List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on May 9, 2023

New Hospital-wide Policies and Procedures

Status	Dept.	Policy #	Title	Notes
New	_LHHPP	20-02	Hospice Care Assessment and Transfer/Discharge Process	New policy around hospice services and assessments.

Revised Hospital-wide Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Revision	_LHHPP	22-07_A01	Restraint Free Environment	1. Revised Policy #1 to state: “It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints 2. Definition of Entrapment removed, with suggestion to include this in the bed rail policy 3. Removed section referring to restraints for emergency situations as this seems to be reflective of the acute care environment. 4. Sections referring to bed rails removed. Suggest to move to a separate bed rail policy 5. Questions from Lorna to be addressed reflect facilities goal to become restraint free, yet some statements contradict this goal.
Revision	_LHHPP	22-10	Management of Resident Aggression	1. Added LHH Behavioral Response Team (BRT), LHH Psychiatry clinicians to assist RCT during aggressive or hostile situations 2. Added clinical staff shall implement the recommendations made by LHH Psychiatry clinicians 3. Updated implementing recommendations across shifts for some residents that require additional support. 4. Added Target behaviors as indicated by physician's ordered to RCT assessments 5.Under Interventions, Add LHH BRT may be notified to provide staff support regarding nonviolent safety interventions and assist staff in identifying early signs of resident distress 6. Added if needed, RCT may request SFSD assistance 7. Updated RCT shall meet as soon as possible to update Plane of Care 8. Updated care plan shall be supported by LHH BRT members, as appropriate 9. Updated medical and nursing leadership shall be consulted for obtaining additional assistance, resources, and appropriate disposition of resident. 10. Added notification section 11. Updated references
Revision	_LHHPP	22-11	Resident Freedom from Abuse on Social Media	1. Added prior to recording resident, written consent must be completed. 2. Added "written" to consent throughout policy 3. Added LHH units shall conspicuously post signage reminding individuals of photography and video recording prohibition

Revision	_LHHPP	22-12	Clinical/Safety Search Protocol	1. Added prior to any search, it is recommended a BRT will be present to support resident behavioral health. Additional support such as security-provider will be proved. 2. Updated SFSO deputy shall be contacted if there is reasonable cause that the resident presents a danger to themselves and others.
Revision	_LHHPP	24-06	Resident /Patient and Visitor Complaints/Grievances	1. Added Administrative Director shall act as the Grievance Officer and will be managing the whole grievance process 2. Added grievance forms and submission boxes will be located near the elevators of each neighborhood and grievances can be submitted without LHH staff assistance. 3. Added Resident/Patient Safety Advocate or designee will pick up suggestion box contents. 4. Added grievances shall be logged into the grievance log and assigned to appropriate departments for timely follow up. 5. Added new grievance data section and reporting committees.
Revision	_LHHPP	24-16	Code Blue	Added "16. CPR data is collected and managed via the defibrillator into a software system for quality improvement purposes. Access to the software system is limited to code blue committee team leaders. No PHI is to be entered into the data system. The system will be audited monthly to ensure no PHI data has been entered." to the Policy section.
Revision	_LHHPP	50-02	Resident Trust Account	1. Added A&E will assist resident with setting up a LHH Trust Account 2. Added checks for discharged or expired residents shall be returned to sender 3. Updated Interest incurred section. 4. Updated ADL to Epic 5. Updated trust account quarterly statements will also be sent to legal representative via mail. 6. Updated overpayments to include checking with SSA to confirm no overpayment is due to SSA before returning funds. 7. Added MSW or designee can/will assist resident with withdrawals and authorization from A&E Financial Counselor is need for amounts up to $100. 8. Added A&E sup visor or manager need to approve amounts over $100. 9. Added resident can access funds 7 days a week (including weekends and holidays) and process in obtaining funds not during Cashier Office hours. 10. Added amounts less than $100 will be approved the same day and over $100 will be approved within 3 banking days (weekdays).
Revision	_LHHPP	72-01	C23 Pneumococcal Immunization	1. Added "the pneumococcal polysaccharide vaccine and/or pneumococcal conjugate vaccine as defined by most current pneumococcal vaccine recommendations" to Policy.
Revision	_LHHPP	75-10	75-10 Appendix H: Visitors Screening Processing	1. Replaced security- provider with Sheriff's Office (SFSO)

Deletion OP Clinic Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Deletion	OP Clinic	A4	Clinic Appointment Scheduling for Community Clients	Request to delete as LHH no longer accepts community referrals nor scheduling
Deletion	OP Clinic	C6	Steam Sterilization	Request to delete as it's not done at LHH anymore.

Revision EVS Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Revision	EVS	X	Equipment, Supplies and Chemicals	1. Added Micro-Kill Bleach Germicidal Wipes to Chemicals (Ready to Use)
Revision	EVS	XVII	Transport, Delivery Time for Biohazard, Trash and Linen	1. Added and updated clean linen delivery section with mentions of the vendor and storage/transport of clean linens.

Revision FNS Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Revision	FNS	1.1	Food from Home or Outside Sources Served Directly to Residents	1. Added residents have the right to accept food from visitors, family or friends as long as it's been identified as non-facility prepared food 2. Updated perishable food is to be labeled with resident's name, date received and expiration date and kept in the designated resident refrigerator 3. Updated food is discarded after 72 hours or per manufacture's recommendation. Any outside food that is not properly labeled will be discarded 4. Added Nursing staff is responsible with labeling, dating and discarding items prior to expiration and nursing staff is responsible for assisting the resident in accessing and consuming the outside food, if the resident cannot do it on their own. 5. Added food from home cannot be accepted, stored, heated, or served by FNS department. 5. Added staff members who receives, labels and dates the food is responsible for either alerting FNS or providing education ton safe food handling. 6. Updated references

Revision Nursing Policies and Procedures				
Status	**Dept.**	**Policy #**	**Title**	**Notes**
Revision	NPP	K 1.0	Assessment and Management of Pressure Injury	1. Appendix 1: Definition of Pressure Injury and Intervention updated by Ossie to include pictures are detailed information 2. Appendix 2: Delete current Skin Care Formulary and change to NEW Laguna Honda Hospital Wound Care Supply List 3. Appendix 3: Changed to Waffle Overlay (Currently Appendix 4) – No changes to appendix content 4. Appendix 4: Deleted (See new Appendix 3) 5. Updated by Ossie and team 6. NEC Change: Rewrote policy #4 to state "Wound, Ostomy, and Continence RNs (WOCNs), trained wound care champion RNs, or physicians can identify and stage pressure injuries,"
Revision	NPP	K 3.0	Wound Irrigation and Cleaning	1. Revised to incorporate Vashe product
Revision	NPP	K 10.0	Prevention and Management of Skin Tears	1. Split policy #1 into 2 separate statements 2. New background statement 3. Added section on skin changes associated with aging 4. Revised Prevention of Skin tear section 5. Added how to manage skin tears to the section titled "Treatment of Skin Tears" 6. Updated equipment list 7. Incorporated Vashe 8. Revised how to care for skin tear without flap or hematoma: Deleted transparent or foam dressing, changed this to non-adherent dressing and foam dressing to be changed daily 9. Added to continue skin tear prevention protocols when tear heals 10.Updated references and documentation section

New Hospital-wide Policies and Procedures

HOSPICE CARE ASSESSMENT AND TRANSFER/DISCHARGE PROCESS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) provides skilled nursing services to a broad range of residents, including those needing end of life care.

2. LHH provides palliative care services directly to the residents within in the facility who are in need of this service.

3. All LHH residents shall be informed of process for hospice services and serviced provided by LHH.

4. For residents who may qualify for hospice services under their Medicare or Medi-Cal benefits, LHH shall:

    a. Inform qualifying residents of their covered hospice service benefits and educate them about the difference between LHH's palliative care services and Medicare and/or Medi-Cal-certified hospice services;

    b. If desired, LHH may attempt to arrange for the provision of hospice services through an agreement with one or more Medicare and/or Medi-Cal-certified hospice organizations or,

    c. If such an agreement(s) has not been arranged, LHH shall assist the qualifying resident to transfer to a facility of the resident's choice that will arrange for the provision of hospice services when the resident requests a transfer.

DEFINITION:

"Discharge" means movement of a resident outside of the certified LHH skilled nursing facility in either of the following instances: (1) To a bed in an acute care facility, including but not limited to the licensed general acute care portion of LHH; or (2) To the community, which may include the resident's home or a facility that provides a lower level of care.

"Facility-initiated Transfer or Discharge" means a Transfer or Discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

"Hospice care" means a comprehensive set of services described in Section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

"Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

"Resident-initiated Transfer or Discharge" means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

"Terminally ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

"Transfer" means the movement of a resident outside of the certified LHH skilled nursing facility in either of the following instances: (1) To a bed in an emergency department; or (2) To another certified skilled nursing facility. Transfer does not refer to movement of a resident to a bed within LHH's skilled nursing facility.

PROCEDURE:

1. At the time of admission and at any time that hospice services are deemed appropriate, LHH shall inform each resident and/or their surrogate decision maker (SDM) about available hospice service providers.

    a. LHH shall inform each resident and/or the SDM that residents who qualify for the Medicare or Medi-Cal hospice services benefit may either elect to opt out of the benefit and remain at LHH, or elect to Discharge or Transfer to a facility that offers such services to utilize the benefit.

    b. If a resident chooses a hospice service provider that does not have an agreement with LHH, then LHH shall assist the resident in Discharging or Transferring, as detailed herein.

    c. If LHH has an agreement with the hospice service provider that the resident chooses, the resident's care will be coordinated pursuant to the terms of the agreement between LHH and the hospice service provider and all applicable LHH policies.

2. Physicians, in partnership with the Department of Care Coordination, shall identify residents who may meet the criteria for hospice services.

    a. To determine qualifying residents for Medicare, the resident would be entitled to Part A of Medicare and certified as being terminally ill. (42 C.F.R. § 418.20).

    b. To determine qualifying residents for Medi-Cal, the resident would be entitled to Medi-Cal, certified as being terminally ill, and voluntarily elect to receive hospice

services in lieu of palliative care services related to the terminal condition. (22 CCR § 51180).

3. The physician shall document the terminal illness in the resident's electronic health care record (EHR).

4. Residents who are eligible for hospice services and elect to use their benefit are entitled to the following covered services:

   a. Nursing care provided by or under the supervision of a registered nurse.

   b. Medical social services provided by a medical social worker under the direction of a physician.

   c. Physicians' services performed by a physician (if resident is a Medi-Cal beneficiary, the physician must be enrolled in Medi-Cal).

   d. Counseling services, including dietary counseling, provided to the terminally ill individuals and family members or other persons caring for the individual.

   e. Short-term inpatient care at a participating hospice care inpatient unit or participating hospital or SNF.

   f. Medical appliances and supplies, including drugs and biologicals.

   g. Home health or hospice aide services furnished by qualified aides.

   h. Physical therapy, occupational therapy and speech-language pathology services.

   i. Any other service specific in the plan of care as reasonable and necessary for the palliation and management of the resident's terminal illness and related conditions for which payment may otherwise be made under Medicare.

5. Residents who opt out of hospice services and elect to remain at LHH are entitled to receive skilled nursing services which includes palliative care services. This encompasses and is not limited to:

   a. Focus on goals of care which take into account the hopes and concerns of the residents and family.

   b. Symptom management of the resident.

   c. Advance care planning.

   d. Celebrations of life such as holiday parties, birthday celebrations, musical entertainment, etc.

e. All other applicable skilled nursing services available to all LHH residents.

6. If a resident elects to use the Medicare or Medi-Cal hospice care services benefit and chooses a hospice service provider that does not have a written agreement with LHH, then LHH shall:

   a. Document the resident's election in the EHR.

   b. Attempt to establish a written agreement with the hospice service provider to allow services to be provided in LHH.

   c. Assist the resident, when the resident requests, in:

      i. Discharging to a facility that provides hospice services or to the community if appropriate, or

      ii. Transferring to a SNF that has an appropriate agreement with a CMS certified hospice service provider, or

      iii. Has an agreement with the hospice provider chosen by the resident, consistent with LHHPP 20-04 Discharge and Transfer Process.

      Such Transfers or Discharges are considered a Resident-initiated Transfer or Discharge.

7. If a resident intends to opt out of the hospice care services benefit and remain at the facility, LHH shall document the resident's decision in their EHR.

   a. If the resident opts out of the hospice services benefit, the resident shall continue to reside at and receive applicable services from LHH.

ATTACHMENT:
None.

REFERENCE:
None.

Original adoption: xx/xx/xx (Year/Month/Day)

Revised Hospital-wide Policies and Procedures

~~PHYSICAL RESTRAINTS/SKILLED UNITS~~ Restraint Free Environment[CC1][G(2]

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.~~ It is the policy of

~~2.~~1. this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

~~3.~~2. LHH supports preventing, reducing, and eliminating the use of restraints and restraint-associated risk through preventive strategies, alternatives, and process improvements.

~~4. The restraint shall be discontinued as soon as it is safe for the resident and staff regardless of the scheduled expiration of the restraint order.~~

~~5. Each restraint order is valid only for the specific occurrence of application and cannot be written as a standing or PRN order.~~

~~6.~~3. The restraint consent form shall be updated annually.

~~7.~~4. **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.

~~8.~~5. 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 if necessary to utilize the least restrictive device only when other less restrictive have been ineffective to provide safety.

DEFINITIONS:

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

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

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

a. The 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.

~~3. Entrapment: is an event in which a resident is caught,~~[G(3]~~ trapped, or entangled in the space in or about the bed rail.~~

~~4.~~3. Chemical restraints are defined as any drug that is used for discipline or convenience and not required to treat medical symptoms

~~5.~~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.[G(4][T(5]

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

~~6.~~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.

~~7.~~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

~~8.~~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.

~~9.~~8. Discipline: any action taken by the facility for the purpose of punishing or penalizing residents.

~~10.~~9. Manual Method: to hold or limit a resident's voluntary movement by using body contact as a method of physical restraint

~~11.~~10. Medical symptom: is defined as an indication or characteristic of a physical or psychological condition.

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~~STANDARDS / GUIDELINES FOR RESTRAINT USE:~~ Compliance Guidelines

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. A physician order must be completed via EHR.~~ The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.

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

   ~~Physical restraints may be used in emergency care~~[C(6][CC7] ~~situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question.~~[R(8]

   ~~LHH recongizes that falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a 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.~~ [G(9]

   [R(10]

2. ~~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.~~

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

~~4.~~2. 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.

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 [G(11]body. [R(12]

~~5. 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.~~

~~6.~~3. ~~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." tely accountable for the resident's care and safety, including clinical decisions."~~ The resident/resident's representative may request the use of a physical restraint, however the facility is responsible for evaluating the appropriateness of the request. The facility shall explain to the resident/resident's representative, the potential risks and benefits of using a restraint, not using a restraint, and alternatives to restraint use. Potential negative outcomes should also be explained including, but not limited to:

- Decline in physical functioning
- Decreased muscle condition
- Contractures
- Increased risk for infection
- Pressure ulcers/injuries
- Delirium
- Agitation
- Incontinence

- Accidents such as falls, strangulation, or entrapment
- Loss of autonomy and dignity
- Withdrawal or reduced social contact [R(13]

~~9. Prior to bed rail use, must consider the use of appropriate alternatives. 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.~~

~~10. Safety assessments shall be completed for residents who use bed rail(s).~~

~~11. 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.~~

~~12. 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.~~

~~13. Continued bed rail use requires at a minimum, a quarterly bed rail safety assessment by the RCT.~~

~~14. 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.~~

~~15. 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.~~[G(14]

PROCEDURE:

1. **Procedure for Using Restraints Determined as Medically Necessary:**

   a. Before applying a new restraint:

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

         - RTC will discuss:
            - Circumstances leading to the use of restraints and what alternative interventions were tried first

               1.a.i...1. 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

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

      2. When a decision is made to order a new physical restraint:[R(15]

      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~~ Resident Care Team will obtain consent for physical restraint. Consents must include discussion with the resident or resident representative regarding:

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

         - Type of restraint and duration of use.

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

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

b. Obtaining a Restraint Consent is a team effort which starts with the RCT determining the need for the restraint and discussing with resident/resident decision maker to discuss potential risks and benefits. Physicians will document the medical need for the restraint and sign the form, and either the physician or other members of the RCT can complete the remainder of the form, including obtaining resident/resident representative signatures.

i. Nursing will update the resident's care plan 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.

~~ii. 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.~~[R(16)]

~~iii.~~ii. The RCT will meet in a timely manner to discuss alternatives and plan for tapering and discontinuation of restraints.

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 ~~-~~to be used.
- Referrals to ancillary departments, as appropriate.
- Continuation of restraint use must be renewed via EHR.

~~3. **PROCEDURE for Bed Rail U~~[G(17]~~se:~~

~~a. 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.~~

~~b. 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?~~

~~c. 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.~~

~~d. 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.~~

~~e. Use of bed rails shall be ordered by the physician via EHR. Physician will complete consent~~

~~a. 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.~~

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

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

~~h. 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.~~

~~i. 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.~~

DOCUMENTATION

~~1. The condition of the resident utilizing a restraint shall be monitored every 2 hours.~~[G(18] Staff will provide ongoing monitoring and evaluation for the continued use of a physical restraint.

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

i. Any changes to circulation (including vascular checks such as capillary refill, temperature, edema and color of skin), Skin integrity of the restrained extremity(ies) if used.

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 nursing summary by the Licensed Nurse.

Monitoring and supervision are to be documented via EHR on the ~~following:See~~following: See Standard work for procedures in ~~reguards~~regards to restraint documentation. [G(19]

Monitoring will include:

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

~~ii.~~iii.

