List of Hospital-wide/Departmental Policies and Procedures Submitted to JCC for Approval on June 13, 2023

New Hospital-wide Policies and Procedures

Status	Dept.	Policy #	Title	Notes
New	_LHHPP	23-03	Screening and Response to Suicidal Ideation	New policy
New	_LHHPP	25-15	Medication Administration	Nursing policy J 1.0 Medication Administration was removed and created as a new hospital-wide policy.

Revised Hospital-wide Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Revision	_LHHPP	20-04	Discharge and Transfer Process	1. Added transfers to policy 2. Added LHH may also transfer to another skilled nursing facility if appropriate 3. Add the policy does not apply to residents who are being relocated to another SNF as a "Facility Closure Transfer" and subject to the requirements described in LHHPP 01-16 Facility Closure Plan. 4. Updated purpose to " to implement a safe and orderly discharge process for residents who desire discharge to the community, no longer need SNF services, and/or are able to be cared for at a lower level of care. To implement a safe and orderly transfer process for residents who require transfer to an emergency department or for resident who desire o be transferred to another SNF, but in this specific instance, only when LHH is not subject to a facility closure plan." 5. Updated definition of Discharge and Transfer. 6. Updated A. Discharge to the Community to include designated members of the rct shall education the resident or SDM when lower level of care is appropriate and shall prepare and finalize discharge to the community. 7. Updated Post Discharge Plan of Care form to AVS (After Visit Summary) and related discharge sections 8. Updated Notification of Resident Regarding Discharge/Transfer from Facility to include nurse or physician shall notify the resident or legal representative of a transfer and reasons for the move in writing. 9. Added Transfer to an Emergency Department (ED), Involuntary Discharges and Transfer to Another Skilled Nursing Facility and Resident Leaving Against Medical Advice
Revision	_LHHPP	20-06	Leve of Absence (LOA), Out on Pass (OOP) and Bed Hold	1. Updated policy title to Leave of Absence (LOA), Out on Pass (OOP) and Bed Hold 2. Added therapeutic leave and Leave of Absence will be granted to residents based on the plan of care. 3. Removed OOP is the responsibility of the RCT 4. Moved LOA due to acute hospitalization to Background 5. Added F843. 483.15 to Background 6. Updated Nursing to provide bed hold information and Notice of Proposed Transfer at the time of transfer or within 24 hours and if legal representative is not present, a phone call will be made to review the bed hold policy. 7. Added MSW will provide and review bed hold information to the resident or legal rep prior to a scheduled OOP
Revision	_LHHPP	22-13	Bed Rail Use	1. Replaced RCT with Resident Care Team 2. Updated 22-07 policy name 3. Replaced physical restraint assessment with bed rail safety assessment 4. Added consent to be reviewed annually at minimum

Revision	_LHHPP	22-14	Resident Activities	1. Added RCT members will understand and learn the resident's lives, hobbies, interests, comforts to support resident to access activities 2. Added LHH will provide a variety of individualized opportunities for meaningful engagement and participation for resident's with dementia 3. Added RCT will offer options for activities that provide meaningful engagement and interaction, ensure residents have access to personal items that they find comforting and offer and giving assistance to resident to visits the garden or other areas of the hospital 4. Added new Resident with Dementia section 5. Updated references
Revision	_LHHPP	24-10	Coach Use for Close Observation	1. Updated "Close observation" to "Long-term close observation" 2. Added "For residents who are having active suicidal ideation and scored at medium risk, a temporary coach shall be provided while waiting for further psychiatric evaluation."3.
Revision	_LHHPP	45-01	Gift Fund Management	Minor grammar updates
Revision	_LHHPP	45-02	Employee Development Fund	1. Defined DPH as Department of Public Health 2. Added Office to City Attorney's 3. Added reference to LHH throughout policy
Revision	_LHHPP	45-03	Donations	Minor grammar updates
Revision	_LHHPP	70-01 B1	Emergency Response Plan	1. Added Command Center telephone number 2. Added Incident Commander or Emergency Manager to Internal Notification Process 3. Added Incident Commander will notify DPH Emergency Response & Prepared branch 4. Added new Staffing & Management of Volunteer section, which includes volunteer staffing during emergencies or disaster, management of staff including volunteer health care professionals at LHH during disaster, licensed independent practitioners and tracking staff & volunteers at LHH during a disaster. 5. Added Contractor Contact Information section and contractor contact list 6. Updated Emergency Contact List with Ombudsman information

Revised Activity Therapy Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Revision	Activity Therapy	A2	Scope of Services	1. Added individualized opportunism for meaningful engagement and participation for residents with dementia 2. Added musical entertainment 3. Added Resident with Dementia section that covers activities for dementia residents

New Food and Nutrition Services Policies and Procedures

Status	Dept.	Policy #	Title	Notes
New	FNS	1.01	Food and Nutrition Services Scope of Service	New policy

Revised Nursing Services Policies and Procedures

Status	Dept.	Policy #	Title	Notes
Revision	Nursing	A 2.0	Nursing Services: Organization, Authority/Responsibility and Operations	1. Removed “Clinical Resource Nurse” “Clinical Resource CNA” 2. Added to QAPI section” 3. “Nursing services follows the process outlined in LHHPP 60-01 QAPI” 4. Remove section/sentence referring to the FOCUS P-D-C-A since LHH does not use the FOCUS system.
Revision	Nursing	A 4.0	Nursing Clinical Competency Program	1. Updated Positions: Removed “Education Coordinator” “Nursing Program Director” “Education Coordinators” 2. Removed pre-test requirement for abuse in-services and trainings, this was removed from HWPP 3.Generalized maintaining BLS to “as required by job description”
Revision	Nursing	A 6.0	Orientation of Nursing Personnel	1. Removed pre-test requirement for abuse in-services and trainings, this was removed from HWPP 2. Clarified to reflect that the evaluation and consideration for orientation extension is based on performance
Revision	Nursing	D 1.0	Restorative Nursing Care	1. Removed Therapy Aide as they will no longer be part of the Restorative Program. 2. Updated duplicate definitions 3.Simplified Assessment section and added discontinuation criteria 4. Added program updates from restorative nursing program
Revision	Nursing	G 7.0	Obtaining, Recording and Evaluating Residents Weights	2. Deleted "Resident weight is obtained on the day of admission/readmission, monthly, as clinically indicated, and during the observation period of the Minimum Data Set (MDS) unless otherwise indicated by a physician order." 3. Replaced "every first weekend" with "within the first 7 days of the month" 4. Replaced "on care plan" with "in the electronic health record"
Revision	Nursing	N/A	Nursing Educational Programs	1. Updated clinical educator roles 2. Remove section on CPI (not necessary in nursing policy), and refer to 73-05 Workplace Violence Prevention Program for program details 3. Included details of when nursing in-service education is offered and referring to Title 22 requirements

Deletion Nursing Services Policies and Procedures				
Status	**Dept.**	**Policy #**	**Title**	**Notes**
Deletion	Nursing	J 1.0	Medication Administration	Delete policy and move to hospital-wide policy.

New Hospital-wide Policies and Procedures

SCREENING AND RESPONSE TO SUICIDAL IDEATION

POLICY:

1. The policy of Laguna Honda Hospital and Rehabilitation Center (LHH) is to provide evidence-based assessment and interventions to equip staff in the evaluation of a resident's expression of suicidal ideation. A resident may communicate passive or active suicidal ideation.

2. LHH staff shall be trained for signs of resident's expression of suicidal ideation and how to respond accordingly.

3. LHH has adopted one evidence-based tool, the Columbia Suicidal Severity Rating Scale (CSSRS), which is used when a resident is heard or observed to verbalize any passive or active suicidal ideation, or to indicate any gesture of suicidal behavior.

4. LHH shall identify residents at risk for suicide by:

    a. Conducting a suicide risk screen using a validated stratified risk screen tool.

    b. Notify the provider for any resident or patient who screens at risk.

    c. Implementing individualized interventions to mitigate the resident or patient's risk of suicidality while considering immediate safety needs.

PURPOSE:

To ensure that each resident who expresses suicidal ideation receive the necessary behavioral health care and services to attain or maintain the highest practicable level of mental, physical and emotional health.

DEFINITION:

Active suicidal ideation: An individual no longer has the motivation to live and has a plan to end their life. Active suicidal ideations sound like "It would be so easy to end my life by ___."

"Close Observation": Refer to LHHPP 24-10 Coach Use for Close Observation

Passive suicidal ideation: An individual no longer has the motivation to live but does not have a plan to take their life. Passive suicidal thoughts sound like "I just wish I could go to sleep and not wake up," or "I wish I could just wander into a fog and just disappear," or "I wish that the world just ended tomorrow."

PROCEDURE:

1. If the resident or patient expresses active or passive suicidal ideation, LHH shall initiate an evidenced-based assessment and interventions based on the level of suicide risk.

2. During the Admission, Quarterly, Annual, and Significant Change of Condition Minimum Data Set (MDS) Assessment, if Section D (Mood) is triggered (score of 7 or higher and/or Section D0200-I or D0500-I), the MDS Coordinator shall immediately relay the information to the Physician, Social Worker and Licensed Nurse for evaluation.

3. When a resident or patient is relocated to another unit, the MDS Coordinator shall assess resident's mood using the MDS Assessment under section D0200 and/or D-0500 (PHQ-9) within 2 weeks from the time of relocation. If a score of 7 or higher or a YES answer to either Section D0200-I or D0500-I, the MDS Coordinator shall immediately relay the information to the Physician, Social Worker and Licensed Nurse for evaluation.

4. A trained Licensed Nurse or Social Worker shall conduct the C-SSRS screen.

5. Residents or patients with triggered at risk of self-harm and/or history of suicidal ideation shall have a target behavior monitoring order.

6. Based on the C-SSRS screening results, individualized suicidality management interventions are implemented. Resident/Patient specific interventions are listed below.

   a. LOW RISK

      i. Create a safe environment.

         - Staff shall assess the environment for potentially dangerous items for self-harm.

         - Consider aeroscout.

      ii. The Licensed Nurse shall inform the provider of the resident's C-SSRS score by call or page (numeric page).

      iii. Immediately notify the provider for evaluation by call or page (numeric page). Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8.

      iv. Consider other resources such as Behavioral Emergency Response Team (BERT) and Psychiatry consultation.

v. Notify the Nursing Operations Supervisor.

b. MEDIUM AND HIGH RISK

i. Create a safe environment.

- Staff shall assess the environment for potential dangerous items for self-harm.
- Provide one to one observation until the resident or patient is evaluated by the Attending physician or on-call physician and/or transferred out to a Psychiatric or Acute Emergency for further psychiatric and/or medical evaluation.
- Maintain visual contact at all times, including bathroom use.

ii. Immediately notify the physician for evaluation by call or page (numeric page). Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8.

iii. Ask the provider to immediately contact LHH Psychiatry for urgent discussion. The provider will call/page LHH Psychiatry.

iv. Consider other resources such as the Behavioral Emergency Response Team (BERT).

v. Immediately notify the Nursing Operations Supervisor.

vi. Notify the resident/patient's representative, if appropriate.

7. IF THE RESDIENT DECLINES C-SSRS SCREENING

a. Create a safe environment:

i. Staff will assess the environment for potential dangerous items for self-harm.

ii. Consider aeroscout.

b. The Licensed Nurse will inform the provider why the screening was indicated and that the resident declined C-SSRS screening.

c. Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8.

8. ATTENDING PHYSICIAN OR ON CALL PHSYCIAN EVALUATION

a. The physician shall determine the clinical level of suicide risk based on medical evaluation and determine if there is a need for change in current management, including urgency of psychiatric consultation.

   i. The attending physician or on-call physician will evaluate the reasons for the screening and the results of the screening.

   ii. The attending physician or on-call physician will evaluate the resident and determine whether suicidal ideation is currently present or at risk for recurring imminently. This evaluation shall include a review of existing recommendations from PCP and psychiatry; assess the resident for the effectiveness of those interventions; and determine what updates to those interventions that may be needed.

   iii. The attending physician or on-call physician will call for urgent LHH Psychiatry Consult if deemed necessary based on risk assessment (e.g., new suicidal ideation, self-harm behavior, etc.).

