generic status. Generic products' primary med name will be listed as the generic name. Brand name products' primary name will be listed as the Brand name. Secondary name will be the corresponding brand or generic name. This process allows for adherence to billing regulations.
        i. Medication naming will follow ISMP Tall Man lettering guidelines.
    b. Manufacturer NDC's input into the system will use the raw 11-digit code. This code will also be used for the product the bar code.
    c. Customer NDC's input into the system will use a truncated version of the raw 11-digit code, with the package code (last 2 digits) being omitted.

    ~~D.~~
E. Enter any other medication details that are required by your pharmacy's standard operating procedures.
F. Select **SAVE**.
~~F.~~G. All new medications added must be approved by the pharmacy supervisor prior to addition and logged in the "NDC Log Notebook"

Note: After a medication is added to Inventory Manager, it must be slotted in Dispense Manager before it can be dispensed from the ATP.
Note: The system will not allow duplicate NDC's or duplicate customer NDC's.

Printing a Canister Label

Note: TCGRx Canister Label stock is required. The canister label will print three labels to affix to the front, top and back of the ATP canister.

A. Open and log-in to the Inventory Manager application.
B. Verify the Main tab is selected.
C. Search to find the desired medication.
D. Select the medication name in the left-hand column.
E. Select **PRINT LABEL** in the lower left corner of the window.
F. Verify that the **CANISTER** is selected for the Type of label.
G. There are six rows of labels on the paper. Select the location on the paper for the first label to print (this allows you to reuse label paper).
H. Select the starting canister and the ending canister. It is possible to print multiple labels if they are in sequential order.
I. Open the printer's paper tray.
J. Place the label paper face down in the tray with the top of the label stock closest to you.
K. Close the paper tray.
L. Select **PRINT** on the screen.

New: 8/22
Revised:
Reviewed:

Revised Environmental Services Policies and Procedures

VIII. SAFETY

Policy:
The Housekeeping Department staff will act and work in a fashion which recognizes good safety practices. Department management will encourage and promote a safety conscious attitude among the staff.

Purpose:
To avoid accidents and to help ensure the safety of patients, staff and visitors.

A. Procedure:
The Housekeeping Department staff will observe established guidelines concerning housekeeping safe work practices.

The Housekeeping Department staff will report safety hazards to their respective supervisor. Department management will inform the responsible department.

The Department will report repairs or equipment problems to Plant Services for action.

The Department will maintain adequate records of repair requests.

B. Safety Related Policies & Procedures:
Policies and procedures relating to safety specific to Environmental Services. Listed below are the policy titles related to safety policies and procedures.

1. Storage of Porter Carts

a. For safety reason all porter carts, both locking and non-locking, with cleaning solutions and materials, will not be left unattended in patient or public areas.

b. All porters will return their carts to the designated storage area when going to break or lunch. Those porters who obtain their cart from Housekeeping Office area will return the cart to this area.

c. All porters will return their carts to the designated storage area when leaving their work area for any reason.

d. Porter supervisors will monitor for compliance. Disciplinary action for both supervisor and porter could result for failing to comply.

Issued. 5/97; Rev. 8/06

2. Porter Closet Doors & Door Wedges

a. Doors to porter closets and supply room must be kept closed at all times and locked when not in use.

b. Use of door wedges to prop doors open is prohibited.

Issued 6/88; Rev. 8/06

3. Locking of Linen Chute Doors

a. All doors in the Linen Room are to be secured when not working in the area. Night shift personnel have the additional responsibility of making a final round at approximately 11:45pm to assure doors are secured before their shift ends.

Disciplinary action will be taken against both Supervisor and Porter/Linen staff if this is not followed. Issued 5/97; Rev. 8/06

4. Covered Toe Shoes

All staff must wear covered toe shoes during work hours. This is not a new policy, rather a reminder of an existing Department Infection control and safety policy. Open toe shoes are unsafe and can contribute to injury.

Employees who choose not to comply may face disciplinary action or be refused permission to work. Issued 5/97; Rev. 8/06

5. Moving of Furniture & Equipment

The following are safety practices when moving furniture and equipment.

a. Flatbed carts should not be overloaded so that items fall off the cart.

b. Large loads that impair vision should be transported with assistance to ensure traffic is cleared out of the way.

c. Large and heavy items, including folding tables, should only be lifted and moved with assistance.

d. When lifting heavy items use the appropriate work gloves.

Request for Furniture Move:

a. Telephone routine requests (44624)

Submit project requests by memo or the appropriate form well in advance of the date the work is to occur. Rev. 5/97, 8/06

6. ~~Wet~~ Mopping Procedure

a. Mop ~~corridors~~ floors in sections, leaving a dry area for traffic.

b. ~~In congested patient wards, M~~m~~m~~op small areas at a time. Mop one room at a time utilizing a wet floor sign at each room~~door~~.

c. ~~Wring mop out adequately~~Damp mops the floors without excessive cleaning solution. ~~. Flooding an area should be done only when the area is properly cordoned off.~~

d. Wet floor signs must be utilized at all times, and placed ~~in such a manner as to be clearly visibl~~ye ~~to~~ to secure ~~, or to clearly define~~ the wet area. ~~In corridors, a porter cart placed at one end of the wet area and a wet floor sign at the other is an acceptable method.~~

~~d.~~e. Communicate with the nursing team/residents about the wet floors

All Hospital staff has an obligation to contribute to a safe work environment. ~~Incorrect mopping techniques contribute to accidents and are a safety violation. Non-compliance will warrant formal counseling and/or possible disciplinary action.~~

Issued 5/97; Rev. 8/06

7. Trash/Waste Disposal

a. Policy:
The Housekeeping Department is responsible for the disposal of dry and contaminated trash/waste generated in the Hospital (except Laundry contaminated waste), and for the removal of hazardous waste generated by the Department.

b. Purpose:
To maintain the Hospital in a clean, sanitary, orderly, and attractive condition, and to ensure the correct disposal of each type of trash/waste.

c. Procedure:
All Hospital trash/waste will be disposed of in accordance with all applicable City, State and Federal regulations, including Title 22, Proposition 65 and Title 8.

The Department management will forward to Industrial Hygiene Department/Safety Engineer for central filing, all hazardous waste manifests.

Revised Facility Services Policies and Procedures

FIRE SAFETY SYSTEM POLICY

POLICY: The Hospital shall have fire warning and other safety systems that are designed, installed and maintained for the purpose of protecting patients, employees, visitors, and property from fire.
PURPOSE: To protect patients, employees, visitors, and property from file.

PROCEDURE:

A. Each patient care building shall have an electrically supervised and manually operated fire alarm system that automatically transmits an alarm to the fire department.

B. Manual pull boxes shall be located throughout the hospital.

C. The fire safety system audible enunciator signals shall be distinctive from all other signals within the hospital.

D. Activation of the Fire Alarm shall automatically release all magnetically held fire doors.

E. The fire alarm system, including: ~~pull boxes~~manual pull stations, smoke, heat, duct and water flow detectors and fire alarm panel batteries shall be maintained
Inspected, tested and documented by a certified fire alarm company vendor in compliance with NFPA regulations . The Safety Engineer shall monitor the Vendor performance and the Director of Facility Services shall report only exceptions to the ~~PIPS~~ EOC Committee.

F. Safety Engineer shall report any Code Red alarms or False alarms to the ~~PIPSCommittee~~EOC Committee.

G. Sprinkler Systems of the Hospital shall be maintained operable at all times and shall be serviced by a certified fire protection system technician every five *(5)* years.

H. Dry Pipe Systems shall be tested and inspected by a certified fire protection system technician every five *(5)* years.

I. Kitchen Fire Suppression System in the Food Service area shall be inspected and tested Semi-annually by a certified fire protection system technician.

J. Fire hoses shall be hydro-tested every three (3) years. The fire hoses shall be unracked and re-hung at different holds annually.

EFFECTIVE DATE: 5/14/97
Revised September
~~2020~~2022

FIRE WATCH

POLICY: Facility staff trained in **R**escue, **A**larm, **C**ontain, and **E**xtinguish/ Evacuate (**RACE**) and the implementation of a facility-wide fire watch.

PURPOSE: A plan of action should the fire alarm system fail to work properly so as to not provide continuous facility-wide fire detection and alarm capabilities. A fire alarm system could include but is not limited to: fire alarm panel, smoke or heat detection system, sprinkler system, and fire department notification system.

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PROCEDURE:

A. Documentation: Each tour is recorded with findings noting date, time, and staff initials. A fire watch tour is a periodic walking tour of the entire or part of the facility by one or more assigned and trained staff. The tour monitors the facility through direct observation of all rooms for possible signs of fire.

B. Occurrence: Fire alarm system outages can occur during construction, renovation, electrical failure or other unplanned events, which eliminate part or, all of the fire alarm system.

1. Contact the Administrator on Duty (AOD) and Facility Director when any problems are encountered with the fire alarm system. (Action: Facility Services staff)
2. Notify the City Dispatch Center at (415) **558 3265** that the fire alarm system is not working correctly (Action: Watch Engineer).
3. Contact the fire alarm company if unable to correct the problem. Fire alarm company shall be on site or on contact until system is repaired, replaced or reinitialized and working. (Action: Watch Engineer).

~~3.~~4. A fire watch must be initiated whenever the fire alarm system is out of service for 4 or more hours in a 24 hour period in an occupied building, or whenever the fire suppression system is out of service for more than 10 hours in an occupied building, and that the fire department is notified.

~~4.~~5. ~~If the alarm system is inoperable for a time period of four (4) hours or more in a 24 hour period~~When a fire watch is initiated in a patient care building, Facility Services will notify the Director of Regulatory Affairs and Chief Quality Officer who will notify the California Department of Public Health (CDPH).~~Facility Services will notify the Quality Director who will notify the Department of Health and Services.~~

~~5.~~6. Fire watch procedure shall designate facility tours designating wing, floor, or building identifier. (Action: Facility Director)

~~6.~~7. Fire watch tours shall occur at 1hour intervals, 24 hours a day. (Action: Facility director)

~~7.~~8. Personnel solely dedicated to the fire watch and no other facility-related activities or events shall perform fire watch. (Action: Facility director).

~~8.~~9. A fire watch should check and document the following in all rooms including:

- Resident rooms (remove smoking materials and extension cords), Dietary and Laundry rooms (remove lint from dryers),
- Mechanical and Electrical rooms (remove combustible/flammable materials),
- Fire department access to the facility (remove obstructions from exits),
- Fire department access to hydrants, sprinkler connections, standpipes, and fire extinguishers,

- Exit access, exits, and exit landing are unobstructed,

- Storage of combustible or flammable materials shall be in approved containers or designated storage areas,
- Fire and Smoke doors closed properly,
- Sprinkler valves shall be open and sealed, gauges indicate normal pressures, and sprinkler heads shall be unobstructed,
- Construction or renovation work areas shall be monitored continuously.
- Be familiar with location of fire extinguishers, wet and dry standpipe and other fire suppression system

9. Watch Engineers shall be available for equipment emergency shut down situations.

10. Additional fire extinguishers shall be distributed facility-wide, and staff shall be informed of locations.

11. In the event a potential fire situation is identified behind a door:
    a. **Do Not Open Door.**
    b. Touch door handle and door leaf and verify raised temperature. (Yes-proceed)
    c. Smell for smoke or fumes. (Yes-proceed)
    d. Implement **'RACE'** program: **R**escue, **A**larm, **C**ontain and **E**xtinguish/Evacuate.
    e. Rescue/remove residents from immediate danger.
    f. Activate a call to local fire department at 911 if the fire alarm is not directly connected to the fire station.
    g. Contain fire by shutting doors.
    h. Extinguish and/or evacuate area.

Effective Date: 03-25-04

Revised ~~September 2020~~
September 2022

LS-12

New Nursing Services Policies and Procedures

NURSING STAFF EDUCATION – ACUTE UNIT

POLICY:

1. The Laguna Honda Hospital (LHH) Acute unit are defined as the Acute Medical and Acute Rehab units.
2. It is the policy of LHH to maintain an effective training, orientation, and education program to maintain and improve staff competence and support an interdisciplinary approach to patient care. The acquisition, maintenance, and improvement of competency in nursing staff supports the facility's goal to continuously improve the outcomes of patient care, promote patient and employee safety, encourage employee self-development and serve the public. LHH promotes participation in educational activities by all levels of nursing staff.
3. Acute Unit nursing staff must all complete all orientation, education, training, and competencies required by the distinct part SNF.
4. All Acute Unit nursing staff are oriented to their job performance expectations and pertinent organization and unit policies and procedures prior to independent performance.
5. Successful completion of the Acute Unit Orientation is achieved when assessment of performance indicates that the orientee is competent to perform Acute Unit duties, as evidenced by demonstration of job-related skills and completion of other learning activities.

PURPOSE:

To delineate the responsibilities and procedures related to the provision of nursing staff education and training for the Acute Unit.
To ensure that LHH Acute Unit nursing staff are competent to provide care and services in accordance with current standards and within their scop of practice.

DEFINITIONS:

A. Competency: the ability to perform a particular job in specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, skills and/or behaviors.
B. Orientation: time specific period introduction to the work setting or job for newly hired and transferred employees. The purpose of orientation is to ensure that all new employees meet minimum standards for health and safety, environment of care, and job specific competencies.
C. Training: the provision of knowledge and demonstration of skills related to a particular job or assignment.
D. Required Elements: defined criteria by job classification, regulatory requirements, and San Francisco Department of Public Health (SF DPH) and LHH policies, programs or initiatives that are evaluated and documented during the annual performance appraisal cycle. These elements are defined at:
E. Required Competencies: defined criteria by specific role that are determine through the evaluation of patient care needs, performance improvement measures, procedures performed, conditions and disease processes, equipment and technology, and professional practice. Like Required Elements, these competencies are differentiated at the organizational, department, and unit level, and are assessed and documented during the annual performance appraisal cycle.
F. Core Staffing: Staff that have a regular assignment on or routinely float to the Acute Unit.

G. Float Staffing: Staff that do not have a regular assignment on or routinely float to the Acute Unit.

PROCEDURE

A. All nursing staff must complete all education, training, and competencies required by the distinct part SNF at orientation and annually.
    a. New employee orientation will be conducted in accordance with policy 80-05 Staff Education Program.
    b. Nursing orientation occurs for all nursing staff in accordance with policy A6.0 Orientation of Nursing Personnel.
    c. Competencies are completed during orientation, annually and as needed, in accordance with policy A 4.0 Nursing Clinical Competency Program.
B. Acute Unit specific orientation
    a. Acute Unit Nurse Manager or Nursing Director will ensure that all newly assigned core Registered Nurses (RN) to the Acute Unit will receive job-specific training and orientation.
    b. Staff receive training to new competencies within their scope of practice and ability to perform per standard is validated prior to performing the competency unsupervised. Refer to policy XX.XX Documentation of Care – Acute Unit.
    c. All float staff, including RNs, Licensed Vocational Nurses (LVN), and Patient Care Assistants (PCAs), new to the Acute Unit receive a unit-specific orientation to environment of care and unit routine prior to providing patient care. LVNs and PCAs have a limited scope of practice in the Acute Unit and will be supervised by an RN. Refer to policy XX.XX Documentation of Care – Acute Unit.
    d. Documentation of Acute Unit specific orientation and competencies will be completed consistent with policies A 6.0 Orientation of Nursing Personnel and A 4.0 Nursing Clinical Competency Program.
C. Acute Unit specific annual performance appraisal
    a. Required Elements and Required Competencies may be evaluated throughout the year. Documentation of the annual required elements evaluations and competency assessment is attached to the performance appraisal for incorporation into the personnel record.
    b. Criteria for these competencies may include, but not are not limited to:
        i. Low volume, high risk activities
        ii. Regulatory changes
        iii. Performance improvement and patient safety data
        iv. Practice changes
        v. New equipment or technology
        vi. Problem prone processes

CROSS REFERENCES

Nursing Educational Programs
A 4.0 Nursing Clinical Competency Program

A 6.0 Orientation of Nursing Personnel
XX.XX Documentation of Care – Acute Unit
80-05 Staff Education Program

REFERENCES

California Code of Regulations, Title 22, Division 5, Chapter 1 – General Acute Care Hospitals. Retrieved from https://www.law.cornell.edu/regulations/california/title-22/division-5/chapter-1 on September 24, 2022

§70217 – Nursing Service Staff

Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing

Standards of Competent Performance, California Code of Regulations, Title 16, Section 1443.5

Department of Health and Human Services 42 CFR Part 482-Conditions of Participation for Hospitals

San Francisco Civil Service Commission Policies

Revised Nursing Services Policies and Procedures

NURSING SERVICES: ORGANIZATION, AUTHORITY/RESPONSIBILITY AND OPERATIONS

POLICY:

The operational units of Nursing Services include skilled nursing, medical acute, and rehabilitation acute care. LHH Nursing Services shall be organized, staffed, equipped, and supplied to meet the needs of the residents of LHH.