~~iii.~~iv. Hydration/meals

~~iv.~~v. 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 .)

3. Staff Training

   a. Nursing Staff[CC20][G(21] 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.).

REFERENCE:
State Operations Manual Appendix PP - Survey Protocol, Regulations and Interpretive Guidelines for Long Term Care (Rev. 173, 11-222017)

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, 22/12/13 (Year/Month/Day)
Original adoption: 96/07/15
Standard Work Document: ????

MANAGEMENT OF RESIDENT AGGRESSION

POLICY:

1. It is the policy of the San Francisco Department of Public Health to provide services in an environment that is safe and secure for all residents, employees and visitors. In order to achieve this, violence or threats of violence will not be tolerated from employees, residents, and visitors.

2. Laguna Honda Hospital and Rehabilitation Center (LHH) employees, volunteers and residents shall make every effort to minimize the risk of aggressive/hostile events.

3. LHH shall establish a consistent and uniform response to any aggressive/hostile situations should they occur.

4. Management of potential or actual aggressive or hostile situations occurring in a neighborhood shall be the responsibility of the Resident Care Team (RCT) with the assistance of the LHH Behavioral Response Team (BRT), ~~the~~LHH ~~Behavioral Health~~Psychiatry clinicians (as needed[Q(1)]), and the San Francisco Sheriff's Department (SFSD) ~~and the LHH Psychiatry staff~~ as needed.

5. Management of potential or actual aggressive/hostile situations occurring in public spaces shall be the responsibility of the SFSD with assistance from the RCT and ~~the~~ LHH Psychiatry staff as needed.

PURPOSE:

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

PROCEDURE:

1. Staff Education

a. New employees shall be provided with training on nonviolent safety management and prevention of challenging behaviors during their orientation.

b. Clinical staff shall be provided with annual updates on nonviolent safety management and prevention of challenging behaviors strategies.[M(2)][KC3]

c. Annual updates on nonviolent safety management and prevention of challenging behaviors strategies are also available for non-clinical staff members.

d. All staff shall receive annual in-service on Prevention of Violence in the Workplace.

e. For resident with challenging behaviors and existing behavioral plan recommendations (Section 4d below), clinical staff shall ~~make the effort to "Break the Glass" in Epic and~~ [Q(4)]implement the recommendations made by LHH Psychiatry clinicians (if any)~~Behavioral Health~~.

f.

~~e.~~g. Nursing staff may receive case-specific education and/or supervision to facilitate effective implementation of recommended interventions across all shifts for some residents that require additional support~~.~~

2. Assessment and Reports

a. Pre-Admission Assessment

i. The behavioral screener (a designated LHH Psychiatry clinician) will screen referrals of individuals with a history of significant psychiatric and/or behavioral problems upon request from the LHH Admission Committee. (LHHPP 20-01 Admission to Laguna Honda & Relocation between SNF Units, Appendix B) The screener shall communicate recommendations for managing potential behavioral problems to the LHH Admission Committee.

b. Nursing Assessments

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

c. Resident Care Team (RCT) Assessments

i. The RCT assesses and monitors the resident's behaviors through:

- Daily observations
- Target behaviors as indicated by physician's ordered
- Review of EHR documentation to identify, track and review the potential risk behaviors. Examples: Behavioral Monitoring Flow Sheet, physician and nursing progress notes, Drug Regimen Review notes
- Regular review and revision of the resident's plan of care
- Discussions during Resident Care Conference
- Unusual Occurrence (UO)
- Behavioral Management Huddles/Rounds
- Feedback from LHH Psychiatry clinicians as a part of their consultations to the RCT and/or ongoing behavioral health treatment for the resident.

d. Behavioral Health Assessments

Upon referral by the primary physician, LHH Psychiatry clinicians provide behavioral health assessment, treatment and consultation for the resident. This may include: psychiatric medication management, mental health treatment, substance use treatment, neuropsychological assessment, behavioral consultation, as well as assistance to RCT in developing and implementing a resident's behavioral management plan.

3. Intervention

a. On LHH Neighborhoods/Units

i. In case of escalating aggressive behavior by a resident:

- The RCT is responsible for using nonviolent safety management and prevention of challenging behaviors principles to attempt to safely defuse actual or potential aggressive/hostile situations that occur on the unit.

~~If needed, the RCT may request the assistance of the SFSD by dialing 4-2319, and giving their name, location, and the nature of the aggressive/hostile event.~~

- The LHH Behavioral Response Team (BRT) may be notified to provide staff support regarding nonviolent safety interventions and assist staff in identifying early sign of resident distress.

- If needed, the primary physician may request the assistance of LHH Psychiatry provider to:
  - perform urgent assessment for possible 5150
  - provide urgent behavioral health interventions as indicated, e.g. psychotropic medication adjustment, crisis counseling
  - initiate new or review existing behavioral plan to mitigate risks for ~~prevent~~t future escalation

- If needed, the RCT may request the assistance of the SFSD by dialing 4-2319, and giving their name, location, and the nature of the aggressive/hostile event.

b. Outside of LHH Neighborhoods/Units

i. In case of actual or potential aggressive/hostile situations by a resident occurring in public areas:

- Employees, volunteers, or visitors in the area shall call 4-2319 and report the event to the SFSD~~.~~

- If any employees are present, they are responsible for using nonviolent safety management and prevention of challenging behaviors principles if able to safely attempt to defuse the situation, while waiting for assistance from SFSD.

- The SFSD may request assistance from the RCT where the resident resides or from LHH Psychiatry staff to further manage the disposition of the resident.

4. Management of Resident Aggressive/Hostile Behaviors

a. In case of an aggressive/hostile event involving weapons, or situations that pose risk of violence or injury, staff can call 4-2999 using the "Dr. Grey" code.

b. If the aggressive behavior is displayed by a resident, the unit physician shall assess the likely cause of such behavior and intervene accordingly, including consulting RCT members, BRT members, and calling the LHH Psychiatry urgent pager or after-hours on-call psychiatrist as needed.

c. The RCT shall assess for environmental and/or psychosocial factors.

d. The RCT shall initiate the behavioral plan and revise the plan of care to ensure safety for all. Ongoing revisions should be based on careful and consistent observation of result of plan implementation.

e. Any plan must be communicated to all shifts to ensure consistency in follow-through.

f. In the event staff require assistance and wish to summon assistance from the SFSD discretely, staff may use their duress tag and/or the duress buttons located under the desk in each nurse's station and in the living rooms at the end of the hallway of each household.

5. Follow-up of Resident Aggressive/Hostile Incidents

a. If it is determined that the resident who displayed aggressive/hostile behavior can continue to be safely cared for at LHH:

i. The RCT shall meet as soon as possible ~~by the next business day~~[M(5)][Q(6)][Q(7][KC8][Q(9]— to develop and/or update the Plan of Care. (RCT members working on the weekends and off hours can meet and update the Plan of Care. This can be re-evaluated the next business day.) Any LHH Psychiatry clinician(s) already working with the resident shall be notified and included in the review.

ii. The RCT shall refer the resident for behavioral health consultation as clinically indicated, if LHH Psychiatry clinicians are not already involved.

iii. A copy of the plan is provided to the resident, if appropriate.

iv. The plan shall be supported by LHH BRT members, as appropriate and must be communicated to all shifts to ensure consistency.

b. If the resident is medically stable and can be safely discharged to the community:

i. The physician may discharge the resident.

ii. The Medical Social Worker, or designee, shall complete the Notice of Transfer/Discharge, explain the Notice and issue the Notice to the resident.

iii. If a discharged resident refuses to leave the facility, the SFSD will be contacted.

c. If the resident medically requires LHH services but cannot be safely cared for at LHH due to aggressive/hostile behavior:

i. The physician shall contact LHH Psychiatry urgent pager or the after-hour on-call psychiatrist for urgent consultation.

ii. The RCT shall update the Plan of Care as soon as possible, provide necessary monitoring and supervision to reduce safety risks.

~~ii.~~iii. Medical and nursing leadership shall be ~~contacted for~~ consult~~ed~~ation for obtaining additional assistance, resources, and/or identifying appropriate disposition for the resident.~~as needed.~~

6. Resident Victims of Physical Aggression

a. The resident shall be examined by a physician and appropriate treatment shall be initiated.

b. Support and counseling will be provided by delegated members of the RCT.

c. If indicated, a referral to LHH Psychiatry for consultation and follow-up will be made by the primary physician.

d. The resident will be observed until baseline behavior and mood indicate stability and goals are met as specified in the plan of care.

7. Staff Witnesses or Victims of Aggression

a. The nurse manager or nursing director shall meet with involved staff to determine need for debriefing or defusing post-incident by the members of BRT.

b. Follow procedures from LHHPP 73-05 Workplace Violence Prevention Program, including DPH Employee Assistance Program (EAP) who may be contacted by the nurse manager or nursing director if further emotional support for unit staff is needed.

8. Notification

a. Following any resident altercation, ~~A~~all appropriate parties shall be notified; ~~i~~ including but not limited to:

i. LHH Quality Management

ii. Ombudsman

iii. Family of resident or surrogate decision maker

iv. California Department of Public Health

~~8.~~9. Documentation

a. A Focused Progress note is entered into the resident's electronic health record (EHR), including an objective description of the behavior, interventions attempted, outcomes, and follow-up measures taken. This note is the responsibility of licensed nurse as well as any RCT staff involved in the situation.

b. Unusual Occurrence (UO)

i. Following an aggressive incident, the staff witness of the event is expected to file a UO.

ii. The incident shall be entered in the Resident's Behavioral Monitoring Flowsheet in the EHR.

iii. Review and revise the Resident's care plan as described under Section 6 above.

ATTACHMENT:

~~Appendix 1: Behavioral Management Process Flow Chart~~[M(10][Q(11]

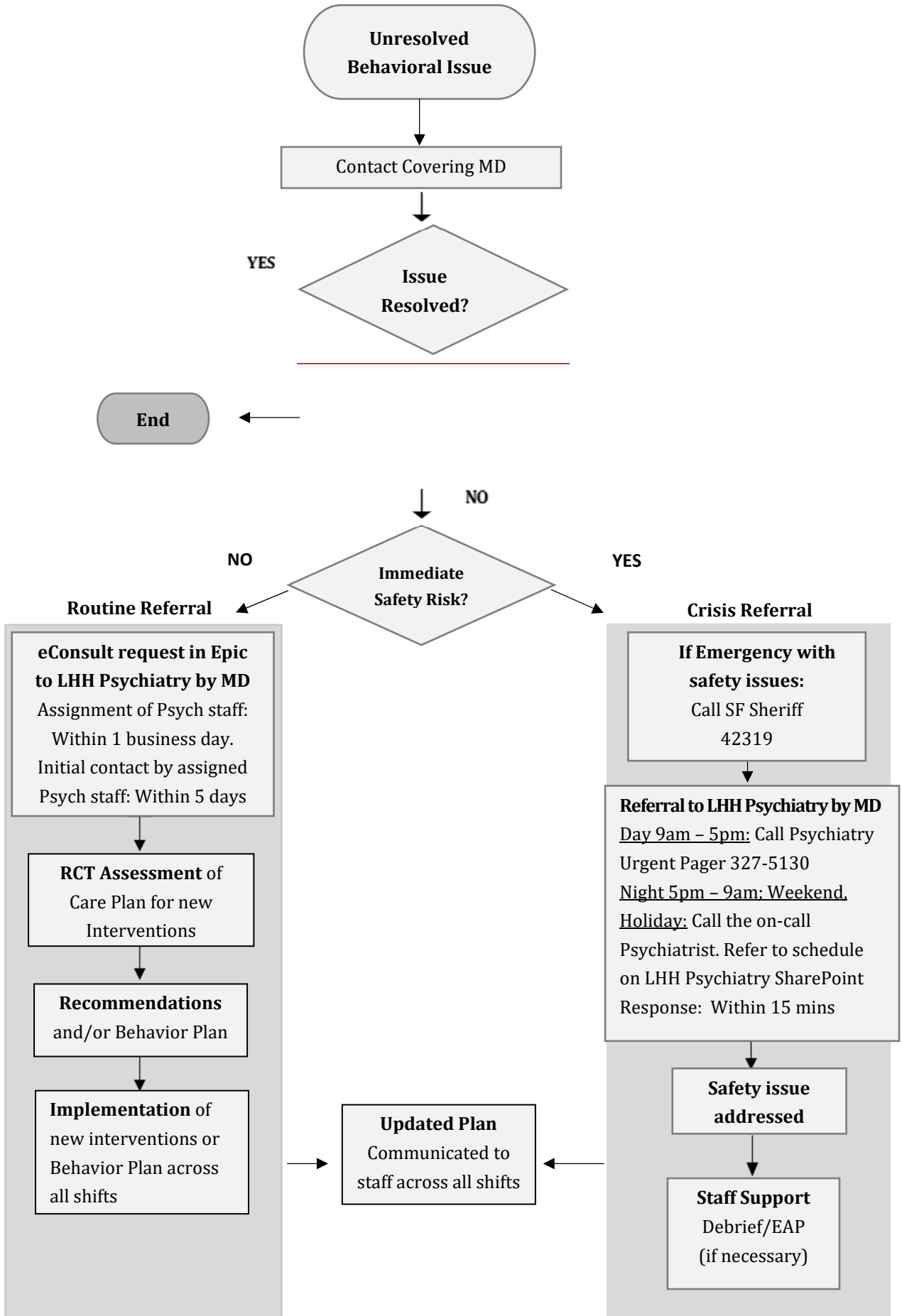
REFERENCE:

LHHPP 20-01 Admission to Laguna Honda & Relocation Between SNF Units
LHHPP 20-04 Discharge Planning
LHHPP 23-01 Resident Care Plan, Resident Care Team and Resident Care Conference

LHHPP 24-28 Behavioral Health Care and Services
LHHPP 60-04 Unusual Occurrences
LHHPP 73-05 Workplace Violence Prevention Program
LHHPP 75-04 Calls for Sheriff's Assistance
LHHPP 75-06 Dr. Grey Code
LHHPP 76-04 Violence in the Workplace: Zero tolerance
Nursing Behavioral G6.O Risk Assessment & Guidelines for Care Planning P& P
Nursing P&PJ2.5 Monitoring Behavior & Effects of Psychoactive Medications
Physician P&P DO8-01 Acute Psychiatric Emergencies

Revised: 2010/06/08, 2016/01/12, 2019/09/10, 2020/09/08, 2021/10/12, 2023/02/14 (Year/Month/Day)
Original adoption:

Appendix 1: Behavioral Management Process Flow Chart




Staff Support
Debrief/EAP
(for ongoing stressors
or safety issues)

RESIDENT FREEDOM FROM ABUSE ON SOCIAL MEDIA

POLICY:

1. The Resident Freedom from Abuse on Social Media policy provides guidance to Laguna Honda Hospital and Rehabilitation Center (LHH) staff regarding a resident's right to personal privacy and dignity of not only his/her own physical body, but also of his/her personal space, including accommodations and personal care.

Taking photographs or recordings of a resident and/or his/her private space without the resident's, or designated representative's prior written consent, is a violation of the individual's right to privacy and confidentiality.

Posting photographs or recordings of a resident and/or his/her private space that demean or humiliate ~~a resident~~them is mental abuse and is prohibited even if the resident or designated representative granted verbal or written consent.

PURPOSE:

It is the intent of this policy to support the effective and responsible use of social media, to protect the privacy and dignity of LHH residents and staff, and to ensure compliance with Federal Health Insurance Portability and Accountability Act (HIPAA) and State privacy regulations.

DEFINITION:

For the purpose of this policy LHH staff includes employees, consultants, contractors, volunteers, and other caregivers who provide care and services to residents on behalf of the facility.

PROCEDURE:

1. Prior to recording a resident, complete a written Consent to be recorded / Authorization for publication form. This form can be found https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAAPolicies.asp

~~1.~~2. Protecting Resident Privacy – Prevention of Abuse on Social Media[LM(1][T(2][LM(3]

a. Abuse Prohibition

i. A photograph or recording of a resident that demeans or humiliates the individual, regardless of whether the resident has provided written consent and regardless of the resident's cognitive status is mental abuse.

- Photographs or recordings that demean or humiliate include photographs and recordings of residents that contain nudity, sexual and intimate

relations, bathing, showering, toileting, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part without the individual's face whether it is the chest, limbs, or back, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position.

i. LHH staff shall not take or use photographs or recordings in any manner that demean or humiliate a resident.

ii. LHH staff shall not keep, distribute, or post a photograph or recording, or link to a photograph or recording, in any format including on social media that demeans or humiliates a resident is prohibited.

iii. LHH staff shall not post statements that demean or humiliate a resident on social media.

b. If an employee sees social media posting(s) that demeans or humiliates a resident as described in Procedure 1, the employee is responsible for reporting such posting to their supervisor and/or to the Quality Management (QM) department and shall submit an Unusual Occurrence (UO) report.

c. Protecting Resident Confidentiality

i. LHH employees shall comply with all LHH and San Francisco Department of Public Health (DPH)-wide policies regarding the confidential information of a patient/resident and relating to the use of social media, including:

- LHHPP 21-01 Medical Records Information: Confidentiality and Release;
- LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response;
- SFDPH HIPPA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI~~); and~~); and
- SFDPH HIPPA Compliance – Social Media Policy.