      - If the resident or patient is placed on 5150, the resident/patient will be sent to an Acute or Psychiatric Emergency.

      - If the resident or patient does not meet 5150 criteria for danger to self but the physician identifies that the facility cannot safely manage the resident or patient with behavioral intervention implemented, the physician can initiate a transfer to an Acute facility.

         - If the clinical team identifies that the facility can manage the patient with appropriate behavioral interventions, the resident or patient shall not be transferred from the facility.

9. INDIVIDUALIZED CARE PLAN REVIEW AND IMPLEMENTATION TO ADDRESS TRIGGERS AND ENHANCE COPING SKILLS

For residents deemed to be appropriate for the level of care provide by the facility:

a. The physicians assessing the resident will within the shift review with the Licensed Nurse the existing care plan and orders to confirm documentation and implementation of any previous or newly recommended interventions, with Psychiatry input (if consult was called).

b. The physician and nurse will hand off to the next daytime shift to inform the Resident Care Team (RCT) members of the results of both the screening and evaluation results, and the recommendations.

c. The RCT will conduct a Resident Care Conference (RCC) as indicated, to discuss the resident or patient's suicidal ideation (SI) risk and update the mitigation plan that includes the psychiatry recommendations if any.

   i. Include the resident/patient's representative, when appropriate.

   ii. Other resources, such as LHH Psychiatry, Chaplain, BERT, etc. will be invited to participate in the RCC.

d. The RCT will develop a comprehensive care plan to address safety related to suicidal ideation risk.

10. IF PSYCH EMERGENCY CALLS THE UNIT FOR RETURN CRITERIA, REFER TO PHYSICIAN IN COLLABORATION WITH PSYCHIATRY.

a. The psychiatry clinician will discuss with Psych Emergency psychiatrist, and determine if the resident can be cleared psychiatrically for returning to LHH and any recommendations for clinical management.

b. The psychiatry clinician will communicate the recommendations (clearance and management) to the attending physician or on-call physician and the Psychiatry team.

c. The attending physician or on-call physician will determine if the resident may return, and if so, will provide the order.

11. IF RESIDENT IS CLEARED TO RETURN TO LHH

a. Maintain a safe environment;

   i. Staff shall assess the environment for potential dangerous items for self-harm.

      - Refer to the Patient Safety and Ligature Identification Checklist.

   ii. Consider aeroscout.

b. Ensure section 9 is completed.

c. Notify the Nursing Operations Supervisor.

d. Inform the RCT members.

e. The RCT shall conduct a Resident Care Conference to discuss the resident or patient's SI risk and identify a mitigation plan that includes the psychiatry recommendations if any.

i. Include the resident/patient's representative, when appropriate.

ii. Other resources, such as LHH Psychiatry, Chaplain, BERT, etc. shall be included in the RCC.

f. The RCT shall developed a comprehensive care plan to address safety related to suicidal ideation risk.

12. The psychiatry provider will alert the RCT should they have significant clinical information or recommendations.

13. DOCUMENTATION REQUIREMENTS

a. C-SSRS Screen shall be charted in the electronic health record.

b. Document the resident/patient's behavior(s) in the electronic health record.

c. The resident/patient's care plan shall be updated to reflect the patient goal to remain free from self-harm.

ATTACHMENT:
A. Columbia-Suicide Severity Rating Scale
B. Patient Safety and Ligature Identification Checklist

REFERENCE:
Harmer B, Lee S, Duong TvH, et al. Suicidal Ideation. [Updated 2023 Feb 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://cssrs.columbia.edu/training/training-options/

LHHPP 22-09 Psychiatric Emergencies
LHHPP 22-12 Clinical/Safety Search Protocol
LHHPP 24-10 Coach Use for Close Observation
LHHPP 24-23 Behavioral Health Service Care and Services
NPP C04.0 Notification and Documentation of Change in Resident Status
MSPP D08-03 Access to LHH Psychiatry Services

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

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring, and documenting medications consistent with their scope of practice.

    a. Only an RN may administer intravenous (IV) medications, whether by IV piggyback or IV push.
    b. The LVN may administer medications per LVN scope of practice, except for IV medications.
    c. The Certified Nursing Assistant/Patient Care Assistant (CNA/PCA) may, under the supervision of Licensed Nurses (LN), administer the following: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.
    d. Exception: Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications and herbal supplements, require a physician's order which includes:

    a. Medication name/agent
    b. Dose
    c. Frequency
    d. Route of administration
    e. Indication for use.
        i. If indication for use is not on order, consult with ordering physician.

3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside.

4. LN will follow the "6 Rights" of medication administration:

    a. Right resident
    b. Right drug
    c. Right dose
    d. Right time
    e. Right route
    f. Right documentation

5. Bar Code Medication Administration (BCMA) is not a substitute for the LN performing an independent check of the 6 Rights of medication administration.

6. Resident arm bands should only be scanned if the arm band is secured on the resident. Arm bands should be replaced if worn, torn, or do not scan.

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

8. The LN will prepare medications at the resident's side (i.e., If resident is in bed, preparation will be at bedside, if resident is in great room, they may receive at chair side).

9. The LN will prepare medication(s) at the time just prior to administration. Do not prepare medications prior to administration or store out of the package.

10. LHH does not allow medication to be separated from the original package and stored for administration at later time, this is considered pre-pouring.

11. IV medications are only prepared by RN for emergency situations and must be labeled with resident name, date and time of preparation, medication name, strength, amount, and name of the person preparing.

12. Medication delivered via transdermal route must have date, time, and LN's initials. Before application of new patch, old transdermal patch must be removed.

13. Medication times are standardized in the Electronic Health Record (EHR). Medication administration times may be modified to accommodate clinical need or resident's preferences. The LN will notify pharmacy via the EHR with medication administration time change request.

14. The safe administration of psychotropic, hazardous, high risk/high alert medications, and reporting of Adverse Drug Reactions (ADR) will be followed as outlined in other LHH policies and procedures.

15. Medications may not be added to any food or liquid for the purpose of disguising the medication, except in the following limited circumstances:

    a. a resident who has capacity to make their own health care decisions and provides written consent; or
    b. a resident who is LPS-conserved and has a current, valid court order that determines the resident does not have the right to refuse the type of medication in question (i.e., "Affidavit B" for psychiatric medications); or
    c. a resident who is conserved under the Probate Code and has a current, valid court order that explicitly grants the conservator authority to consent to health care, whether or not the conservatee objects, and the conservator consents in writing; or
    d. a resident who has been found by a court or their physician to lack capacity to make their own health care decisions and has in place a current, valid, signed durable power of attorney or advanced directive form which explicitly authorizes

the legal decisionmaker to consent to all medications or the type of medication in question and the decisionmaker consents in writing.

16. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container, including crushed, dissolved, or disguised medications. Controlled substances shall be disposed of in the RxDestroyer located in the medication rooms. All other medication is disposed of in the yellow and white pharmaceutical waste bin.

17. Partial doses of controlled substances being pulled from Omnicell must be pulled at time of administration with witness and immediately wasted with co-signer/other LN at the time of retrieval from Omnicell.

    a. 2nd LN shall witness when the medication is still in the sealed packaging, and the actual wasting of the partial dose.
    b. Partial doses should not be placed in medication cart for administration at later time.

18. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

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

20. Oral medications that are safe to be crushed can be crushed at the discretion of the LN.

21. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications for oral administration (medications may not be combined for enteral tube administration as noted above), and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

22. A provider order must be obtained for medications to be mixed with pudding.

23. Medications mixed with food mediums (e.g., apple sauce, pudding) must have the food medium dated, timed and discarded at the end of each medication pass.

24. It is the legal and ethical responsibility of the LN to prevent and report medication errors.

25. Topical creams and ointments that are ordered “until healed” can be discontinued by the LN via an order in the EHR, and ordered “per protocol, co-sign required”.

26. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.

27. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of nasal naloxone if ordered.

28. Residents who request to self-administer medications and/or herbal supplements must be assessed by Resident Care Team (RCT) and determined to be able to safely self-administer medications.

29. Herbal supplements are not medications. The contents and purity of herbal supplements are not regulated and may contain undeclared contaminants. A limited number of herbal supplements are on the hospital formulary. Non-formulary herbal supplements are limited to USP verified supplements.

30. All medications and herbal supplements for self-administration will be stored securely by nursing, including rescue medications, except nasal naloxone. Rescue medications, such as inhalers will be given to resident when they go out on pass with physician order and will return medication for safe storage on their return, with the exception of nasal naloxone that resident can safely store on person or at bedside.

DEFINITIONS:

- BCMA: Bar Code Medication Administration
- eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record
- EHR: Electronic Health Record
- WOW: Workstation on Wheels

PURPOSE:

Medications will be competently and safely administered.

A. CRITICAL POINTS

1. Six Rights of Medication Administration

a. Right Resident

i. Two forms of identification are mandatory.
ii. Verify identity of resident using any of the following two methods:

iii. Successful scan of identification band, only if arm band is on the resident, or successful scan of identification card for the resident who meets criteria (See appendix II)
iv. Resident is able to state his/her first and last name (Ask for first and last name without prompting)
v. Resident Medication Profile Photograph matches the resident image in the EHR.
vi. Resident is able to state date of birth (Ask without prompting.)
vii. In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.
viii. Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

2. Right Drug

a. Review eMAR for drug/medication ordered
b. Review resident allergies to medications or any other contraindication
c. Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.

i. Checks or verifies information about medication using one or more of the following references, when needed:
i. Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
ii. Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

3. Right Dose

a. Review eMAR for dose of drug/medication ordered
b. Check medication label and confirm accuracy of dose with eMAR

4. Right Time

a. Review eMAR for medication administration time.

i. Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin, and any medication ordered more often than every 4 hours will be administered within 30 minutes before or after schedule time.
ii. All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
iii. See Appendix I for routine medication times and abbreviations.
iv. Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.

5. Right Route

a. Review routes of administration

   i. Aerosol/Nebulizer: Refer to NPP J 1.3
   ii. Enteral Tube Drug Administration: Refer to NPP E 5.0
   iii. Eye/Ear/Nose Instillations: Refer to J 1.4

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

6. Right Documentation

a. Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.
b. If resident is not wearing an armband, or refuses to allow scanning of their arm band, document reason in override section.
c. If product/medication is not scanned, document the reason in override section.

B. OVERRIDE OF MEDICATION ADMINISTRATION

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

C. TWO LN INDEPENDENT CHECK OF MEDICATIONS

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

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

1. Crushing medications is based on nursing judgement and resident care plan.
2. Do not crush hazardous, enteric, sustained release or medications with “do not crush” in the admin instructions of the eMAR.
3. Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.
4. Pill crushers will be cleaned with alcohol wipe at the end of the medication pass prior to returning to medication room for charging, and PRN.

5. Staff may choose to wear mask when crushing or cutting pills.
6. Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food), unless pharmacy has reviewed the medications for safety and efficacy, and pharmacy has documented that it is safe to mix crushed medications together and the physician has placed an order for crushing and combining the medications.
7. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:
    a. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.
    b. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)
    c. If using pudding as the food medium to administer medications, a physician order is required for the pudding.
    d. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

E. HAZARDOUS MEDICATIONS

1. Special precautions need to be applied when preparing and handling and disposing of hazardous medication. (Refer to Hazardous Drugs Management LHHPP 25-05).
2. Instructions for administering the medication can be found in administration instructions on the MAR.