PURPOSE:

To describe and communicate LHH Nursing Services structure, authority, responsibility, and operations.

RELEVANT DATA:

1. The Chief Nursing Officer (CNO) or designee:

   a. Holds an active Registered Nurse license and is employed by by SFDPH~~the facility~~ as the CNO on a full-time basis, defined as 40 or more hours per week,

   ~~a.~~b. Actively participates in the organization's leadership functions with the Governing Body, Medical Staff, Hospital Management, and Clinical Leaders in the Hospital's decision-making structures and processes;

   ~~b.~~c. Ensures the continuous and timely availability of nursing services to residents;

   ~~c.~~d. Ensures that Nursing Practice Guidelines and Nursing Policies and Procedures are consistent with current evidence-based practice and nationally recognized professional standards;

   ~~d.~~e. Implements the findings of current research from nursing and other literature into policies and procedures that govern the provision of nursing care;

   ~~e.~~f. Ensures that Nursing Services staff carry out applicable processes in resident care and organization wide functions;

   ~~f.~~g. Assigns responsibility for individuals or groups of nursing staff members to act on improving the performance of Nursing Services through the implementation of an effective, ongoing program to measure, assess, and improve the quality of nursing care delivered to residents;

   ~~g.~~h. Participates with leadership from the Governing Body, Medical Staff, Hospital Management, and other Clinical Leaders in planning, promoting, and conducting organization wide performance improvement activities;

   ~~h.~~i. Collaborates with other hospital leaders in designing and providing patient care programs, services, policies, and procedures that describe how residents' nursing care needs are assessed, evaluated, and met;

   ~~i.~~j. Develops and implements the organization plan for providing nursing care to those residents requiring nursing care;

   ~~j.~~k. Participates with hospital leaders in providing for a sufficient number of appropriately qualified nursing staff to care for residents; and

l. Manages the Nursing Services' portion of the hospital budget.

~~k.~~ May ~~S~~serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents.

m.

ORGANIZATION

LHH Nursing Services are provided within a decentralized organizational structure. (See Appendix A "Nursing Organizational Chart")

The Nursing Services Administration includes the following personnel:

i. Chief Nursing Officer

ii. Nursing Directors

iii. Nursing Operations Supervisors

iv. Shift Supervisors

v. Nurse Managers

vi. Nursing Leadership which supports nursing management and/or resident care functions (e.g., Advanced Practice Nurses, Clinical Nurse Specialists, Clinical Resource Nurses, Clinical Resource CNA, MDS-RAI Program Coordinators, MDS Coordinators, Informatics Nurses, Nurse Recruiter, Nursing Orientation Coordinator, and Clinical Educators)

All areas providing Nursing Care/Service are represented at the Nursing Executive Committee (NEC) that is chaired by the CNO/designee.

AUTHORITY/RESPONSIBILITY

All areas providing Nursing Services are accountable to the Chief Nursing Officer for Nursing Practice Guidelines, Nursing Policies & Procedures, and Nursing Performance Improvement Programs.

1. Authority for Nursing Services is specified in the job descriptions of the nursing leadership staff.

2. The CNO is usually present in the hospital during business hours Monday through Friday. When the CNO is not present, she/he will designate a Nursing Administrator Director to assume overall responsibility for the operation of Nursing Services. The Nursing Operations Supervisor assumes all responsibility on evening and night shifts, weekends, and holidays.

3. The Nursing Directors are usually present in the hospital during business hours Monday through Friday. Each is responsible for making arrangements for administrative coverage for their divisional/unit operations in the event of their absence.

4. Individuals in nursing administrative/nursing leadership positions are knowledgeable about hospital/nursing services goals and objectives, hospital/nursing organizational structure, hospital/nursing policies and procedures, nursing staff job descriptions, staffing methodologies, scope of services provided by each nursing unit, and mechanisms for monitoring/evaluating the quality and appropriateness of resident care.

OPERATIONS

a. INTEGRATION

i. The Nursing Directors, Nursing Operations Supervisors, Clinical Nurse Specialists, Advanced Practice Nurses, MDS/RAI Program Coordinators, Chair of the Nurse Managers Council, and Director of Quality Management are members of the Nursing Executive Committee.

ii. Nursing Services administrative staff (listed as above) participate with other hospital leaders in the decision-making of structures and processes.

iii. Nursing Services are represented and participate on hospital, medical staff, and nursing committees.

iv. The NEC may appoint Task Forces and Ad Hoc Committees when needed to accomplish specific projects or goals.

b. MANAGEMENT FUNCTIONS

i. Structure:

The Nursing Services organizational structure, delineating lines of authority and accountability, is displayed graphically in the Nursing Organizational Chart (See Appendix A). Other documents describing authority, accountability, and communication within the department are located in job descriptions and in policy/procedure statements.

ii. Personnel Policies and Procedures:

Nursing Services works within the framework of personnel policies/procedures set forth by the Human Resource Services Department that have been developed and reviewed with input and involvement of the Hospital Executive Committee.

The CNO and members of the NEC are responsible for the identification of qualifications required for each classification of nursing positions. The CNO, in collaboration with the Director of Nursing Operations, Nurse Recruiter, and a representative from Human Resources, has the authority to make decisions with regard to employment, deployment, and assignment of nursing staff. Employment activities and placement of nursing personnel are coordinated with the Human Resource Services Department through the Nurse Recruiter or designee.

The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.

iii. Nursing Policies & Procedures, Criteria/Indicators:

Nursing Services Policies and Procedures are reviewed and approved by the NEC. Performance criteria are derived from job descriptions and policies/procedures. Individual nursing performance criteria are evaluated through criteria-based performance appraisals annually. Quality improvement indicators are used to measure, assess, evaluate, and improve the quality of Nursing Services. Quality improvement activities are reported to the Nursing Quality Improvement Coordinating Committee.

iv. Nursing Executive Committee (NEC):

- The Nursing Executive Committee is the decision-making body relating to Nursing Services at LHH. The goals of the NEC are:
  - to set policy for Nursing Services;

- to define the mission, philosophy, and goals for nursing at LHH;

- to approve Hospital Policies and Procedures that affect nursing services and care delivery;
- to promote communication throughout all levels of Nursing Management across the organization;
- to oversee nursing practice throughout the organization;
- to discuss innovations in nursing care delivery and management systems;
- to discuss and promote interdepartmental and institutional relation.

- Members of the Nursing Executive Committee are:
  - Chief Nursing Officer (Chair)
  - Nursing Directors
  - Chair of Nurse Manager Council
  - Operations Supervisors
  - Clinical Nurse Specialists
  - Bed Control Coordinator
- The Chief Nursing Officer and a Nurse Manager co-chair the Nursing Executive Committee. The NEC meets once a month. An agenda is prepared and a permanent record of proceedings is maintained.

v. Licensing and Certification:

Nursing Services participates in the Licensing and Certification Survey with DHS. Nursing administrative staff has knowledge of the Title 22 Regulations and other regulatory standards.

vi. Licensure:

- Nursing Services complies with Title 22 and other regulatory requirements regarding staff licensure and certification requirements.
- Nursing Services hires Registered Nurses, Licensed Vocational Nurses/Licensed Psychiatric Technicians, and Certified Nurse Assistants who are licensed or certified to practice in the State of California. The process for verifying and monitoring current licensure or certification status is written and available for review. Human Resource Services (HRS) Department has the responsibility of verifying and ongoing maintenance and monitoring of all personnel licenses. HRS collaborates with the Nursing Department through the Director of Nursing Operations or designee to ensure that the system of ongoing license monitoring is achieved.
- The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.
- Temporary Agency Nurses (e.g. Nurse Registries) are required to show their license to the Nursing Supervisor/NAOD or designee on her/his initial shift. The responsibility for verifying licensure and ongoing maintenance rests with the employing agency per the Temporary Services Contract language.

vii. Competency Assessment Program:

- The competency of all Registered Nurses, Licensed Vocational Nurses, Certified Nursing Assistants, and other nursing personnel is evaluated at the time of hire, at the end of the probationary period, and annually thereafter. Evaluations for nursing personnel involved in direct patient care activities are criteria-based and related to performance criteria specified in the individual's job description.

- Employees from temporary help agencies (e.g. Nurse Registries) are evaluated by the unit Nurse Manager or designee, with input from nursing staff, following their initial shift and annually thereafter if the assignment is for an extended period of time.

viii. Job Descriptions:

- The job description for each nursing classification delineates functions, responsibilities, and qualifications of the position. Job descriptions are reviewed and revised when necessary to reflect changing job requirements. They are maintained in the nursing office and by Human Resource Services Department.

- Job descriptions are available to nursing personnel at the time they are hired and when requested.

- Appropriate staff will demonstrate competence in cardiopulmonary resuscitation (CPR) basic life support (BLS) issued by the American Heart Association (AHA) in compliance with the California Code of Regulations: Title 22, and according to established standards of the AHA.

  - Competence must be demonstrated by direct care providers such as LHH Registered Nurses (includes staff nurses, nurse managers, nursing directors, clinical nurse specialists, educators, supervisors, and nursing directors), Licensed Vocational Nurses (LVNs), Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Respiratory Care Practitioners.

  - CPR training is provided at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) monthly, while taking into consideration the availability of on-campus BLS instructors. AHA Standards are used to evaluate levels of competency.

  - Prospective employees are expected to show proof of current CPR certification from the AHA prior to being considered for employment in any class requiring CPR/BLS as a minimum qualification. Current BLS cards will be submitted as part of the hiring packet/process. Copies of AHA eCards are also acceptable, as long as they are able to be verified using the AHA eCard verification system.

  - Staff with no evidence of valid CPR certification and no valid documentation of physical disability are unable to work until proof of current certification is presented to their manager/supervisor.

ix. Staffing:

- Nursing Services plans for and implements staffing requirements according to staffing guidelines, policies, legislative requirements, and budgetary considerations.

- Each nursing area specifically plans for staffing assignments based on staff competencies, resident/client care needs, the care delivery system, and volume indicators.

- Skilled nursing areas are budgeted according to Hours Per Patient Day (HPPD).

x. Nursing Process, Plan of Care, and Documentation:

Nursing contributes to the inpatient interdisciplinary plan of care and documents resident assessment, planning, intervention, and evaluation as defined in policies/procedures.

xi. Education/Training Programs:

- Education/training programs for nursing services staff are ongoing and designed to augment knowledge of pertinent developments in resident care and to maintain current competence.
- The scope and complexity of the program is based on the educational needs of nursing staff. Educational needs are identified through monitoring and evaluation activities, annual competency evaluation, and needs assessment surveys.
- Nursing collaborates with the Department of Education and Training in development and coordination of nursing hospital orientation activities and required training.

xii. Quality Assessment and Performance Improvement:

Nursing Services has a planned and systematic process for monitoring and evaluating the quality and appropriateness of resident care and for resolving identified problems. The process selected is FOCUS P-D-C-A and is coordinated through the Nursing Quality Improvement Council (NQIC). This committee reports to the Hospital Performance Improvement Committee.

xiii. Interdepartmental Relationship:

Nursing Services work collaboratively with other hospital departments and disciplines to promote quality resident care. Policies and procedures are developed collaboratively with other disciplines for the provision of an interdisciplinary approach to resident care.

ATTACHMENTS:

Appendix A: Nursing Organizational Chart

REFERENCE:

California Code of Regulations: Title 22
https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

Date Adopted: 2007/10

Revised: 2022/07/12

Reviewed: 2022/07/12

NURSING CLINICAL COMPETENCY PROGRAM

POLICIES:

1. Nursing administration, supervisors, and nurse managers are responsible for assuring competent nursing practice at LHH.

2. Registered nurses are responsible and accountable for assuring their own clinical competence as elaborated in the California Nurse Practice Act and as consistent with the American Nurses Association's Code of Ethics for Nurses.

3. Licensed vocational nurses are responsible and accountable for assuring their own clinical competence consistent with scope of practice set by the California Boards of Vocational Nursing and Psychiatric Technician (BVNPT).

~~2.~~4. Certified nurse assistants and home health aides are responsible and accountable for assuring their own clinical competence consistent with certification set by the California Department of Public Health Licensing and Certification Program.

~~3.~~5. The Nurse Recruiter collaborates with Human Resources to recruit and hire qualified nursing personnel.

~~4.~~6. The Nursing Orientation Coordinator, ~~Clinical Resource Nurse~~ Nurse Educator, ~~and/or~~ Education Coordinator, Charge nurse, and/or preceptor provide competency-based orientation and evaluation of new nursing employees.

5. The Nursing Orientation Coordinator and/or charge nurse will assign orienting RNs and LVNs to an experienced, competent licensed nurse preceptor for the duration of the orientation program. The Nurse Manager and/or charge Nurse will assign experienced, competent CNAs to precept the new CNAs, PCAs, or HHAs.

6. Upon completion of orientation and throughout the employee's employment, the Nurse Managers and supervisors, with the support of Department of Education and Training (DET) Nurse Educators and Advanced Practice Nurses, provide ongoing competency evaluations.

7. DET shall conduct a biannual review revision of the topics of its in-service training program to the Nursing Executive Committee (NEC) for review. After approval from NEC, the proposed in-service training program will be sent to Performance Improvement and Patient Safety Committee for a final review. Thereafter it will be sent to CDPH for approval. This process is to ensure that topics are relevant to the facility and its needs.

8. DET and Quality Management will collaborate on abuse in-services and trainings to ensure that gaps in knowledge of abuse prevention are addressed. In addition, prior to the start of each abuse Inservice, a pre-test will be administered to assess the current state of learners' abuse prevention knowledge.

9. Annual performance appraisals will include a competency to assess knowledge of employee's abuse prevention.

10. On all shifts, immediate needs for clinical training to assure safe practice are routed through the nurse manager, if present, nursing operations or the clinical resource nurse, who have access to

educational materials and can assist in coordinating 1:1 coaching. An experienced, competent clinician may also be asked to assist with the instruction.

PURPOSE:

To ensure that LHH nursing employees are competent to provide care and services in accordance with current standards and within their scope of practice**.**

DEFINITION:

Competency is defined as the employee's ability to perform a particular job or function or skill in a specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, and demonstration of skills and behaviors.

PROCEDURES:

A. Clinical nursing staff (RNs, LVNs, CNAs, PCAs, and HHAs) competency includes:

1. Maintaining a current and active license and/or certification to practice.

2. Updating and maintaining skills and knowledge through:

   a. Classroom-based review and demonstration of procedure prior to actual practice.
   b. Review of video tapes, CDs and web-based training programs.
   c. Review of procedures using resources such as policy and procedure manuals, current clinical practice guidelines or other approved written materials, such as textbooks and current articles.
   d. Demonstration/ return demonstration or actual practice guided by a competent and experienced clinician at the bedside.
   e. Participation in general, program-based or unit-based education.

3. Participating in formal needs assessment process to identify individual learning needs.

4. Participating in LHH mandatory annual trainings and other training programs.

5. Attending continuing education conferences and professional seminars to remain clinically relevant, and as required for recertification (CNA, PCA, HHA.) or re-licensure (RN / LVN).

6. Maintaining BLS (CPR) current certification for ~~(licensed nurses).~~ RNs, LVNs, and PCAs.~~.~~

7. Participating in the performance appraisal process, including self-appraisal to evaluate clinical practice and to identify areas of practice for professional development.

B. Nurse Manager/Nursing Program Director

ROLE: Ensures clinical staff competency which includes:

1. Communicates job expectations to staff.

2. Collaborates with Nursing ~~Education~~ Orientation Coordinator to provide new staff with neighborhood or program-specific orientation.

3. Completes probationary performance evaluation ~~for new nursing staff~~ together with Nursing Orientation Coordinator and/or Nurse Educator for new nursing staff with inputs from Nurse Managers, ~~Nursing Orientation Coordinators~~ preceptors, and/or mentors.

4. Completes ongoing performance evaluation in collaboration with human resources, including annual and intermittent competency evaluations, recommendations for development, training and progressive discipline up to and including separation of employees unable to meet job expectations. An action plan will be developed for employees who are not meeting standards and/or competency(ies).

5. Encourages and supports employees' self-development and independent learning efforts.

6. Schedules nursing staff to regularly participate in annual and ongoing training.

7. Ensures resident -specific neighborhood training as needed.

8. Maintains documentation of competency assessment.

C. Clinical Nurse Specialist

ROLE: Supports competency development which includes:

1. Participates in interdisciplinary committees and performance improvement teams to:
   a. assess program needs in clinical areas,
   b. develop related program or interventions for individual residents,
   c. evaluate processes that support or detract from nursing practice and performance.