~~2.~~3. Compliance

a. DPH and LHH reserve the right to request to have online communications stop if DPH or LHH believe communications from an employee, physician, fellow, patient, resident, volunteer, and/or students are in violation of organizational policies, values or local, state or federal laws privacy laws.

b. Violations of this policy shall be reported to the Compliance Office and to the ~~Quality Management~~QM department.[ML4][T(5][LM(6]

c. Violations shall be investigated to determine the nature, extent and potential risk to the hospital. Refer to LHHPP 22-01~~:~~ Abuse Prevention, Identification, Investigation and Response for investigation procedures.

d. All LHH staff who witness or are informed of a violation of this policy, including suspected abuse as clarified in this policy, shall follow the protection and reporting protocols, and other processes outlined in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.

e. All LHH staff who violate this policy shall be subject to the investigation protocol and other processes outlined in LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response.

~~e.~~f. LHH units ~~are ?encouraged/required?~~[LM(7][L(8]~~shallto~~ conspicuously post signage reminding individuals of the ~~social media practices~~photography or video recording prohibition.

ATTACHMENT[LM(9][T(10]**:**
None.

REFERENCE:
LHHPP 21-01 Medical Records Information: Confidentiality and Release
LHHPP 22-01 Abuse Prevention, Identification, Investigation and Response
CMS Survey & Certification: 16-33-NH
SFDPH HIPPA Compliance – Patient/Client Resident Rights regarding Protected Health Information (PHI)
SFDPH HIPPA Compliance – Social Media Policy

Revised: 20/10/13 (Year/Month/Day)

Original adoption: 16/11/08

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.

4. Facility staff will have knowledge of signs, symptoms, and triggers of possible 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, 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.

    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 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, 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.

7. If facility staff identifies items or substances that pose risks to residents' health 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

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, 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.

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

a. LHH clinical or facility staff may initiate searches to ensure the health and safety of residents and staff 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.

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 be requested prior to any search. ~~-~~ ~~I~~t is recommended that a member of the Behavioral Response Team, BRT, be present to support the behavioral health of the resident and to prevent escalating behavior during the search. Additional support will be provided by the contract-security-provider to assistance as a deterrent or backup to the hospital staff's actions, and under the direction of a physician, affiliated professional, or nurse, moderate or prevent any escalating behavior.

e. A SFSO deputy should be contacted when there is reasonable cause to believe that a resident presents a danger to themselves and others.

~~d. present for searches that involve a resident who may display behavioral escalation during the search.~~

~~e.~~f. 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.

~~f.~~g. 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.

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

~~h.~~i. 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 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 a member of the Behavioral Response Team, BRT, to support the behavioral health of the visitor and to prevent escalating behavior during the search. Additional support will be provided by the contract-security-provider to assistance as a deterrent to moderate or prevent any escalating behavior.

A SFS~~D~~DO Deputy should be called when there is reasonable cause to believe that the visitor presents a danger to themselves and others. ~~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, 22/12/13 (Year/Month/Day)
Original adoption: 19/03/12

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.

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

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

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.

6. When methods for resolving concerns have not been successful and residents/patients/visitors choose 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 manner.

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.

8. The 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.

~~7.~~

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.
   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.

~~3.~~4. Grievance forms and submission boxes shall be located near the elevators of each neighborhood so that residents, families and visitors may submit grievances without the assistance of LHH staff.

~~4.~~5. 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 Resident/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.~~6. 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~~ may be submitted via the Grievances boxes near the elevators on the neighborhoods, 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.~~7. 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~~near the elevators on the neighborhoods, at the Pavilion lobby entrance (ground floor), Out-patient clinic lobby (first floor Pavilion) and the Administration lobby.

~~7.~~8. Contents from Suggestion boxes shall be picked up Monday through Friday, excluding holidays by ~~a designee from Administration~~the Resident/Patient Safety Advocate or designee. Complaint/Grievance forms and Suggestion forms sent via email shall be routed to the Administrative Director or their designee.

~~8.~~9. The Resident/Patient Safety Advocate, with guidance from the Administrative Director as needed,~~r~~ shall triage the complaint/grievance. The grievance shall be logged into the grievance log and assigned to the appropriate departments for timely follow up.

~~1. The 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.~~

~~Grievance data will be analyzed for trends and patterns by the Grievance Official and will be reported out in the following committes and meetings:~~
~~Weekly at the Executive Committee meeting to ensure leadership have the opportunity to address complaints during leadership rounding. Discussion of the data shall be documented in the minutes.~~
~~a. Monthly at Resident Council and during Community Meetings. Discussion of the data shall be documented in the respective groups' meeting minutes.~~

~~9.~~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.

~~10.~~11. If the complaint/grievance is anonymous, follow up with the ~~complaintant~~complainant 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.

~~11.~~12. The Grievance Official shall respond to the complaint/grievance with a final resolution in 30 business days.

~~12.~~13. Appropriate corrective action(s) shall be implemented by the facility if an alleged violation of resident's rights is confirmed.

~~13.~~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. Complaints/grievances shall be evaluated and analyzed by the Grievance Official with respect to type, timely follow-up, trends, identification of problems/process gaps and the prevention of similar future problems. Data will be reported out in the following committes and meetings:
    a. Weekly at the Executive Committee meeting to ensure leadership have the opportunity to address complaints during leadership rounding. Discussion of the data shall be documented in the minutes.
    b. Monthly at Resident Council and during Community Meetings. Discussion of the data shall be documented in the respective groups' meeting minutes.
    c. monthly at the Quality Assurance Performance Improvement/Performance Improvement and Patient Safety (PIPS) meeting.

~~14. Data on complaints/grievances shall be aggregated and presented quarterly monthly at the Quality Assurance Performance Improvement/Performance Improvement and Patient Safety (PIPS) meeting. Complaints/grivancesgrievances 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 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, 22/12/13, 23/02/21 (Year/Month/Day)
Original adoption: 92/03/01

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.

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

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).

6. All licensed nurses and patient care assistants (PCA) shall be trained and remain current in BLS.

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

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.

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, 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.

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.

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.

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.

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).

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.

~~15.~~16. CPR data is collected and managed via the defibrillator into a software system for quality improvement purposes. Access to the software system is limited to code blue committee team leaders. No PHI is to be entered into the data system. The system will be audited monthly to ensure no PHI data has been entered.

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

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

ii. Locations

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

iii. Maintenance

- The crash carts on each SNF neighborhoods, acute units, clinic, and rehab during 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.

b. 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.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 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, activat 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, Gerald Simon Theater or other areas of the hospital, or 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.

ii. All physicians in the tower with emergency.

- For Pavilion Mezzanine SNF, Pavilion Mezzanine Acute, 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

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 respective unit/floor, including elevator and hallway areas.

ii. North Tower: One licensed nurse from North 2 and North 4 shall respond to emergencies in the North Tower. the South Tower: One license nurse from South 2 and South 4 shall respond to the emergencies in the South Tower and all other hospital areas.

iii. A licensed nurse from Pavilion Mezzanine SNF shall respond to each code.

b. Pavilion [ncluding Pavilion Mezzanine SNF, Pavilion Acute Medical and Acute Rehabilitation (also known as the Inpatient Rehabilitation Facility “IRF”), Rehabilitation Department

i. Nursing staff from Pavilion the unit are required to respond to all emergencies on Pavilion.

ii. One licensed nurse from each neighborhood on North 2, and South 2 shall respond to the emergency.

iii.

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.

e. Serenity Park (previously known as Harmony Park)

   i. One licensed nurse from North 2 and North 4 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. The Chapel, Gerald Simon and all other indoor areas of main hospital building not addressed above

   i. One licensed nurse from South 2, 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.

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 , 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, 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/patientis 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, obtain 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 Licensed Nurse is recording the Code Blue events in the Code Blue Record.

ii. Ensures that the Code Blue Record is complete 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. 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

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, 22/12/13 (Year/Month/Day)
Original adoption: 97/06/01 as MSPP Code Blue; 98/11/16 as LHHPP Code Blue Drill

RESIDENT TRUST ACCOUNT

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to abide by CMS regulations to act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. If the resident has a burial trust account, LHH is responsible for managing that Burial Trust Account as in accordance of the Social Security Operations Manual and Medi-Cal regulation requirements.

PURPOSE:

The purpose of the policy is to provide guidelines for setting-up, managing and safeguarding resident's funds deposited into the LHH Trust Accounts and identifying the roles and responsibilities of each department/staff involved in carrying out the procedure.

PROCEDURE:

1. ~~Patient~~ Resident **Trust Account:**

   a. LHH can establish~~es~~ a ~~Patient~~ Resident Trust Account to assist residents in managing their funds during their stay at LHH. The ~~ADL~~ EPIC module system is ~~s~~used to record deposits and disbursements in the individual Trust Account for each resident.[G(1][T(2][V(3] At the end of each month, accounting performs a reconciliation to balance EPIC~~ADL~~[G(4][T(5][V(6].

   b. The Accounting department may consolidate into a single account per admission or multiple accounts over the residents stay at LHH. However, the R~~r~~esident~~'s~~ Trust Account shall not be co-mingled with facility funds or with the funds of any other person.

2. **Set-Up of Resident Trust Account:** Residents admitted to LHH shall be assigned a medical record number and ~~account number. A new account number shall be assigned with each readmission.~~ the resident and/or designee will be asked if they would like to utilize the Resident Trust Account service.. The **Admissions & Eligibility (A&E)** ~~A&E~~ Financial Counselor will assist those residents and/or designee interested in establishing a Resident Trust Account at LHH. The A&E Financial Counselor shall ask the resident to sign the direct deposit form to have his/her funds deposited electronically to the LHH Trust Account.[G(7][G(8][T(9][V(10]

3. **Checks:** LHH receives check payments from SSA/SSI, Private Retirement Pensions, or other sources.

   a. Checks received for Share of Cost (SOC) related or a combination or SOC/Personal Need (PN) shall be mailed/sent directly to the Billing Department.

The Billing Department shall complete the check log listing the check number, resident's name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.

b. Mailed checks received by **Admissions & Eligibility (A&E)** for PN only are sent directly to the Cashiers. A&E shall complete the PN check log listing the check number, resident's name, episode number, and check amount. After completing the log, the check log and checks shall be sent to the Cashiers.

c. The Cashiers enter checks in the Trust Account daily, generate~~s~~ batch entry reports, and post~~s~~ information into the ~~Optimum ADL~~EPIC system. The cashiers photocopy the checks and file the photocopies with the batch entry report in the department deposit files.

d. All hand delivered checks and cash go directly to the Cahier's Off~~f~~ice. MSWs, other hospital personnel, Residents, and/or Resident's representative hand delivering checks and/or cash shall be directed to drop off at the Cashier's Office for deposit or routing. A receipt process is already in place keep timestamped record of the exchange. Checks for residents who have discharged or expired shall be returned to the sender by A&E.

e. Checks for residents who have discharged or expired shall be returned to the sender by A&E.

~~d.~~f. All funds received are divided into share of cost and PN. PN allowance for residents receiving Social Supplemental Income (SSI) is posted in the PN account.

All funds received are divided into share of cost and PN. PN allowance for residents receiving Social Supplemental Income (SSI) is posted in the PN account.

4. **Interest:** ~~The department of Human Services calculates the amount of share of cost based on the resident's income. The resident allowance is the current monthly PN allowance. If the resident does not use his monthly PN allowance, it remains in the PN account. When the amount reaches $50.00, it will start to earn interest. Interest is posted after the interest distribution from the Controller's Office, City and County of San Francisco. Accounting, A&E and Billing receive the monthly adhoc SOC report. After the patient expires or discharges with zero fund balance, Accounting shall write off any interest amount up to $10.00. Interest that is writing off shall be used to compensate a portion of the bank charge in operations.~~ The resident allowance is the current monthly PN allowance. If the resident does not use his monthly PN allowance, it remains in the PN account. Active PN accounts (including burial account if applicable) with a balance of $50 or more will earn interest. Interest is posted to active PN after the interest distribution from the Controller's Office, City and County of San Francisco. After the patient expires or discharges with zero fund balance, Accounting shall write off any interest amount up to $10.00. Interest that is written off shall be used to compensate a portion of the bank charge in operations.

5. **Cash Deposits at the Cashier Window:** Cash deposits are accepted only at the cashiers window. After verifying the cash amount, the cashier prepares the daily log, cash receipt and issues the receipt to the depositor. After the transaction is completed, the cashier places a copy of the receipt and cash into the safe for the next bank deposit and input it into the EPIC~~ADL~~ System

6. **Wire Transfer:** SSA and VA, or other pension plan may send benefits by wire transfer directly to the Bank of America "~~Patient~~ Resident Trust Account" on a monthly basis. A report detailing the transfer from the CCSF Department of Treasure is emailed to the Accounting Department.

    a. Accounting divides all received into share of cost and PN based on the SOC list that the Accounting Department receives from the Billing Department on the first of ~~the~~ each month. Patients receiving SSI do not have a share of cost. Accounting posts the monthly SSI allowance in the PN account.

7. **Definition:**
    a. Medi-Cal current rate: A dollar amount per month that qualified residents may draw. Medi-Cal periodically changes this current rate, which is available from the A&E Financial Counselor ("FC"). B. SSI Current Rate: A dollar amount per month that qualified residents may draw. SSI periodically changes this current rate, which is available from the A&E Financial Counselor.

8. **Representative Payee Program, Legal Conservator and Public Guardian:** In most situations, a resident is presumed to be capable of managing their funds. Residents may have a Public Guardian or other legal conservator appointed to manage the residents' money. As an alternate option, the resident or legal conservator may elect to have LHH as the representative payee. The main responsibility is to ensure that money spent is to pay for the needs of the resident and properly save any money not needed to meet current needs. LHH as representative payee must also keep records of expenses. To become the representative payee, LHH must submit forms SAA-787 and SSA-11 (completed by A&E Financial Counselor) and follow guidelines set forth by SSA.~~.~~

~~9. **Establishing Resident Trust Account:** At the time of the resident's admission to LHH, the A&E Financial Counselor assists the resident in establishing a patient Trust Account at LHH. The A&E Financial Counselor shall ask the resident to sign the direct deposit form to have his/her funds deposited electronically to the LHH Trust Account.~~

~~10.~~9. **Trust Account Quarterly Statements:** The Accounting Department issues a fiscal quarterly "Resident Trust Account Statement" (hereafter Statement) ending September, December, March and June. The Statements shall be delivered ~~thru~~ mail to the ~~interdepartmental mail to~~ individual Nursing Neighborhoods. ~~and the nurse manager or designee of each Nursing Neighborhood shall distribute the Statement to residents.~~ When a legal representative manages the residents' funds~~, Accounting Department delivers the Statement to the A&E Department who then in turn distributes~~

~~by mail to the residents' legal representative.~~ the statement shall also be sent by mail to the address provided to LHH by the representing party.

~~11.~~10. **Distribution Funds after Death:** Upon the death of a resident, the A&E Department shall Request that Patient Funds (only) be transferred to SSRV (Social Security R~~e~~eserve) and hel~~f~~d for approximately 1 year to avoid negative balances caused by SSA takebacks. It is the responsibility of the A&E Financial Counselor to withhold any overpayment from SSA, VA or retirement system.

a. To avoid negative account balances:

   i. A&E shall request that overpayment amounts received electronically be transferred to SS-reserve fund for future electronic reverse payment.

   ii. All other funds not identified as overpayment shall be distributed to the family, conservator, or Public Administrator but only after A&E had contacted SSA and receives official documentation of no overpayments are found and to be returned.~~.~~

b. Over payments received by check shall be returned via US postal service. Funds received after death shall be held until FC receives notice or email confirming that resident has no over payment.

c. Accounting shall provide the SS-reserve balance report quarterly to A&E and A&E shall review the SS-reserve balance report quarterly and cleanup annually when necessary to avoid accumulation.

d. A&E shall request a check from a~~A~~ccounting to issue to SSA (up to 1yr later). Unless, sends an official letter of overpayment requesting funds sooner than 1 year.[G(11)][T(12]

e. All potential write-offs for ~~nefative~~negative balances due to SSA takeback are sent to Chief Financial Officer (or designee), A&E Manager (or designee), and Controllers Office for review and approval.

~~12.~~11. **Burial Account:**

a. The preference is to purchase a burial plan vs. setting up a burial fund in ~~ADL~~EPIC. The resident may reserve $1500.00 plus interest in a prepaid Burial trust accounts (or as otherwise allowed by law) money that is not subject to the resident's resource limit amount.

   i. Burial funds must be for the ~~indeed~~ purpose of either burial expenses or purchasing a burial plan.

   ii. Burial Accounts shall not be offered if the resident has a Legal Representative, is an SSI AS-Needs-Based Recipient, has a Social Security Representative (Rep) Payee, or if patient is admitted for short stay, which includes patients

admitted to the following services, PM SNF Rehab, PM Acute Rehab, LSS Short Stay (any unit). In order for SSI As-Needs-Based Recipient to open an LHH Burial Trust, the resident must provide LHH with Social Security clearance of no overpayment.

b. Transferring funds to and from the burial fund: The A&E Financial Counselor shall complete the Authorization form to the Accounting Office and to the Cashier's Office to request transfer of funds to and from the burial account.

Disposition of Funds when Resident is Discharged: Title 22 Section(8) Upon discharge of a patient, all money and valuables of that patient which have been entrusted to the licensee and kept within the facility shall be surrendered to the patient or authorized representative in exchange for a signed receipt.

i. If LHH is the Rep Payee, burial funds shall be sent back to SSA, only if the funds are SSI income per SSA Title II Retirement Recipient process. All other funds unrelated to SSI can be sent to the new rep. payee or to the legal representative identifying funds as burial funds.

ii. A&E shall notify Social Services if LHH is the Rep Payee; and when patient is discharged and funds are withdrawn and/or forwarded to the new Rep Payee or to Social Security Administration (SSA) if income was SSI based.

iii. If residents withdraw funds from the burial fund, they shall be informed that the amount may be counted as income and may affect their monthly SSI benefits.

iv. If the resident or their decision maker withdraws funds, the A&E Financial Counselor shall inform them of the Medi-Cal/SSA requirement to deposit funds into a Burial Trust Account.