F. PHYSICIAN ORDER

1. LNs may accept telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident's medication allergies with prescriber and read back the order entered into the EHR for accuracy with the physician. Verbal orders should only be taken during emergent situations when provider is unable to enter the order due to care being provided to resident.
2. STAT medication orders are processed immediately and administered no later than four hours after the order was written.
3. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.
2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.
    a. Pull those resident's cassettes from medication cart and place on top of WOW,or bring med cart inside med room if space permits.
        i. Ensure each cassette is labeled with the correct resident name.
        ii. Do not overcrowd the WOW with too many cassettes.
    b. Bring WOW with the resident(s) medication cassette(s) into the medication room.
        i. If using medication cart with computer screen attached, bring the entire cart into the medication room.
    c. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.
    d. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.
        i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.
    e. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.
    f. Repeat this for each resident that need medication(s) removed if needed.
    g. Return to medication cart with WOW and cassettes and put cassettes in medication cart.
        i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette, and immediately followed by placing cassettes in medication cart.
3. Log into the EHR and review the medications which will be administered. Remove those medications from resident’s cassette and place on top of WOW. Bring the WOW with only the medications to be administered and needed supplies to the resident’s side.
4. Confirm with the resident that they are ready to receive their medications in the location they are located if they are not in their room, such as the great room.

5. Scan the arm band of resident to correctly identify resident and open their MAR.

    a. If the resident is wearing their arm band, this will serve as is one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.

    b. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.

    c. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

6. Scan medication(s) barcode(s) at bedside/chairside.

7. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights.

8. Immediately prepare medication(s), if appropriate. (e.g., crush), and administer medication(s).
    a. If this is the first dose being given, document that the “1st dose” resident education has been performed as appropriate.

9. Remain with the resident until all medications have been taken.
    a. Never leave medications at the bedside/chairside.

10. Document in real time in the EHR medication(s) given, not given, etc.

11. Log out of the EHR. If medication cassette was brought to bedside, disinfect it and return the cassette to the medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

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

2. Do not add medication directly to an enteral feeding formula.

3. Prior to administering the medication, stop the feeding and flush the tube with at least 15 mL of water.

4. Dissolve the tablets or dilute the medication in at least 30 mL of water, to sufficiently allow for medication to pass through the tube.

5. Each medication should be administered separately. After each medication flush the tube with 15 mL of water.

6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

7. Give medication at the appropriate time in relation to feeding.
   a. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).
   b. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.
   c. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

8. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication, and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication(s) is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document the amount of the flush used for medication administration in the flowsheet.

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. As needed, and for newly admitted residents, the LN will explain to resident that due to hospital safety reasons, confirmation of swallowing is required after administering medication:
   a. After performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:
      i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.
      ii. Request the resident to repeat a sentence such as “no, ifs, ands, or buts,” to ensure the oral medication have been swallowed.
   b. If resident declines to allow confirmation, notify the resident the narcotic medication will be held and notify provider for further guidance.
      i. Notify the physician of refusal to follow protocol and request for follow-up such as change of order to liquid opioids or crushed medications.
      ii. If resident initially agrees to new procedure but then refuses to open mouth for inspection, stay with resident and ask 2nd LN to notify charge nurse to call physician.
      iii. Notify resident care team of refusal for discussion of alternatives and interventions.
      iv. Document occurrence in a nursing note and update care plan.
2. Administration of buprenorphine-naloxone.
   a. Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed.
   b. Buprenorphine administration is as follows:
      i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.
         - 5-10 minutes for sublingual tablet
         - 3-8 minutes for film
      ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.
      iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.

c. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).

   i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

A. Monitor resident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process, and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).
2. Whenever the resident's condition warrants, and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or when there has been a change in the treatment.
3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Appendix 4, follow Manufacturer's Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.
2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.
3. When using multiple inhaled medications, wait 5 to 10 minutes between drugs to get maximum benefit. NOTE: If both bronchodilator and a steroid inhaler are prescribed, use the bronchodilator first.
4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.
5. Compressor/ Nebulizer (brand name Misty-Fast)
   a. Use with nebulizer face mask, which has medication cup and lid.

   b. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.

   c. Air source

      i. Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced.
      ii. Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.

iii. For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.

d. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

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

1. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed and suction as clinically indicated.
2. Assess the resident's response to treatment.

SPECIAL CONSIDERATIONS:

1. If the resident does not wish to take medication(s) at the prescribed time, you may attempt to return and administer later if medication is still unopened and in the original packaging.
2. If medication(s) is not given within the time schedule, review "Appendix II: Specific Medication Administration Times and Abbreviations" to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.
3. Other medications should be reviewed for modification of times (see Policy Statement #9.
4. If non-time-sensitive medications are given outside of the time schedule, document the rationale in the override section of eMAR.
5. If medications have been prepared/removed from packaging, and resident does not take the medication(s), the medication must be wasted and documented in eMAR.
6. Request from pharmacy any missing doses and/or need for replacement.

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

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

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

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

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

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

SHAKING MEDICATIONS OR MIXING A SUSPENSION

1. Medications labeled “shake well” must be shaken vigorously to evenly distribute the dose, immediately before administration.

2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”

3. Any rolling motion used is acceptable as long as the suspension appears milky, and the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Scan the arm band of resident to correctly identify resident and open their eMAR.

2. Every cardiovascular drug requires vital sign monitoring as outlined below:

    a. Frequency of monitoring:

        i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.
        ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.

    b. Default parameters:

        i. Hold medication for SBP < 105 and/or hold for HR < 55.
        ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.

    c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.

d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.

e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.

3. PRN Cardiovascular Medication Orders

a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics

a. Document VS and response to therapy once every shift for duration of therapy.

2. Pain

a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT-TOSHIFT LN REPORTING

1. During change of shift, hand-off and when reporting to team lead or charge nurse, report:

a. Any new medications started, indication and monitoring required.

b. Any suspected Adverse Drug Reactions (ADRs).

c. If receiving medication that requires monitoring, report clinically relevant data including abnormal VS or laboratory results.

d. Time or food sensitive medications to be given on incoming shift.

e. PRNs given at end of shift requiring evaluation of effect.

f. Refusal of medication.

2. Document application and location of patch in the eMAR.

3. Verification of patch placement and monitoring

a. Inspect site of application every shift to verify that the patch remains in place.

b. Document verification in the eMAR.

c. If the patch has come off, attempt to locate the patch and dispose of it. If the patch is not recovered, complete an unusual occurrence report. Reapply a new patch and document per application procedure above.

d. Do not apply heat source to the patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.

e. If resident is diaphoretic, the patch may come off. In some instances, applying a transparent dressing covering the patch may help to keep it in place.

f. The resident may shower, wash and bathe with the patch in place, as long as not scrubbing over the patch area which will disturb the adhesive.

4. Disposal

a. Fentanyl patch disposal requires a two LN independent check of medication disposal and will be documented in Omnicell.

b. After removing the patch, fold the old patch in half so that the adhesive sides are in contact, request 2nd license nurse to witness the disposal in medication room disposal container and both LN's will complete documentation of the waste in Omnicell.

SELF-ADMINISTRATION

The resident must be assessed by the Resident Care Team (RCT) and

determined to be able to safely self-administer medications and re-assessed quarterly and as needed thereafter. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note and include input from the resident during this process.

1. Self-Administration

a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration. This assessment must include:

i. The medications appropriate and safe for self-administration.

ii. The resident's physical capacity to swallow without difficulty and to open medication bottles;

iii. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;

iv. The resident's capability to follow directions and tell time to know when medications need to be taken;

v. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.

vi. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.

vii. The resident's ability to ensure that medication is stored safely and securely. Appropriate notation of these determinations must be documented in the resident's medical record and care plan.

b. If the resident assessment or re-assessment has determined that a resident cannot safely self-administer medication this will be communicated to the physician and to the resident.

c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed and the assessment is complete.

d. Orders will be entered in the EHR for medications and herbal supplements.

e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.

f. The resident will prepare and take their own prescribed medications and/or prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self-administration preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated.

g. If the nurse notices the resident is about to make an error, the nurse will intervene to stop the preparation. The nurse will also discuss and clarify with the resident the accurate manner of self-administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.

h. The LN observing the resident taking the appropriate prescribed medications and/or herbal supplements via self-administration will document in MAR as 'given' and "self-administered"

i. For self-administration of a rescue medication stored at bedside that was not observed, the resident will report to the LN who will document in the MAR as given and "self-administered" and include a comment of 'patient reported' in the MAR.

    i. If a resident fails to report self-administration of a medication despite on-going education, the RCT will re-assess if self-administration is appropriate

j. Education and training skills will be documented, and care planned in the EHR.

k. The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications

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

WASTING MEDICATION

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

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

i. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error, should go in medication waste bin.

ii. Empty medication cups go in the garbage.

iii. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.

iv. The empty spoon can go in the garbage.

v. If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.

vi. For residents who are at risk for digging through the garbage, care plan your intervention to attempt to minimize and avoid this behavior.

vii. Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage.

viii. Empty packets of powered medications can be thrown in the garbage.

2. The LN must secure narcotics/controlled substances from time of receipt/removal from Omnicell to administration by having in physical possession or securely locked in medication cart.

3. Narcotics/controlled substances that are removed and not administered and/or are only partially administered, shall be immediately wasted in pharmaceutical waste container with witness of a 2nd LN.

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

4. If resident refuses medication, the LN shall return the medication to original package.

    a. 2nd LN will also witness the waste of the controlled substance in the Omnicell.

    b. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.

i. This may be done via looking up the IC medication tag through Lexicomp.

c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.

d. Both LNs shall document waste in Omnicell.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

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

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the the EHR for each out-on-pass medication, including controlled substance medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.

    i. The nurse will have the order filled at the hospital Pharmacy.

    ii. The pharmacist will dispense the medications in properly labeled child-proof containers.

    iii. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.

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

    i. Controlled substances may not be dispensed by the physician from the neighborhood’s supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.

    ii. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident’s own supply.

    iii. The physician will counsel the resident on proper use of his/her medications.

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

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:

    a. Will be given to family or guardian to take home.

    b. If medications are not returned to family or guardian, they are to be taken to Pharmacy or placed in the pharmacy pick-up tray.

    c. Pharmacy manages the medications and may dispose of as necessary.

    d. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.

    e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by the LHH Pharmacy.

2. Personal medications will not be obtained, stored or used by residents.

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

MISSING MEDICATIONS

1. After confirming a medication that is due is missing, document on the MAR the med is not available, and actions taken to secure a supply.

2. Notify pharmacy via MAR message of need for dose

3. Administer when dose is available

4. If dose is grossly overdue, confer with physician and/or pharmacy on administering vs waiting till next dose is due

5. If not administered on shift it is due, a brief note should be entered in EHR indicating plan and follow up

EXCESS MEDICATIONS

1. If resident is refusing medications and there is an excess of medications, notify the Pharmacy.

ATTACHMENT:

Appendix I Specific Medication Administration Times

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

Appendix III – LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

REFERENCE:

Lexicomp Online website: http://www.crlonline.com/crlsql/servlet/crlonline
Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. Institute for Safe Medication Practices. Retrieved from http://www.ismp.org/tools/donotcrush.pdf or https://onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053

AeroChamber Plus® Flow-Vu® Cleaning Instructions

DeWit, Susan, Fundamental Concepts and Skills for Nursing, 3rd edition, 2009

EBSCO - Nursing Reference Center - How to Use Your Metered Dose Inhaler (Adults)

Lippincott, Williams, & Wilkins, Best Practices: Evidence-Based Nursing Procedures, 2nd ed, 2007

Nettina, Sandra, Lippincott Manual of Nursing Practice, 8th edition, 2005

CROSS REFERENCES:

LHHPP File: 25-01 High Risk – High Alert Medications
LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal/Telephone Orders
LHHPP File: 25-04 Adverse Drug Reaction Reporting Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 25-11 Medication Errors and Incompatibility
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines
LHHPP File: 73-11 Medical Waste Management Program
LHH Pharmacy P&P 01.02.02 Stop Orders

LHH Pharmacy P&P 02.01.02 Disposition of Medications
LHH Pharmacy P&P 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P 09.01.00 Automated Medication Dispensing Cabinets
LHH Pharmacy P&P 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P 02.02.00 Controlled Substances
LHH Pharmacy P&P 02.02.00b Distribution of Medications and Medication Order Processing
Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds
Nursing P&P J 1.3 Aerosol/Nebulizer Medications.
Nursing P&P I 5.0 Oxygen Administration
Nursing P&P J 7.0 Central Venous Access Device Management
Nursing P&P *** Herbal Supplements: Formulary and Non-Formulary

Original adoption: 23/06/13 (Year/Month/Day)

Revision Hospital-wide Policies and Procedures

DISCHARGE and AND TRANSFER PROCESS

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) has a responsibility to provide timely access to skilled nursing services to San Franciscans who are in need of such services. In order to fulfill this responsibility, LHH continually facilitates timely and safe resident discharges or transfers to the appropriate level of care.