2. Provides consultation to enhance competent clinical practice.

3. Participates with quality improvement and interdisciplinary committees in analyzing resident outcome data in order to link competency training with desired resident outcomes.

D. Nursing Orientation Coordinator, ~~Clinical Resource~~ Nurse educators, and Education Coordinators

ROLE: Supports staff competency which includes:

1. Ensures nursing orientees (whether CNA, PCA, HHA, LVN, RN, CNS, NM, Nursing Supervisor or Nursing Director) meet standards for clinical competency consistent with their scope of practice and job description.

2. Participates in the assessment of educational needs required for the job and setting in collaboration with LHH Performance Improvement Teams (PITs), Nursing QI Program, committees and department managers.

3. Develops, implements and evaluates nursing orientation and training programs for nursing staff, as outlined in the Nursing Educational Programs Policy A ~~3.0~~ 6.0. Programs are based on CDPH approved orientation program, assessed needs, core competencies, quality improvement findings, and evaluation of learner and~~/~~or resident outcomes.

4. Participates in the development of nursing practice standards.

5. Participates with quality improvement and interdisciplinary committees in analyzing resident outcome data in order to link competency training with desired resident outcomes.

6. Ensures Licensed Nurses will complete a~~n~~ Point of Care Test (POCT) Training on Accu-check (glucocheck) device initially during orientation, six (6) months post orientation, and then annually thereafter, under the guidance of the POCT Coordinator. ~~update training on the Glucocheck device.~~

REFERENCES:

California Nurse Practice Act, Standards of Competent Performance
Excerpt from California Code of Regulations, Title 16 - Chapter 14

CROSS REFERENCES:

Hospitalwide Policy and Procedure
01-03 Hospital Organization
80-03 Employee and Volunteer Orientation
80-05 Staff Development
80-12 Staff Competency

Nursing Policy and Procedure
~~A 3.0 Nursing Educational Programs~~
A 6.0 Orientation of Nursing Personnel

Human Resources Policy for the Developmental Plan/Disciplinary Action.

ATTACHMENT:

California Code of Regulations Standards of Competent Performance for RNs.

Adopted: 12/2007

Revised: 2012/05/22; 2021/02/09

Reviewed: 2021/02/09

Approved: 2021/02/09

Reviewed: 2022/09/19

NURSING CLINICAL AFFILIATIONS (Student Placements)

POLICY:

1. Laguna Honda Hospital (LHH) supports the clinical training and education of nursing professions, including Nursing Assistants, Unit Clerks, Home Health Aides, Paramedic Students, Licensed Vocational Nurses, Registered Nurses, Advanced Practice Nurses and those enrolled in doctoral programs.

2. Each clinical instructor will not exceed ~~ten~~ eight (~~10~~ 8) students per clinical shift. Clinical instructor will provide supervision to all their students.

3. All nursing students or preceptees, whether pre-certification, pre-licensure, or in a post-licensure course of education must:

    a. Be enrolled in an educational institution approved by the Board of Registered Nurses, and/or Board of Vocational Nursing and Psychiatric Technicians,
    b. Be enrolled in an educational program that has a current contract with the Department of Public Health. The contract stipulates responsibilities of faculty and of LH staff consistent with legal and ethical standards of practice,
    c. Adhere to the following procedures.

4. The clinical instructor must communicate all planned treatments and medications prior to implementation for approval to ~~of~~ the Charge Nurse.

5. The clinical instructor will complete the *Clinical Instructor's Sign-in Sheet* in the Nursing Office each day that they are on-site with the students. The Clinical Instructor will provide a copy of students' daily signin sheets to Department of Education and Training (DET).

6. Department of Education and Training (DET) is responsible for monitoring current affiliations' agreements and following up on clinical or educational concerns that occur as a result of student placements and will provide a regular update to the Director of DET and/or Chief Nursing Officer.

7. To avoid conflicts of interests~~,~~: ~~LHH nursing staff are not permitted to be paid employees of educational programs and to supervise students at LHH.~~

    - LHH nursing staff are not permitted to be paid or unpaid clinical instructors of educational programs and supervise students at their place of employment.
    - LHH nursing staff are not permitted to be placed into a student placement at LHH.
    - LHH nursing staff are not permitted to serve as a nursing student preceptor for other LHH nursing staff.

PURPOSE:

1. To outline guidelines to ensure a safe and educationally sound clinical experience.

2. To clarify the roles and responsibilities of the school and the nursing staff of LHH.

PROCEDURE:

A. ~~One~~ Two months prior to the practicum

    1. The clinical instructor will send a request via email for student replacement to the Affiliation Coordinator in the Department of Education and Training Department.

2. The clinical instructor will electronically send a clinical syllabus to the Affiliation Coordinator.

3. All schools who utilize LHH as a clinical site must have an approved school affiliation contract with the City and County of San Francisco.

~~3.~~4. If the school has not had a recent affiliation with LHH (i.e. within the past school year), the Affiliation Coordinator will verify with the Contracts Office at (415) 554-2839 to determine if a current contract exists between the school and DPH.

~~4.~~5. The clinical instructor and the Affiliation Coordinator, in collaboration with the Nurse Manager, when applicable, shall determine the practicum dates, days, hours and the resident care units where students will be placed.

~~5.~~6. A written agreement is reached describing the clinical experience among the faculty, Affiliation Coordinator, and Nurse Manager. This agreement will specify the days and hours the student will be on the neighborhood, the skills the student will be practicing, services the students will be providing and programs the students will be developing. The written agreement will specify in writing the faculty's responsibility related to supervising pre-licensure students' administration of medication or treatments.

~~6.~~7. Students will receive orientation prior to the first day of their clinical rotation via SF Learning ELM and EHR (Epic) training as appropriate.

~~7.~~8. The clinical instructor will send the list of students with complete demographics for pre- and onboarding and to obtain POI numbers for each students. Affiliation Coordinator will conduct pre-boarding and communicates with the clinical instructors all instructions to disseminate instruction to the students. ~~send updates of orientation and new materials as needed to instructors. The instructors will submit an orientation attendance sheet and all required signed forms to Affiliation Coordinator on the first day of clinical rotation:~~

~~a. User Confidentiality, Security and Electronic Signature Agreement Form~~
~~b. Dependent Adult/Elder Abuse Prohibition and Reporting Requirement Form~~
~~c. Received a Copy of Resident's Bill of Rights Form~~
~~d. Attestation of Abuse~~

~~8.~~9. ~~For~~ All ~~new~~ clinical instructors will need to inform~~,~~ the Affiliations Coordinator and provide complete demographics in order to start the pre-boarding and onboarding process. Orientation of clinical instructors will be conducted via SF Learning ELM, complete required EHR (Epic) training, and attend in-person nursing orientation. ~~will give an orientation to LHH.~~ Scheduling~~e~~ of orientation can be arranged with the Affiliation Coordinator and/or the New Employee Orientation ~~c~~Coordinator via email or~~f~~ phone call.

~~9.~~10. Once request for clinical rotation is confirmed, the Affiliation Coordinator will electronically send required Student/Instructor Health Screening Verification Form, and Student/Instructor Roster/Clinical Schedule, preboarding and onboarding, and orientation instructions.

B. Orientation to Clinical Instructor

1. Clinical Instructor orientation will be ~~conducted~~ coordinated by the Affiliation Coordinator, New Employee Orientation Coordinator, and/or Nursing Orientation Coordinator~~.~~

2. The following orientation content will be covered during the clinical instructor orientation via SF Learning ELM:

   a. Welcome and Overview ~~History of Laguna Honda Hospital~~

~~b.~~ Hospital and Nursing Organizatio ~~Descriptions of neighborhood and services provided by the hospital~~
c. Resident Rights and Civil Rights ~~Confidentiality~~
d. Abuse Video: Film on "it's Your Legal Duty" and Mandated Reporting Law
e. Abuse Post Test, Attestation,
f. Code of Conduct
g. Confidentiality Agreement
h. Privacy and Compliance
i. Infection Control
~~COVID-19 Education~~
j. Fire Safety,
k. Disaster Preparedness
l. Cardiopulmonary Emergencies
m. Prevention of Workplace Violence
n. Injury Illness Prevention Program
o. Quality Assurance Performance Improvement (QAPI)
p. Cultural Humility
q. Dementia and Behavior
r. Trauma Informed Care
~~e.~~s. Resident Color Codes, Code Green
~~f.~~t. Individualized Precautions to Prevent Aspiration
~~g. Fire Safety, Code Green, and Hand Hygiene~~
~~h.~~u. Therapeutic Communication
~~i.~~v. Facility tour by the Clinical Instructor

C. Clinical Instructor Responsibilities

1. The clinical instructor shall collaborate with the Charge Nurse and/or Nurse Manager to determine students' resident assignments.

2. The clinical instructor will ensure that students receive hand-off report from the Charge Nurse or designee before providing care.

3. The clinical instructor will provide direct/line of sight supervision for each student during medication administration, and each student will be supervised during treatments by either the clinical instructor or the LHH licensed nurse. Students will **not** administer controlled substances. The clinical instructor will co-sign the student in the EHR for each medication administered, and the clinical instructor or LHH licensed nurse will co-sign in the EHR for the treatment administered.

4. The clinical instructor will co-sign all EHR documentation completed by student.

D. Student Responsibilities

1. Each student must wear a visible school ID badge so that it can be easily identified.

2. Each student must obtain a hand-off report from the Charge Nurse or designee before providing care. When leaving the neighborhood, students will provide appropriate hand-off report to the Charge Nurse or designee, and clinical instructor.

3. Students needing to review medical records prior to clinical rotation must check in with the Charge Nurse and adhere to LHH policy on confidentiality (LHH 21-01 Medical Record Information: Confidentiality and Release).

4. Seek guidance from their faculty member or Affiliations' Coordinator regarding activities and student role.

E. Affiliation Coordinator Responsibilities

1. Ensure students completion of required forms and required information for pre- and onboarding prior ~~for~~to orientation.

2. Request for POI access and coordinate ELM orientation and EHR (Epic) training~~Provide required materials~~ for clinical instructor and student orientation prior to start of clinical rotation.

3. Keep records of clinical instructors and students orientation and training documents.

~~3.~~4. Maintain communication with the school affiliation.

~~4.~~5. Maintain communication with the school affiliation and report any problems related to the student.

~~5.~~6. Keep records of student roster and neighborhood assignments including assigned clinical instructors.

ATTACHMENT:

NONE

CROSS REFERENCE:

Hospitalwide Policy and Procedure
Laguna Honda HHPP 84-01 Student Affiliation
LHH 21-01 Medical Record Information: Confidentiality and Release

Adopted: 1/2005

Revised: 2007/10; 2011/09/27; 2015/09/08; 2019/07/09

Reviewed: 2019/07/09

Approved: 2019/07/09

Revised: 2022/09/19

ORIENTATION OF NURSING PERSONNEL

POLICY:

1. All nursing staff employees are oriented to their job performance expectations and pertinent organizational and divisional policies and procedures prior to independent performance. Successful completion of orientation is required to pass the probationary period.

2. The Nursing Orientation program is developed by the Department of Education and Training (DET) in coordination with many other clinical departments, such as the Department of Public Health Occupational Safety & Health (OSH) and Laguna Honda Hospital (LHH) Human Resources.

3. The orientation program consists of:

    a. Didactic orientation to facility attributes, policies, procedures, regulations and specific job description.

    b. Clinical experiences guided and supervised by the Nurse Managers, ~~clinical~~ Nurse ~~e~~Educators, C~~c~~linical N~~n~~urseS~~-~~specialists, ~~clinical resource~~ ~~nurse and/or~~ preceptors, and mentors.

    c. Documentation that objectively reflects job competencies, as well as provides a method for performance appraisal or competency to assess knowledge acquisition and evaluating performance.

4. Successful completion of the Nursing Orientation Program is achieved when assessment of performance indicates that the orientee is competent to perform duties of the job description, as evidenced by the demonstration of job-related skills and completion of other learning activities.

5. Successful orientees will demonstrate the following:

    a. The Certified Nursing Assistant (CNA), Patient Care Assistant (PCA), or Home Health Aide (HHA) orientee will complete: a Skills Demonstration Competency Checklist including equipment and technologies, ~~a post-orientation self-evaluation,~~ a Mealtime Competency Evaluation, a signed proof of having read the Patients Bill of Rights, a post test and an evaluation of the orientation, as well as other assignments made by the Nursing Orientation Coordinator and/or Nurse Educators.

    b. The licensed orientee {Registered Nurse (RN) or Licensed Vocational Nurse (LVN)} will complete the above plus a Competency Evaluation in Physical Assessment, a Medications Administration Competency Evaluation, Nutrition Competency Evaluation and Point of Care ~~t~~Test~~ing~~ (POCT) training on use of the Accu-check (glucometer) and Occult Blood testing~~.~~ ~~-~~In addition, the orientee ~~s/he~~ will also complete exercises on the Management of Sharps, Using Information Resources Page and other assignments given by the Nursing Orientation Coordinator and/or designee.

6. The orientee will be given the opportunity to complete the Orientation Program in an environment that is conducive to learning. A designated period of time for the CNA, PCA, HHA and for licensed staff will be allotted for the orientation to identify learning needs, obtain experiences, demonstrate knowledge and skills, and receive an evaluation of performance.

7. The orientee shall receive Abuse training. Prior to the start of the abuse training, a pre-test will be administered to assess the current state of learners' abuse prevention knowledge. Comparison of the pre- and post-tests can help assess the effectiveness of the training.

8. If the orientee has not completed all of the competencies within the time allotted, and the assessment indicates that they may be achieved, the need for extension will be evaluated. The length of the extension of orientation will be determined by the Nurse Manager and/or Nursing Orientation Coordinator in consultation with the Nursing Director, Nurse Manager, Nurse Educator and/or preceptor/mentor. Notification will be ~~given~~ provided to the DET Nursing Director and/or to the Chief Nursing Officer.

PURPOSE:

To provide an orientation program to newly hired nursing staff who provide or supervise direct patient care, and to staff who function in roles of consultation.

PROCEDURE:

A. **Ongoing Assessment and Documentation**

1. Classroom time will be provided for didactic teaching according to job description.

~~2. Orientees will complete an individual Needs Assessments and Pretests.~~

3. Clinical experiences are provided so that performance assessments which address the criteria-based objectives will be observed, practiced, and demonstrated by the orientee.

4. The orientee's ability to perform specific skills will be documented on the Orientation Checklist by those who observe the orientee's performance or provide instruction, as designated by the Orientation Coordinator.

5. The Nurse Manager and/or preceptor will discuss with the orientee ~~and preceptor~~ specific skills required and whether criteria are met by the orientee and assess need~~.~~ for further training. The orientee and Nursing Orientation ~~c~~Coordinator will review the documentation together.

B. Unmet Competencies

If the orientee has specific learning needs that requires additional orientation time, efforts will be made to address those needs. The Nursing Orientation Coordinator will be informed by the Nurse Manager if the orientee is unable to meet criteria/skills required.

1. A collaborative team of the Nurse Manager, Nursing Orientation Coordinator and/or ~~Clinical Resource~~ Nurse Educators will write a developmental plan to assist the orientee to meet required program objectives.

2. The developmental plan will be outlined in writing and attached to the documents for orientation completion for the individual orientee.

3. In a conference, the orientee will be advised by the Nurse Manager, Nursing Orientation Coordinator and /or ~~Clinical Resource~~ Nurse Educator as to performance expectations, the developmental plan, and the target date for the completion of the plan.

4. The Developmental Plan will be signed by those participating in the conference.

5. If, at the end of the designated time, the orientee has not met job expectations as defined by the Initial Orientation Checklists and the Developmental Plan, termination of employment will be recommended to Human Resources.

C. Orientation Program

An orientation program will be provided for the following categories of nursing and affiliated staff:

1428 Unit Clerk

2583 Home Health Aide

2302 Certified Nursing Assistant

2303 Patient Care Assistant

2312 Licensed Vocational Nurse

2320 Registered Nurse

Leadership orientation will be given to staff that are new to Laguna Honda Hospital:

2320 Acting Nurse Manager, ~~Clinical Resource~~ Nurse Educator
2322 Nurse Manager
2323 Clinical Nurse Specialist
2324 Nursing Supervisor or Nursing Director
0941 Chief Nursing Officer, Hospital Associate Administrator

CROSS REFERENCES:

NONE

ATTACHMENT/APPENDIX:

NONE

Adopted: 1/2006

Revised: 2007/10, 2012/05/22; 201/01/13; 2021/02/09

Reviewed: 2021/02/09

Approved: 2021/02/09

Revised: 2022/09/19

Appendix A: Pavilion Acute Unit Staffing Grid

At the end of each shift, licensed nurses will prospectively assess care level for the next shift. Each scores for all patients are added and then divided by total number of patients. Average score for all patients will be acuity level for entire shift. Up to four (4) hours before end of each shift, please call nursing office to inform census and acuity level.