~~13.~~12. **Funds Transferred to Billing for late SOC payment:**

a. The billing department is responsible for ensuring that the current months SOC is credited to the patient's account by the 15th of the month.

b. The biller must contact the A&E Financial Counselor if the SOC payment is for previous months. The A&E Financial Counselor shall verify that funds in the Trust Account are designated as SOC funds for previous months. The A&E Financial Counselor shall inform the biller if money is for PN or SOC payment.

~~14.~~13. **Funds Credited from Billing to the ~~Patient~~ Resident Trust Account:**

a. Billing shall contact A&E via email to notify them of overpayment on SOC to be credited back to the trust account.

b. A&E Financial Counselor shall respond with a date that funds shall be transferred

back to the ~~Patient~~ Resident Trust Account.

c. On the date of transfer, Billing shall notify the Accounting Department via email to proceed with the credit to the ~~Patient~~ Resident Trust Account.

~~15.~~14. **Resident Has Financial Decision Making Capacity and Requests Withdrawal of Money from the ~~Patient~~ Resident Accounts/Cashier Window:** If the resident wishes to withdraw funds from his/her ~~patient~~ Resident Trust Account, the resident will inform their MSW of the need to withdraw. Then the resident and/or MSW and/or MSW Designee completes the Authorization to Accounting Office form (ATAO). The A&E Financial Counselor must countersign authorization requests for amounts up to $100. The A&E Supervisor/Manager or Designee must countersign authorizations ~~over SSI current rate. The A&E Manager must countesign authorizations over $300 for discharge only. Refer to 18e for window cash withdrawal over $300. Patient Access Director (or designee) must countersign authorizations for over $1000~~for amounts over $100. Authorization requests are returned to the MSW for submission to the Cashier's Office. Residents who are able will go to the Cashier to obtain their money, or if resident is unable, Social Worker will go to the Cashier on behalf of the resident..

a. Cash shall be authorized if resident is being final discharged from LHH.

b. Any questions regarding an unreasonable request by a resident who may need guidance in managing his/her funds are to be resolved by the members of the resident's care team.

~~16.~~15. **Annual Authorization to Withdraw Monthly Allowance:** The resident or MSW may choose to receive monthly allowances (Medi-Cal current rate or SSI current rate) through Annual Authorization by completing and signing the Annual ATAO form. The A&E Financial Counselor writes on the top of the form "Annual Authorization", and an expiration date. The A&E Financial Counselor forwards the original copy to the Cashier and a copy of the form is filed in A&E file. The Cashier shall file the ATAO original copy to use as reference to verify residents who participate in Annual Authorizations. Annual authorization covers monthly allowance not to exceed the SSI/Medi-Cal current rate. Additional requests for withdrawal require~~s~~ resident to sign an ATAO form for each request. Annual Authorizations are renewed on December 31, of each year. Residents/MSWs wishing to continue with annual authorizations must complete a new authorization for the upcoming year.

~~17.~~16. **Steps for Authorization of Funds:** The expense of the funds is intended for the resident's use to provide for his/her comfort and happiness. Included in the legitimate use of resident's funds, but not limited:

a. The purchase of specially prepared or alternative food that meets the resident's dietary needs instead of the food generally prepared by LHH.~~;~~

b. Telephone; clothing; personal comfort items, including novelties, and confections; cosmetics and grooming items in excess of those for which payment is under Medi-Cal or Medicare.

c. Reading materials; social events and entertainment offered outside the scope of the activities program.

d. Flowers and plants; and television/radio/audio appliances for PN.

e. Discretionary (PN) funds may not be used to pay past-due SOC or other hospital bills. Other than current months SOC, transfer of funds to Billing must be approved by the A&E Financial Counselor via email,

The following chart displays required signatures for authorization or withdrawal from the resident's account. Exceptions are listed below:

Withdrawal Amount	Amounts up to Medi-Cal or SSI Current rate	Amount exceeds Medi-Cal or SSI Current rate	Amount exceeds $100~~300~~.00	~~Amount exceeds $1,500.00 w/o Residents signature~~
PFS staff signature requirements	A&E Financial Counselor	A&E Supervisor or D~~d~~esignee	~~A&E Manager or designee~~A&E Supervisor or Designee	~~Director of PFS, CFO, or designee~~
The LHH A&E Manager may approve authorization for any amount when funds are intended for: a. Resident's Burial or purchase of a burial plan, b. Resident Discharge or Pending Discharge c. Distribution of funds to family/estate after resident expires d. Funds sent to the Department of Human Services, Public Guardian, Public Administrator, or a legal representative or Rep. Payee. e. Payment of resident's bills f. Authorizations approved by the resident or Legal Representative. via email or letter, by signing the authorization form				

~~18.~~17. **Authorizations Requested by Resident**:

~~In response to the~~As a result of the COVID19 emergency declaration, LHH Patient Access A&E had~~is~~ modified~~ying~~ the process for patients to request cash from their trust accounts. The purpose of this modification is to minimize non-essential face-to-face and paper transactions for the health and safety of our residents.

The process for assisting residents who would like to withdraw cash from their trust account will be as follows:

a. The resident shall have access to their funds 7 days a week (including weekends/holidays) during Cashier Office operating hours and through Nursing Operations at all other hours. ~~Resident will notify their social worker that they would like to withdraw cash. (Able residents will no longer visit the A&E office in person to make this request.)~~

~~a.~~b. Normal operating hours: Resident will notify social worker that they would like to withdraw cash. (Able residents will no longer visit the A&E office in person to make this request.)

c. Social worker will assist patient to complete the form and sign it.

~~b.~~d. The social worker will notify A&E via email of the request.

e. A&E will confirm availability of funds and forward the signed Cash Authorization form to the social worker.

~~c.~~f. Social worker will submit the completed authorization to the Cashier's Office.

~~d. Social worker will assist patient to complete the form, sign it and scan/email the completed form to Cashier, and cc A&E on the email.~~

~~e.~~g. Residents who are able will go to the Cashier to obtain their money, or if resident is unable, Social Worker will go to the Cashier on behalf of the resident.

~~f.~~h. If authorization is a final liquidation of the resident account due to discharge a copy of residents account in ~~ADL~~ EPIC shall be printed

i. For cash withdrawal requests for amounts over $300, A&E shall contact the cashier's office two business days in advance to ask if cash is currently available. If not, resident can arrange to pick up the cash when available or the cashier's office may issue a check for amounts over $300.

j. After Hours/Weekend/Holidays: Follow steps k-p.

k. Resident will notify their Charge Nurse/designee that they would like to withdraw cash.

l. Charge Nurse/designee will assist resident to complete the form and sign it.

m. Charge Nurse /designee will deliver form to Nursing Operations

n. Nursing Operations will confirm availability of funds and issue cash directly to Charge Nurse/designee

o. Charge Nurse/designee will deliver cash to resident.

p. Next Day: A&E will confirm availability and transaction of funds and forward the signed Cash Authorization to the Cashier's Office

~~g.~~q. Cashier's Office will post the transaction in EPIC

18. Fund Withdrawal Guidelines and Timing (After Hours/Weekend/Holidays):

- Requests for less than $100 ($50 for Medicaid recipients) will be approved the same day.
- Requests for $100 of more ($50 for Medicaid recipients) will be approved within three banking days (weekdays).

19. Reimbursement to Authorized Decision Maker when Resident Lacks Financial Decision Making Capacity

a. If a resident lacks capacity to make financial decisions, person identified by the MSW as the person having authority to access the resident's Trust Account.

b. If LHH is the Rep Payee, the Social Worker must sign ATOA form. Resident may sign the form if he/she has capacity to make decisions

c. MSW shall provide A&E with name and contact information of person authorized to access the resident's Trust Account.

   i. The A&E Financial Counselor shall keep a record of the name and contact information for the financial decision maker in the A&E file.

   ii. The A&E Financial Counselor shall verify that person requesting funds is the authorized decision maker. If not, the person shall be referred to contact the resident's social worker.

   iii. If the person is authorized to access funds, the A&E finance counselor shall review the Trust Account ledger to verify that funds are available and ask the person to provide Government identification.

   iv. The authorized decision maker must submit a written request for funds indicating amount and reason for the request.

   v. Authorized decision makers must submit receipts for resident purchases for reimbursement when the resident lacks financial decision-making capacity.

   vi. Refer to ~~item 8a thru 8k for steps on authorization of funds.~~ Steps for Authorization of Funds

20. **Authorization Request by MSW**

a. If in the opinion of the residents' care team, the resident is unable to manage his/her funds and the resident does not have a legal representative, the hospital or designee shall designate the MSW to manage the resident's funds. Any questions regarding an unreasonable request by a resident who needs guidance in managing his/her funds are to be discussed and resolved by the members of the resident's care team.

b. Steps for Authorizing Funds to the Medical Social Worker:

   i. The MSW shall notify the A&E Financial Counselor of request for funds in writing indicating amount and reason for the request.

   ii. The MSW shall submit receipts for purchases to the A&E Financial Counselor within one week.

iii. The MSW shall maintain a transaction record, which must be signed by the resident whenever money is distributed to the resident. The transaction record shall be forwarded to the A&E Financial Counselor, who shall place the form in the resident's file.

iv. MSW and MSW Management signature is required when requesting funds for residents or reimbursement P-Card or personal funds used for purchases or services

v. MSW signature is not require if:

- Resident is able to sign bill payment
- Funds sent to Medi-Cal Recovery Unit – California Department of Health Services
- Funds returned to Social Security
- Funds used for Burial Plans
- Funds sent to Public Administrator
- Funds sent to family/estate after death

vi. Refer to ~~item 8a thru 8h for steps for authorization of funds.~~Steps for Authorization of Funds

21. **Monitoring Compliance**:

a. A&E: The A&E supervisor may~~shall~~ conduct a random sample audit each month, reviewing and reconciling receipts against funds withdrawn and reimbursed to the authorized decision maker at any time. The A&E Manager is responsible for monitoring compliance.

b. Accounting Department performs monthly Trust Fund bank reconciliation. The Chief Financial Officer is responsible for reviewing this reconciliation.

ATTACHMENT:
None.

REFERENCE:
Nursing Department Policy for Handling Money Held on the Nursing Neighborhood

Revised: 98/11/16, 00/05/25, 04/12/02, 07/12/18, 10/04/27, 10/08/10, 11/03/24, 16/01/12, 18/03/13, 19/03/12, 21/09/14 (Year/Month/Day)

Original adoption: 93/09/01

PNEUMOCOCCAL IMMUNIZATION

POLICY:

1. ~~Laguna Honda Hospital (LHH) residents who meet the established Centers for Disease Control and Prevention (CDC) clinical criteria shall be screened or evaluated for the pneumococcal polysaccharide vaccine (PPSV23) and/or pneumococcal conjugate vaccine (PCV20).~~
   Laguna Honda Hospital (LHH) residents who meet the established Centers for Disease Control and Prevention (CDC) clinical criteria shall be screened or evaluated for the pneumococcal polysaccharide vaccine and/or pneumococcal conjugate vaccine as defined by most current pneumococcal vaccine recommendations.

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

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

PURPOSE:

To reduce morbidity and mortality from pneumococcal diseases, residents who meet the clinical criteria established by the CDC will be vaccinated with the appropriate pneumococcal vaccine(s).

PROCEDURE:

1. The physician assesses resident eligibility for vaccination. A reasonable attempt will be made to determine prior vaccination history. Resident with unknown or unsure vaccination status will be considered unimmunized. For those not vaccinated, the reason will be documented.

2. The physician screens residents for contraindications and precautions to administer the pneumococcal vaccine:

   a. **Contraindications**: History of a serious allergic reaction (e.g. anaphylaxis) after a previous dose or severe allergy to any component of the pneumococcal vaccine.

   b. **Precautions**: Moderate or severe acute illness with or without fever. Consider vaccinating the residents after they have recovered unless the physician deems the benefits of vaccination to outweigh the risks.

3. The physician orders the appropriate pneumococcal vaccine.

4. The licensed nurse shall provide the resident or responsible party with the current Vaccine Information Statement (VIS) for the appropriate pneumococcal vaccine prior to administering the vaccine.

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

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

ATTACHMENT:
None.

REFERENCE:
Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Register/Vol 70, No. 194, 42 CFR Part 483 Medicare and Medicaid Programs, Condition of Participation: Immunization Standard for Long Term Care Facilities.
CDC Pneumococcal Vaccine Recommendations available at:
https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html
CDC Pneumococcal Vaccination: Summary of Who and When to Vaccinate available at:
https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html.
CDC Pneumococcal ACIP Vaccine Recommendations available at:
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html
CDPH Pneumococcal Disease available at:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Pneumococcal-Disease.aspx
CDC Vaccine Information Statements (VIS) available at:
https://www.cdc.gov/vaccines/hcp/vis/index.html
Immunization Action Coalition Vaccine Information Statements available at:
https://www.immunize.org/vis/

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

Appendix H: Visitors Screening Process

1.0 Scope:

Applies to clinic staff and physicians throughout the campus, including the inpatient care units, rehabilitation and wellness centers, patient/resident neighborhoods and other areas on campus. The provisions of this procedure apply to visitors and vendors entering Laguna Honda Hospital and Rehabilitation Center.

2.0 Procedure:

2.1 During visiting hours, the Sheriff's Office (SFSO) ~~contract security provider~~ shall verify, obtain authorization, log visitors, and issue visitor passes to authorized visitors.

2.2 If a physician has specified that visitors would not be in the best interest of the patient/resident, the contract security provider shall support the physician in communicating with the patient's/resident's decision maker.

2.3 If isolation precautions are required, the contract security provider shall support the neighborhood's nursing staff, when advising visitors of the necessary precautions.

2.4 The Nursing Office/Neighborhood Resident Care Team shall address special considerations to visitors for residents/patients with visiting restrictions.

2.4.1 Visitation restrictions or prohibition shall be enforced without regard to race, ethnicity, color, national origin, ancestry, religion, culture, language, sex (including gender, gender identity, gender expression), sexual orientation, age, genetic information, marital status, registered domestic partner status, veteran's status, medical condition, socioeconomic status, educational background, physical or mental disability, or the source of payment of care.

3.0 Limitations on Visitors

3.1 Refer to the LHHPP 24-07 Visiting policy.

3.2 Two visitors at one time are preferred.

3.3 Space constraints may limit the number of visitors.

3.4 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.

3.4.1 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.

3.5 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.

3.6 Visitors who refuse to undergo the screening procedures shall not be permitted to enter the facility or remain anywhere on the LHH campus.

4.0 Visiting Hours

4.1 Recommended visiting hours are daily, from 10:00 a.m. to 9:00 p.m.
4.1.1 Visitors may only enter the facility through the Pavilion Lobby entrance.

5.0 Visitor Screening and Authorization

5.1 Security screening units shall be operated by the San Francisco Sheriff's Office (SFSO) for visitor screening.

5.1.1 Visitors shall be requested to empty their pockets and place all items including jackets/coats, packages/bags/backpacks/purses, and items that are not attached and are easily removable from wheelchairs on the package scanner conveyor belt.

5.1.1.1 Visitors may be asked to remove items from their packages/bags/backpacks/purses that obstruct clear images from the package scanner.

5.2 Should the package scanner alert to the possible presence of contraband or other prohibited items, the individual will be instructed to open their package/bag/backpack/purse etc. and place their items on the inspection table for a visual inspection.

5.2.1 The individual will be required to open each compartment and remove contents that may be obstructing the visual inspection.

5.3 If Contraband or a prohibited item is found, the SFSO Deputy shall investigate.

5.3.1 Visitors shall be informed of prohibited contraband and advised that it is not allowed in the facility. Except when the prohibited item involves illegal weapons or drugs as described below, visitors shall be given an opportunity to leave the item in their car or return without the item, but the person shall be subject to a new screening when they return.

5.3.1.1 SFSO will notify Nursing Ops when a visitor is found with contraband or prohibited items, including the name of the visitor, the name of the patient(s) the visitor was attempting to visit, and the contraband or prohibited item(s) found.

5.3.1.2 Nursing Ops shall keep a log of all contraband or prohibited items reported by SFSO, which includes the name of the visitor, the name of the patient(s) the visitor was attempting to visit, the LHH unit where the patient(s) resides, the contraband or prohibited item(s) found, the date when the contraband or prohibited item(s) was found.

5.4 Actions when illegal weapons or drugs are found:

5.4.1 Illegal weapons/metal objects

5.4.1.1 Shall be confiscated and disposed of pursuant to SFSO procedures.

5.4.2 Drugs and drug paraphernalia

5.4.2.1 Individuals with a current original prescription for a detected item must have in their possession, the medication in the bottle with a legible label showing the name of the individual.

5.4.2.2 Drugs shall be confiscated and disposed of pursuant to SFSO procedures

5.4.2.2.1 Visitors – Cadets or Deputies shall inform visitors that they cannot enter the facility.

5.4.3 Any visitors found to have brought, or attempted to bring in, contraband or prohibited items shall have restrictions placed during any future visits to LHH, and may be prohibited from entering the facility or loitering on campus at the discretion of the SFDPH Director of Security and/or the LHH CEO.

6.0 Visitor Authorization

6.1 The neighborhood staff/care team shall inform the SFSO staff ~~contract security provider~~ of visitor restrictions as applicable.