POLICY:

1. LHH strives to assist every client/resident (hereafter "resident") to achieve their optimal health, functioning, and well-being and achieve discharge to the lowest level of care possible. When discharge from a skilled nursing unit or rehabilitation unit is not achievable, the Resident Care Team (RCT) shall continue to support maximal social integration. In addition, LHH may also transfer patients to another skilled nursing facilities facility to continue the current level of care of skilled nursing needs if appropriate based on hospital operation.

2. LHH provides inter-disciplinary discharge planning services that meet the resident's health and safety needs with appropriate and available resources in the community, taking into account the resident's preferences.

3. Residents who no longer meet skilled nursing facility (SNF) level of care and/or whose SNF needs can be met a lower level of care shall be prepared for discharge into the community with supportive services.

4. Intensive discharge planning support and skills training shall be provided to the resident to assist him or herthem to transition from an institutional setting to community living.

5. The RCT shall recognize that residents with decision-making capacity and/or their surrogate decision-maker (SDM), have the right to decline recommended discharge/transfer options aimed at achieving their optimal health outcome, and that they have the right to appeal their discharge/transfer plan.

6. Residents with decision making capacity who repeatedly decline discharge/transfer options, or refuse to participate in discharge/transfer planning shall be provided with sufficient notice and issued a written Notice of Proposed Transfer/Discharge when a viable, safe and orderly post-discharge plan of care has been formulated by the RCT. The notice requires that a discharge/transfer address and discharge/transfer date be obtained prior to issuance.

7. This policy does not apply to Residentsresidents who are being relocated to another skilled nursing facilitySNF as a "Facility Closure Transfer," only when LHH is subject to a facility closure plan, as described in LHHPP 01-16 Facility Closure Plan. LHH

Policy # LHH XXXX, "Facility Closure Policy." Facility Closure Transfers are subject to the requirements and procedures described in LHHPP 01-16 Facility Closure Plan, LHH Policy # LHH XXXX, "Facility Closure Policy." Residents who are discharged to the community, including their home or a lower level of care facility, when LHH is subject to a facility closure plan will be discharged according to the procedures outlined in this policy, LHHPP 20-04 Discharge and Transfer Process, "Discharge Planning."

6.8. For residents who qualify for Medicare hospice care services, LHH will either arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices or, if such an agreement(s) has not been arranged, then LHH will assist the qualifying resident to transfer or discharge to a facility that will arrange for the provision of hospice care services when the resident requests a transfer or discharge.

PURPOSE:

To implement a safe and orderly discharge process for residents who desire discharge to the community, no longer need SNF services, and/or are able to be cared for at a lower level of care. To implemetimplement a safe and orderly transfer process for residents who will continue to require skilled nursing carerequire transfer to an emergency department or for residents who desire to be transferred to another skilled nursing facilitySNF, but in this specific instance, only when LHH is not subject to a facility closure planies.

DEFINITION:

"**Facility-initiated Ttransfer or Ddischarge**": A Ttransfer or Ddischarge 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.

"**Resident-initiated Ttransfer or Ddischarge**": 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).

"Transfer and Discharge": Includes movement of a resident to a bed outside of the certified LHH skilled nursing facilitythe certified 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;whether that bed is in the same physical plant or not, or (2). to the community, which may include the resident'sir home or a facility that provides a lower level of care. DTransfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident

expects to return to the original facility. DDischarge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or otheranother location in the community, when return to the original facility is not expected.

"Transfer": Includes movement of a resident to a bed outside of the certified facilityLHH skilled nursing facility in either of the following instances:, (1). to a bed in an emergency department whether that bed is in the same physical plant or not;, or (2). to another certified skilled nursing facility. Transfer does not refer to movement of a resident to a bed within the same certified facilityLHH's skilled nursing facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility, when return to the original facility is not expected.

"Anticipated Discharge": A discharge that is planned and not due to unforeseen circumstances, including, for example, the resident's death or an emergency.

"Continuing Care Provider": the entity or person who will assume responsibility for the resident's care after discharge. This includes licensed facilities, agencies, physicians, practitioners, and/or other licensed caregivers.

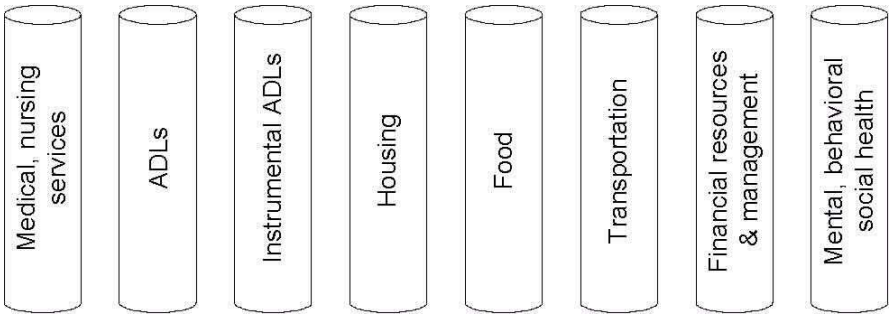
"Recapitulation of Stay": a concise summary of the resident's stay and course of treatment in the facility.

"Reconciliation of Medications": a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.

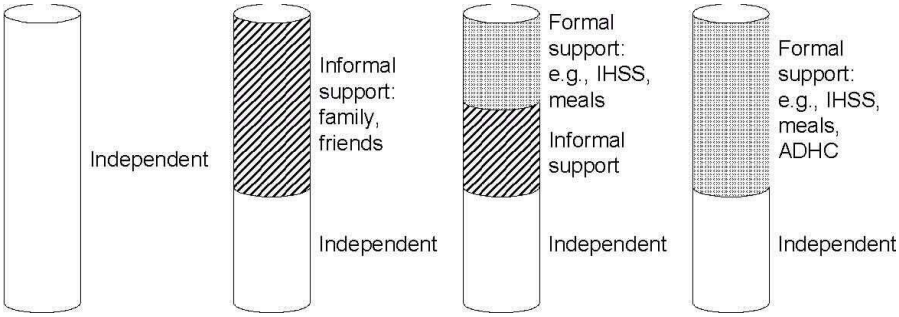
Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs): Activities of daily living (ADLs) are the basic activities necessary for self-care or care by others. Instrumental activities of daily living (IADLs) are higher-level activities necessary for living in the community. ADLs and IADLs are sometimes remembered by the mnemonics DEATH and SHAFT:

ADLs	IADLs
Dressing	Shopping
Eating	Housework
Ambulating	Accounting/finances
Toileting	Food preparation
Hygiene	Transportation

Assessment domains: Discharge planning begins with assessment of needs and resources in multiple domains that often overlap and interact. These domains include medical and nursing services, ADLs, IADLs, housing, food, transportation, finances, emotions, behavior, personal relationships, and work. Safety issues often arise in many of these domains.



Informal and formal support: Informal support refers to unpaid services such as family, friends, and neighbors. Formal support refers to services received through an agency that is reimbursed. Four examples are shown below. The assessment process could reveal that a person is independent in ADLs. Another might be only partially independent but get adequate informal care giving support from family and friends. Another, also partially independent, could get ADL needs met with a combination of informal support and formal support services such as In-Home Supportive Services (IHSS) and Meals on Wheels. Another may have no informal caregivers but could live independently with formal supports such as IHSS, meals, and adult day health care (ADHC).



PROCESS GUIDELINE:

1. **Discharge assessment process considers:**

   a. The resident's characteristics, needs, and resources (including informal and formal supports) in functional, medical, and psychosocial domains (see definitions appendix).

   b. The resident's values and preferences.

i. These values and preferences remain central to the assessment process even when they are contradictory, inconsistent over time, or in need of interpretation across cognitive deficits.

ii. The resident's self-assessment of needs and priorities may legitimately differ from that of the RCT[1].

2. Discharge planning:

a. Begins during the resident's admission assessment.

b. Is an ongoing process that adapts to changes in the resident's needs, resources, and preferences.

i. A resident may need to progress through several stages of increasing independence prior to discharge.

ii. Certain residents may be expected to leave LHH and return, perhaps repeatedly.

iii. The experience of residents who have been at a lower level of care for one or more limited periods can lead to valuable refinements of the discharge plan.

c. Requires negotiation of the goals of care, the interventions needed to overcome barriers to discharge, and the overall discharge plan.

i. Informed choice is a fundamental principle of service delivery.

ii. Independence and autonomy are often in conflict with safety, protection, and beneficence. The resident (or SDM), caregivers and RCT members may have different risk tolerances and may differ in how to weigh independence versus safety.

iii. Residents, SDMs, caregivers, and RCT members may enlist the Clinical Leadership Committee, ombudsman program, and/or administrative leadership for help in resolving conflicts.

3. Utilization Resourcesissues:

[1] Consumer-centered care means also that providers cede some decision-making to consumers and that consumers be permitted to make tradeoffs that they consider important in choosing a care setting and provider and the details of a care plan. The idea that a single 'appropriate' setting exists for each consumer based on disability level must give way to an understanding that more than one choice can work for many consumers." (Institute of Medicine: Improving the Quality of Long-Term Care, 2001, p. 291).

a. Resident independence and resource stewardship are LHH values that inform discharge planning.

   i. Residents shall be discharged to the lowest possible levels of care, consistent with the notions of least restrictive setting and most integrated setting. This includes residents who meet SNF Medicare and or Medi-Cal criteria but whose care needs can be safely provided in the community, as well as residents whose medical conditions have improved and no longer require daily SNF level of care.

   ii. If there are barriers to discharge, the resident and RCT shall set reasonable care plan goals to maintain living skills, self-care readiness, and a sense of hope for future possibilities.

4. Conservatorship and decisional capacity:

a. Some conserved residents retain the legal right to make decisions regarding discharge, whereas others do not.

b. Unless otherwise specified in a written advance health care directive or absent legal adjudication, the primary physician bears responsibility for determining if a resident lacks or has recovered capacity to make health care decisions, including informed choices about interventions and discharge planning.

   i. A resident may have only partial or varying capacity to make informed decisions.

   ii. Capacity determination for residents with mild-moderate impairments is a clinical art about which good clinicians may responsibly disagree.

   iii. The conservatorship process may be helpful in resolving disputes and protecting residents.

c. A resident with capacity retains the right to make decisions that RCT members consider unwise.

   i. RCT members shall educate the resident (or conservator or other SDM), about the risks associated with their decision(s) and document their concerns, but a resident with capacity has the final say in defining his/her well-being and self-interest.

d. For a resident who is conserved or lacking capacity, the RCT shall nevertheless elicit, document, and consider the resident's current and/or past values and preferences relevant to discharge.

e. A resident (for example with multiple hospital stays or history of homelessness) may not be able to formulate an informed preference about where to live and may have ill-informed fears about living in the community. RCT members should attempt a strategy that gradually exposes these residents to appropriate community settings, events, shops, and religious and recreational centers.

5. Collaboration:

a. LHH is committed to developing collaborative relationships with other organizations in order to meet the residents' needs.

b. The RCT members shall be familiar with community-based services appropriate to their disciplines.

c. The RCT members shall seek positive collaborations with members of the resident's informal and formal support systems, encouraging face-to-face meetings prior to and after discharge.