See sample:	**# of patients (pts)**	**Level Score**	**Acuity Score (# pts x level score)**
	2	4	8
	3	3	9
	2	2	4
	0	1	0
Total census =	**7**		**3 Acuity Level = *Total Scores/Total pts***

Based on acuity level of 3, staffing for next shift will be at medium acuity (see acuity level guidelines below)

Guidelines for Acuity Level

Acuity Model: Level 1 = Minimum Routine Care, Level 2 = Average Care, Level 3 = Above Average Care, Level 4 = Almost Constant Care

Unit Level Score:	**Acuity:**
3.51 – 4.00	High
2.51 – 3.50	Medium
1.00 – 2.50	Low

	Medium Acuity – Day				**Medium Acuity PM**			**Medium Acuity AM**		
Census	**CRN**	**RN**	**CNA/PCA**	**HHA**	**CRN**	**RN**	**CNA/PCA**	**CRN**	**RN**	**CNA/PCA**
15	1	4	2	1	1	4	2	1	3	1
14	1	4	2	1	1	4	2	1	3	1
13	1	4	2	1	1	3	2	1	2	1
12	1	3	2	1	1	3	2	1	2	1
11	1	3	2	1	1	3	1	1	2	1
10	1	2	2	1	1	2	1	1	2	1
9	1	2	1	1	1	2	1	1	2	1
8	1	2	1	1	1	2	1	1	1	1
7	1	2	1	1	1	2	0	1	1	1
6	1	1	1	1	1	1	1	1	1	0
5	1	1	0	1	1	1	0	1	1	0
4	1	1	0	1	1	1	0	1	0	1
3	1	0	1	1	1	0	1	1	0	1
2	1	0	1	1	1	0	1	1	0	1
1	1	0	1	1	1	0	1	1	0	1

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	0	1	0
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Unit Level Score:	**Acuity:**
3.51 – 4.00	High
2.51 – 3.50	Medium
1.00 – 2.50	Low

	High Acuity – Day				**High Acuity PM**			**High Acuity AM**		
Census	**CRN**	**RN**	**CNA/PCA**	**HHA**	**CRN**	**RN**	**CNA/PCA**	**CRN**	**RN**	**CNA/PCA**
15	1	5	2	1	1	5	1	1	4	1
14	1	5	2	1	1	5	1	1	4	0
13	1	5	1	1	1	4	1	1	3	1
12	1	4	1	1	1	4	1	1	3	1
11	1	4	1	1	1	4	1	1	3	0
10	1	3	1	1	1	3	1	1	3	0
9	1	3	1	1	1	3	0	1	3	0
8	1	3	0	1	1	3	0	1	2	0
7	1	3	0	1	1	2	1	1	2	0
6	1	2	0	1	1	2	0	1	1	1
5	1	1	1	1	1	1	0	1	1	1
4	1	1	0	1	1	1	0	1	1	1
3	1	0	1	0	1	0	1	1	0	1
2	1	0	1	0	0	0	1	1	0	1
1	1	0	1	0	0	0	1	1	0	1

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

PATIENT ACUITY CLASSIFICATION

Addressograph

	NIGHT				DAY				EVENING			
CARE INDICATORS	1	2	3	4	1	2	3	4	1	2	3	4
• ADL – Minimum assist/supervision												
• Hygiene – Moderate assist/supervise												
• Mobility: Moderate assist/supervise												
Mobility or Hygiene: Maximum assist/supervise												
• Diet: Moderate assist/supervise												
Diet: Maximum assist/supervise												
• IV or Saline lock with additives												
• Assess/intervene: Average												
Assess/Intervene: above average												
Assess/Intervene: Almost Constantly												
• Care Management: Moderately Complex												
Care Management: Very Complex												
• Weighting factors	✓	✓	0.5		✓	✓	0.5		✓	✓	0.5	
• Total												
	DATE/TIME				DATE/TIME				DATE/TIME			
	SIGNATURE				SIGNATURE				SIGNATURE			

	NIGHT				DAY				EVENING			
CARE INDICATORS	1	2	3	4	1	2	3	4	1	2	3	4
• ADL – Minimum assist/supervision												
• Hygiene – Moderate assist/supervise												
• Mobility: Moderate assist/supervise												
Mobility or Hygiene: Maximum assist/supervise												
• Diet: Moderate assist/supervise												
Diet: Maximum assist/supervise												
• IV or Saline lock with additives												
• Assess/intervene: Average												
Assess/Intervene: above average												
Assess/Intervene: Almost Constantly												
• Care Management: Moderately Complex												
Care Management: Very Complex												
• Weighting factors	✓	✓	0.5		✓	✓	0.5		✓	✓	0.5	
• Total												
	DATE/TIME				DATE/TIME				DATE/TIME			
	SIGNATURE				SIGNATURE				SIGNATURE			

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

PATIENT ACUITY CLASSIFICATION

Addressograph

	NIGHT				DAY				EVENING			
CARE INDICATORS	1	2	3	4	1	2	3	4	1	2	3	4
• ADL – Minimum assist/supervision												
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• Mobility: Moderate assist/supervise												
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Assess/Intervene: above average												
Assess/Intervene: Almost Constantly												
• Care Management: Moderately Complex												
Care Management: Very Complex												
• Weighting factors	✓	✓	0.5		✓	✓	0.5		✓	✓	0.5	
• Total												
	DATE/TIME				DATE/TIME				DATE/TIME			
	SIGNATURE				SIGNATURE				SIGNATURE			

	NIGHT				DAY				EVENING			
CARE INDICATORS	1	2	3	4	1	2	3	4	1	2	3	4
• ADL – Minimum assist/supervision												
• Hygiene – Moderate assist/supervise												
• Mobility: Moderate assist/supervise												
Mobility or Hygiene: Maximum assist/supervise												
• Diet: Moderate assist/supervise												
Diet: Maximum assist/supervise												
• IV or Saline lock with additives												
• Assess/intervene: Average												
Assess/Intervene: above average												
Assess/Intervene: Almost Constantly												
• Care Management: Moderately Complex												
Care Management: Very Complex												
• Weighting factors	✓	✓	0.5		✓	✓	0.5		✓	✓	0.5	
• Total												
	DATE/TIME				DATE/TIME				DATE/TIME			
	SIGNATURE				SIGNATURE				SIGNATURE			

Appendix C: Evalysis® Patient Classification System: Care Indicator Instructions to Calculate Acute Acuity Level Score

CARE INDICATOR	INSTRUCTIONS
ADL: Minimum assist/supervise	The patient can *appropriately* manage his/her own personal care activities such as grooming, hygiene (basin at bedside, tub, or shower), toileting, positioning, and diet with no supervision, encouragement, or direction. If this indicator is selected, none of the following Hygiene, Mobility, or Diet indicators can be checked.
Hygiene: Moderate assist/ supervise	The patient needs partial assistance, supervision and/or encouragement to accomplish various hygiene activities. If the patient needs help only to wash his/her back, this indicator should not be checked. This item should not be checked if the patient requires *complete or maximum* assistance and/or supervision with hygiene needs.
Mobility: Moderate assist/supervise **OR**	The patient can assist in turning or positioning in bed, but cannot move and/or ambulate independently. The patient may need help in maintaining proper body alignment.
Mobility or hygiene: Maximum assist/supervise	The patient requires complete assistance in turning, positioning, range of motion, and/or ambulation. The patient *can not, will not, or should not* accomplish these activities without the constant presence, supervision, and/or assistance of staff. This indicator should also be checked if the patient requires complete assistance with hygiene (toileting, bathing, grooming). Either "Moderate assist" or "Maximum assist" may be checked, but not both.
Note: If the patient is NPO, neither of the "Diet" indicators should be checked.	
Diet: Moderate assist/supervise **OR**	The patient can feed him/herself after help with opening cartons, cutting meat, etc. The patient may require supervision and/or encouragement to eat. Post-stroke patient who needs close observation. Aspiration Precautions including Passy Muir Valve.
Diet: Maximum assist/supervise	The patient needs to be fed, or needs constant supervision and/or encouragement. He/she may require tube feedings bolus with or without residuals. TPN is not included and should be accounted for in the appraisal of the amount of assessment and intervention required. Either "Moderate assist" or "Maximum assist" may be checked, not both.
Note: Do not check for saline lock with routine flushes.	
IV; or Saline lock with additives	The patient has an IV and/or saline lock *with* additives.
Note: The following "Assess/intervene" care indicators should reflect the *frequency, duration, complexity*, and/or *intensity* of assessment and/or intervention required by the patient in the following five areas: 1) medications; 2) treatments; 3) procedures; 4) teaching; and/or 5) psychosocial support. This care is over and above the care already indicated, and should include patient and family characteristics such as emotional state, age or developmental stage, language ability, and/or cultural issues which may impact the level of assessment/intervention.	
Assess/intervene: Average **OR**	The patient requires assessment and intervention every 4 hours such as routine vital signs, IV checks, dressing checks, wound checks, shift assessment. Medication passes take 15 minutes or less. Patients may be receiving 3 or less IVPB. Patients that are on drips that require q 4 to 6 hour interventions. Tele/CPO patient who is asymptomatic with routine monitoring requiring min interventions. The patient and/or family may require uncomplicated teaching around diagnosis/procedure/medications. Emotional support is met with routine rounding.
Assess/intervene: Above average **OR**	The patient requires assessment and intervention every 2 hours: such as checks for vital signs, neuro status, blood glucose monitoring, epidural catheter, dressings, or frequent treatments, and/or procedures. Medication passes take longer than 15 minutes but less than 30 minutes. Patients may be receiving 4 or more IVPB. The patient may be on telemetry/CPO and having arrhythmias/respiratory complications which require interventions/treatments q 2 hours. The patient and/or family teaching is more complicated focus is typically on a new diagnosis i.e. TBI, stroke, newly diagnosed diabetes. Emotionally the patient and family require more support than is met with routine rounding.
Assess/intervene: Almost constant	This patient's need for care arises from frequent, multiple, complex, and/or prolonged treatments, procedures, or other associated problems that require almost constant assessment and/or intervention every hour or more frequently i.e. active alcohol withdraw, CBI. Chemo patients receiving their first treatment, IV push therapy or highly reactive chemo agents being used. Medication passes require more than 30 minutes. The care may be further complicated by the need for restraints because of agitation, or IV drips necessitating frequent monitoring, etc. The patient with time limited assessment/intervention of q 1 hour for 6 hours or less should not be listed as constant; but, Above Average. The patient and/or family members may be cognitively impaired and require constant education. Patient may require an above average amount of psychosocial, emotional support. Only one of the "Assess/intervene" indicators may be checked. If a patient requires almost constant intervention, in most instances, the patient should be classified as Level 4 regardless of the number of checks in each column.

(continued next page)

CARE INDICATOR	INSTRUCTIONS
Note: The next two care indicators relate to the complexity of "Care management" and involve the level of effort associated with the planning, coordination, and management of the patient's care. If the patient's care management is relatively routine and/or uncomplicated, *neither of these indicators should be selected.*	
Care management: Moderately complex	The patient's physiological, psychological, social, and/or spiritual condition and/or circumstances require a considerable amount of planning, coordination, and management by the nurse. These care management activities require an *above average* amount of interaction with others to plan and manage the care. Examples Patient may have a language barrier, the nurse may be making multiple calls to coordinate care of 3 or more procedures.
Care management: Very complex	The patient's physiological, psychological, social, and/or spiritual condition and/or circumstances are extremely complicated, numerous, and/or difficult to manage requiring an unusual amount of planning, coordination, and management by the nurse. These care management activities require an *extraordinary* amount of interaction with others to plan and manage the care.
Total	The check marks are added in each column, and the total of each column is written in the column "Total" area. The column with the highest total is the patient's care level. *CIRCLE* the care level number at the top of the appropriate column. If two columns have the same total, the higher care level is circled.

GENERAL REMINDERS

1. *Check only those care indicators actually applying to the patient*. If a care indicator does not describe the patient's care needs go on to the next care indicator. These indicators are arranged so that if the patient's care needs do not fit a particular care indicator they will be taken into account in a subsequent indicator within the tool.

2. Remember to check all of the white boxes that follow a care indicator if it applies to the patient. For example, the "**IV; or Saline lock with additives**" indicator has three white boxes following it. If the patient has any kind of IV infusion and/or saline lock with additives, check all three white boxes.

3. Total the check marks carefully and circle the appropriate care level (1, 2, 3, or 4) in the top section of the tool.

DECENTRALIZED STAFFING

POLICY:

1. ~~The Nurse Staffing Office (NSO) is responsible for completing staffing schedules that meets the minimum budgeted staffing requirements based on the residents care needs, daily census, and nursing model. Likewise, the Nurse Operations Nurse Manager, Neighborhood Nurse Managers and the Nursing Staffing Assistants (NSA) will collaboratively maintain a daily staffing pattern that responds to variations in acuity and census.~~ The Nurse Staffing Office (NSO) is responsible for completing staffing schedules that meets the minimum budgeted staffing requirements based on the residents care needs, daily census, and nursing model. Likewise, the Nurse Operations Nurse Manager, Neighborhood Nurse Managers and the Nursing Staffing Assistants (NSA) will collaboratively maintain a daily staffing pattern that responds to variations in acuity and census in the Skilled Nursing Facility and the A~~a~~cute C~~c~~are U~~u~~nits.

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

3. All staff are responsible for reviewing their schedules.

PURPOSE:

To provide adequate staffing needs in each neighborhood.

RELEVANT DATA:

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

PROCEDURE:

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

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

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

3. **Pavilion Acute Unit:** Pavilion Acute Licensed Staff will calculate the Pavilion Acute Units' [Pavilion Medical Acute, and the Acute Rehab Unit (also known as the Inpatient Rehabilitation

Facility's "IRF" unit)] acuity level score. The Acuity Level Score (1.00-2.50 = low, 2.51 - 3.50 + medium, 3.51 - 4.00 = high) is based on a formula which incorporates the total census and each residents' "Patient Acuity Classification" score. The Pavilion Acute staff report this score to the NSA before the next shift. The NSA will staff the unit based on this Acuity Level Score ~~Pavilion acute unit's acuity level score~~ and Pavilion Acute Unit Sstaffing Ggrid (see Appendix A). ~~which is reported before the next shift. The Acuity Level Score (1.00-2.50 = low, 2.51 - 3.50 + medium, 3.51 - 4.00 = high) is based on a formula which incorporates the total census and each residents' "Patient Acuity Classification" score~~.

a. Per Title 22 Regulations § 70053.2 Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1275, Health and Safety Code:
Patient Classification System. Means a method for establishing staffing requirements by unit, patient, and shift that includes:
1. A method to predict nursing care requirements of individual patients
2. An established method by which the amount of nursing care needed for each category of patient is validated for each unit and for each shift.
3. An established method to discern trends and patterns of nursing care delivery by each unit, each shift, and each level of licensed and unlicensed staff.
A mechanism by which the accuracy of the nursing care validation method described in (a)(2) above can be tested. This method will address the amount of nursing care needed, by patient category in patient populations, skill mix of the staff, or patient care delivery model.
5. A method to determine staff resource allocations based on nursing care requirements for each shift and each unit.
6. A method by which the hospital validates the reliability of the patient classification system for each unit and for each shift.
b. using Evalisys ® Patient Classification System
~~3.~~ 1. Pavilion License Staff complete Acute Acuity Tool (Appendix B) by evaluating the level of care needed using the "Care Indicator Instructions" (Appendix C)

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

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

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

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

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

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

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

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

D. APPROVAL OF TIME OFF:

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

E. DELINEATION OF ROLES AND DUTIES:

1. Nursing Director of Operations

a. The Nursing Director of Operations oversees and supervises the nursing office staff including: Operations Nurse Managers, Nursing Staffing Assistants and other clerical support staff.

b. The Nursing Director of Operations is available 24/7 for consultation related to staffing issues and problems. He/she will make the decision regarding utilization of staff up to and including authorization for overtime usage to ensure deployment of sufficient staffing on all units.

2. Operations Nurse Manager:

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

b. If staff is re-assigned from their initial assignment made, the Nursing Operations Nurse Manager or NSA will review as necessary with the Nurse Manager of the reason for the re-assignment before the end of the shift.

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

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

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

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

.

g. Without a Nursing Staffing Assistant:

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

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

3. Program Nursing Directors:

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

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

4. Neighborhood Nurse Managers:

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

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

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

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

5. Nursing Staffing Assistant:

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

b. Prints and reviews staffing worksheets per shift.

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

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

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

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

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

h. Notifies the Nursing Operations Nurse Manager of any AWOL and telephones the employee to determine his/her whereabouts.