6.2 Upon the visitor signing in, the SFSO ~~contract security provider's s~~staff shall determine the neighborhood/department that the person will be visiting and/or call for authorization as applicable.

6.3 If authorization is granted, using the visitors pass kiosk, the officer shall issue a visitor's pass.

7.0 Visitor Pass Log

Laguna Honda Hospital and Rehabilitation Center
VISITOR PASS LOG

DATE:	SECURITY REPRESENTATIVE:	POSITION:

VISTOR PASS	PATIENT/RESIDENT, DEPARTMENT NAME	RLTN TO PATIENT	VISITOR NAME	ROOM#	TIME

Deletion OP Clinic Policies and Procedures

CLINIC APPOINTMENT SCHEDULING FOR COMMUNITY CLIENTS

POLICY:

It is the policy of the Laguna Honda Hospital (LHH) Outpatient Clinics to provide access to health care in a timely and cost-effective manner. All clinics require a scheduled appointment. Drop-ins are accepted according to the resident's or clients clinical needs as directed by their Attending or Consulting Physicians.

LHH provides equal access to services to Limited English Proficient (LEP), and the hearing impaired/deaf through the interpreter and designated bilingual Hospital employees, and video medical interpretation (VMI).

PURPOSE:

The purpose of this policy is:

1. to define the standard procedure for the scheduling of Community Client (client) appointments based on urgency and health care concerns and
2. to facilitate the effectiveness and efficiency of the Laguna Honda Hospital (LHH) Outpatient Clinics regarding client appointments

PROCEDURE:

1. Request for Clinic Services:
    a. The Attending or other authorized physician completes an E-Referral request for consultation. (refer to E-Referral Consultation for Outpatient Clinics Policy MSPP-A00).

2. Scheduling:
    a. Clinic Staff or the Consultant reviews the E-Referral request for consultation.
    b. Clinic Staff schedules an appointment through the EHR system for the client based on the availability of the Consultant Staff and LHH contractual arrangement.
    c. The Clinic Staff will provide to the Admissions and Eligibility Department (A&E) the client's name, the physician's name and date of the clinic visit.
    d. The Clinic Staff will notify the client by phone of the upcoming appointment.
    e. At the time of the clinic visit the client will report to A&E at least 45 minutes prior to appointment time. At that time the patient data/lab services card and face sheet are generated and issued to the patient.
    f. The client reports to the Clinic with the patient data card, face sheet, COT and HIPAA notice to submit for services and for filing in the LHH Medical Records.
    g. The consultant will type the clinic note into the EHR system.
    h. Subsequent follow-up visits will require notification and registration as outlined above.
    i. If a Clinic is cancelled or rescheduled, the Clinic Staff reschedules the client for the next available Clinic and the client is notified by phone of the rescheduled appointment.
    j. If a client misses an appointment the Clinic Staff reschedules the client for the next available Clinic and the client is notified by phone of the rescheduled appointment.
    k. Follow up appointments are scheduled per the request of the Consultant or Attending physician.

REFERENCES:
Medical Services Department Policy MSPP-A00 "E-Referral Consultation for Outpatient Clinics"

Most recent review: 19/05/21
New: 13/09/24

STEAM STERILIZATION

POLICY:

1. Reusable medical instruments and other items are steam sterilized whenever possible. Moist heat in the form of saturated steam under pressure is the most widely used and the most dependable method of sterilization.
2. Steam sterilization is conducted in accordance with LHH Infection Control Policy G9, "Steam Sterilization Standards".

PURPOSE:

Steam sterilization is a process for the sterilization of critical patient care devices (devices that enter sterile tissue or access the vascular system).

DEFINITIONS:

Steam sterilization is a sterilization process that uses saturated steam under pressure for a specified exposure time and at a specified temperature, as the sterilizing agent to eliminate all forms of viable microorganisms including spores.

PROCEDURE
Pre-sterilization

- Item(s) are taken to the Soiled Utility Room
- They are cleaned of any type of soil, including organic debris
- After cleaning, the item(s) are transported to the Wrapping Room, and wrapped and ready to be placed in the steam sterilizer

Sterilization using a Pre-Vacuum Steam Sterilizer

The minimum exposure period for steam sterilization of wrapped supplies is at 270° F (132° C) with 4 minutes exposure time and 20 minutes for drying time.

1. Wrapping and packaging
   The following types of sterile packaging are currently approved:
   - Rigid sterilization containers
   - Paper-plastic peel pouches
   - Non-woven wrappers (polypropylene). Two layers of wrap (double wrap) are used

2. Loading the sterilizer

   a. Label each package with:
   - Load identifier
   - Sterilization date
   - Staff's initials

b. Load all items in a way that allows steam to circulate freely around each item and does not allow moisture to collect. Peel pouches face the same direction. Instrument sets are on the bottom shelves

- Instrument sets cannot be stacked; steam must be able to circulate freely around each item.
- Items capable of holding water (i.e. basins) should be positioned in a fashion that would allow water to drain out of them.
- Metal items cannot be placed above textile items.

c. Loading racks or baskets are used for peel pouches so that they can be placed on edge and properly spaced.

3. Sterilization

a. Record the unique load identifiers used for the sterilization.

b. Visually verify that all settings are correct.

c. Initiate sterilization cycle following specific instructions that are provided in Appendices to this document.

d. Include a *Challenge Pack* in each load.

4. Unloading the sterilizer

a. Visually inspect the *Indicator Tape* on all packages for black bars indicating that sterilization conditions have been achieved. Record results in *Sterilization Log*, which is kept adjacent to the steam sterilizer.

b. Visually inspect the *Chemical Strip* in the *Challenge Pack* for color change indicating that sterilization has been achieved., Record results in *Sterilization Log*, which is kept adjacent to the steam sterilizer.

c. If printout/graph is used, visually inspect the printout/graph and verify that the sterilization parameters of 270° F (132° C) of 4 minutes of exposure time and drying time of 20 minutes have been met. Initial and date the printout/graph and retain in *Sterilization Load Records*.

d. The sterilized items must remain on the sterilization carriage until they have cooled to room temperature. Do not place the carriage under cool-air vents and if possible, place it in a low traffic area and label it with a "Caution Hot" sign.

e. Use gloves to unload items. Set aside items to be dust covered. Inspect packages and trays for damage and moisture.

5. Release of sterilization load for use

a. The Clinic Nurse is responsible for:

- Assembling all testing information in the *Sterilization Load Record*
- Verifying completeness of the *Sterilization Load Record* detailed below

- Reviewing all test results for each load
- Releasing the load for use based on acceptable test results (see Appendix B: Release of Sterilized Load)
- Notifying Clinic Nursing Director if testing results are not acceptable for release of the load

6. Sterilization load records

Sterilization Load Record for each steam sterilized load includes:

a*. Steam Sterilization Log* in which are recorded:
- Unique identifier for each load. If only one load is run per day, this identifier can be the sterilization date
- Date and time cycle was run
- Printed name and initials of operator
- Identification of sterilizer
- Chemical Tape results
- Chemical Strip (from *Challenge Pack*) results

b. Temperature and time of exposure. This can be either the temperature printout/graph or manual documentation of time and temperature demonstrating sterilization at 270° F (132° C) for 4 minutes of exposure time and a drying time of 20 minutes.

c. Biological monitor results including:
- Date of testing
- Lot number of Biological indicator
- Test Biological indicator results
- Control Biological indicator results

d. Signed *Release of Sterilization Load* including printed name and signature of Clinic Nurse releasing the load for use.

e*. Sterilization Load Records* are maintained on-site for a period of three years.

7. Sterilization monitors
The steam cycle is monitored by Mechanical, Chemical and Biological Monitors.

a. Physical Monitors of chamber temperature and time are verified by monitoring the gauges and printout/graph.

At the end of the cycle/day the temperature printout/graph is removed, dated and retained in *Sterilization Load Records.*

Alternatively chamber temperature and time are monitored visually, recorded manually and retained in the *Steam Sterilization Log*, which is kept adjacent to the sterilizer.

b**.** Chemical Monitors do not verify sterility but verify that the conditions required for the process have been met. Chemical indicators are affixed to outside and incorporated into the pack to monitor temperature or time and temperature exposure

- Indicator Tape is used to secure packages. Black bars appear on the surface of the Indicator Tape when it is exposed to sterilization conditions
- Chemical Strips are placed inside each sterilization package. The Chemical Strip changes color from rose to brown and validates that the inside of each sterilization package has been exposed to sterilization conditions
- At the end of the sterilization cycle, when the steam sterilizer is being unloaded, the Indicator Tape securing wrapped packages is interpreted and the results are recorded in the *Steam Sterilization Log*, which is kept adjacent to the steam sterilizer.
- **NEVER USE AN ITEM IF THE INDICATOR TAPE OR CHEMICAL STRIPS HAVE NOT CHANGED COLOR**

c**.** Biological Monitors validate the effectiveness of the steam sterilization cycle. Spores of *Geobacillus stearothermophilus,* (formerly known as *Bacillus stearothermolious*) are used as the *Biological Indicator*. On incubation, viable spores in the *Biological indicator* will germinate and produce acidic metabolic products that cause the media to change color from purple to yellow. A successful sterilization process will kill all spores and the media color will remain purple on incubation.

A *Challenge Pack* is included in every sterilization load. The *Challenge Pack* contains a Chemical Strip and a Biological Indicator sealed in a paper plastic peel pouch. The *Challenge Pack* is placed in the most challenging area for the steam sterilizer. This is typically on the bottom shelf, near the door and over the drain.

At the end of the cycle, the Biological Indicator is labeled "test" and dated. A control Biological Indicator from the same lot is labeled "control" and dated.

Both test and control Biological Indicator are placed in the Attest Auto-Reader which will provide an alert when the incubation is completed.

- After completion of the steam sterilization cycle, fully open the sterilizer door for a minimum of 5 minutes to achieve adequate cooling of the biological indicator prior to removal from the sterilizer.

  If the biological indicator **is not contained** in a test pack or any other heat absorbing packaging material, remove the biological indicator from the sterilizer and allow to cool for an additional 10 minutes prior to crushing OR,

  It the biological indicator **is contained** in a test pack or any other heat absorbing packaging material, the test pack or packaging material should be removed from the sterilizer and opened up for 5 minutes to dissipate heat prior to removing the biological indicator. Then allow the biological indicator to cool outside the test pack for an additional 10 minutes prior to crushing.

Results are interpreted according to the manufacturer's instructions and records are retained in the *Sterilization Load Records* along with the testing date and name of technician performing the test and interpreting the results.

Reference:
LHH Infection Control Policy G9 :Steam Sterilzation Standards"
CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008
Appendix A: Operation of the Pre-Vacuum (Pre-Vac) Steam Sterilizer

Appendix B: Release of Sterilization Load
Appendix C: Procedure for Performing the Bowie-Dick Test on the Steam Sterilizer
Appendix D: Procedure to Perform a Leak Test on Steris Sterilizer
Appendix E**:** Procedure for the use of Chemical Intergrator Strip for Steam Sterilizer

Most recent review: 10/10
Revised:14/01/28

APPENDIX A: OPERATION OF THE PRE-VACUUM (PRE-VAC) STEAM STERILIZER

OPERATION:

1. Load sterilizer cart. Place items on the cart ensuring:

a. proper packing
b. proper labeling
c. correct expiration date on Instrument containers only
d. Biological Spore Test package

2. Put a sterilizer label which includes the date.

3. Load all items in such a way that moisture will not collect. Peel pouches face in the same direction. Instruments sets should be placed on the bottom shelves.

4. Load sterilizer and close the door.

5. Hi-vacuum sterilizer in SPD screen should say **"PREVAC PREVAC"**. Press #4 on the touch screen pad to start cycle.

6. After cycle starts, record the cycle # in the monitoring log.

7. At the end of the cycle, the machine will intermittently buzz, and the screen will display **"COMPLETE"** cycle. Printout the monitoring record automatically.

8. Review the print out and check for the correct date, time and temperature including 4 minute exposure time and 20 minutes drying time and initial it.

9. Unload the sterilizer after 30 minutes, and cool for 1 hour.

10. Remove items from cart with gloved hands, and cool or dispense as appropriate.

APPENDIX B: RELEASE OF STERILIZATION LOAD

PRIOR TO STERILIZATION TESTS

Cycle Number: _____

Sterilization Date: _____

Sterilization Operator: _____

LEAK TEST _____PASS _____FAIL

Cycle Number: _____

Sterilization Date: _____

Sterilization Operator: _____

AIR REMOVAL TEST (BOWIE DICK)
Color change from Yellow to Dark Blue _____PASS _____FAIL

STERILIZATION MONITORING RESULTS

Physical Monitoring:
_____ 270 degrees F for 4 minutes and 20 minutes drying time

Chemical Monitoring:

_____ Indicator Tape outside of all packages has developed black bars
_____ Chemical Strip in Challenge Pack has changed color from yellow to black

Biological Monitoring:

Lot number of Biological indicators: _____

_____Test Biological Indicator remains purple (negative) on incubation

Lot number of Biological indicators for "Control": _____

_____ Control Biological Indicator turns yellow (positive) on incubation

PACKAGING INTEGRITY:

Cycle Number: _____

Sterilization Date: _____

Sterilization Operator: _____

_____ All packages are intact
_____ All packages are dry
_____ All packages are without stains or water marks

Load #_____ Date:_____

RECALL NOTES:

LOAD RELEASED FOR USE BY:

_____ _____
CRSCT/Printed Name Date

_____
Signature

_____ _____
Clinic Nurse/Printed Name Date

_____
Clinic Nurse/Signature

APPENDIX C

PROCEDURE FOR PERFORMING THE BOWIE-DICK TEST ON THE STEAM STERILIZER

To test for air leaks in the vacuum system of a vacuum type sterilizer once a week. The test should be done at the same time each day, and when possible the test should be the first run of the day.

PROCEDURE:

This cycle is used to conduct a Bowie-Dick test on the sterilizer. Tests such as DART (Daily Airway Removal Test) or Bowie-Dick are designed to document the removal of residual air from a sample challenge load. A DART (Bowie-Dick test) cycle should be done daily before processing any loads. The chamber must be at operating temperature when DART (Bowie-Dick test) cycle is performed. The DART Warm-up cycle should be completed prior to performing DART (Bowie-Dick test) cycle.

1. Press **MORE CYCLES** touch screen pad at the cycle selection menu to access the second screen of cycles. Press **DART TEST** touch screen pad.

2. A second menu then appears on the screen. A DART test should only be run in a machine that is at operating temperature (that is, has run one or more cycles). If the sterilizer has not run any cycles prior to the DART test, run the DART WARM-UP cycle.

a. The operator is prompted to close the chamber door, if it is open. Once closed, the door seals automatically.
b. The sterilizer automatically runs a cycle with three minute sterilize and one minute dry values.
c. Once the Warm-up cycle is complete, the display returns to cycle select menus.

3. Open the chamber door (if it is not already open). Load the DART indicator and close the door.

4. Start the DART cycle. The cycle runs automatically, as follows:

ACTIVATE SEAL- Steam enters the door seal, pressing seal against inside surface of door.
PURGE- Chamber is purged with steam. Start of condition is printed.
PULSE #1 through **PULSE #2**- Vacuum point is printed and pressure/vacuum pulse is repeated.
CHARGE- Chamber is charged with steam. Start of steam charge is printed.
STERILIZE- Start of sterilization exposure is printed when the chamber reaches set temperature. Chamber temperature is printed every minute. Chamber is controlled at set point plus overdrive.
FAST EXHAUST- Start of exhaust is printed and chamber is exhausted to 4.0 psig.
DRY- Start of dry is printed and display counts down dry time remaining.
AIR BREAK- Chamber is returned to atmospheric pressure.
RETRACT SEAL- A vacuum is drawn on the seal, retracting it from inner surface door.
COMPLETE- Complete tone sounds. Cycle summary and end of cycle messages are printed.

Review and verify critical cycle parameters were achieved during processing, then sign printout to indicate verification.

5. Once the cycle is complete:

a. Open the chamber door by pressing on the food pedal.
b. Unload the DART test pack.

Refer to instructions packaged with DART indicator. Forward the exposed test strip to the appropriate personnel for examination.

APPENDIX D

PROCEDURE TO PERFORM A LEAK TEST ON STERIS STERILIZER

This procedure is used to confirm that the sterilizer vacuum is intact in the piping and door. This cycle automatically checks for leaks in the piping and door seal, it is NOT a substitute for the BOWIE-DICK Test. Test should be done a minimum of once a week and documented in the monitoring record.

PROCEDURE:
This cycle is used for testing vacuum integrity of the sterilizer's piping.
A Vacuum Leak Test cycle should be run on the sterilizer at least once each week. In this cycle, the sterilizer automatically checks for vacuum leaks in the piping and door

seal. If the sterilizer fails that leak test, it must be inspected by a service technician. This test is not a substitute for a Bowie-Dick test. The leak test can be used to confirm that the sterilizer piping is intact after performing repairs.
NOTE: The measured leak rate (mm Hg per minute) is calculated by the control over a timed 10 minute period and is included in the cycle printout. A leak rate of 1.0 mmHg/minute or less is considered acceptable.
1. Press **MORE CYCLES**. The leak test cycle touch screen pad appears on the display.
2. To start the leak test press the **LEAK TEST** touch screen pad. Printer records cycle start. Cycle runs automatically as follows:
ACTIVATE SEAL- Steam enters the door seal, pressing seal against inside surface of door.
PURGE- Chamber is purged; printer records end of purge.
PULSE #1 (and **PULSE#2**)- Two vacuum and pressure pulses then occur and the printer records each.
CHARGE- After the pressure pulses, temperature rises to 270 F (132 C), unit begins to draw a vacuum for 10 minutes. (Printer records temperature at beginning of 10 minute vacuum time.)
LEAK TEST/EVACUATING- Printer records temperature and vacuum at end of evacuation time.