PROCEDURE:

A. Discharge to the Community

1. Discharge assessment and planning is initiated on admission and re-assessed, at a minimum, quarterly, or sooner; or when the resident's condition improves, and s/he no longer require SNF services. The RCT assessment and discharge planning process is collaborative and includes the resident, their designated family member(s), or SDM.

2. Upon admission and periodically during admission, designated members of the RCT shall educate Tthe resident and/or their SDM shall be educated on admission by designated members of the RCT that when their health condition sufficiently improves, or outcomes have been achieved, and a lower level of care is deemed appropriate, discharge plans shall be prepared and finalized to transition the resident back to the community.

3. If there is internal disagreement amongst members of the RCT on the adequacy of the discharge plan, the Director of Social Services or designee, the Utilization Management Nurse Manager or designee, the Chief Medical Officer or designee, and Chief Nursing Officer or designee, shall promptly meet and to resolve the issues and make recommendations for implementing a safe and orderly discharge plan for the resident.

4. RCT Roles and Responsibilities
The following roles and responsibilities exist unless specific alternate arrangements are made. All responsibilities assume appropriate consultation from others. Communication with outside caregivers assumes appropriate permission from resident or surrogate.

a. RCT Responsibilities[2]
The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, or speech therapist with others as needed:

i. Perform the discharge assessment process as described and negotiate the discharge plan.

ii. Review the discharge plan at least quarterly and document progress toward measurable discharge-related goals.

iii. Encourage the resident to sustain healthy relationships and interests in the community.

iv. Strive to find effective graduated strategies for residents who lack motivation for discharge, who are chronically non-adherent with the care plan, who are unable to formulate an informed preference regarding discharge, or who have ill-informed fears about discharge.

v. Identify education needs for discharge, provide or arrange for education to resident and caregivers, and document the education provided.

vi. Identify need for evaluation of resident's baseline function in regard to ADLs, IADL, or mobility that require rehabilitative services to assess readiness for discharge.

vii. Document the resident's (and/or SDMsurrogate's) understanding of the discharge plan.

viii. Complete the appropriate sections of the AVS (After Visit Summary) and related discharge –sections on –the Social Work Activity Tab in Epic.Post-Discharge Plan of Care form.

b. Physician

i. Addresses the resident's preliminary rehabilitation and discharge potential in the admission History & Physical.

i.ii. Communicates with the resident (or surrogateSDM), caregivers, and with other RCT members regarding the resident's conditions and expected course so that the goals of care can be adjusted as needed.

[2] The RCT is flexibly defined for discharge planning purposes. The resident and the surrogate and informal caregivers, if present, can be considered central members of the RCT. Others called into the process as needed may include the vocational rehabilitation coordinator, psychologist, psychiatrist, physiatrist, other specialty physicians, substance abuse specialist, physical, occupational, and speech therapists, respiratory therapist, community case manager, and other community-based staff.

ii.iii. Documents rehabilitation and discharge potential in quarterly reassessments and as needed.

iv. Attempts to simplify the resident's medication regimen, preferably months or weeks prior to discharge.

iii.v. Ensures that appropriate post-discharge medical follow-up is arranged.

iv.vi. Writes discharge order.

c. Social Worker

i. Coordinates the discharge assessment process and plan.

ii. Contacts the resident's caregivers and community-based support services to inform them of the admission, to invite them to care conferences, and to seek their collaboration.

iii. Attempts to secure the resident's housing if discharge is appropriatepossible.

iv. Identifies Medicaid waivers available to the resident and encourages and facilitates the application process.

v. Enters into the electronic health record (EHR) any resident who expresses desire for discharge, has a supportive person interested in discharge, or is expected to improve and transition to a lower level of care.

vi. Updates the EHR discharge section as needed due to pertinent changes or upon readmission to LHH.

vii. If discharge is not currently a viable option and is not included in the formal care plan, documents the reason(s).

viii. Identifies differences of opinion among RCT members in regard to the resident's discharge and encourages open discussions based upon professional assessments.

ix. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

x. Makes referrals for community placement (housing and other services) consistent with the discharge assessment and plan.

xi. Makes additional referrals as needed prior to discharge.

xii. Discusses the discharge plan with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

xiii. Prepares and provides the resident and Ombudsman with a preliminary copy of a of the After Visit Summary (AVS) when the resident is issued a Notice of Proposed Transfer/Discharge. If the date changes, a revised Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.

xiv. After nursing signs and prints the AVS, Rreviews the AVS after nursing signs and prints it out with resident. , updates the plan as necessary and provides the resident with a revised copy of the After Visit Summary (AVS) just prior to the resident's discharge from the facility.

xv. Documents discharge planning efforts and resident preparation and orientation to the discharge plan to ensure a safe and orderly discharge from the facility.

d. Nurse

i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.

ii. Provides resident and family education to support self-care and independence, based on the care plan. Identifies and advocates for referrals to rehabilitative services to improve self-care and independence.

iii. Arranges for discharge supplies as needed.

iv. Arranges pre-discharge pharmacy consultation for medication education.

iv.v. Completes and prints out the AVS on day of discharge for resident.

e. Activity Therapist

i. Assesses and documents the resident's pre-admission interests.

ii. Promotes maintenance/enhancement of IADLs through activities.

iii. Involves the resident in campus-based and community-based programs to provide living skills learning, socialization, and self-confidence.

iv. Provides information and education to the resident and family regarding community resources to support living in the planned discharge setting.

f. Rehabilitation Specialist (occupational, physical, speech therapy) upon receipt of referral from physician: Performs evaluation of resident's overall functioning including basic activities of daily living, instrumental activities of daily living, community re-integration, recommendations and training for use of Durable Medical Equipment, recommendations for continued therapy and support services at the appropriate level of care post-discharge.

g. Other Disciplines/Services
In addition to the RCT responsibilities noted above:

i. Pharmacist provides medication education to the resident and caregiver and completes the appropriate section of the EHR Post-Discharge Plan of Medication Instruction.

ii. Dietitian provides nutrition education to residents on therapeutic diets prior to discharge and collaborates with the social worker on enteral feeding supplies.

iii. Utilization management staff provides focused studies of the quality of discharge/transfer planning and documentation based on level of care.

iv. Vocational Rehabilitation, the PREP (People Realizing Employment Potential (PREP) Coordinator) meets with interested residents about pre-vocational options, training, and community resources.

v. Peer Mentors provide education and practical support about In-Home Support Services (IHSS) to residents transitioning into the community.

5. Notification of Resident Regarding Discharge/Transfer from Facility

a. The social worker, nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of the discharge/transfer and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or surrogate SDM is entitled to written 30-day notification except under the following conditions:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

iii.i. Improvement in medical condition requiring a lower level of care.

iv.ii. The health or safety of individuals in the facility is endangered.

iii. Resident has resided in the facility less than 30 days.

b. The nurse, or physician shall notify the resident and, if known, a family member or legal representative of the resident, of a transfer and the reasons for the move in writing and in a language and manner they understand and record the reasons for discharge in the resident's medical record. A resident or SDM is entitled to written notification on the day of transfer based on the conditions below:

i. Medical emergency.

ii. Deterioration in medical condition requiring a higher level of care.

c. The social worker will forward a copy of the Notice of Transfer/Discharge provided to the resident or legal representative and Ombudsman.

b.d. Written notice (MR 707) to the resident or surrogate SDM shall include:

i. Name of resident

ii. Date resident notified

iii. Reasons for discharge/transfer.

iv. Date the discharge/transfer will occur.

v. Discharge/transfer -destination.

vi. Name, address, and phone number of the State ombudsman.

vii. For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals.

viii. For residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act

ix. Resident's right to appeal to the California State Department of Health Services.

x. Witness signature, and explanation if resident or resident's representative did not sign the written notice.

xi. Resident's right to request a seven-day bed hold.

c.e. Residents may choose to waive their notice period if they wish to be discharged/transferred- prior to the conclusion of the notice period.

d.f. If the resident or SDM is opposed to discharge/transfer, s/he will be encouraged to discuss it with the RCT and ombudsman.

i. Utilization Management leadership (UM) will alert the Medical Director, Chief Nursing Officer or designee, Chief Quality Officer, and Executive Administrator (or their designee) prior to issuance of the written notification of discharge/transfer.

ii. One or more of these executive leaders will meet with the resident or surrogate if so desired.

iii. When the Resident Care Team (RCT) identifies that a resident's health has improved sufficiently to allow discharge/transfer to the community, and the resident verbalizes that s/he disagrees with the plan to be discharged/transferred to the community and refuses reasonable placement options, the Social Worker shall request for a level of care review by Utilization Management (UM).

iv. The UM Nurse shall conduct a review of the resident's medical record and determine if the facility has met the conditions for discharging/transferring the resident to the community. A Discharge Plan Review form is available for use to assure that a comprehensive review is carried out.

v. The UM Nurse shall notify the RCT with a recommendation to proceed with the Notice of Proposed Transfer/Discharge or continue to address identified discharge planning issues prior to issuing the Discharge/Transfer Notice within 3 – 5 working days.

vi. The resident shall be presented with the Notice of Proposed Transfer/Discharge at least 30 days before the resident is scheduled for discharge. If the resident falls into the five categories listed above, the notice may be less than 30 days. Otherwise, tThe 30-day period may be waived only in cases of resident-initiated transfer or discharge.

vii. When a resident chooses to appeal his or her discharge from the facility, the facility may not discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals.

- The RCT shall document the danger(s) that failure to transfer or discharge would pose.

viii. The Social Worker shall notify the Utilization ManagementUM Department as soon as s/he is aware that the resident has filed a complaint to contest the discharge/transfer.

ix. The UM leadership or designee shall gather pertinent resident information and be prepared to respond to resident issues that may be investigated by the assigned Licensing and Certification Health Facilities Evaluator Nurse.
x.ix.

xi.x. When the facility is notified of a scheduled discharge hearing date, the UM leadership or designee shall coordinate with the RCT, UM Nurse and if necessary, the Deputy City Attorney to prepare oral and written testimony for the discharge hearing to demonstrate compliance with resident discharge planning requirements.

xii. The RCT shall present oral testimony, clarify concerns and submit written documentation to the assigned Hearing Officer at the scheduled discharge hearing.
xiii.xi.

xii. The resident may not be involuntarily discharged from the facility prior to the discharge hearing or issuance of the Decision and Order, but may choose to be voluntarily discharged and s/he can request for assistance with discharge planning arrangements from the RCT.

xiv.xiii. While the appeal is pending, the facility can proceed to discharging the resident when failure to transfer or discharge endangers the health or safety of the resident or other individuals in the facility. The facility must document that the failure to transfer or discharge would pose.

- The UM leadership shall coordinate a meeting to discuss the safety risk with the LHH Executive team and, if necessary, the Deputy City Attorney's Office.

- The facility's Administrator or designee is required to provide DHCS Office of Administrative Hearings and Appeals written notification as soon as possible if the resident is transferred or discharged prior to the hearing under this exception.

xv.xiv. The RCT shall clearly document that such discharge planning arrangements were made based on the resident's request.

xvi.xv. If the resident is voluntarily discharged from the facility, the QM designee is responsible for notifying the California Department of Public Health Office of Regulations and Hearings and the local Licensing and Certification Office.

xvii.xvi. Following the discharge hearing, the State of California will issue a Decision and Order and the facility shall proceed with the issued directions contained in the document.