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

Adopted: 10/2007

Revised: 2011/05/13; 2015/03/10; 2020/03/17

Reviewed: 2020/03/17

Approved: 2020/03/17

RESIDENT IDENTIFICATION AND COLOR CODES

POLICY:

1. Each resident is to wear a legible wrist identification band with resident name, hospital number and have a photograph on the Medication Administration Record (MAR). Any member of nursing staff may change wrist bands as needed.

2. Residents requiring designated ongoing precautions and safety monitoring are assessed by the Resident Care Team (RCT) and identified using a consistent system of wristbands with adhesive dots for associated precautions and safety alerts. ~~For residents that are unable to wear a wrist band or non-adherent with use of a wrist band, a color coded ribbon shall be used as an alternative to identify aspiration risk, elopement risk, and special approach.~~

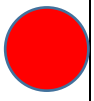
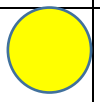
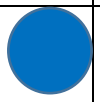
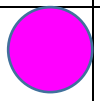
3. The nurse manager, charge nurse or nursing team leader will designate the use of color coding and safety alert interventions based on a thorough assessment of individual resident needs and risks.

PURPOSE:

To promote resident safety by ensuring quick and accurate identification of high-risk diagnoses and problems, and special needs approaches.

PROCEDURE:

A. Color Coding Grid Table

Colors	Adhesive Sticker Placed on ID Wristband	Bed Ccard ~~stickers~~Stickers
No Stickers~~White~~	No ~~p~~Precautions	~~n/a~~N/A
Red 	Allergies	N/A~~n/a~~
Yellow 	Diabetic	Diabetic
Blue 	Seizure	Seizure
Hot Pink 	Aspiration ~~Precaution~~	Aspiration ~~Precaution~~

Purple 	N/A~~n/a~~	**Unpredictable, aggressive behavior, uses special or cautious approach**
~~Orange~~	~~n/a~~	~~n/a~~

B. Safety Alerts

1. Care Alert (Confidential Resident Information)

2. Dialysis Care Alert (e.g., NO BP/IV on Right Arm)

3. Fall Risk (Star on Room Name Plate)

~~B.~~C. Wristbands

1. Obtain wristbands from central supply and colored adhesive stickers.

2. Apply associated colored stickers onto label that will be printed

3. To print wristbands:
   Log onto LCR
   Select Resident's name
   On the left frame, scroll down then click "Clerical Fxns" link
   Click "Print/Send Pt Info" link
   Click "Print Patient Info" link
   From the list of cases, click "Next Page" until you see the resident current Hospital Service Code with no Discharge Date.

Click "Resident Current Hospital Service Code"
Click "LHH Wristband Printing
"Wristband Generated" will be displayed

4. Use colored dot stickers for the following precautions (Refer to Procedure A: Color Coding Grid Table)

~~**C. Colored Ribbon Identification**~~

~~1. Obtain colored ribbons from central supply.~~

~~2. Use colored ribbons as a means of identification to promote resident safety (Refer to Procedure A: Color Coding Grid Table)~~

~~3. Colored ribbons being used to identify a problem are to be pinned or sewn onto the resident's clothing.~~

D. Documentation

Document precautions in Electronic Health Record (EHR)

CROSS REFERENCE:

LHHPP~~Hospitalwide Policy and Procedure~~
26-02 Management of Dysphagia and Aspiration Risk

Revised: 2011/11, 2005/0, 2010/01; 2011/04/26, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

DOCUMENTATION OF RESIDENT CARE/STATUS by the LICENSED NURSE - SNF

POLICY:

The Licensed Nurse (LN) is responsible for documenting assessments findings, developing care plans based on identified needs, implementing or supervising nursing interventions, and evaluating and revising the resident care plan.

PURPOSE:

To communicate relevant information regarding assessment, interventions, and outcomes to Resident Care Team (RCT) to promote continuity and quality care for our residents.

BACKGROUND:

Documentation of resident care includes the resident's physical, emotional, spiritual, recreational status, functional capabilities, attainment of care plan goals and/or other changes in status and reflect resident responses to nursing care and interventions for problems identified through assessment and care planning processes.

PROCEDURE:

A. Refer to Appendix 1 Obtaining Medical Records

B. Refer to LHHPP File: 21-05 Medical Record Documentation

C. Frequency of Nursing Documentation

Documentation frequency varies as the resident's condition changes. The licensed nurse is responsible for ensuring that documentation in the electronic health record reflecting assessment, planning, interventions, outcomes, and evaluation are completed in a timely manner. Any written documentation must be legible with licensed nurse name and title.

~~1. Pavilion Mezzanine Acute~~

~~Document as warranted by patient condition with a minimum of once per shift. Documentation includes assessment data, interventions implemented, and evaluation of patient's response to interventions.~~

~~2.~~1. Skilled Nursing Neighborhoods

a. Admissions, relocations, and post procedures – document a minimum of once per shift for at least 72 hours until condition is stable and resident has made the adjustment to the new environment. Summaries are completed weekly.~~Weekly summaries are completed for at least 4 weeks and may be extended based on the resident's condition.~~

b. Medicare designation – Document a daily note at minimum, for the duration of coverage as indicated. Nursing documentation will specifically describe aspects of skilled nursing care

designated as the focus of coverage in addition to routine physical assessment data. When no longer covered by Medicare, progress to ~~monthly~~ weekly documentation scheduled.

c. Unanticipated Change in resident condition or potential/actual decline – Document a minimum of once per shift for 72 hours and as often as clinically indicated depending on the nature of the change. ~~-~~Then document daily until condition stabilizes or resolves. Some examples of changes in resident condition may include, but are not limited to, change in cognitive function or unusual behavior, abnormal vital signs, meal intake of less than 50%, infectious processes requiring antibiotics, loss of functional ability, new incontinence, and exacerbation of a chronic condition.

d. Pavilion Mezzanine SNF – Document a minimum of once weekly for duration of rehabilitation. Documentation should reflect detailed description of the outcome of interventions, with an emphasis on degree of independence, resident education, and progress towards discharge planning goals.

e. Long Term SNF residents - Comprehensive ~~monthly~~ weekly summaries will be documented for all residents. This summary is an evaluation of the resident's response to care provided. Data collection for the ~~monthly~~ summary includes physical assessment, review of the care plan, activities of daily living, progress notes in electronic health record, vital signs, height and weight, medication and treatment records. ~~-~~If the resident has an unanticipated change in condition, frequency of documentation will increase as often as condition warrants and until stabilized.

f. Discharge – refer to NPP C 1.3 Discharge to Acute and LHHPP 20-04 Discharge Planning.

g. The Care Area Assessment (CAA) - documentation will be done after completion of a comprehensive MDS assessment and care planning.

D. Documentation other than Progress Notes

1. Admission documentation (Refer to Admission-Relocation-Discharge Procedures).

2. The electronic health record contains the Nursing Admission Assessment and other nursing assessments.

3. Licensed nurse documentation includes completion of specific assessment and evaluation tools in the electronic health record (EHR). ~~(See Appendix 1).~~

4. Medication and Treatment Administration Documentation in the EHR

   a. For medication administration, refer to J 1.0 ~~Documentation~~Medication Administration. ~~on electronic health record includes name of drug, dosage, route, time and site for parenteral drugs, and frequency.~~

   b. Documentation ~~on electronic record sheets~~ for treatments includes the time, the treatment as ordered, pertinent observations.

   c. When PRN medications or treatments are administered, the reason and result of intervention are documented on the electronic health record.

5. Activities of Daily Living (ADL) in the EHR

a. Licensed Nurse is responsible for creating individualized ~~individualizing electronic health record with~~ resident~~-~~ specific tasks and interventions in the care plan (~~e.g.~~e.g., restorative interventions or assistance during meals).

b. Licensed Nurse will document ~~in the electronic health record~~ if the LN provides direct assistance with resident's ADL.

c. Refer to NPP C 3.2 Documentation of Resident Care by Nursing Assistant.

d. Licensed Nurses are responsible for reviewing the documentation on the ~~the~~ electronic health record to ensure that care is provided as per care plan.

~~6.~~ Medication orders, vital signs, height, weight, labs, immunization, ~~allergies,~~ and point of care testing are documented in the EHR~~electronically~~.

6. Allergies: Nurses and physicians review allergies upon admission. Residents should be observed for allergic reactions and adverse drug reactions throughout their stay. For any new reactions, notify the physician. The physician adds new allergies and/or adverse drug reactions to the EHR allergy section.

~~F.~~7. ~~See Appendix 2 for Charting/Documentation/Reporting Expectations~~

APPENDICES:

Appendix 1: Obtaining Medical Records
~~Appendix 2: Charting/Documentation/Reporting Expectations~~

REFERENCES:

~~Health Information Services Universal Chart Order~~
CMS's RAI Version 3.0 Manual v1.17.1 (2019)
~~RAI/MDS Manual~~

CROSS REFERENCES:

Hospitalwide Policy and Procedure
20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
20-04 Discharge Planning
21-05 Medical Record Documentation

Nursing Policy and Procedure
B 5.0 Resident Identification and Color Codes
C 1.0 Admission and Readmission Procedures for Skilled Nursing Facility
C 1.2 Relocation ~~Procedure~~Between Laguna Honda SNF Neighborhoods
C 1.3 Discharge Procedure to Acute
C 3.2 Documentation of Resident Care by the Nurse Assistant~~s~~
C 4.0 Notification and Documentation of a Change in Resident Status

Adopted: 8/2002

Revised: 2009/09; 2015/06/16; 2015/09/08, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

TRANSCRIPTION AND PROCESSING OF ORDERS

POLICY:

1. Licensed nurses, including ~~(~~Registered Nurses (RN)~~,~~ and Licensed Vocational Nurses ~~L~~(LVN), are responsible for acknowledging orders prescribed on their shift. Cut of times are AM shift 7am, Day shift 3pm and PM shift 11pm.

2. Incomplete, questionable or confusing orders are clarified with the prescriber and if appropriate, pharmacy, prior to implementation for resident/patient safety. The Nurse Supervisor/Manager on duty should be called if the clarification has not remedied the licensed nurse's concern.

3. Physician orders are entered via Computerized Provider Order Entry (CPOE).~~s orders are accepted electronically.~~

4. Telephone and verbal orders are used only when absolutely necessary, and then read back by the recipient, and confirmed or corrected by the prescriber. Refer to LHHPP 25-03 Verbal Telephone Medication Orders.

5. Physicians are authorized to give verbal orders.

~~6.~~ Each resident's orders are reviewed monthly by the physician. ~~and the licensed nurse.~~

~~7. All residents' charts are reviewed nightly by A.M. (night) shift LN.~~
6.

PURPOSE:

To assure that orders are accurately and appropriately transcribed and processed.

PROCEDURE:

A. Nursing Orders

1. Nursing orders shall be placed in the Work list.

B. Telephone or Verbal Orders

1. See Hospital~~-~~-wide Policy 25-03 for Verbal/Telephone Orders.

C. Processing Orders to Pharmacy

1. CPOE for medications are ~~E-prescription by the physician will be~~ sent electronically by the EHR to the Pharmacy.

D. "STAT" Orders & Pharmacy Response Time

1. STAT labs: STAT Courier is called for immediate pick up ~~if pick up of is not near time collection~~or if collection time is not near a schedule pick up time.

2. NOW Labs: Labs will go out the next scheduled courier pick up

3. For order processing by pharmacy and nursing for new medication orders, stat medication orders, new anti-microbial orders, and new orders or severe pain, nausea, agitation, diarrhea or other severe discomfort, refer to Nursing policy J 1.0 Medication Administration, and Pharmacy policies 02.03.00 Emergency and Supplemental Medication Supplies and 02.01.00a Acute Care Order Processing and Med Distribution.

~~3. Nursing and pharmacy shall process stat orders immediately during regular pharmacy hours. Outside of pharmacy hours STAT orders are obtained by Nurse Operations Manager/Supervisor refer to Pharmacy Policy 02.03.00 Emergency and Supplemental Medication Supplies.~~

~~4. Medications shall be ready for administration within one hour of the time ordered. Drugs ordered "STAT" which are available in the unit emergency drug box shall be administered immediately.~~

~~5. New orders for anti-infectives and medications that are used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.~~

~~6. Except as indicated above, all new drug orders shall be available prior to the next scheduled administration time.~~

F. Discontinued Medication Orders

1. Refer to NPP J1.1 for Obtaining, Handling, Storing of Medications.

~~**G. Monthly review of Printed Physician's Order Sheets:**~~

~~1. The physician reviews medication orders monthly and documents the review in the EHR.~~

~~**H. Nightly Verification of Order Processing and Transcription by A.M. Shift Licensed Nurse**~~

~~1. Licensed Nurses will review the EHR for each resident for new orders in the past 24 hours.~~

~~a.~~

CROSS REFERENCE:

Hospitalwide Policy and Procedure
- 25-02 Safe Medication Orders
- 25-03 Verbal Telephone Medication Orders

Nursing Policy and Procedure
- J 1.0 Medication Administration
- J 1.1 Obtaining, Handling and Storing of Medications

Pharmacy Policy and Procedure
- 02.01.00aa Acute Care Order Processing and Med Distribution
- 01.01.00b Skilled Nursing Distribution of Medications and Order Processing
- 02.03.00 Emergency and Supplemental Medication Supplies

Clinical Laboratory Policies and Procedures
A1 Clinical Laboratory Procedures

Revised: 2001/08, 2006/04, 2006/12, 2008/03, 2008/08, 2010/10, 2014/02, 2015/07/14, 2019/03/12; 2020/06/23

Reviewed: 2020/06/23

Approved: 2020/06/23

FOOT CARE

POLICY:

1. Nursing assistants, are responsible for inspection of the resident's feet/foot daily, routine nail and toenail trimming and reporting of any unusual findings to the licensed nurse.

2. The Licensed Nurse is responsible for completing scheduled and as-needed skin assessments to identify residents at an increased risk of impaired skin integrity of the foot (i.e., impaired sensation, peripheral vascular disease), documenting and observing the unusual findings, and informing the physician. Consider requesting wound care consult and/or podiatry referral.

3. Each resident will be provided with individual nail and toenail clippers labeled with their name. ~~and stored in a treatment cart when not in use.~~ Individual nail clippers are cleaned after each use and stored in a treatment cart. If a resident uses a nail file, nail files are to also be labeled with their name, cleaned after each use and store in the bedside drawer or treatment cart.

4. Residents with diabetes, peripheral vascular disease, peripheral arterial disease, immobility or other foot disorders (but not limited to such as corns, neuromas, calluses, bunions, hammertoe, heel spurs, nail disorders) refer to physician for podiatry referral.

PURPOSE:

To describe the process for routine foot care.

PROCEDURE:

A. Routine Foot Care

1. Inspect skin condition of resident's feet, including between and under the toes to check for cuts, blisters, redness, swelling, irritation, discoloration, or any other unusual skin condition. Observe for any new deformity changes to nails, changes in range of motion or new loss of sensation. Report any unusual findings to the Licensed Nurse.

2. Use soap or foam cleanser to clean feet and toe nails.

3. Rinse and gently dry feet, paying attention to the areas between and under the toes then apply moisturizer.

4. Apply socks or stockings before applying shoes or before resident stands and ambulates.

5. Shoes should be well-fitting and non-compressive. Check the inside of the shoes to make sure that they do not have any protrusions, rough spots or bumps.

6. When the resident is in bed,

    a. Heel protectors may be applied as warranted.
    b. Foot cradle may be placed at the foot of the bed to prevent weight of top bedding from exerting pressure on the toes and to provide support for the feet.

B. Toenail trimming as needed, considering safety and resident preference:

1. Check with the licensed nurse for any precautions before trimming nails.
~~1.~~2. Trim toenails straight across.
~~2.~~3. Never cut or dig out corner of nails. Do not trim skin.
~~3.~~4. Smooth rough edges with an emery board as needed.
~~4.~~5. Inform Licensed Nurse if unable to trim nails.

C. Documentation

1. Nursing Assistants will document on the electronic health record for any unusual foot issues and report to the Licensed Nurse.

2. Licensed Nurse will document any skin changes and physician notification in the Integrated Progress Notes.

3. Nursing will document and update care plan.

REFERENCES:

Bryant, R.A. & Nix, D.P. (2012). Acute & chronic wounds: current management concepts, (4th ed), St. Louis, MO: Elsevier

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

CROSS REFERENCES:

Nursing Policy and Procedure
D2 2.0 Bathing Alternatives and Bed Baths
D2 4.0 Operating and Cleaning Jacuzzi Tub
K 2.0 Wound Management and Assessment

Revised: 2000/08; 2010/02; 2014/07/22; 2015/07/14; 2019/03/12; 2022/11/08

Reviewed: 2019/03/12; 2022/11/08

Approved: 2022/11/08

RANGE OF MOTION EXERCISE

POLICY:

1. Registered Nurse (RN) will assess need for Range of Motion (ROM) and any contraindications consistent with the resident's goal of care.