APPENDIX E

PROCEDURE FOR THE USE OF CHEMICAL INTEGRATOR STRIP FOR STEAM STERILIZER

Provide an indication that the sterilization process was performed.

SUPPLIES AND EQUIPMENT NEEDED:
Chemical Steam Integrator strip

PROCEDURE:
Place an integrator strip inside every package sterilized. There are no exceptions. The integrator strip is a chemical indicator that monitors time and temperature conditions. Chemical indicators do not guarantee

sterility, but help demonstrate if certain parameters have been met and can be used to troubleshoot or to validate cycle parameters.

An integrator monitor strip will be placed in each package containing an implantable item (i.e. bone screws and plates, Tevdek suture.)

Revision EVS Policies and Procedures

X. EQUIPMENT, SUPPLIES AND CHEMICALS

POLICY:
The Environmental Services Department will maintain adequate supplies, equipment and cleaning chemicals for the efficient operation of the Department and Hospital.

PURPOSE:
To allow the Environmental Services Department to carry out its function and to maintain a clean and safe Hospital environment.

PROCEDURE:

All cleaning chemicals used will be purchased and approved by ~~Safety~~[TN(1]~~, and~~the Infection Control Committee~~s~~ and procured from sources approved by the City. Cleaning chemical use, disposal and/or diluted disposal will comply with all City, State and Federal regulations.

Records will be kept of requisitions for supplies and equipment. Equipment operating instructions and warranties will be kept until that piece of equipment is replaced or discarded. Equipment will be maintained at all times.

Records will be kept of requisitions for cleaning chemicals. SDS (Safety Data Sheets) will be maintained for all chemicals in use and for chemicals used, but not currently in use.

Equipment, supplies and cleaning chemicals shall not be removed from the Hospital.

A. Cleaning Cart Set-Up
To provide the EVS porter with a checklist of equipment and supplies that will be needed to complete a routine job assignment. (Project work assignments will require different and/or equipment and supplies).

1. The following items should appear on a properly equipped cleaning cart:

Materials

- 1 Wet Mop Handle
- 1 Microfiber Dust Mop Handle with 1
- 1 string mop handle with 1 microfiber string mop
- 14 microfiber Mops
- 2 Mop Buckets with Wringer
- 1 High Duster Handle
- 2 High Duster Heads
- 6Wet Floor Signs
- 1 Toilet Bowl Swab
- 1 Toilet Brush
- Hand Paper Towels
- Toilet Paper
- Toilet Seat Covers
- Trap Duster

Materials

- 1 Caddy
- 1 Dust Pan with Broom
- Microfiber rags
- Putty Knife
- Gloves
- Plastic Bags (clear~~, ,~~)
-

~~Chemicals~~Chemicals (Ready to use)

- Glance: Glass & Surface Cleaner
- Virex 256 Disinfectant Cleaner
- Stride: daily cleaner for floors and other hard surfaces
- Crew: Non-Acid Bowl and Bathroom Disinfectant
- Oxivir 1: Disinfectant Wipes
- Micro-Kill Bleach Germicidal Bleach Wipes/Solution: Sporicidal, fungicidal, bactericidal and virucidal disinfectant

2. The EVS porters are expected to keep cleaning carts clean and organized at all times.
   - Top shelf of cart must be kept clear of cleaning supplies~~.~~. No large containers, personal belongings or food are allowed on the cart.
   - Two mop buckets with wringers should be on the cleaning cart.
   - Soiled cleaning rags should not be seen on the cart or allowed to accumulate. They should be wrapped on clear plastic bags and dropped through the soiled linen chutes or stored in the Janitor Closets until the end of shift.
   - Extra plastic bags should be kept in the pouches on the exterior of the cart bag. Do not drape bags on the exterior of the cart.

3. All cleaning solutions should be in properly labeled bottles that are clear and readable. All ~~ready to use~~Ready-to-use cleaning products should be in bottles with flip-top caps for dispensing cleaning products.

4. Carts will be inspected randomly by a supervisor or manager. All carts will be checked for proper cleanliness, assigned/tagged equipment and operation.

Cleaning Chemical Products

Product	Color	Usage	PPE	Disposal
Virex 256 Disinfectant Cleaner	Light Blue	One-Step Disinfectant Cleaner and Deodorant to clean all high touch areas, bed/bed frame, mattress, bedside stands, doors, floors and walls. ~~Ten-minute~~10-minute contact time.	Gloves Goggles	In accordance with local codes
Oxivir 1	Wipes	Disinfectant wipe used for horizontal and vertical surfaces. One minute contact time.	Gloves	In accordance with local codes
Micro-Kill Bleach Germicidal Bleach	Wipes/ Solution	A disinfectant with sporicidal activity against Clostridium difficile spores. 3 minutes contact time	Gloves	In accordance with local codes
Crew	Green	Non-Acid Bowl and Bathroom Disinfectant Cleaner to clean restroom toilets, sinks, urinals, under-pipes, etc. ~~10-minute~~10-minute contact time	Gloves Goggles	In accordance with local codes
Glance	Blue	Glass and multi-Purpose Cleaner NON-Ammoniated to clean mirror, chrome and glass surfaces.	Gloves Goggles	In accordance with local codes
Stride	Light red	Citrus Neutral Cleaner to clean daily use on floors, walls. and other hard surfaces	Gloves Goggles	In accordance with local codes

Addendum: In the event of an emergency, the department may use approved disinfectants and cleaners as an alternative to our standard.

XVII. Transport, Delivery, Time for Biohazard, Trash and Linen

Staffing: Staff is scheduled 7 days per week to perform above duties routinely

North Building - 6:30am-3:00pm and 3:30pm-12:00am
South Building/Pavilion Mezzanine - 6:30am-3:00pm and 3:30pm-12:00am

South Residence Building

Soil linen – Staff shall collect soiled linen from the chute, wrap the cart with a plastic bag and transport to the 2nd~~.~~ floor loading dock for pick up by the vendor.

Bio-Hazards/ Trash and Recyclables [TN(1)]– Staff shall ~~P~~pick up biohazards from the Biohazard Room and transport to the temporary storage located at the G-Wing of the Administration Building for vendor pickup.~~,~~

Trash & recycles – Staff shall pickup from the Biohazard Rooms during their shift and transport and dispose of items at the appropriate collection bins.

NOTE: Bin(s) must be covered with a lid during transport at all times.

North Residence Building:

Soiled linen – Staff shall collect soiled linen from the chute, wrap the cart with a plastic bag and store in the North Mezzanine temporary storage ~~R~~room for pick up by the vendor.

Trash & recycles – Staff shall pickup from the Biohazard Room during their shift and transport to the North Mezzanine loading dock and dispose~~s~~ of items in the ~~in~~ appropriate compactor.

Biohazard – Staff shall pick up biohazards from the Biohazard Room during shift and transport to the North Mezzanine temporary storage for pick up by the vendor.

NOTE: Bin(s) must be covered with a lid during transport at all times.

Clean linen delivery:

1. Clean linen will be delivered daily ~~from 3:30pm to 4:30pm, 7:30pm to 6:00am. Vendor will off load clean linen at loading dock~~by the ~~Laundry~~laundry vendor.
2. ~~,~~EVS staff will ~~pick up~~transport the clean linen to the designated clean linen/utility rooms. ~~and deliver to resident neighborhoods.~~
3. Clean linen is to be stored in the designated clean utility rooms or carts.
4. ~~1.~~Clean linen is to be kept covered for storage at all times and during transportation of clean linen.

Note: Service corridor in the Pavilion Building will be utilized whenever possible
(a) Unit storage has Biohazard symbol on the door
(b) Biohazard Temporary storage – loading dock has two languages

Revision FNS Policies and Procedures

1.1 Food from Home or Outside Sources Served Directly to Residents

Established and Revised: 10/98, 9/06, 12/06, 7/09, 8/18, 2/23

Reviewed: 8/13, 8/14, 8/18, 3/23

Policy: Food intended for resident consumption from outside sources shall be held to the same high levels of food safety and sanitation, storage, handling and consumption as properly applied in the Food and Nutrition Services Department. Volunteers and Staff shall adhere to all aspects of this policy.

Purpose: To help visitors, friends, and family members understand safe food handling practices which may include holding or transporting foods containing perishable ingredients. This shall be done by assisting in the safe and sanitary storage, handling, reheat, and discard, using safe food handling practices.

Definition: Outside sources are those sources of food from any place not produced within the portals of Laguna Honda Hospital. The resident is a resident, patient, or client receiving care or services from Laguna Honda Hospital.

Procedure: Reasonable attempt shall be made to meet the following:

1. Residents have the right to accept food from a visitor, family, or friend as long as it is identified as non-facility prepared food.
1.2. Food ~~shall be provided from approved sources and~~ shall[RC1] be handled in accordance with applicable food sanitation guidelines.
~~Foods shall be in its original packaging and procured from institutional sources such as a grocery store, retail delicatessen, or commercial restaurant.~~
Food brought in by family or visitors shall be stored separately or easily distinguishable from facility food.
Perishable food is labeled with the resident's ~~patis~~ name, ~~,~~ date received and expiration date, and kept in the designated resident refrigerator.
~~Patient refrigerator.~~
3.
Food from home is discarded after 72 hours or per manufacture recommendation. ~~for unopened, pre-packaged items, by the~~
4. ~~expiration date listed on the product.~~
Any food brought in from outside will be discarded if not properly labeled and dated.
5. Nursing staff is responsible for labeling, dating, and discarding items prior to expiration.
6. Nursing staff is responsible for assisting the resident in accessing and consuming outside food, if the resident is not able to do so on his or her own.
7. Food from home cannot be accepted, stored, heated, or served by Food and Nutrition[RC2]
~~2.~~ department
~~3. Residents have the right to accept food from a visitor, family, or friend as long as it is identified as non-facility prepared food.~~
4.8. The staff member who receives, labels and dates the food is responsible for either alerting FNS or providing education on safe food handling (see references). This may include safe cooling/reheating processes, hot/cold holding temperatures, preventing cross-

contamination and hand hygiene.~~Family and visitors shall be provided information in a language~~[RC3] ~~they understand to help understandhelp understand safe food handling practices. This may include safe cooling/reheating processes, hot/cold holding temperatures, preventing cross-contamination and hand hygiene.~~

~~5. Preparation of any foods on the neighborhoods for resident consumption shall be only prepared in approved kitchen or galley by trained staff. All employees, other than nutrition service employees, who prepare food shall understand basic food safety guidelines for safe storage and handling of food.~~

~~6.~~ 10. Any volunteer or staff member serving foods shall follow safe food handling procedures.~~The Director of Food and Nutrition Services with the Chief Dietitian or designee shall have the sole authority to authorize the use of facilities and procedures in handling of food described above. If procedures are not followed and/or facilities are not maintained, the Director of Food and Nutrition Services shall close down a service that is not in compliance.~~

References:

~~CMS Regulations 483.15, F242~~

- Safe Minimum Internal Termperatures <https://www.fda.gov/food/foodborneillnesscontaminants/buystoreservesafefood/ucm255180.htm > Accessed 3/1/2023.
- Safe Food Handling: What You Need to Know <https://www.fda.gov/food/foodborneillnesscontaminants/buystoreservesafefood/ucm255180.htm > Accessed 3/1/2023.

Revision Nursing Policies and Procedures

ASSESSMENT, PREVENTION, AND MANAGEMENT OF PRESSURE INJURY

POLICY:

1. The Registered Nurse (RN) is responsible for assessing each resident for presence and risk of pressure injury (PI) on admission and/or following any significant/clinical change in condition that may increase the resident's risk of developing a pressure injury.

2. Upon resident's intra-facility (within Laguna Honda) relocation, including Pavilion Acute, and/or vice-versa, the sending licensed nurse is responsible for conducting skin checks and completing skin section in the electronic health record (EHR) for any presence of pressure injury/complex wound.

3. The sending RN from SNF and/or Pavilion Acute and the receiving RN from SNF and/or Pavilion Acute will perform skin assessment of the resident.

4. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and complete skin section of the EHR.

5. ~~Upon identification of PIs), two RNs are required to verify and accurately stage the injuries~~ [SJ(1)]Wound, Ostomy, and Continence RNs (WOCNs), trained wound care champion RNs, or physicians can identify and stage pressure injuries.

6. The RNs, Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA), within his/her scope of practice, for observing and reporting changes in the resident's skin status ~~and implementing pressure injury prevention measures and/or treatment.~~

PURPOSE:

To provide guidelines to nursing in prevention and management of pressure injury.

PROCEDURE:

1. Prevention of Pressure Injury for Resident at Risk

a. Skin care: nursing assistants should keep the resident clean and dry and minimize exposure to moisture and associated irritants from incontinence, perspiration, or wound ~~drainage as much as possible~~. Handle skin gently and minimize friction (refer to Appendix B for LHH Skin Care products).

b. Skin check: nursing assistants are to thoroughly check the resident's skin at least once daily, paying particular attention to bony prominences and report changes to the primary nurse (team leader) and charge nurse This may be incorporated into the resident's daily hygiene care.

c. Positioning: position using the 30-degree rule — no greater than 30 degrees on either side, or the head of the bed should not be elevated more than 30 degrees when possible. Avoid positioning directly on trochanter or existing ulcer.

d. Repositioning: reposition residents who are immobile, at least every 2 hours or per care plan. Draw sheets can be used for repositioning.

e. Use caution when moving a resident. Avoid shearing/friction by using lifting devices such a trapeze or bed linen to move (rather than drag) residents who cannot assist during transfers and position changes.

f. Positioning devices: use wedges, and/or pillows~~, and pads~~ to [SJ(2]keep bony prominences from direct contact with one another.

g. Support surfaces: nursing staff will apply a pressure-relieving support surface (bed/wheelchair) and/or specialized mattress when needed after evaluation from the physician and RCT. If re-evaluation is needed notify the physician for evaluation and/or consult with the wound specialist or to the Plastics clinic (Refer to LHPP 24-03 Support Surfaces).

Note: To check whether a support surface reduces pressure enough slide hand with palm up and fingers flat under the support surface, just under the pressure point. With good support, one inch or more of uncompressed support surface is between the hand and the resident. If there is less than 1 inch, request adjustment of the device.

h. Protective devices:

   i. Protectors for ankle and elbow to minimize friction.
   ii. Heel protectors/devices or pillows under the length of the lower legs to suspend the heels. Do not put the pillow directly under the knees.
   iii. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet.
   iv. Foam arm rest covers (available from central supply under “arm desk stabilizer lateral”) for wheelchair arms can be used.

i. Careful placement in chairs: position chair-bound resident with good postural alignment, and distribution of weight, balance and pressure relief.

   i. Refer to occupational therapy for evaluation of appropriate seating device.
   ii. Avoid sitting directly on the pressure injury.
   iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.
   iv. Rest elbows, forearms and wrists on arm supports. Use foam armrest supports on wheelchair.
   v. Instruct or assist residents to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes if they are able.
   vi. Document the use of positioning devices and repositioning schedule (as tolerated) in the resident care plan.

2. Assessment of ~~Pressure Ulcer/~~Pressure Injury

The licensed nurse shall complete the Braden scale to identify residents at risk of developing PI. The Braden scale shall be completed on admission, every Tuesday thereafter for 3 consecutive weeks; then quarterly and annually following the Minimum Data Set (MDS) schedule; and when there is a significant decline or change of condition. If the resident’s day of admission falls on a Monday, the next Braden scale shall be completed on Day 8.

a. The charge nurse or licensed nurse will inform the Resident Care Team (RCT) of any resident identified at risk for pressure injuries and develop an initial care plan. The RCT will review and contribute to the care plan as needed.

b. The charge nurse or licensed nurse will ensure that the plan of care is reviewed with nursing staff and ensure through direct supervision that the plan of care is being implemented.

c. The RN will assess pressure injuries when present. The LVN may assist in data collection under supervision of RN:

i. location
ii. size (length, width, depth in cm)
iii. stage of injury
iv. presence and quality of granulation tissue
v. whether the wound edge around the ulcer is hard, thick, rolled or white-gray tissue, macerated edge, or open edge (healthy edge)
vi. presence of pain, exudate, slough, necrotic tissue and odor
vii. sinus tracts, tunneling, undermining
viii. periwound for erythema, warmth, maceration, or induration
ix. signs of wound infection, such as tenderness of surrounding tissue, edema or swelling, purulent drainage or foul odor

Indicators of a deteriorating pressure injury include increase in injury size, increase in exudate, loss of granulation tissue, purulent drainage and development of slough, necrosis, eschar or odor.

d. The RN will reassess pressure injuries, at least weekly, to determine whether the prescribed treatment is working and document on the electronic health record (EHR) until healed. A clean pressure injury should show evidence of some healing within two weeks.

e. The RN will reevaluate the treatment plan weekly, or as soon as there is any evidence of deterioration in the condition of the resident or the wound. If the injury fails to respond to treatment, notify the physician to evaluate and/or refer the resident to the Plastics clinic.