6. After Visit Summary (AVS)

   a. For Anticipated DischargesShould LHH anticipate discharge of a resident, the physician shall develop a discharge summary for the resident shall be developed by the physician and shall include:

      i. An overview of the resident's stay including, but not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results;

      ii. A final summary of the resident's status including items from the resident's most recent comprehensive assessment (Refer to LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC), Procedure 1(c)(ii).) that may be available to authorized persons and agencies upon consent of the resident or resident's representative;

      iii. A reconciliation of the resident's pre-discharge medications with his/her/their post-discharge medication, both prescribed and over the counter; and,

      iv. A post-discharge plan of care that is developed with consideration to the resident's and/or the resident's representative preferences, which shall include where the resident shall live, information on the resident's follow-up care, any necessary medical and non-medical services, and information on how and when to contact the continuing care provider(s).

   b. The discharge summary shall be complete and conveyed, with the resident's permission, to the receiving provider at the time the resident leaves the facility.

7. Transfer to an Emergency Department (ED)

   a. Physician
      i. The physician will assess the need for higher level of care. If appropriate, the physician will order the LOA order for transfer to the ED.

      ii. The physician will conduct a hand-off with the receiving ED.

      iii. Document in the EHR of the medical assessment and need for higher level of care.

      iv. Complete the Interfacility Transfer Record.

   b. Nursing

      i. Document that Change of Condition in the EHR.

ii. Place the resident on LOA in the EHR.

iii. Print out necessary transfer documents from the EHR to send with the resident.

8. Discharge to an Acute Care Facility

a. Bed Hold (refer to LHHPP 20-06 Leave of Absence, Out on Pass and Bed Hold Policy)

b. Nursing

i. Contacts the acute facility to determine if the resident was admitted.

c. Physician

i. Writes a discharge summary in the EHR.

9. 8C. Involuntary Discharges

i. Involuntary discharges, whether arising from level of care or behavioral issues, require careful assessment, planning, and documentation. Legal counsel shall be consulted in circumstances when the resident and or SDM refuses to participate in discharge planning efforts (e.g., refuses to sign release of information forms or complete housing applications, etc.).

ii. A Notice of Proposed Transfer/Discharge may be issued after a resident and or the SDM has been presented with two housing options that the RCT considers to be the best viable discharge option available in the community.

10. E. Transfer to Another Skilled Nursing Facility

a. The physician, social worker, nurse, activity therapist, dietitian, rehabilitation specialist, occupational therapist, physical therapist, or speech therapist with others as needed. Each member will perform the Transfer assessment process according to the transfer plan.

b. Physician

i. Addresses the resident's continued skilled nursing needs as transfer potential in the progress note.

ii. Communicates with the resident (or surrogateSDM), caregivers, and with other RCT members regarding the resident's conditions and expected course so that the goals of care can be adjusted as needed.

iii. Attempts to simplify the resident's medication regimen, preferably months or weeks prior to transfer, if appropriate.

iii.iv. Ensures that appropriate post-transfer medical follow-up is arranged.

iv.v. Writes transfer order.

c. Social Worker

i. Coordinates the transfer assessment process and plan. Documents the assessment and plan in the EHR.

ii. Contacts the resident's caregivers and community-based support services to inform them of the transfer, to invite them to care conferences, and to seek their collaboration.

iii. Updates the EHR discharge section as needed due to pertinent changes or upon readmission to LHH.

iv. If transfer is not currently a viable option and is not included in the formal care plan, documents the reason(s).

v. Identifies differences of opinion among RCT members in regard to the resident's transfer and encourages open discussions based upon professional assessments.

vi. Provides counseling and psychosocial support to help the resident (or surrogate) and caregivers manage current and expected transitions.

vii. Makes referrals to other skilled nursing facilities.

viii. Discusses the transfer plan with the resident (or surrogate) and caregivers, preferably months or weeks prior to discharge.

ix. Prepares and provides the resident and Ombudsman with a preliminary copy of a of the After Visit Summary (AVS) when the resident is issued a Notice of Proposed Transfer/Discharge. If the date changes, a revised Notice of Proposed Transfer/Discharge will be given to resident and the Ombudsman.

x. After nursing signs and prints the AVS, Rreviews the AVS after nursing signs and prints it out with resident. , updates the plan as necessary and provides the resident with a revised copy of the After Visit Summary (AVS) just prior to the resident's discharge from the facility.

xi. Documents transfer planning efforts and resident preparation and orientation to the transfer plan to ensure a safe and orderly discharge from the facility.

d. Nurse

i. Collaborates with the resident and family to provide assessment and interventions to maintain or improve self-care functioning.

ii. Provides resident and family education to support self-care and independence, based on the care plan.

iii. Prepares resident's personal belongings prior to the transfer. Conduct inventories to ensure that all belongings are transferred to the receiving facility.

iv. Completes and prints out the AVS on day of transfer for resident. Include additional medical records requested by a receiving facility.

11. E. Residents Leaving Against Medical Advice (AMA)

a. When a resident indicates that he or she intends to leave without a discharge order, the nurse will inform the physician of the need for an urgent visit to assess the resident and situation.

b. If the resident is conserved or does not understand the nature and consequences of a decision to leave LHH without permission, the physician will immediately attempt to contact the SDMsurrogate.

c. If leaving LHH would have life-threatening consequences for the resident, the physician will obtain emergency psychological or psychiatric consultation.

d. If the consultant deems the resident a danger to self or others due to mental illness, the consultanthe or she will initiate a psychiatric hold and transfer the resident to acute care.

e. The nurse or physician will present the form MR 804, "Request to Leave the Hospital Against Medical Advice," to the resident (or surrogate) in the presence of a witness.

i. If the resident or surrogate refuses to sign, the nurse or physician will write on the form, "Resident refuses to sign." Nurse/physician and witness will sign.

f. The nurse or physician will complete an Unusual Occurrence form.

g. When RCT members have adequate advance warning regarding a resident leaving AMA, they should consider providing appropriate medication referrals, in addition to providing a list of emergency shelters and food sources.

12. Residents Qualifying for Hospice Care Services

a. If a resident qualifies for hospice care services and chooses a hospice provider that does not have an agreement with LHH, then LHH willshall assist the resident in discharging to a facility or transferring to a SNF that uses the hospice chosen by the resident.

b. If a resident requests to discharge or transfer to a facility that provides hospice care, LHH will follow the procedures detailed in this policy for resident-initiated transfers or discharges and is not required to provide a notice of discharge or transfer.

ATTACHMENT:
Attachment A: Residential Substance Use Treatment and Dual Diagnosis Treatment Placement for LHH Residents
Attachment B: LHH Referral Protocol for Opiate Replacement Treatment

REFERENCE:
LHHPP 20-06 Leave of Absence (Out on Pass)
LHHPP 20-10 Transfer and Discharge Notification
LHHPP 22-10 Management of Resident Aggression
LHHPP 23-01 Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)
NPP C1.0 Admission, Relocation and Discharge Procedures

Revised: 08/04/29, 09/10/27, 13/05/28, 13/09/24, 13/11/21, 15/05/12, 17/09/12, 19/03/12, 19/07/09, 20/10/13, 22/07/12 (Year/Month/Day)
Original adoption: 03/07/15

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

POLICY:

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

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

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

   a. Therapeutic Leave - for purposes other than required hospitalization based on the resident's plan of care.
      ~~a.~~i. Scheduled appointments (Clinic/Dialysis, OR/IR/Cath Lab)
   b. Out on Pass (day/overnight/weekend) - Absences for purposes other than required hospitalization which shall be appropriate to the physical and mental well-being of the resident. It is the responsibility of the unit Resident Care Team (RCT) and may be granted for, but is not limited to, the following in accordance with the resident's plan of care:
      ~~c.~~i. A visit with relatives or friends.
      ~~i.~~ii. Participation by developmentally disabled residents in an organized summer camp for developmentally disabled persons.
      ~~ii.~~iii.
   ~~d.~~c. A~~nnother~~ acute facility for higher level of care (Emergency department/Psychiatric emergency services/Acute care)
   ~~e.~~d. Off campus with staff (for example, home evaluation, bus trip)

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

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

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

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

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

3. Bed Hold – When a resident is admitted to an acute care hospital and LHH holds the resident's bed.

a. The attending LHH physician writes an order regarding transfer to the ER or acute hospital.
b. The bed hold is limited to maximum of seven days per acute hospitalization.

~~d.~~

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

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

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

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

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

PURPOSE:

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

BACKGROUND:

1. F843. 483.15 - When a nursing facility transfers to an acute facility, including LHH acute unit, or the resident goes on a therapeutic leave, the nursing facility must provide

a written notification of the facility's bed hold policy and Notice of Proposed Transfer or Discharge to the resident and resident's representative.

2.

~~1.~~3. A resident who is receiving Medicare Part A SNF benefits is permitted to go OOP as necessary; however, Medicare will not provide reimbursement to the facility for that day of leave if the resident does not return to the facility by midnight.

~~2.~~4. If the LOA is an overnight visit (or longer) to the home of relatives or friends, LOA reimbursement by Medi-Cal is restricted as follows: Maximum time period of 18 days per calendar year for non-developmentally disabled recipients; Up to 12 additional days of leave per year may be approved in increments of no more than two (2) consecutive days when the following conditions are met:

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

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

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

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

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

5. For LOA due to acute hospitalization

1.

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

1.

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

1.

c. A resident whose hospitalization exceeds the LOA period under the State plan is re-admitted to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident requires the

services provided by the facility and is eligible for Medi-Cal nursing facility services or Medicare skilled nursing facility services.

1.

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

~~3.~~

PROCEDURE:

1. Notification of LOA Policy

a. Upon admission, A&E provides the resident, or family member, or legal representative with the California Standard Admission Agreement which includes written information regarding LOA-acute hospitalization.

b. Nursing~~The MSW~~ provides bed hold information and Notice of Prooposed Transfer at the time of transfer, or within 24 hours of transfer in cases of emergency transfer. Should the written information change, LHH shall reissue the new information to the resident, their family member, or legal representative.

~~a.~~c. MSW will provide the bed hold information to the resident, their family member, or legal representtive prior to the scheduled OOP (day/overnight/weekend).

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

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

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

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

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

~~b.~~ The Licensed Nurse shall provide the Bed Hold form and policy, and the Notice of Proposed Transfer form to the resident, family member or legal representative prior to transfering the resident. If the family member or legal representative is not physically present in the facility, a telephone call will be made to review the bed hold policy and Notice of Proposed Transfer/Discharge.

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

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

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

f. LHH claims must identify the inclusive date of the LOA.

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

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

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

~~4.~~5. Request for OOP

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

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

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

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

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

~~e.~~f. MSW will review and provide the bed hold policy and form to the resident, SDM or representative.

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

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

~~5.~~6. Census Management

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

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

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

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

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

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

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

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

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

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

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

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

i. The resident's whereabouts is known.

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

iii. Therapeutic LOA.

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

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

ATTACHMENT:
Attachment A: Check-In Form – Resident Returning from an Out on Pass
REFERENCE:
LHHPP 22-12 Clinical Search Protocol
Pharmacy Services P&P 02.01.04
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold
Revised: 09/10/27, 14/01/28, 14/03/25, 17/11/14, 19/05/14, 19/09/10, 22/07/12 (Year/Month/Day)
Original adoption: 99/04/29

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

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

ADDRESSOGRAPH

CHECK IN FORM RESIDENT RETURNING FROM AN OUT ON PASS

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

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

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

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

_____ _____

NAME OF LICENSE STAFF **DATE**

BED RAIL USE

POLICY:

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

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

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

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

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

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

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

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

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

PURPOSE:

To ensure safe and appropriate use of bed rails.

DEFINITIONS:

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

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

PROCEDURE:

1. A safety assessment shall be completed by the RCT and documented via electronic health record (EHR) by the Registered Nurse taking into consideration the resident's current medical diagnosis, physical condition (size and weight), functional ability (bed mobility, transfer, ability to toilet self), cognition, communication, sleep habits, medication(s), physical and/or behavioral symptoms.
2. For beds with rails that are incorporated or pre-installed, the facility must determine whether or not disabling the bed rail poses a risk for the resident. Some considerations would include, but are not limited to • Could the rail simply be moved to the down position and tucked under the bed • When in the down position, does it pose a tripping or entrapment hazard? • Would it have to be physically removed to eliminate a tripping or entrapment hazard?
3. Facilities should follow manufacturers' recommendations/instructions regarding disabling or tying rails down. If bed rails are not appropriate for the resident and the facility chooses to keep the bed rail on the bed, but in the down position, raising the rail even for episodic use during care would be considered noncompliance if all of the requirements (assessment, informed consent, appropriateness of bed, and inspection and maintenance) are not met prior to the episodic bedrail use for the resident.