2. Licensed Nurse (LN), Certified Nurse Assistant (CNA), or Patient Care Assistant (PCA) can perform range of motion exercises.

3. Nursing Assistants receive initial training ~~and competency skill evaluation~~ during orientation ~~or initial restorative basic training~~. Other trained~~, competent~~ staff or volunteers may lead residents through Active ROM (AROM).

PURPOSE:

Range of motion exercises are used to maintain or restore range and maximal function, prevent deformities, stimulate circulation, and enhance a sense of well-being.

PROCEDURE:

A. Assessment

1. The ~~The~~ RN begins the functional assessment for range of motion needs ~~of new residents~~during the admission assessment.
2. SNF: Functional assessments are completed as required by MDS (Section G and/or GG as appropriate) at least annually and when a significant change of condition occurs. Refer to policy 23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS).

~~1. by completing the physical function sections (G) of the MDS. Functional assessments are then completed at least annually and when a significant change of condition occurs.~~

~~2.~~ Assess whether limitations in Range of Motion (ROM) are related to unrelieved joint pain based on resident's report of pain or observation of pain related behaviors, such as moaning, striking out, or grimacing.

3.

~~3. Further assessment is initiated by requesting a~~A physician may~~'s~~ order a~~for~~ physical or occupational therapy consultation on admission or anytime there is an assessed need, such as an unanticipated functional decline or contracture.

4.

~~4.~~5. Consider if resident is high risk for fracture before implementing ROM.

B. Planning

1. If appropriate, initiate ROM interventions based on assessment or as ordered..
2. SNF:
   a. Range of motion programs that ~~are to~~ occur daily ~~or most days~~for 15 min/day generally qualify as restorative and should be care planned as such with maintenance or ~~improvement oriented~~improvement-oriented goals.
   b. ~~-~~Range of motion that is incidental to Activities of Daily Living (ADL) only does not qualify as a restorative AROM and/or Passive ROM (PROM) program and does not necessitate a full care plan.

~~1.~~ Refer to policy D 1.0 Restorative Nursing Program.

~~2. Range of motion that is incidental to Activities of Daily Living (ADL) only does not qualify as a restorative Active ROM (AROM) and/or Passive ROM (PROM) program and does not necessitate a full care plan.~~

c.

~~3.~~ ~~Plan pain management interventions for residents with contractures and/or chronic joint pain to enable resident's maximal participation in the ROM program and to prevent further functional limitation. Gentle ROM is considered an intervention for degenerative joint disease related pain and high risk for fracture.~~Acute:

a. Acute rehabilitation: provide ROM based on assessment, as ordered, or as part of rehabilitation program in conjunction with rehabilitation therapists as part of the Acute Rehab plan of care.

b. Acute medical: provide ROM as appropriate based on assessment or as ordered and as permitted by acute condition.

~~3.~~4. Plan pain management interventions for residents with contractures and/or chronic joint pain to enable resident's or patient's maximal participation in ROM exercises and to prevent further functional limitation. Gentle ROM is considered an intervention for degenerative joint disease related pain and high risk for fracture.

C. Interventions

~~1.~~ SNF: Range of motion may be accomplished during bathing, dressing, grooming, or at scheduled times according to resident need or preference, however, range of motion that is incidental to ADLs cannot be considered a restorative nursing program.

1.

~~2.~~ Provide pain interventions as planned and appropriate.

2.

3. Loosen or remove restrictive clothing or devices.

4. ROM Procedure:

Refer to "Range of Motion Exercises" on Elsevier Clinical Skills for detailed information: https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco

~~3. PROM~~

~~a. The LN or nursing assistant provides PROM by moving the body part around a fixed point or joint until the resident's maximum available range of motion is achieved with no assistance from the resident. (See guidelines and illustrations of the PROM technique provided at the end of this procedure).~~

~~b. Precautions during PROM exercises include:~~

~~i. Support the joint while doing the exercises. Hold the extremity above or below the joint (e.g. elbow, wrist, or knee) and move the joint smoothly, slowly, and gently through its range).~~
~~ii. Avoid forcing any part of the body to move beyond its free range of motion.~~
~~iii. Keep movement within a pain-free range, stopping at the point of pain. Appropriate pain medication and non-pharmacological interventions for pain are commonly needed.~~
~~iv. When "increased tone" (spasticity) is present: circular motion is more effective in reducing spasticity than direct opposition. Move the joint slowly to the point of resistance. Then exert gentle, steady pressure until the muscle relaxes.~~

~~v. Do the exercise the same number of times on each side of the body. Move each joint through its range of motion for at least 5 repetitions, at least once and preferably twice daily or as indicated by the care plan.~~
~~vi. When performing range of motion on upper extremities, mobilize the scapulas first to facilitate relaxation in the remainder of the extremity.~~
~~vii. When working on the lower extremities, mobilize the hips first to facilitate relaxation in other lower extremity joints.~~
~~viii. When working on the back, begin with head and neck flexibility only to the extent that the resident is able to do independently with cueing to prevent head/neck injury.~~

~~4.~~ AROM
5.
~~a.~~ AROM is performed by the resident/patient with cueing as needed and supervision from LN or nursing assistant. When the resident does most of the exercise, but needs some assistance with the final stretch, it is still considered active range of motion.
a.
b. SNF: AROM may be provided in a group with a 1:4 ratio of staff/ or trained volunteer as part of a Restorative AROM program. Videos, music, and small weights are often used to enhance the program.

D. Evaluation / Documentation and Reporting

1. SNF: document minutes of ROM provided.
~~1. Resident~~ Care Plan ~~(RCP)~~
2.

~~ROM that is not part of a restorative program can be written on the front card of the care plan.~~

a. Document a measurable goal with individualized ROM interventions.
b. SNF: ROM that is not part of a restorative program should be care planned, but not included in a restorative care plan.

3. SNF weekly summaries: document ROM progress toward care planned goals or any changes from baseline is addressed with each nursing summary to evaluate the resident's response to the program.
4. Acute care plan note: document progress toward care planned goals every shift.
~~2. Nursing Summary~~

~~At minimum, ROM that is only on the front card and not part of a restorative program is addressed in the summary when changes from baseline occur.~~

~~The licensed nurse documents progress in relation to restorative nursing goals for AROM or PROM programs in the summary to evaluate the resident's response to the program.~~

REFERENCES:

~~Lippincott Manual of Nursing Practice (9th Edition, 2010)~~
~~Mosby's Textbooks for Nursing Assistants (6th Edition, 2004)~~
MDS 3.0 RAI Manual v1.17.1R Errata October 1, 2021. Retrieved on 9/20/22 from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

Elsevier Clinical Skills:
https://epm601.elsevierperformancemanager.com/Personalization/Home?virtualname=sanfrangeneralhospital-casanfrancisco

CROSS REFERENCES:

C 3.0 Documentation of Resident Care/Status by Licensed Nurse
C 3.2 Document of Resident Care by the Nursing Assistant
D 1.0 Restorative Nursing Program ~~Nursing Policy and Procedure D1.0 Restorative Nursing Program~~
XX.XX Documentation of Care – Acute Unit
23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)

Revised: 12/2004; 1/2008; 03/25/2014

Reviewed: 03/25/2014

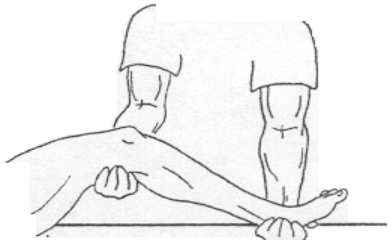
Approved: 03/25/2014

Pictorial Guidelines for Range of Motion

Head and neck flexion and lateral rotation are not pictured because passive ranging of the head and neck can cause injury and should only be done if specifically indicated after appropriate assessment. Active ranging of the head and neck can be done by the resident to the degree comfortable for the individual.

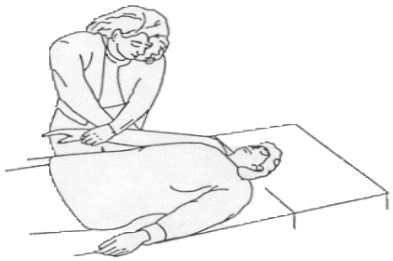
Use techniques for good **body mechanics** throughout, such as moving with the limb you are ranging or placing one knee on the bed. Use cupping or cradling to support the joint.

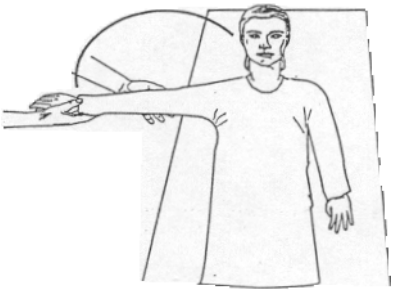
Cupping: **Cradling:**

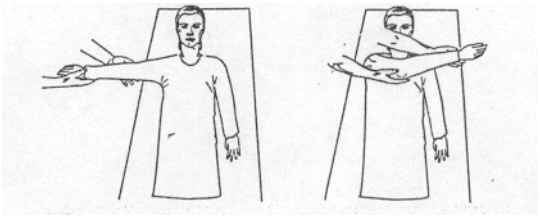


Shoulder flexion: Shoulder abduction: Horizontal adduction and abduction:

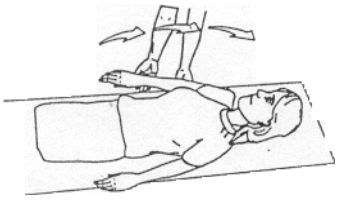
Passive range of motion is usually begun at the shoulder joint. The cross over technique shown facilitates good body mechanics while ranging the shoulder.

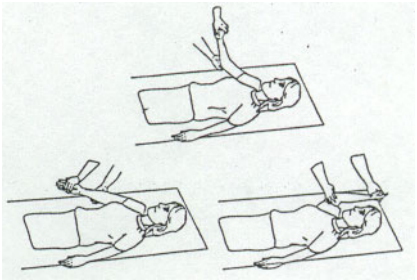


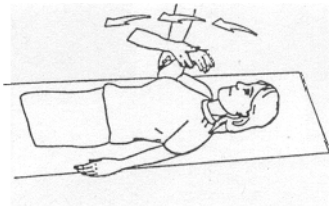


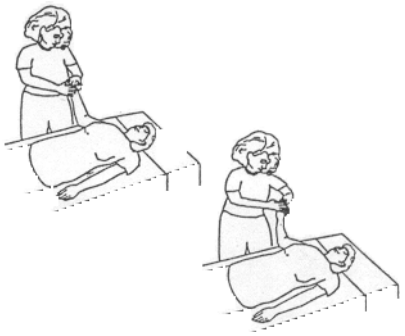


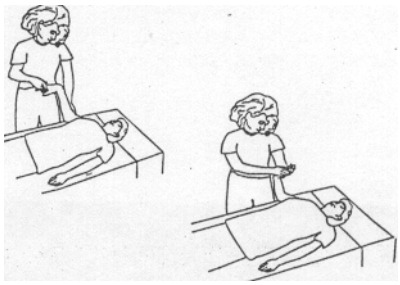
Elbow flexion Internal and external rotation







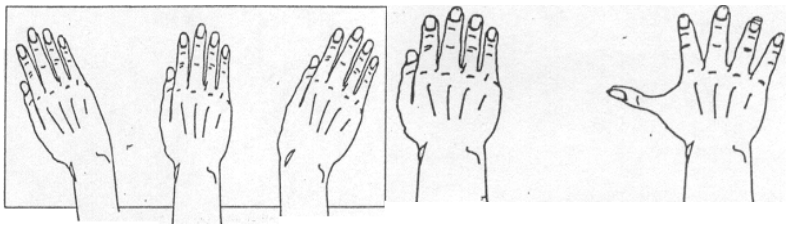




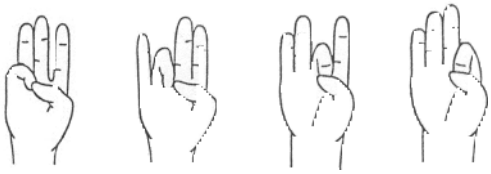
~~Supination and pronation of the hand~~ ~~Flexion and extension of the wrist~~

~~Ranging the hand and fingers is more comfortable for the resident if done with the **forearm resting on the bed/surface**. (It is shown here with the arm elevated to see the motion, however, this position becomes painful as it begins to negatively effect the circulation.)~~

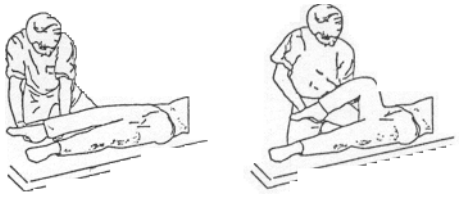
~~Radial and ulnar deviation:~~ ~~Finger and thumb abdution and adduction:~~

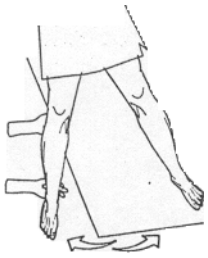


~~Opposition: Touch the tip of the thumb to each finger.~~

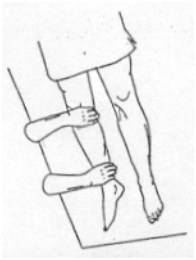


~~Hip flexion and extension:~~ ~~Hip abduction and adduction:~~

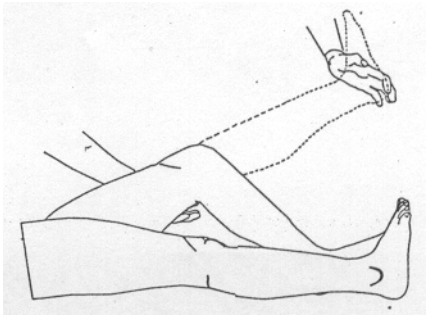




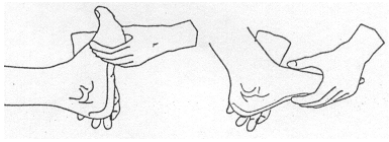
~~Internal and external rotation:~~



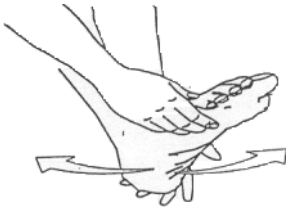
~~Knee flexion and extension:~~



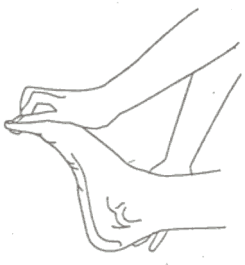
~~Dorsiflexion and plantar flexion:~~



~~Inversion and eversion:~~



~~Flexion and extension:~~



OXYGEN ADMINISTRATION

POLICY:

1. A licensed nurse may administer oxygen during an urgent situation pending the physician's evaluation.

2. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.

3. Residents requiring continuous oxygen shall be placed in a room that has wall oxygen.

4. Oxygen tank shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.
~~4.~~5. Disposable oxygen tubing administration devices shall be labelled with the date and initials every 7 days and PRN. Routine weekly changes shall be documented by the AM shift nursing staff.

PURPOSE:

To safely administer oxygen therapy.

BACKGROUND:

Disposable oxygen devices may include but are not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula, mask or tracheostomy mask

PROCEDURE:

A. Equipment:

1. Obtain oxygen delivery system supplies from neighborhood storage room or central supply.

2. Obtain from Central Supply, as needed:

   - "NO SMOKING" sign(s)
   - Small “E” tank oxygen cylinder with valve protection device attached. (Each Neighborhood will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)
   - Appropriate regulator
   - Compressed Air Connector if no humidification required
   - Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm.

B. Safety measures for oxygen are to be followed.

1. Residents and visitors are to be informed of the risks of smoking when oxygen in use, as needed.

2. “OXYGEN IN USE” signs are to be clearly visible:

   a. around the neck of the wall mounted oxygen flow regulators
   b. on oxygen or compressed air tanks in carriers or on wheelchairs
   c. outside the door of resident’s room when oxygen or compressed air is in use in the room

3. "OXYGEN STORAGE. NO SMOKING. NO OPEN FLAME" signs visible where oxygen is stored

4. **No alcohol or tincture, oil, glycerin, Vaseline or petroleum** product is to be used on or near residents receiving oxygen.

5. When oxygen tubing is not in use, make sure oxygen is turned off and tubing is stored in bags by the resident's bedside

6. Do not connect or disconnect electrical devices such as suction machines, electric razors and cell phones or any heat producing device during oxygen treatment,

7. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.

8. If fire breaks out on the neighborhood, turn off all oxygen sources. If a resident cannot survive without oxygen therapy, move resident/bed to a safe area before resuming oxygen.