3. Management of /Pressure Injury

a. Following detection of a pressure injury, the charge nurse or designee will promptly:

i. notify the neighborhood provider (or if immediate treatment is needed, on-call physician) and a treatment plan shall be implemented within eight (8) hours;
ii. notify the dietitian within 24 hours (call Dietary office)
iii. notify the resident and / or Surrogate Decision Maker (SDM) within forty-eight hours
iv. complete a wound assessment and progress note in the electronic health record (EHR)
v. develop a plan of care for prevention and treatment for the injury(ies) with physician input
vi. submit an Unusual Occurrence
vii. ~~schedule~~ Schedule a Resident Care Conference (RCC). The RCT shall conduct a meeting to review the plan of care of resident with newly identified PI.

b. The RN will assess pressure injury(ies) weekly. The LVN may assist in gathering data under the supervision of the RN.

c. The RCT will reevaluate the treatment plan if the injury(ies) fails to show evidence of healing within two weeks, or when the injury(ies) shows signs of deterioration.

The Attending Physician in conjunction with the ~~RN wound specialist and RN~~[SJ(3][S(4][G(5]- RCT will evaluate non-healing and worsening pressure injuries. The Physician will refer to the Plastics Clinic ~~as~~when it is needed.

4. Documentation of Pressure Injury

a. Admission: Complete the Braden Scale and a skin assessment in the EHR.
b. Annually: document condition of skin as part of Minimum Data Set (MDS) and complete the Braden scale.

c. Intra-facility relocation: the sending licensed nurse is responsible for conducting skin checks and completing the skin assessment in the EHR for any presence of pressure injury/complex wound.

d. Discharge to acute:

   i. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and completing the skin assessment in the EHR.
   ii. LHH Acute: The sending RN from SNF and the receiving RN from Pavilion Acute will perform skin assessments of the resident.

e. Complete the Braden scale on admission, every Tuesday thereafter for 3 consecutive weeks, then quarterly and annually following the Minimum Data Set (MDS), and for any decline or signification change in condition.

f. Resident Assessment Instrument (RAI): When a pressure ulcer/pressure injury is triggered as a Care Area Assessments (CAA) Problem Area, the MDS Coordinator will:

   i. Utilize the CAA guidelines to identify additional areas needing assessment.
   ii. Document the assessment in the CAA notes, including the decision to care plan or not.
   iii. Review the RAI policy and consult with the physician and RCT to determine if a significant change in condition MDS assessment must be completed when a resident develops a stage 2 or higher pressure ulcer/pressure injury.

g. Resident Care Plan: If the resident is identified as being at risk for pressure injuries as determined through the Braden scale or has a pressure injury, a comprehensive, interdisciplinary care plan is developed that:

   i. identifies problems (i.e., PI risk factors and/or presence of injury),
   ii. develops individualized goal(s),
   iii. develops interventions to address prevention or treatment
   iv. develops interventions for wound and wound treatment pain if assessed as problem

h. SNF and Acute care units: Wound assessment~~s are~~ is done weekly and/or when there is a decline in the condition of the wound. These assessments are documented in the EHR.

i. Nursing Assistants are to document any changes in skin condition they observed in the EHR, including the name of the licensed nurse notified.

j. Weekly nursing summaries: Summaries include assessment of any new ~~-~~risk factors for developing a pressure injury as well as an evaluation of the effectiveness of implemented treatment/interventions and revision of care plan as needed.

k. Notification: Document all notifications to the physician,~~-~~ dietitian and family or SDM when a ~~pressure ulcer/~~pressure injury is detected and when the ulcer shows no evidence of healing.

l. Resident education/counseling: Resident teaching or counseling related to prevention/management of ~~pressure ulcers/~~pressure injuries is to be documented in the EHR and/or resident care plan.

APPENDICES:

Appendix 1: Definition of Pressure Ulcer and Intervention
Appendix 2: LHH Skin Care Formulary
Appendix 3: LHH Wound Care Formulary
Appendix 4: Waffle Overlay

REFERENCES:

Acute & Chronic Wounds: Current Management Concepts, Elsevier, 4th edition, 2012

Evidence-Based Pressure Ulcer Prevention: A Study Guide for Nurses, HC Pro, 2008 Sizewise

European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP), Pan Pacific Pressure Injury Alliance (PIPPIA). (2019). In *Prevention and treatment of pressure ulcers/injuries: Clinical practice guidelines. The international guideline* (3rd ed.).

Wound, Ostomy and Continence Nurses Society-Wound Guidelines Task Force WOCN 2016 Guideline for Prevention and Management of Pressure Injuries (Ulcers), Journal of Wound, Ostomy and Continence Nursing: May/June 2017 - Volume 44 - Issue 3 - p 241-246

CROSS-REFERENCES:

Hospitalwide Policy and Procedure
- 24-15 Prevention and Management of Pressure Ulcer

Nursing Policy and Procedure
- C 1.0 Admission and Readmission Procedures
- C 1.2 Nursing Guidelines for Relocation between Laguna Honda SNF Neighborhoods
- C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
- C 4.0 Notification and Documentation of Change in Resident's Status

Document originated: 2001/11

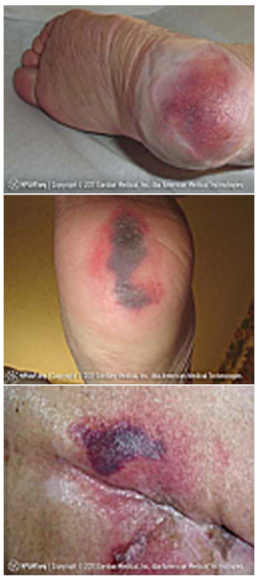
Revised: 2005/02; 2008/03; 2015/12/04; 2017/11/04; 2018/03/06; 2019/03/12; 2022/10/11

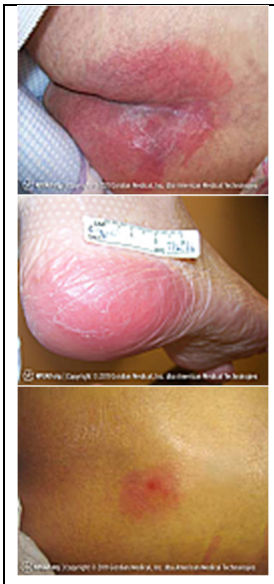
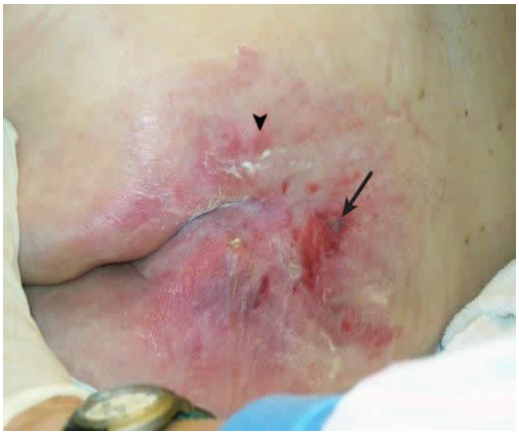
Reviewed: 2022/10/11

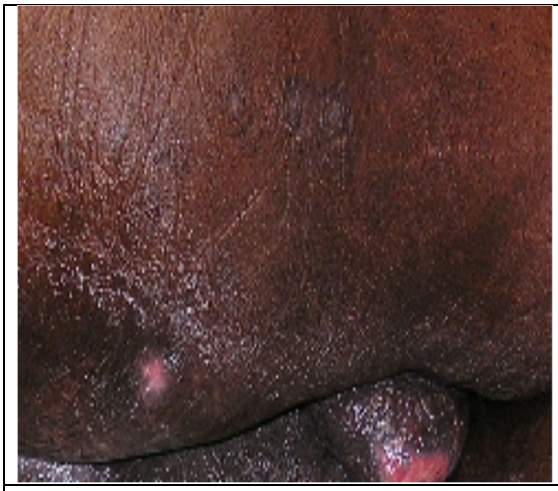
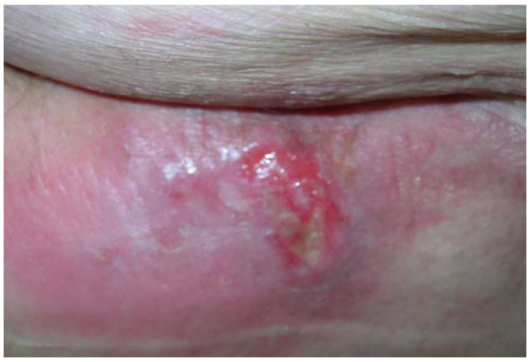
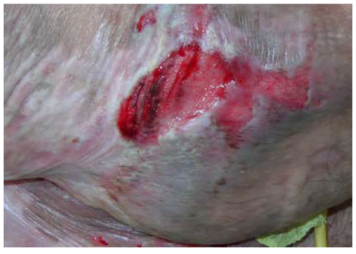
Approved: 2022/10/11

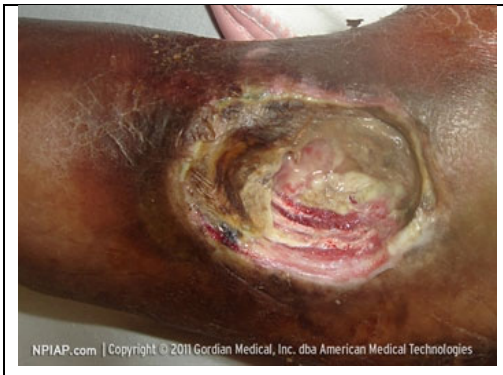
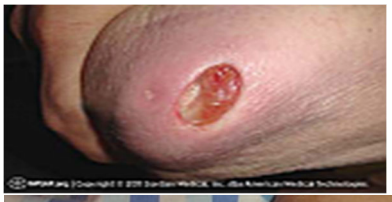
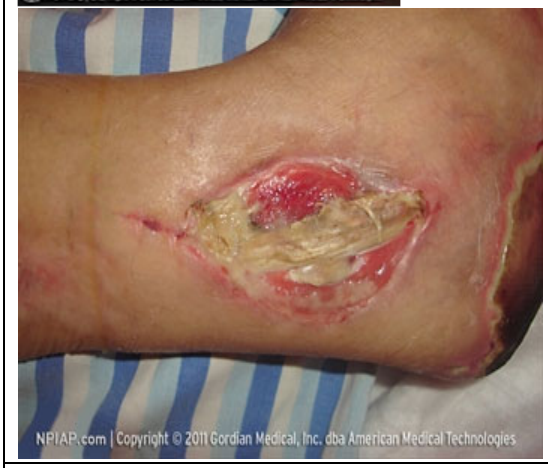
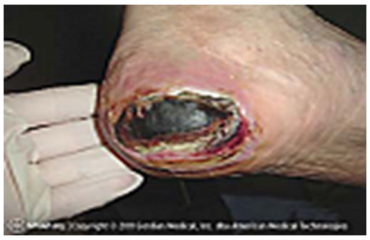
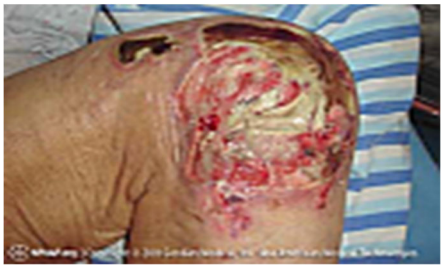
APPENDIX 1: Definition of Pressure Injury and Intervention [S(1]

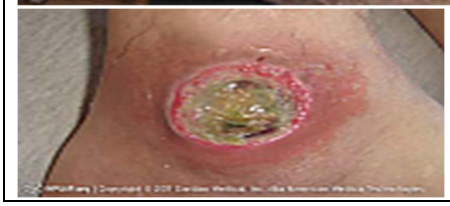
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

STAGE	DISCRIPTION	INTERVENTIONS
DEEP TISSUE PRESSURE INJURY-DTI 	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister, Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions	**Pressure Redistribution Devices: Obtain from CPD** 1.Waffle overlay (*i.e. Ehob)* for bed 2.Waffle seat or gel foam cushion for chair (*i.e. Ehob)* 3.Heel protectors *(i.e. RCAi, make sure to measure foot size)* *4. Apply Turning Wedges if sensory, activity and mobility are compromised* ***Consider,* Upgrade to low air loss mattress (LAL)** ** train unit clerks to order mattress & Wound Care specialist to continue tracking log
STAGE 1	Non-blanchable erythema of intact skin Intact skin with a localized area of	1. Reposition patient off the affected area to relieve pressure.

	non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. ***Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.*** **Tissue** may be painful, firm, soft, warm or cool as compared to surrounding tissue.	2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9.Heel protectors *(i.e. RCAi, make sure to measure foot size)*
STAGE 2 	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum filled blister. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), Denudation due to stool, intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule.

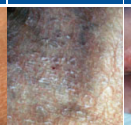
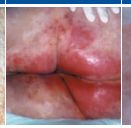
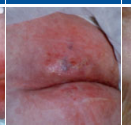
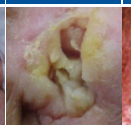
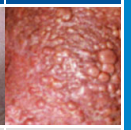
		7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9.Heel protectors *(i.e. RCAi, make sure to measure foot size* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM**
STAGE 3  	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. *The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage 3injuries can*	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9. Heel protectors *(i.e. RCAi, make sure to measure foot size.* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM**
STAGE 4	Full-thickness skin and tissue loss with exposed or directly palpable fascia,	1. Reposition patient off the affected area to relieve pressure.

  	muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. Stage 4 injuries can extend into muscle and/or supporting structures (e.g., fascia, or joint capsule) making osteomyelitis possible.	2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule. 7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9. Heel protectors *(i.e. RCAi, make sure to measure foot size.* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM**
UNSTAGEABLE  	Unstageable Pressure Injury: Obscured full thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar	1. Reposition patient off the affected area to relieve pressure. 2. Initiate an Optifoam dressings for all bony prominences and float heels. 3. Communicate in report at end of shift and, Wound Champions and charge nurse. 4. Enter Wound assessment data in the Avatar: Mark the correct location. 5. Document in Nursing notes new PI onset, including interventions that are implemented to promote healing. 6. Initiate turning clock and schedule.

 	***(i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or Removed.*** ***PAINT WITH BETADINE SWAB UNTIL ASSESSED BY WOUND Specialist.***	7.Apply pressure redistribution surface (bed & chair) to area, 8. Patients with incontinence/frequent loose stool - use skin barriers, inter-dry sheet within all folds, and consult with MD. 9. Heel protectors *(i.e. RCAi, make sure to measure foot size.* **10.COMMUNICATE WITH PRIMARY DR/PLASTIC TEAM**

Laguna Honda

SKIN CARE FORMULARY

			Normal Intact Skin	Moderate to Severely Dry Skin *including xerosis & fissures*	Incontinence Associated Dermatitis	Denuded Skin	Macerated Wet Skin	Venous Dermatitis and Lymphedema
								
	Cleanser	**Remedy with Phytoplex Hydrating Foaming Cleanser** Gentle, effective cleansing and conditioning pH balanced for every day use. Strong enough for removing barrier pastes, heavy creams, blood and fecal material. Tear Free, Hypoallergenic, & Non-Sensitizing .	●	●	●	●	●	●
	Barrier – Protection	**Remedy Dimethicone Skin Protectant** Provides a breathable barrier that protects against moisture and excessive transepidermal water loss (eTEWL). Doubles as an excellent long-term moisturizer for use on sensitive skin. pH balanced and enhanced with Olivamine®.	●	●	●			
	Barrier – Protection	**Soothe & Cool INZO** Leaves a non-greasy, invisible moisture barrier with a non-petrolatum formula that won't obstruct brief pores. Contains 5% dimethicone and 5% zinc oxide, as well as vitamins A, D & E and aloe. Specially formulated without dyes or perfumes. Ideal under tape.	●	●	●	●	●	●

FOR MORE CLINICAL INFORMATION CALL
THE EDUCARE® HOTLINE AT: 1-888-701-SKIN (7546)

www.medline.com/Woundcare

WAFFLE™ Overlay

Indications for Use

Primary

- Prevention and management of pressure injuries
- Comfort

Secondary

- Assists caregivers with patient turning, repositioning and lateral transfers

Contraindictations

- Unstable spine
- Recent sacral flap or graft surgery, unless otherwise determined by physician
- Patients with contraindications for the prone position per facility protocol should not be placed in the prone position on the WAFFLE Overlay

Interventions

- Hand checks should be performed at least once per shift and after repositioning
- Ensure airway remains unobstructed in patients who are unable to reposition self
- The WAFFLE Overlay straps may be a ligature risk for some patients. Follow your facility's ligature risk policy.

Additional Information:

- Single patient use
- Patients may require the WAFFLE Bariatric Overlay based on body type
- The WAFFLE Overlay can be used across the continuum of care
- Weight limit: 600 pounds
- Ensure there is a sheet between the overlay and patient

Instructions for Use

Set-Up

Step 1: Prepare

Unfold the overlay with the closed red and clear valves facing up at the foot of the bed. The red valve is for rapid deflation (CPR). Secure the straps under the corners of the bed.

Step 2: Inflate

Using the clear valve, inflate the overlay with the WAFFLE® M.A.D. Hand Pump. The recommended number of strokes can be found on the pump or overlay and should be used as a starting point.

Step 3: Check

To check for proper inflation, slide your hand between the overlay and support surface, under the patient's sacral area. Your hand should slide easily beneath the patient and you should notice approximately 1/2 inch to 1 inch of air. If there is more than 1 inch of air, remove air by tapping the clear valve. If your hand does not slide easily beneath the patient, add additional air.

Turning and Repositioning

Step 1: Position Patient

The caregiver on one side of the support surface grasps the overlay hand wells. He or she hands off the overlay to the caregiver on the opposite side, while rolling the patient.

Step 2: Place Wedges

Place the first Position Perfect® Wedge just above the waist area and the second just below the hip area, one hand-width apart, to offload the sacrum. Return the patient down onto the wedges.

Step 3: Check

The wedges are properly positioned when you can slide your hand between them and verify the sacrum is offloaded.