4. The safety assessment takes into consideration the following:

    a. Risk of entrapment,

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

c. Fall risk,

d. ~~Physical restraint assessment~~ bed rail safety assessment,

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

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

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

6. The Resident or Resident Representative shall consent to bed rail use by signing the informed consent. Consent is to be renewed annually at a minimum.~~.~~

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

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

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

REFERENCE:

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

Revised: 10/11/10, 16/09/13, 18/03/13, 19/03/12, 20/10/13, 21/10/12, 22/12/13 (Year/Month/Day)
Original adoption: 08/21/09

RESIDENT ACTIVITIES

POLICY:

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

2. All LHH Resident Care Team members understand the importance for residents to have a choice about which activities they participate in, whether they are part of the formal activities program or self-directed. LHH Resident Care Team members also understand that importance of learning as much as possible about residents' lives, hobbies, interests, preferences, and comforts, in order to support each resident to access activities that are meaningful and personalized.

3. LHH provides an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of the resident. This includes providing a variety of individualized opportunities for meaningful engagement and participation for residents with dementia.

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

PURPOSE:

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

PROCEDURE:

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

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

- Offering options for activities that provide meaningful engagement and interaction, including those that relate to daily living such as dressing, eating, and personal care

- Ensuring that residents have access to personal items that they find comforting such as dolls, blankets, photographs, or other items
- Offering and giving assistance to residents to visit the garden or other areas of the hospital as they are able
- Giving assistance, equipment and supplies needed for a resident to enjoy an independent activity
- Informing residents about the activity schedule on the neighborhood
- Assisting with transport to and from off neighborhood activities
- Adapting activities, individual or group, to support maximum participation

RESIDENTS WITH DEMENTIA

Activities for residents with dementia are customized to the individual so that they are meaningful. Through comprehensive care assessments, LHH staff learn as much as possible about the resident's preferences and pursuits prior to their arrival at LHH. This includes but is not limited to work history, hobbies, and physical activity preferences. The focus is on the resident, and not the condition. The goal is to offer more simple, brief individualized activities and less structured group activities to promote and maintain existing skills. Activities shall include but are not limited to large and small motor activities, cognitive, sensory stimulation, and socialization.

EXAMPLES OF ACTIVITES FOR RESIDENTS WITH DEMENTIA

1. Large motor activities: outdoor strolls in the garden, dance parties, Sit and Be Fit group exercise, balloon or beach ball toss
2. Small motor activities: Fiddle Boxes, untying knots, fabric boxes, arts and crafts
3. Cognitive activities: reminiscing, memory with pictures (of families, familiar objects), card games (e.g., Blackjack)
4. Sensory stimulation: fabric boxes, music/music appreciation, smelling of essential oils, putting lotion on hands,
5. Socialization: dance parties, music appreciation, reminiscing, community meetings

Activities preferences for residents with dementia, as well as all residents at LHH, shall be reassessed quarterly, annually, and as needed with appropriate updating of care plans.

ATTACHMENT: none

REFERENCE:

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

CCR Title 22 § 72381 Activity Program- Requirements

Palliative Care for People with Dementia: why comfort matters in Long Term Care; caringkind-palliativecareguidelines.pdf (caringkindnyc.org)

20 Practical Activities for people living with Alzheimer's Disease (goldencarers.com)

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

COACH USE FOR CLOSE OBSERVATION

POLICY:

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

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

   a. High risk for falls

   b. Impulsive behavior

   c. Risk for aggression

   d. Elopement risk

   e. Intrusive behavior

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

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

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

   ~~h.~~a. For residents who are having active suicidal ideation and scored at medium risk, a temporary coach shall be provided while waiting for further psychiatric evaluation.

~~3.~~4. The need of a coach is a nursing decision and is intended as a short-term intervention while developing a long-term plan for resident safety.

~~4.~~5. The RCT is responsible for the initial assessment and ongoing evaluation/need for close observation measures.

~~5.~~6. Nurse Director/Supervisor shall approve all coach assignments based upon the RCT assessment.

~~6.~~7. Coaches shall provide continuous close observation of engage the resident as appropriate and provide all care needs within the scope of their licensure or certification while avoiding any distractions as follows:

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

b. Using personal cell phone,

c. Reading,

d. Sleeping on the job.

~~7.~~8. LHH Patient Care Assistant (PCA)/ Certified Nursing Assistant (CNA) are expected to contribute to the electronic health record (EHR) documentation each hour for a resident who is provided with a coach.

~~8.~~9. The team leader/charge nurse is responsible for checking the resident's condition frequently and as needed.

~~9.~~10. The Licensed Nurse (LN) shall review EHR coach documentation for their shift and determine if the coach status is initiated, continued, or discontinued.

PURPOSE:

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

PROCEDURE:

1. **Role of the RCT**

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

i. Assess the need

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

ii. Develop an observation and intervention plan as follows:

- Possible close observation measures may include, but are not limited to:

- Increasing/decreasing the frequency of observation time periods

- Assignment of staff to provide close observation/cohort residents needing close observation
- Develop measurable goal/s related to the use of close observation. iii. Implement the plan

- The nurse manager/charge nurse shall assign staff as permitted, preferably unit staff who have received coach training and know the resident, to promote resident safety while providing direct care needs. The charge nurse/team leader shall round frequently to check on the resident's condition and for updates.

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

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

v. Evaluate the plan (Focused Review)

- While close observation is implemented, the RCT shall meet regularly and at least quarterly to:

  - Review any changes in resident's condition.

  - Assess effectiveness of current interventions.

  - Evaluate resident goals and the need for ongoing close observation.

- The RCT shall summarize each meeting via EHR.

  - The RCT and other consultants may conduct a Focused Review

  - If no progress is made, resident case may be referred to clinical leadership for long term placement.

2. **Role/Expectations of the Coach Providing Close Observation**

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

i. Why they are assigned to the resident.

ii. What goals are identified for this resident.

iii. What interventions can be employed with the resident.

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

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

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

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

iv. Observing, reporting and document resident behavior, including observation antecedants the agitate or improve resident behavior.

v. Providing nursing care as within their scope, which may include feeding, bathing, transferring, toileting (including incontinence care), repositioning, dressing, skin care and pivot transfers as ordered.

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

vii. Contributing to the RCT discussions and/or plan of care.

vii. Transporting/escorting residents to internal/external scheduled appointments.

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

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

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

i. Feeding residents on a Specialized Feeding Plan

ii. Showering/bathing

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

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

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

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

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

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

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

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

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

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

REFERENCE:
None.

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

Attachment A: Coach Use for Close Observation
Roles and Responsibilities

Role	Responsibility
LHH PCA/CNA	• Responsible for all duties within their scope of practice for assigned resident. • Documents via EHR and communicates resident behaviors to regular CNA and or team. • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet
Registry Coach	• May assist LHH nursing assistant or licensed nurse but not • use any equipment or assistive devices for which they have not been trained
Regular CNA	• Completes EHR documentation with input from Coach • Communicates any behaviors to the Licensed Nurse to be documented in EHR behavior monitoring flowsheet
Charge Nurse/ Licensed Nurses	• Assigns coach based upon available nursing staff. • Gives report to oncoming coach • Completes rounds frequently for updates • Documents any behaviors in EHR behavior monitoring flowsheet • LN will review EHR coach documentation for their shift and determine was the coach status initiated, continued or discontinued.
Resident Care Team	• Assesses need for Close Observation • Conducts focused review to evaluate continued coach need • May provide focused review with consultants • May refer to Clinical Leadership for placement

GIFT FUND MANAGEMENT

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to maintain a gift fund for the purpose of receiving all gifts, donations and contributions of money, stocks and/or other financial donations made for the general benefit and comfort of LHH residents/patients in accordance with the San Francisco Administrative Code (Section 10.100-201 Public Health Gift Funds).

All expenditures from the Gift Fund shall be made for the purposes for which the gift or donation was originally made.

PURPOSE:

The purpose of this policy is to provide guidance to effectively manage the Gift Fund and to ensure oversight and accurate disbursements.

PROCEDURE:

1. Donations and Gifts:

a. Project codes for cash gifts have been established for the general benefit and comfort of patients. The project code list is managed by the Chief Financial Officer and Gift Fund program coordinator.

b. In the event a donation is made for a purpose/intent outside of the existing established project codes, a new project code may be established with the authorization of LHH's Chief Financial Officer (CFO). At the discretion of the Gift Fund Committee, a new project code in the name of a donor may also be created in honor of the donor.

c. The process for donation(s) or gift(s) made to LHH is as follows:

   i. If a donation is made by cash or check, the staff person who receives the donation shall deliver it to the LHH's CFO/designee for deposit.

   ii. If the donation is in another form ~~,~~ (ei.ge., property, stocks, bonds)~~,~~ the recipient will inform the CFO, who will take steps to secure and receive the donation.

   iii. The Accounting staff notifies the Director of Public Health of each donation over $100, and the Director of Public Health will send an acknowledgement of appreciation to the donor.

iv. The donation is deposited in the project code that is specific to the donor's purpose/intent.

v. If the donor's intent/purpose is nonspecific, the donation will be deposited in the Miscellaneous Gift Fund for the general benefit and comfort of the residents/patients.

vi. Donations exceeding $25,000 require Health Commission and Board of Supervisors' approval.

vii. Names of individuals or organizations making donations of $100 or more to the Gift Fund are posted on the LHH website on an annual basis in accordance with the San Francisco Administrative Code (Section 67.29-6 Sunshine Ordinance).

2. Fund Oversight and Reporting:

a. Program Monitor.
Each project code will have an assigned Program Monitor to assist in budget planning and supervising the budgeted expenses/expenditures for the assigned project code(s).

b. Gift Fund Management Committee.
The Gift Fund Management Committee shall consist of the following: Chief Financial Officer, Chief Nursing Officer, Chief Quality Officer, Assistant Hospital Administrator, Director of Rehabilitation Services, Director of Social Service, and Ombudsman.. The Gift Fund Management Committee will meet at least quarterly to review and make recommendations for budget planning and expenditures.

c. Executive Committee
The CFO, on behalf of the Gift Fund Management Committee, will provide quarterly reports of Gift Fund activities, i.e., donations and expenditures, to the Executive Committee. The Executive Committee provides additional and overall supervision of Gift Fund management.

d. Health Commission
The CFO and Executive Administrator, through the Health Director, will provide updates as needed to the Health Commission of Gift Fund activities, including but not limited to donations, expenditures, and Gift Fund related policy and procedure revisions.

LHH will work with the Department of Public Health to provide a report on an annual basis, in writing to the Health Commission and the Board of Supervisors a listing of all gifts, donations and contributions of money or personal property related to the Gift Fund.

e. The City Controller's Office has the right to conduct final review and approval of all expenses.

3. Budgetary Planning:

a. Each fiscal year, no later than July 1, the CFO will provide to the Executive Administrator and the Gift Fund Management Committee Members the expenditure budget for the upcoming fiscal year. The CFO and Executive Administrator will then present the annual budget recommendations to the Joint Conference Committee each year for approval.

b. An out-of-budget funding request during the fiscal year shall be brought to the Joint Conference Committee for approval before the expenditures can be made for any proposed expenditures from the Gift Fund not already included in the fiscal year budget approved by the Health Commission, or that do not fall under the miscellaneous category of the Gift Fund budget,

4. Stock Management:

Each fiscal year, no later than August 1, the CFO will provide the Office of the Treasurer and Tax Collector (Treasurer's Office) the project codes that contain donated stocks so that the department can actively manage the portfolio of stock bequests in the Gift Fund in accordance with the Treasurer's Office's investment policy. Any recommendations to change status of any stocks will be reviewed by the Gift Fund Management Committee prior to the Health Commission approval.