9. If oxygen cylinders are required:
    a. Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
    b. Always look at the cylinder gauge to determine contents before administering any.
    c. Oxygen cylinders in storage shall be equipped with valve protection devices, and stored in oxygen cabinet.
    d. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.
    e. Cylinder valves shall be closed before moving cylinder on all tanks including empty cylinders.

C. Setting up and monitoring oxygen cylinders:

1. Remove cap and plastic cover.
2. Open and close valve quickly to remove dust from valve.
3. Place proper diameter-indexed regulator, with adapter attached, on the tank and position so that regulator is perpendicular to tank for easy reading.
4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
5. No smoking sign will be p~~o~~asted on front of tank. Also a no smoking tag, plastic bag with oxygen tubing, cannula, mask and compressed air connector will be hung on tank.
6. Always check the amount of oxygen in cylinder before dispensing.
7. Unless in use, the oxygen regulator is closed.
8. Cylinders are to be stored on unit in appropriate cylinder holder. Cylinders stored in the open are protected from weather.
9. Empty cylinders are segregated from full cylinders.
10. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply

D. Breaking down oxygen cylinders.

1. Remove regulators from cylinders.

2. Place valve covers on cylinders.
3. Nursing will disinfect the oxygen cylinder (avoiding valve stem) with a 70% isopropyl alcohol agent.
4. Nursing will put "empty tag" on the oxygen cylinder and place the disinfected cylinder in the oxygen storage cabinet in the clean utility room in the designated location for empty cylinders.

~~3.~~5. ~~Return empty cylinders to~~ Central Supply will pick up used/empty cylinders.

E. Procedure

1. Refer to Elsevier Clinical Skills titled "Oxygen Therapy: Nasal Cannula or Oxygen Mask."

~~**Preparation of the Resident and Visitors:**~~

~~1. Explain the procedure and reasons for it to the resident.~~

~~a. Show resident the catheter or mask to be used.~~
~~b. Reassure resident that you will be checking him/her.~~
~~c. Elevate the head of the bed.~~
~~d. Check that the call light is accessible. Give instruction on how to operate the call light, if needed. Reassure the resident that you want him/her to turn on the call light to inform you of any difficulties.~~
~~e. If the resident is apprehensive, and if staffing permits, assign someone to stay with him/her until he adjusts.~~

~~2. Explain the "NO SMOKING" policy to the resident and visitors.~~

~~**F. Preparation of Equipment:**~~

~~1. Wash hands.~~

~~2. Connect tubing to the flowmeter or humidifier and the administering device.~~

~~3. Assess equipment for proper functioning. Open oxygen flowmeter. There should be bubbles visible in the water of the humidifier, if used.~~

~~**G. Administration**:~~

~~1. Apply and adjust nasal cannula, mask or catheter to resident. Check placement frequently. If needed, use 4 x 4 gauze to cushion tubing that presses against the face or ears. Keep skin clean and dry. Observe these skin areas for skin breaks when oxygen is prolonged.~~

~~2. Turn on the oxygen and adjust flow rates as prescribed.~~

~~3. Increase frequency of oral hygiene as needed by resident's condition.~~

~~3. Nasal oxygen administered at 4 liters or less/minute does not need to be routinely humidified.~~

~~4. When humidifiers are used with oxygen, use pre-filled humidifier.~~

~~7. Check oxygen flow rate at frequent intervals.~~

~~8. Observe the resident frequently for signs of insufficient oxygen which may include:~~

~~a. BP - increase above baseline or narrowed pulse pressure,~~

b. Pulse - tachycardia,
c. Respiration changes in rate, rhythm, depth, absence or presence of dyspnea,
d.Decreased mental alertness - confusion, restlessness,
e.Changes in skin and fingernail color, perspiration.

9. For Infection Control purposes, the opened nasal cannula, when not in use, will be stored in a clean bag.

H. Methods of Administration

Refer to Respiratory Services Departmental Policies and Procedures in the Cross Reference Section or The Lippincott Manual of Nursing Practice listed in the Reference Section of this NPP for Administering Oxygen by Nasal Cannula, Simple Face Mask With/Without Aerosol, Venturi Mask (High air flow oxygen entrapment [HAFOE] system, Partial Rebreathing or Nonrebreathing Mask, Continuous Positive Airway Pressure Mask, or by Manual Resuscitation Bag.

I. Documentation for Oxygen:

1. Tubing Label:
All disposable used oxygen administration devices shall be labelled with the date and initials every 24 hours and as needed.

3. Electronic Health Record (EHR):

a. For continuous use of oxygen each shift, the licensed nurse documents administration
b. For PRN use of oxygen, licensed nurse documents when given and includes comment about how the oxygen was tolerated
c. When treatment is given by the respiratory therapist, the respiratory therapist documents the administration.
d. The replacement of all disposable used oxygen administration devices shall be documented on the ehr by AM shift nursing staff.
e. Vital signs are recorded in the EHR.
f. Monthly/weekly summary or more frequent PRN documentation based upon the resident's condition and the judgment of the nurse.
g. Resident's response to treatment including adverse reactions and tolerance to the procedure, which may include the following items, as applicable.
    i. Date, time and performing the procedure
    ii. Oxygen liter flow rate.
    iii. Method, frequency and duration of administration
    iv. Specific assessments which may include vital signs, skin color, and level of consciousness.
h. Resident teaching done and the resident's level of understanding and compliance. Include oxygen administration and respiratory status on the Care Plan

ATTACHMENTS/APPENDICES:

Attachment 1: Oxygen Therapy Devices

REFERENCES:

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

~~Louis, MO: Elsevier~~
~~Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins~~
~~Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadelphia, PA: Lippincott Williams & Wilkins~~

Elsevier Clinical Skills: Oxygen Therapy: Nasal Cannula or Oxygen Mask, Adapted from Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills & techniques* (10th ed.). St. Louis: Elsevier. Published: September 2021

https://point-of-care.elsevierperformancemanager.com/skills/380/quick-sheet?skillId=GN_22_1&virtualname=sanfrangeneralhospital-casanfrancisco

CROSS REFERENCES:

Respiratory Services Policies & Procedures:
- A 2. Safety Regulations for Oxygen Therapy
- A 6. Oxygen Administration: Nasal Cannula
- A 7. Oxygen Administration: Simple- Oxygen Mask
- A 8. Oxygen Administration: Non-Rebreather Mask
- A 9. Oxygen Administration: Venturi Mask

Revised: 2006/03, 2006/04, 2009/08, 2017/01/10; 2019/03/12; 2022/01/11; 2022/07/12

Reviewed: 2022/07/12

Approved: 2022/07/12

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring, and documenting medications consistent with their scope of practice.

    a. Only an RN may administer intravenous (IV) medications, whether by IV piggyback or IV push.
    b. The LVN may administer medications per LVN scope of practice, except for IV medications.
    c. The Certified Nursing Assistant/Patient Care Assistant (CNA/PCA) may, under the supervision of Licensed Nurses (LN), administer the following: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.
        - Exception: Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications ~~and formulary herbal supplements~~, require a physician's order which includes:
    a. Medication name/agent
    b. Dose
    c. Frequency
    d. Route of administration
    e. Indication for use.
        - If indication for use is not on order, consult with ordering physician.
3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside.

4. LN will follow the "6 Rights" of medication administration:
    a. Right resident
    b. Right drug
    c. Right dose f
    d. Right time
    e. Right route
    f. Right documentation

5. Bar Code Medication Administration (BCMA) is not a substitute for the LN performing an independent check of the 6 Rights of medication administration.

6. Resident arm bands should only be scanned if the arm band is secured on the resident. Arm bands should be replaced if worn, torn, or do not scan.

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

8. The LN will prepare medications at the resident's side (i.e., If resident is in bed, preparation will be at bedside, if resident is in great room, they may receive at chair side).

9. The LN will prepare medication(s) at the time just prior to administration. Do not prepare medications prior to administration or store out of the package.

10. LHH does not allow medication to be separated from the original package and stored for administration at later time, this is considered pre-pouring.

11. Narcotic (opioid) medication administration will have a two LN independent check of administration and each LN will document in EHR.

12. IV medications are only prepared by RN for emergency situations and must be labeled with resident name, date and time of preparation, medication name, strength, amount, and name of the person preparing.

13. Medication delivered via transdermal route must have date, time, and LN's initials. Before application of new patch, old transdermal patch must be removed.

14. Medication times are standardized in the Electronic Health Record (EHR). Medication administration times may be modified to accommodate clinical need or resident's preferences. The LN will notify pharmacy via the EHR with medication administration time change request.

15. The safe administration of psychotropic, hazardous, high risk/high alert medications, and reporting of Adverse Drug Reactions (ADR) will be followed as outlined in other LHH policies and procedures.

16. Medications may not be added to any food or liquid for the purpose of disguising the medication, unless informed consent has been granted by the resident or the surrogate decision maker.

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

18. Partial doses of controlled substances being pulled from Omnicell must be pulled at time of administration with witness and immediately wasted with co-signer/other LN at the time of retrieval from Omnicell.
    a. 2nd LN shall witness when the medication is still in the sealed packaging, and the actual wasting of the partial dose.
    b. Partial doses should not be placed in medication cart for administration at later time.
19. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

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

21. Oral medications that are safe to be crushed can be crushed at the discretion of the LN.

22. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications, and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

23. A provider order must be obtained for medications to be mixed with pudding.

24. Medications mixed with food mediums (e.g., apple sauce, pudding) must have the food medium dated, timed and discarded at the end of each medication pass.

25. It is the legal and ethical responsibility of the LN to prevent and report medication errors.

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

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

28. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of nasal naloxone, ~~-~~rescue inhalers, and other documented, approved rescue medications if ordered. If an approved medication is to be stored at the bedside, the resident must be assessed for their ability to ensure that the medication is stored safely.

29. Residents who request to self-administer medications ~~and/or herbal supplements~~ must be assessed by Resident Care Team (RCT), and determined to be able to safely self-administer medications.

30. Herbal supplements are not medications. Please see Herbal Supplement Policy for guidance around ordering, use, and storage of herbal supplements. ~~The contents and purity of herbal supplements are not regulated and may contain undeclared contaminants. A limited number of herbal supplements are on the hospital formulary. Any requests for non-formulary herbal supplements will be reviewed by pharmacy and medicine for evaluation.~~

31. All medications ~~and herbal supplements for~~ for self-administration will be stored securely by nursing, with the exception of nasal naloxone, rescue inhalers, or other documented approved rescue medications. ~~Other rescue medications may be considered to be stored at the bedside after a safety evaluation by pharmacy and medicine team.If an approved medication is to be stored at the bedside, the resident must be assessed for their ability to ensure that medications are stored safely~~.

RELEVANT DATA & DEFINITIONS:

BCMA: Bar Code Medication Administration
eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record
EHR: Electronic Health Record
WOW: Workstation on Wheels

CRITICAL POINTS:

A. SIX RIGHTS OF MEDICATION ADMINISTRATION

1. RIGHT RESIDENT

- Two forms of identification are mandatory.
  - Verify identity of resident using any of the following two methods:
    - Successful scan of identification band, only if arm band is on the resident, or successful scan of identification card for the resident who meets criteria (See appendix II)
    - Resident is able to state his/her first and last name (Ask for first and last name without prompting)
    - Resident Medication Profile Photograph matches the resident image in the EHR.
    - Resident is able to state date of birth (Ask without prompting.)
    - In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.
    - Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

2. RIGHT DRUG
    - Review eMAR for drug/medication ordered
    - Review resident allergies to medications or any other contraindication
    - Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.
        - Checks or verifies information about medication using one or more of the following references, when needed:
            - Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
        - Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

3. RIGHT DOSE
    - Review eMAR for dose of drug/medication ordered
    - Check medication label and confirm accuracy of dose with eMAR

4. RIGHT TIME
    - Review eMAR for medication administration time
        - Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin, and any medication ordered more often than every 4 hours will be administered within 30 minutes before or after schedule time.
        - All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
        - See Appendix I for routine medication times and abbreviations.
        - Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.

5. RIGHT ROUTE
    - Review routes of administration
        - Aerosol/Nebulizer: Refer to NPP J 1.3
        - Enteral Tube Drug Administration: Refer to NPP E 5.0
        - Eye/Ear/Nose Instillations: Refer to J 1.4
    - IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

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

B. OVERRIDE OF MEDICATION ADMINISTRATION

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

C. TWO LN INDEPENDENT CHECK OF MEDICATIONS:

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

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

1. Crushing medications is based on nursing judgement and resident care plan.

2. Do not crush hazardous, enteric, sustained release or medications labeled “do not crush.”

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

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

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

6. Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food), unless pharmacy has reviewed the medications for safety and efficacy, and pharmacy has documented that it is safe to mix crushed medications together and the physician has placed an order for crushing and combining the medications.

7. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:
    a. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.
    b. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)
    c. If using pudding as the food medium to administer medications, a physician order is required for the pudding.
    d. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

E. HAZARDOUS MEDICATIONS

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

2. Instructions for administering the medication can be found in administration instructions on the MAR.

F. PHYSICIAN ORDER

1. LNs may accept telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident’s medication allergies with prescriber and read back the order entered into the EHR for accuracy with the physician. Verbal orders should only be taken during emergent situations when provider is unable to enter the order due to care being provided to resident.

2. STAT medication orders are processed immediately and administered no later than four hours after the order was written.

3. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

PURPOSE:

Medications will be competently and safely administered

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.

2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.
    a. Pull those resident's cassettes from medication cart and place on top of WOW, or bring med cart inside med room if space permits.
        i. Ensure each cassette is labeled with the correct resident name.
        ii. Do not overcrowd the WOW with too many cassettes.
    b. Bring WOW with the resident(s) medication cassette(s) into the medication room.
        i. If using medication cart with computer screen attached, bring the entire cart into the medication room.
    c. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.
    d. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.
        i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.
    e. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.
    f. Repeat this for each resident that need medication(s) removed if needed.
    g. Return to medication cart with WOW and cassettes and put cassettes in medication cart.
        i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette, and immediately followed by placing cassettes in medication cart.

3. Log into the EHR and review the medications which will be administered. Remove those medications from resident’s cassette and place on top of WOW. Bring the WOW with only the medications to be administered and needed supplies to the resident’s side.

4. Confirm with the resident that they are ready to receive their medications in the location they are located if they are not in their room, such as the great room.

5. Scan the arm band of resident to correctly identify resident and open their MAR.
    a. If the resident is wearing their arm band, this will serve as ~~is~~ one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.
    b. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.
    c. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

6. Scan medication(s) barcode(s) at bedside/chairside.

7. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights.

8. Immediately prepare medication(s), if appropriate. (e.g., crush), and administer medication(s).

    a. If this is the first dose being given, document that the "1st dose" resident education has been performed as appropriate.

9. Remain with the resident until all medications have been taken.

    a. Never leave medications at the bedside/chairside.

10. Document in real time in the EHR medication(s) given, not given, etc.

11. Log out of the EHR. If medication cassette was brought to bedside, disinfect it and return the cassette to the medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

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

2. Do not add medication directly to an enteral feeding formula.

3. **Prior to administering the medication, stop the feeding and flush the tube with at least 15 mL of water.**

4. Dissolve the tablets, or dilute the medication in at least 30 mL of water, to sufficiently allow for medication to pass through the tube.

5. **Each medication should be administered separately. After each medication flush the tube with 15 mL of water.**

6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

7. Give medication at the appropriate time in relation to feeding.

    a. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).
    b. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.
    c. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

8. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication, and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication(s) is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document the amount of the flush used for medication administration in the flowsheet.

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. Narcotic medication administration may happen requires a two LN independent check of medication administration.
2. Prior to entering the resident's room, LN shall request 2nd LN to serve as witness for observation and dual sign off of narcotic administration.
3. As needed, and for newly admitted residents, the LN will explain to resident that due to hospital safety reasons, a second licensed nurse will observe them take their opioid medications
a. 1. Aafter performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:
    i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.
    ii. Request the resident to repeat a sentence such as "no, ifs, ands, or buts," to ensure the oral medication have been swallowed.
b. If resident declines 2nd LN observation, notify the resident the narcotic medication will be held and notify provider for further guidance.
    i. Notify the physician of refusal to follow protocol and request for follow-up such as change of order to liquid opioids or crushed medications.
    ii. If resident initially agrees to new procedure but then refuses to open mouth for inspection, stay with resident and ask 2nd LN to notify charge nurse to call physician.
    iii. Notify resident care team of refusal for discussion of alternatives and interventions.
iv. iii. Document occurrence in a nursing note and update care plan.

4. 2. Administration of buprenorphine-naloxone.
    a. Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed..
    b. Buprenorphine administration is as follows:
        i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.
            1. 5-10 minutes for sublingual tablet
            2. 3-8 minutes for film
        ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.
        iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.
    c. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).
        i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

A. Monitor resident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process, and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

2. Whenever the resident's condition warrants, and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or when there has been a change in the treatment.