Continued on other side ▶

WAFFLE® Overlay Additional Instructions for Use

Lateral Patient Transfers

Weight limit: 350 lbs.

Step 1: Prepare Surfaces

Ensure both surfaces are at a comfortable height and are locked in place.

Step 2: Release Overlay Straps

Remove the overlay straps from underneath the corners of the support surface.

Step 3: Transfer Patient

Grasp the hand wells and gently slide the patient onto the receiving surface.

Prone Position

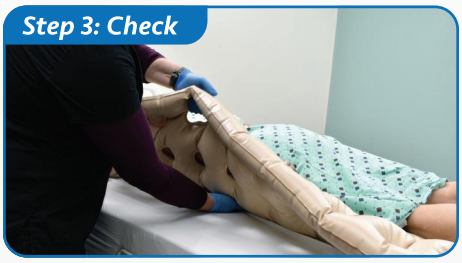
Step 1: Deflate Overlay

Prior to repositioning the patient from supine to prone, deflate the overlay and ensure the straps are looped under the corners. **Follow your facility protocol for placing a patient into the prone position.**

Step 2: Inflate

Once the patient is in the prone position, inflate the overlay. Reinflation may require less air than listed on the product.

Step 3: Check



To check for proper inflation, slide your hand between the overlay and support surface, under the patient's iliac crest area. Your hand should slide easily beneath the patient and you should notice approximately 1/2 inch to 1 inch of air. If there is more than 1 inch of air, remove air by tapping the clear valve. If your hand does not slide easily beneath the patient, add air.

Cleaning Instructions

The WAFFLE Overlay is single patient use but can be cleaned with standard hospital cleaning wipes if soiled. A complete list of approved cleaning products is available upon request.

For complete instructions, refer to product package insert.

Scan the QR code to view an instructional video.

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WOUND IRRIGATION AND CLEANSING

POLICY:

1. Wound irrigation requires a physician's order. Irrigation order must include the type of wound irrigation solution to be used.

2. The Licensed Nurse is responsible for performing wound irrigation.

3. All wound care and treatment supplies including cleaning/irrigation solutions, dressings, scissors, medicated topical ointments shall be stored in the treatment cart and/or where treatments are stored in the medication cart.[SJ(1]

4. Over-the-counter skin creams and lubricant (i.e., protective barriers, Vitamin A & D, Aquaphor) and personal hygiene products (i.e., shampoos and soaps) are stored in a locked container.

PURPOSE:

To provide guidelines for appropriate and effective wound cleansing and irrigation.

DEFINITIONS:

"Cleansing" refers to the use of an appropriate device and solution to clean the surface of the wound bed and to remove the looser foreign debris or contaminants in order to decrease microbial growth.

"Irrigation" refers to a type of mechanical debridement, which uses an appropriate solution delivered under pressure to the wound bed to vigorously attempt to remove debris from the wound bed. Licensed Nurses in Laguna Honda may only perform mechanical and chemical wound debridement.

Types of Syringes used for Wound Irrigation

1. 60-ml catheter tip piston syringe delivers approximately 4 psi of pressure. This is recommended for general irrigation and cleansing.

2. 35-ml syringe with an 18-gauge angiocath delivers approximately 8 psi of pressure. This is recommended for deep undermining, sinuses and tunneling, and for loosening adherent debris.

Types of Irrigation Solutions

1. Normal Saline, or Vashe - most commonly used and least toxic irrigation/cleansing solution.

2. Chemical Solutions – must be use for a limited period, unless specified by the physician. These types of solution may damage healthy wound bed tissues or granulating tissues. The Licensed Nurse must reassess use of chemical solutions weekly and notify physician.

    a. Povidone Iodine (Betadine)
    b. Dakin's Solution (1/4 strength and 1/20 strength)
    c. Hydrogen Peroxide - may be used to remove crusts from fixators and orthopedic

pins. Once the crusts are removed, the site is cleansed with ~~normal saline~~Vashe.

3. Commercial Wound Cleanser – do not contain harmful chemicals. This contain surfactants and other chemicals intended to enhance their efficacy. Wounds with adherent materials may benefit from a wound cleanser.

PROCEDURE:

A. Equipment

60 ml catheter tip piston syringe or *35 ml syringe with 18-gauge angiocath (*requires special order from CSR)
Prescribed wound solution or cleanser
Wound irrigation kit
4 x 4 gauze
Cotton tip applicator
Pad or towel
Tape
Secondary wound dressing
Stockinet (if needed)
Kidney basin (if needed)
Gloves
Plastic Bag

B. General preparation

1. Explain the procedure to the resident. Assess resident for pain prior to wound treatment.
2. Provide privacy.
3. The treatment cart is never to be used as a work surface when performing the treatment.
4. Wound cleansing or wound irrigation uses clean technique, unless otherwise specified to use sterile technique.
5. All wound irrigation solutions, normal saline, and wound cleansers when opened must be labelled with date, time, and licensed nurse initials.

    a. Normal Saline must be discarded 24 hours after being opened.
    b. Other unused, opened wound irrigation solution or cleanser is discarded before the expiration date.

C. Preparation of Resident for Wound Irrigation

1. Gather all necessary equipment for wound irrigation.
2. Position the resident and expose the affected wound area.
3. Protect bedding with a pad or towel under area to be irrigated.
4. Create a clean working area (i.e. bedside table) to open wound irrigation kit, prepare the irrigating solution to be used, irrigating syringe, secondary dressing, tape, gloves, and plastic bag.
5. Put on clean gloves. Remove wound dressing. Place soiled dressing and gloves into the plastic bag.
6. Change to another clean gloves and proceed with wound irrigation.
7. Fill the syringe with irrigating solution.
8. Position kidney basin to catch the solution during irrigation.
9. Gently insert tip of syringe or angiocath into wound areas and irrigate until returns are clear. Be sure solution reaches all areas of the wound.
10. As needed, clean periwound skin with moistened normal saline, or vashe, gauze and pat to dry.

11. Apply secondary dressing.
12. Discard the irrigation kit and gloves.

D. Preparation of Resident for Wound Cleansing

1. Gather all necessary equipment for wound cleaning.
2. Spray wound cleanser may be applied directly to the wound or can be sprayed ontoclean 4x4 gauze then applied to the wound.
3. Put on clean gloves. Remove wound dressing. Place soiled dressing and gloves intothe plastic bag.
4. Change to another clean gloves and proceed with cleaning of wound.
5. Using the wound spray cleanser, hold the spray bottle approximately 1 inch from the wound bed. Aim the nozzle at the wound, spray directing the stream of cleanser along the base and sides of the wound.
6. Blot up excess moisture with a clean gauze.
7. Dry the surrounding skin.
8. Apply secondary dressing.
9. Discard plastic bag.

E. Documentation

1. Licensed Nurse will document wound care in the electronic health record

F. Storage of Supplies (See NPP B 6.0 Items at Bedside)

Wound care and treatment supplies are normally stored in a treatment cart, which is locked when not in use or stored in a place inaccessible to residents. The following must be stored in the treatment cart when not in use.

a. Chemical solutions and commercial wound cleansers must be stored in a locked treatment cart
b. Syringes and scissors must be stored in a locked treatment cart

REFERENCES:

Sardina, D. (2013). Is your wound-cleansing practice up to date? *Wound Care Advisor; May/June* 2(3), p 15-17
CMS Manual System, Pub. 100-07 State Operations, transmittal 4, Nov. 12, 2004

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-15: Pressure Ulcer Management

Nursing Policy and Procedure
B 6.0 Items at Bedside
K 1.0 Pressure Ulcer prevention and Treatment
K 2.0 Wound Assessment and Management

Revised: 2000/08, 2005/02, 2008/02, 2019/07/09, 2022/07/12

Reviewed: 2022/07/12

Approved: 2022/07/12

PREVENTION AND TREATMENT OF SKIN TEARS

POLICY:

1. The Licensed Nurse is responsible for initiating, ~~prevention~~ intervention strategies for preventing skin tears.

~~1.~~2. Licensed nurse is responsible for~~, and~~ notifying and obtaining a treatment order from the physician when a resident develops and/~~or~~/ is admitted with minor skin tears that are not related to pressure.

~~2.~~3. The Licensed Nurse ~~staff~~ will evaluate, document the healing or worsening of a skin tear weekly, and shall notify the physician of any complications when needed.

PURPOSE:

1. To prevent skin ~~breaks~~ tears from occuring~~which are unrelated to pressure ulcer~~s.

2. To ~~foster~~ promote healing of skin tears.

BACKGROUND:

Skin tears are traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces including blunt trauma, fall, poor handling, equipment injury or removal of adherent dressings. In already fragile or vulnerable skin (e.g., in aged or very young skin), less force is required to cause a traumatic injury, meaning that incidence of skin tears is often increased.

Skin tears can occur on any part of the body but are often sustained on the extremities such as upper and lower limbs or the dorsal aspect of the hands.

When a patient presents with a skin tear, the initial assessment should include a full, comprehensive assessment of the patient as well as the wound. It is also important to establish the cause of the injury. ~~gets thinner and weaker with age or who have been on long-term steroid therapy. Fragile skin must be cared for with extra gentleness, avoiding excess pressure, friction, or twisting of skin in opposite directions when moving a resident in bed or chair, transferring from one place to another, turning or repositioning, and washing and drying the skin after cleansing. Wet skin can cause rashes and lead to skin breakdown.~~

~~Resident activity that causes the skin to be rubbed or twisted can cause the skin of arms and legs to easily tear from the friction. Such activities as putting an arm into a tight sleeve, scratching an itch, or moving about in bed or wheelchair without assistance can tear the thin skin, resulting in a flap of loose skin attached to a denuded area which may bleed or become infected.~~

The changes to the skin associated with ageing include

- Thinning of the epidermis and flattening of the epidermal junction
- Loss of collagen, elastin and glycosaminoglycan
- Atrophy and contraction of the dermis (causing appearance of wrinkles and folds)
- Decreased activity of sweat glands and sebaceous glands, causing the skin to dry out
- Thinning of blood vessel walls and a reduction of blood supply to the extremities

~~■ Increased dermal LEP, including solar elastosis, may represent a risk factor for skin tears~~Prolonged sun exposure

Categories:

Type 1 skin tear — No skin loss
Linear or flap tear where the skin flap can be repositioned to cover the wound bed.

Type 2 skin tear — Partial flap loss
The skin flap cannot be repositioned to cover the whole of the wound bed.

Type 3 skin tear — Total flap loss
Total skin flap loss that exposes the entire wound bed.

PROCEDURE:

A. Prevention of Skin Tears

1. Inspect skin and investigate previous history of skin tears
2. If patient has dry, fragile, vulnerable skin, assess risk of accidental trauma
3. Manage dry skin and use emollient to rehydrate limbs as required
4. Implement an individualized skin care plan using a skin-friendly cleanser
5. Prevent skin trauma from adhesives, dressings and tapes, (use silicone tape and cohesive retention bandages)
6. Consider medications that may directly affect skin (e.g. topical and systemic steroids)
7. Be aware of increased risk due to extremes of age
8. Discuss use of protective clothing (e.g. shin guards, long sleeves or retention bandages)
9. Staff should ~~Avoid sharp fingernails~~ not have or jewelery in patient contact
10. Provide a safe environment
11. Caution with repositioning and transferring resident to avoid any surface that can cause skin tearing.

    a. Use transfer techniques that prevent friction or shear.

    b. Pad bedrails, wheelchair arms, and leg supports.

    c. Support dangling arms and legs with pillows or blankets

~~1. Provide a safe environment~~

~~a. Offer residents to wear long sleeves, pants, socks, or shoes to protect their extremities.~~

~~b. Provide adequate light to reduce the risk of bumping into furniture or equipment.~~

~~c. Provide a safe area for wandering residents.~~

~~2. Protect from self-injury or injury during routine care~~

~~a. Apply lotion or moisturizer, especially on dry skin on arms and legs daily.~~

~~b. When washing resident with fragile skin, use no-rinse soapless products.~~

~~c. Caution with repositioning and transferring resident to avoid any surface that can cause skin tearing.~~

~~d. Use transfer techniques that prevent friction or shear.~~

~~e. Pad bedrails, wheelchair arms, and leg supports.~~

~~f. Support dangling arms and legs with pillows or blankets.~~

B. Management and Treatment of Skin Tears

- ■Control bleeding by apply pressure and elevate the limb if appropriate.
- ■ when controlling bleeding is the main goal, dressings to assist with hemostasis may be used
- ■ Cleanse/irrigate the wound as per local protocol and remove any residual debris or hematoma, gently pat the surrounding skin dry to avoid further injury.
- ■ If the skin flap is present but necrotic it may need to be debrided; care should be taken during debridement to ensure that viable skin flaps are left intact and fragile skin is protected.
- ■ If viable, re-approximate the skin flap to use as a 'dressing.' Ease the flap back into place using a gloved finger, dampened cotton tip, tweezers or a silicone strip.
- Manage infection/inflammation
- ■ Wound inflammation from trauma should be distinguished from wound infection.
- ■ Wound infection can result in pain and delayed wound healing; diagnosis of infection should be based on clinical assessment and appropriate infection control measures taken.
- ■Check tetanus immunization status and take further steps if necessary.
- Consider moisture balance/exudate control
- ■Skin tears tend to be dry wounds, but there may be some circumstances in which exudate is an issue
- ■Moisture balance is essential to promote wound healing and to protect the peri-wound skin from maceration.
- ■Observe the volume and viscosity of the exudate when selecting a topical wound dressing
- Monitor wound edge/closure
- ■Skin tears are acute wounds that should typically proceed to closure in a timely fashion and follow an acute wound closure trajectory of 14–21 days.
- ■Ensure that all potential factors that could delay healing (e.g. diabetes, peripheral edema, nutritional issues) have been addressed.
- ■Compression therapy should be considered if the wound is on the lower leg. Before applying compression, a full leg assessment including vascular assessment.

~~B.~~**1.**

~~1.~~2. Equipment

UrgoTul Ag or An Aquaphor Vaseline gauze	Clean gloves
2" x 2" or 4" x 4" sterile gauze pads	Plastic waste bag
Sterile ~~butterfly~~ tape strips (Steri-Strips~~)~~	Sterile applicators
Stretchy roller gauze	~~Tubular non-adhesive wrap (tubi pad)~~
Tubular Stockinet	

~~2.~~3. Treatment of Skin Tears

a. Basic Care for Skin Tears

i. Cleanse all skin tears with ~~normal saline~~Vashe. DO NOT USE PEROXIDE.
ii. Use non-adherent dressings, if possible.
iii. Apply skin protective barriers or a non-adherent wound dressing with gauze or secondary dressing such as silicone ~~or telfa-type dressings~~.

iv. Use gauze wraps, stockinettes, flexible netting to secure dressings rather than tape. If you must use tape, use paper tape.
v. If adherent dressings are required, use caution when removing the dressing or use adhesive remover pad prior to removing the dressing to prevent skin tearing.

b. Skin tear with skin flap present

i. Some skin tears have a skin flap; treatment goal should be to avoid dislodging the flap.
ii. Reposition the torn flap over the wound so that there is a chance of it reattaching to the wound bed.
iii. Approximate edges together by gently sliding flap over exposed wound with sterile cotton tip applicator.
iv. Cover with moist wound dressing, such as hydro gel, foam, petroleum-based protective ointment (Vaseline gauze), or Steri-strip.
v. Secure non-adherent dressings with a gauze or tubular non-adhesive wrap (tubi pad or tubular stockinet).
vi. Change dressing daily ~~or according to manufacturer's recommendations.~~
vii. Monitor for signs and symptoms of infection; if present notify the physician for new treatment.

c. Skin tear without flap or with hematoma

i. Cover with ~~Transparent or foam dressing. Change every 5-7 days and PRN when drainage is outside dressing.~~non-adherent dressing and a foam dressing. Change daily.
ii. Monitor for signs and symptoms of infection, notify MD
~~i.~~iii. Continue with skin tear prevention protocols when tear heals

~~ii. Discontinue dressing when healed.~~
~~iii. Monitor for signs and symptoms of infection; if present notify the physician for new treatment.~~

C. Documentation

1. Refer to NPP K 2.0 Wound Assessment and Management.

2. Record on ~~Resident Care Plan (RCP) Front Card if resident has fragile skin.~~the Avatar wound location and assessment

REFERENCE:

Nettina, S., The Lippincott Manual of Nursing Practices, 9th edition, 2010

LeBlanc K, Campbell KE, Wood E, et al. Best practice recommendations for prevention and management of skin tears in aged skin: an overview. J Wound Ostomy Continence Nurs. 2018;45:540–2.

Van Tiggelen H, Van Damme N, Theys S, et al. The prevalence and associated factors of skin tears in Belgian nursing homes: a cross-sectional observational study. J Tissue Viability 2019;28:100–6.

Hawk J, Shannon M. Prevalence of skin tears in elderly patients: a retrospective chart review of incidence reports in 6 long-term care facilities. Ostomy Wound Manage 2018;64(4):30–6.

Woo K, LeBlanc K. Prevalence of skin tears among frail older adults living in Canadian long-term care facilities. Int J Palliat Nurs 2018;24:288–94.

Parker CN, Finlayson KJ, Edwards HE, MacAndrew M. Exploring the prevalence and management of wounds for people with dementia in long-term care. Int Wound J 2020;17:650–9.

CROSS-REFERENCES:

NPP K 2.0 Wound Assessments and Management
LHHPP File 23-01 Resident Care Plan, Resident Care Team, & Resident Care Conference

Revised: 8/2002, 2/2005, 4/2008; 05/27/2014

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