3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Appendix 4, follow Manufacturer's Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

3. When using multiple inhaled medications, **wait 5 to 10 minutes between drugs** to get maximum benefit. **NOTE:** If both bronchodilator and a steroid inhaler are prescribed, **use the bronchodilator first**.

4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

5. Compressor/ Nebulizer (brand name Misty-Fast)

    a. Use with nebulizer face mask, which has medication cup and lid.
    b. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.
    c. Air source
        i. Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced.
        ii. Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.
        iii. For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO_2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.
    d. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

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

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

2. Assess the resident's response to treatment.

SPECIAL CONSIDERATIONS:

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

2. If medication(s) is not given within the time schedule, review "Appendix II: Specific Medication Administration Times and Abbreviations" to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.

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

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

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

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

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

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

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

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

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

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

SHAKING MEDICATIONS OR MIXING A SUSPENSION

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

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Scan the arm band of resident to correctly identify resident and open their eMAR.
2. Every cardiovascular drug requires vital sign monitoring as outlined below:
    a. Frequency of monitoring:
        i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.
        ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.
    b. Default parameters:
        i. Hold medication for SBP < 105 and/or hold for HR < 55.
        ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.
    c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.
    d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.

e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.

3. PRN Cardiovascular Medication Orders
    a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics
    a. Document VS and response to therapy once every shift for duration of therapy.

2. Pain
    a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT-TOSHIFT LN REPORTING

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

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

1. Application
    a. Don gloves during any time you will be touching patch.
    b. If resident currently has a patch on, remove the old patch before applying a new patch.
    c. Select appropriate site for patch, on flat area, such as chest, back, flank or upper arm. Apply patch to non- irritated, non-irradiated skin.
    d. Clip hair if needed (Do Not shave) prior to applying patch. Avoid use of oils, alcohol, or soaps to surface area as they may affect patch adhesion or drug absorption. Allow skin to dry completely before applying patch.
    e. Peel liner from the back of the patch and press patch firmly to skin using the palm of the

hand for at least 30 seconds to obtain seal.

f. Date and initial patch after application.

2. Document application and location of patch in the eMAR.

3. Verification of patch placement and monitoring
   a. Inspect site of application every shift to verify that the patch remains in place.
   b. Document verification in the eMAR.
   c. If the patch has come off, attempt to locate the patch and dispose of it. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.
   d. Do not apply heat source to the patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.
   e. If resident is diaphoretic, the patch may come off. In some instances, applying a transparent dressing covering the patch may help to keep it in place.
   f. The resident may shower, wash and bathe with the patch in place, as long as not scrubbing over the patch area which will disturb the adhesive.
4. Disposal
   a. Fold the old patch in half so that the adhesive sides are in contact and discard in medication disposal container.
   b. Document disposal on the eMAR.
   ~~b.~~ c. A waste/witness co-signature is ~~not~~ required for a used patch.

SELF-ADMINISTRATION

The resident must be assessed by the Resident Care Team (RCT), and determined to be able to safely self-administer medications and/or ordered and approved herbal supplements. See Herbal Supplements: Formulary and Non-Formulary policy.

1. Self-Administration
   a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement~~t~~ self-administration.
   b. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note.
   c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed.
   d. Orders will be entered in the EHR for medications and herbal supplements.
   e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.
   f. The resident will prepare and take their own prescribed medications ~~and/or prescribed~~ and/or ordered herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self administration preparation at each ~~medication~~ administration time and answer the resident's questions, or reinforce the teaching as indicated.
   g. If the nurse notices the resident is about to make an error, he/she will intervene to stop the preparation. He/she will also discuss and clarify with the resident the accurate manner of self-administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.
   h. The LN observing the resident taking the appropriate prescribed medications and/or

ordered herbal supplements, and the LN will document in MAR as given and will note "self-administered".

i. Education and training skills will be documented and care planned in the EHR.

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

a. Prior to providing nasal naloxone, a rescue inhaler or other approved rescue medication at the bedside, the RCT shall determine that the resident can safely self-administer the medication and an appropriate individualized plan of care shall be written.

b. Medication(s) for bedside storage must be safely stored by resident. The Pharmacy will label all bedside medications in appropriate lay-language.

c. The medication used will be recorded in the resident's health record, based on observation or resident self reporting of the medication being administered.

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See LHHPP 73-11 Medical Waste Management Program & LHHPP 25-05 Hazardous Drugs management).
   a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Nonhazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.
      i. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error, should go in medication waste bin.
      ii. Empty medication cups go in the garbage.
      iii. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.
      iv. The empty spoon can go in the garbage.
      v. If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.
      vi. For residents who are at risk for digging through the garbage, care plan your intervention to attempt to minimize and avoid this behavior.
      vii. Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage.
      viii. Empty packets of powered medications can be thrown in the garbage.

2. The LN must secure narcotics/controlled substances from time of receipt/removal from OmniCell to administration by having in physical possession or securely locked in medication cart.

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

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

wasting of the partial does.
d. Both LNs shall document the waste in Omnicell.

4. If resident refuses medication, the LN shall return the medication to original package.

   a. ~~The~~ A 2nd LN ~~who was witnessing the attempted administration to~~will provide the co-sign in Epic will also witness the waste of the controlled substance in the Omnicell.
   b. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.
      i. This may be done via looking up the IC medication tag through Lexicomp.

   c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.
   d. Both LNs shall document waste in Omnicell and the MAR.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

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

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

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

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

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

PERSONAL MEDICATION

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

e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by the LHH Pharmacy.

Personal medications will not be obtained, stored or used by residents.

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

MISSING MEDICATIONS

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

EXCESS MEDICATIONS

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

ATTACHMENTS:

Appendix I Specific Medication Administration Times

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

Appendix III – LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

REFERENCES:

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

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

AeroChamber Plus® Flow-Vu® Cleaning Instructions

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

EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler (Adults)

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

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

CROSS REFERENCES:

LHHPP File: 25-01 High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal Telephone Medication Orders
LHHPP File: 25-04 Adverse Drug Reaction Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 25-11 Medication Errors and Incompatibilities
~~LHHPP File: 25-10 Use of Psychoactive Medications~~
LHHPP File: 25-13 Herbal Supplements: Formulary and Non-Formulary
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines: Infection Control Manual

LHHPP File: 73-11 Medical Waste Management Program

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

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

Revised: 2000/10, 2006/01, 2008/01, 2010/10, 2011/03/15, 2013/09/24, 2017/01/05, 2017/11/04, 2018/07/10, 2019/03/12, 2019/07/09, 2019/09/10, 2020/01/14; 2020/03/17, 2021/02/24, 2021/09/14; 2022/05/10

Reviewed: 2022/05/10

Approved: 2022/05/10

Deletion Nursing Services Policies and Procedures

DOCUMENTING/REPORTING RESIDENT ALLERGIES/ADVERSE DRUG REACTIONS

POLICY:

Licensed nurses and other clinicians who learn of a resident's allergies and/or adverse drug reactions (e.g., medication, food, environmental, other) fare responsible for reporting and documenting this information so as to ensure patient/resident safety.

PURPOSE:

To communicate residents' allergies and/or adverse drug reactions.

PROCEDURE:

A. Upon admission and for the duration of the resident's stay, identified allergies and/or adverse drug reactions are documented in the following places:

   1. Electronic Health Record (EHR):

      a. The physician writes allergy and/or adverse drug reactions into the orders.
      b. For new allergies, for an established resident, the physician will document the allergy in EHR.

   2. Electronic Medication Administration Record and Treatment Administration Records will indicate any known allergies.

   3. Resident Identification Band: Red sticker indicates allergies.

   4. Allergy and/or adverse drug reactions information is also recorded in the EHR by clinicians at Laguna Honda Hospital and throughout the San Francisco Department of Public Health.

B. Residents should be observed for allergic reactions and adverse drug reactions throughout their stay.

CROSS REFERENCES:

Hospitalwide Policy and Procedure
25-04 Adverse Drug Reaction (ADR) Reporting Program

Nursing Policy and Procedure
B 5.0 Color Codes – Resident Identification
C1.0 Admission and Readmission Procedures
C 1.2 Relocation Procedures
C 1.3 Discharge to Acute
J 1.0 Medication Administration

Revised: 2004/12, 2010/01, 2013/09/24; 2015/07/14, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

Revised Food and Nutrition Services Policies and Procedures

1.74 Safety Inspection for Working Environment

Established and Revised: 3/87, 1/89, 5/97, 10/03, 9/06, 7/09, 6/11, 11/22
Reviewed: 8/13, 8/14

Policy: Inspections will be made on a regular basis to report substandard safety conditions in all areas of Nutrition Services Department.

Purpose: To insure a safe working environment for all employees.

Procedure:

1. On a weekly basis, with the Standard Sanitation Check List or "Mr. Clean" Food Service Supervisors or Food Service Worker will inspect the areas in each Galley located up on each floor of South, North and Link building.

2. The Chefs will inspect all food production areas, pot and pan washing area, refrigerators/storage areas, cafeteria, and dining room area.

3. Report all substandard safety conditions to the Food Service Director or Food Service Manager.

4. Follow through on substandard conditions by initiating necessary corrective action; e.g. Prepare electronic Facility Services Work Requests.

5. Follow up with re-inspection to assure substandard conditions were corrected.

6. It is the responsibility of all Nutrition Services employees to report any substandard condition that may be a safety hazard to their supervisor.

1.93 Food Preparation Standards

Established and revised: 5/98, 9/06, 7/09, 11/10, 11/22
Reviewed: 8/13, 8/14

Policy: All food items will be prepared in a manner that will ensure the best quality food product. Cooking methods will be used to conserve good nutrient value, to maintain food temperatures outside of the danger zone, and to maintain good color, texture, and flavor of the food item. Food will be cooked progressively and held for service under heated conditions for no more than 45 minutes.

Procedure:

1. All food items will be received, stored, issued and processed under the HACCP guidelines. Thawing of food products will be completed under the HACCP guidelines. Chefs will monitor this process.

2. All cold food items will be stored covered under proper refrigeration. Employees will handle the food item in batches to ensure that standards are maintained at all times. Cold Food Preparation (Advance Prep) will be monitored by the Production Chef and be assigned for completion by trained staff 24-48 hours in advance of service date.

3. All hot food items, if not being heated for service, will be stored covered in the refrigerator.

4. All hot food items will be cooked in batches and will not be left in a holding cabinet for more than 45 minutes.

5. Vegetables will be stored under refrigeration until the cooking process begins. All vegetables will be batch cooked for meal service.

6. The cooks will make temperature and quality checks on all food items prior to leaving the production area for cafeteria and tray service.

7. Cooling Down Log Policy

    a. Each day the on duty Chef or designee will check and monitor the cool down temperature of a lunch and dinner meal selection (entrée, mechanical soft = ground and puree) in addition to one other menu selection.
    b. Temperatures will be measured when the selected foods reach 140°F.
    c. All foods will be cooled in two (2") inch uncovered inserts in the blast chiller.
    d. Large cuts of meat will be cut into five (5#) pound pieces and cooled in the blast chiller.
    e. All foods must be cooled from 140°F to 70°F or below within two hours (2) hours; then from 70 – 40 F or below within four (4) hours or the food will be discarded. Chef shall take immediate corrective action if cooling is not progressing in a timely manner.
    f. All food products will be labeled, covered and stored in a refrigerator after the food reaches 40°F or lower. Food will be stored in 4" or 6" deep inserts, only after the food is at 40°F or lower.

8. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards.

a. Thawing – approved methods for thawing frozen foods include thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at room temperature is not acceptable.

b. Cooking – foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.

c. Cooling – various strategies (e.g., placing foods in shallow pans, cutting roasts into smaller portions, utilizing ice water baths, and stirring periodically) shall be implemented to cool foods so that the total time for cooling does not exceed 6 hours.

d. Holding – staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.

e. Reheating – food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165°F. Ready-to-eat foods that require heating before consumptions must be heated to at least 135°F.

9. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to:

a. Covering all foods when traveling a distance (i.e., down a hallway, to a different unit or floor).

b. Using tray lines, mobile food carts or portable steam tables transported to dining areas.

c. Washing hands properly before distributing trays.

d. Washing hands between contact with residents and after collecting soiled plates and food waste.

e. Use of gloves when touching and assisting with ready-to-eat foods.

f. Timely distribution of all meals/snacks.

10. All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination.

a. Staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment.

b. Clean dishes shall be kept separate from dirty dishes.

c. Staff shall wash hands prior to handling clean dishes, and shall handle them by outside surfaces or touch only the handles of utensils.

11. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.

a. Staff shall wash hands according to facility procedures.

b. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas.

c. Staff who exhibit a communicable or infectious disease shall be restricted from working in accordance with the facility's work restrictions/infectious diseases policy.

d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food.

e. Hairnets should be worn when cooking, preparing, or assembling food, such as stirring pots or assembling the ingredients of a salad. However, staff do not need to wear hairnets when distributing foods to residents at the dining table(s) or when assisting residents to dine.

f. Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection.

g. Staff shall keep jewelry to a minimum and cover hand or wrist jewelry with gloves when handling food.

h. Gloves will be worn when directly touching ready-to-eat foods and when serving residents who are on transmission-based precautions. However, staff do not need to wear gloves when distributing foods to residents at the dining table(s) or when assisting residents to dine unless touching ready-to-eat food.

12. Additional strategies to prevent foodborne illness include, but are not limited to:

a. Preventing cross-contamination of foods.

b. Washing fresh fruits and vegetables prior to use.

c. Keeping cut and raw fruits and vegetables refrigerated.

d. Proper refrigeration of meat, poultry, and pasteurized dairy products.
~~f.~~ e. Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines.

1.94 Safety Standards

Established and revised: 4/95, 9/06, 7/09, 11/22
Reviewed: 8/13, 8/14

Policy:

1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident.

2. Procurement (obtaining) of food will occur through sources approved or considered satisfactory by federal, state, and local authorities.

a. This provision does not prohibit the facility from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices, and the facility's policy for food grown in facility gardens.

b. This provision does not preclude residents from consuming foods not procured by the facility. Staff and residents shall follow facility policy regarding personal foods.

3. All Food will be received, stored, and processed in accordance ~~within~~with Safety Guidelines as set forth in California Uniform Retail Food Facilities Law.

Procedure:

1. 1. The Director of Food and Nutrition Services shall order food from approved sources and maintain invoices from food vendors that show the source of food acquisition and the date of delivery.
2. 2. When food is brought in from an off-site kitchen, the Director shall maintain records that the kitchen has been approved and inspected by the appropriate federal, state, or local authorities.

~~1.~~3. Food production standards are maintained through the use of ServSafe Course~~bood~~ – Fourth Edition, 2006 The National Restaurant Foundation

~~2.~~4. Many HACCP checks are performed daily through temperature monitoring by Cooks and Chefs.

~~3.~~5. At least three HACCP CQI Activities are scheduled annually to verify production safety of potentially harmful foods (such as egg salad).

~~4.~~6. These standards are made a part of every sanitation and food production in-services.

Deletion Food and Nutrition Services Policies and Procedures

1.7 Weekly Menus

Established and Revised: 3/81, 3/84, 3/85, 1/89, 5/97, 2/04, 9/06, 7/09, 7/13, 8/15
Reviewed: 8/13, 8/14, 8/15

Policy: Two weeks of menus are distributed to hospital Neighborhoods.

Purpose: To provide communication to resident and employees of the menu planned for each day for a period of two weeks.

Procedure:
Menus, as approved by the Chief Dietitian, available for viewing on each Neighborhood will consist of a two (2) week package consisting of the current weeks menu and the week after the current weeks menu, which includes substitutions. Standard Substitutes are listed in the back of each day's menu.

In addition to the English language, menus will be written in Chinese, Spanish and Tagalog.
eg:

- Diet Office Coordinator

The Diet Office coordinator (or relief) will update Resident menu for all menu line items changes within 48 hr of approved changes (by Chief Clinical Dietitian or relief). 2- Diet Office Coordinator will progressively revise dates on menus in the computer for accuracy prior to distribution to Neighborhoods by Diet Clerk

- Diet Clerk

The late Diet Clerk (or relief) will send approved and revised menus correctly dated to CCSF Distribution department at least two weeks in advance of Neighborhood posting date 2- Upon of return to LHH Nutritional Services Department the Diet Clerk delivers menus to LHH Mail room on Thursday (not later than Friday) of each week for distribution to the LHH Resident Neighborhoods by Monday morning.

The menus for the five major diets are listed. Portion sizes are printed next to all the menu items.

CBORD reports are printed on a daily basis.

Menu Substitutes are prepared for each meal. These menu substitutions are made on the Service Summary Report in the Kitchen of the Nutrition Services Department after it has been approved by Chief Dietitian or appointee.