5. Interest:

Interest generated from all Gift Fund project codes is distributed to the Miscellaneous Gift Fund project code.

6. Expense Incurred:

a. Before expenses are incurred, all expenses must be reviewed and authorized by the assigned Program Monitor. Purchases must be made consistent with City policies and procedures for contracting and purchasing, i.e., purchases from City-approved vendors, encumbrances in place prior to ordering the item(s).

b. All catering expenditures must be additionally pre-approved by the Chief Operations Officer.

7. Reimbursement Process:

a. Except for professional services (e.g., catering services), employees may purchase nominal (up to $200) and singular items, but pre-approval for the purchase must be obtained from the applicable Program Monitor. The employee

who incurs an expense shall follow the reimbursement policy to submit reimbursement requests to the LHH Accounting Department. Accounting staff will review documentation for appropriateness, validity, completeness and mathematical accuracy and will submit the documents to the CFO for approval. Accounting staff will process approved requests through the City Controller's Office who provide final review and approval. Estimated time for reimbursement to the employee is about seven days from the date approval is obtained from the Accounting Department.

8. Revolving Funds:

a. A number of resident programs funded through the Gift Fund require the regular availability of cash or purchasing flexibility outside of the hospital's routine purchasing mechanisms. For these programs revolving funds have been established.

   i. Community Outings
   ii. Community Reintegration
   iii. Hospital-Wide Programs
   iv. Substance Treatment and Recovery Services (STARS)
   v. Social Services Petty Cash

b. The appropriate Program Monitor or designee shall complete and submit a Gift Fund Revolving Fund Reimbursement form, Appendix A, with original receipts to replenish the Revolving Fund on regular basis.

c. Procurement Cards (P-Cards) are used in conjunction with these programs as deemed appropriate by the Chief Financial Officer

ATTACHMENT:
Attachment A: Gift Fund – Revolving Fund Reimbursement Form

REFERENCE:
LHHPP 50-06 Employee Reimbursement Request Guideline
LHHPP 50-11 Procurement Card
Materials Management Purchasing Policy
San Francisco Administrative Code (Section 10.100-201 Public Health Gift Funds)
San Francisco Administrative Code (Section 67.29-6 Sunshine Ordinance)
Revised: 98/11/16, 00/05/25, 04/12/02, 10/04/15, 11/01/25, 16/11/08, 18/06/12, 22/07/12 (Year/Month/Day)
Original adoption: 93/09/01

Attachment A:

Gift Fund – Revolving Fund Reimbursement Form

LAGUNA HONDA HOSPITAL
CITY AND COUNTY OF SAN FRANCISCO
GIFT FUND – REVOLVING FUND REIMBURSEMENT

To: Accounting Department **Date:** _____ ☐ P-Card ☐ Cash

From: _____ **Telephone No.** _____
Print Name

Fund: 22150 **Department** 251865 **Project/Activity** _____ **Program** P0066

Authority 10001

Account:

546990 $_____ Food	549610 $_____ Recreation supplies	549990 $_____ Other materials & supplies
535710 $_____ Subscriptions	527030 $_____ Transportation services	535990 $_____ Other current expenses

Total Requested Amount: $ _____ **Date(s) of expense:** _____

Reason for Expenditure:

☐ Social Services Petty Cash ☐ STARS ☐ Community Outings

☐ Community Reintegration ☐ Hospital-Wide Programs ☐ Neighborhood Money

---

Resident's Name (if applicable):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Staff and/or Volunteer's Name (if applicable):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Requested by: _____ _____ Date: _____
Employee: Print Name Signature

Pre-approved by: _____ _____ Date: _____
Program Monitor/Division Head: Print Name Signature
(or)
Pre-approved by: _____ Date: _____
Mivic Hirose, CEO or authorized designee

Approved by: _____ Date: _____
ChiaYu Ma, CFO or authorized designee

Note: Original receipts/invoices must be attached when submitting to Accounting. Revised: May 4, 2017

EMPLOYEE DEVELOPMENT FUND

POLICY:

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

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

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

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

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

6. Oversight of the fund is the responsibility of the Executive Leadership Team.

PURPOSE:

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

2. To assure that the acceptance and expenditure of donations earmarked for staff development meet the specific requirements of the San Francisco Department of Public Health (DPH) Grants Office as well as the specific requirements of the Health Commission, Board of Supervisors, Controller, and City Attorney's Office.

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

PROCEDURE:

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

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

   a. Fund – 21650
   b. Project Code - 10023362
   c. Authority – 10000
   d. Activity - 0001

3. Requests for funding of employee development activities shall be submitted to the LHH Executive Leadership Team.

4. Proposals and recommendations for use of the fund shall be reviewed by the LHH Executive Leadership Team.

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

6. The Chief Financial Officer shall provide an annual financial report to the LHH Executive Leadership Team.

7. Staff training sponsored by the fund requires a course certificate or proof of attendance and/or completion of the training classes to be eligible for the reimbursement of the training costs.

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

9. Gift Fund Coordinator shall keep on record copies of all training requests, approvals, and completion certificates for reporting purposes.

ATTACHMENT:
None

REFERENCE:
LHHPP 45-03 Donations
LHHPP 65-01 Procedures for Grant Application, Acceptance and Expenditure

Revised: 20/01/14, 22/01/11 (Year/Month/Day)
Original adoption: 15/11/09

DONATIONS

POLICY:

1. The hospital accepts and processes donations, including in-kind and financial donations, to the enhancement of its mission.

2. Generally, the hospital does not arrange for the pickup of donated in-kind items. The donors are responsible for getting donated items to the hospital.

3. The hospital respects the intention of its donors, and maintains the integrity of designated funds or items through proper procedures for the receipt, use, disposal, or return of donations or in-kind gifts, as well as the expenditure of funds that result from the liquidation of gifts and their conversion to cash.

4. The hospital maximizes the value of donations it receives, and sells, donates, or recycles materials not of immediate use.

5. All donations to the hospital with a value of $100 or more are reported to the appropriate City entity including the Joint Conference Committee, the full Health Commission, and the Board of Supervisors.

PURPOSE:

To ensure that donations to the hospital are utilized appropriately for the benefit of the hospital and the residents it serves.

PROCEDURE:

1. In-kind Donations

a. In-kind donations are non-financial donations of items such as clothing, furniture or equipment.

b. The Volunteer Services Department is responsible for accepting and processing non-designated in-kind donations per Volunteer Services policy.

c. The Volunteer Services Department maintains a list of acceptable items for donations and regularly makes that information as well as the hospital's policy on processing donated items available to the general public.

d. A Gift Receipt form is completed for each donation.

   i. The donor may request an acknowledgement letter for the donation. That request is documented on the Gift Receipt Form. The Volunteer Services

Coordinator is responsible for generating an acknowledgement letter from the Executive Administrator (unless donor contact information is not known).

ii. Copies on all Gift Receipt Forms are kept on file for 3 years by the Volunteer Services Department.

e. Valuation.

i. Undesignated non-monetary donations of clothing, jewelry, or other gifts do not have value placed upon them by hospital employees for purposes of donor tax obligation. Valuation for tax purposes is the responsibility of the donor.

ii. If the Volunteer Coordinators evaluate the donation to have a potential value of $100 or more, the Coordinators will evaluate the donation by requesting information from the donor or conducting independent research online. The value of the donation is recorded on the Gift Receipt form.

iii. In the unusual circumstance where the hospital may receive a donation believed to have unrecognized extraordinary monetary or historical value (i.e., a book, antique, fine jewelry), the Chief Executive Officer may authorize use of hospital funds to obtain an appraisal for the hospital's purposes. The value of the donation is recorded on the Gift Receipt Form.

f. The Volunteer Coordinators shall determine if a donor or in-kind items valuated at $100 of more has a financial interest in the City of San Francisco and document that information on the Gift Receipt form.

i. If a donor in unwilling to declare if she/he has a financial interest in the City, the donation shall be respectfully declined.

g. Designated non-monetary donations are distributed according to the terms of the donation if the hospital chooses to accept the donation; otherwise, the donation is declined with applicable reasons provided to the prospective donor.

h. The Volunteer Services Department determines the disposition of undesignated non-cash donations. Undesignated donated items shall be distributed directly to hospital departments or directly to residents, sold at the hospital's gift shop, or sold/given to a third-party organization to remove from the premises.

i. No in-kind donations shall be distributed to staff unless designated otherwise by the donor.

ii. Revenue generated by sales of undesignated non-cash donations are distributed to the Resident Gift Fund.

i. Donated equipment and furniture that will be used by residents will be evaluated and certified by the Facility Services Department and must meet UL and NFPA regulations for hospital usage.

j. The Volunteer Services Department forwards a copy of all Gift Receipt Forms to the Finance Department on a quarterly basis for reporting purposes.

   i. The Accounting Department maintains a list of in-kind donations valued at $100 or greater for reporting purposes.

k. In-kind donations valued at $10,000 or greater, must be accepted by the San Francisco Board of Supervisors for San Francisco Administrative Code 10.100-305.

   i. Retroactive acceptance of gifts already received. When a gift has already been received, it is possible to obtain retroactive acceptance by the above authorities via the same process as prospective acceptance. Retroactive acceptance of gifts is intended for use only in the exceptional case (e.g., acceptance of expensive wheelchairs~~).~~)

2. Monetary Donations

a. Prospective donors are directed to the Accounting Department Representative, who will advise the donor as to options for making a monetary donation. Those options include:

   i. The Resident Gift Fund, deductible as a gift to a fund of a charitable hospital.

      - Donations to the Resident Gift Fund may be designated to a specific program or grant code.
      - In the event a donation is made for a purpose or intent outside of the established grant codes, a new grant code may be established with the authorization of Laguna Honda's Chief Executive and Chief Financial Officer.
      - The hospital also accepts monetary donation to the Resident Gift Fund via its website.
      - Donations to the Resident Gift Fund are processed per LHHPP 45-01, Gift Fund Management.
      - Financial Donations to the Laguna Honda Gift Fund or $25,000 or more shall be accepted the Board of Supervisors per San Francisco Administrative Code, Section 10.100-201.

   ii. The Employee Development Fund

- Financial Donations made to the Employee Development Fund of $10,000 or more shall be accepted by the Board of Supervisors per San Francisco Administrative Code 10.100-305.

iii. The CityBridge, Laguna Honda, 501(c)(3) NFP tax deductible.

- The potential donor is providing with the contact information for CityBridge, Laguna Honda. Hospital staff do not accept fund on behalf of CityBridge, Laguna Honda.

iv. The San Francisco Public Health Foundation.

- The potential donor is providing with the contact information for the San Francisco Public Health Foundation. Hospital staff do not accept fund on behalf of the San Francisco Public Health foundation

b. For monetary donations of $100 or more to the Laguna Honda Gift Fund or Employee development fund, the Accounting Department must determine if the donor has a financial interest in the City.

i. If the donor declines to provide that information, the donation shall be respectfully declined.

c. Monetary donations shall be acknowledged by the Chief Executive Officer.

3. Reporting

a. Laguna Honda Hospital maintains a list of donations made to the hospital on its website.

i. The information includes the name of the donor, the amount of the donation, the disposition of the donation and whether the donor has a financial interest in the City.
ii. Donor information is maintained on the website for 12 months.

b. All donations with a value of $100 or more for a specific fiscal year is reported to the Department of Public Health within the first week of July. DPH complies the information for within the entire department and reports the information to the Board of Supervisors.

4. Solicitation for donations by hospital staff is prohibited.

5. Use of the Laguna Honda name or logo for fund-raising

a. Entities with contracts with the hospital may use the hospital name and/or logo for the purpose of raising funds for donation to or future use by the hospital to the extent authorized in the mutual agreements.

ATTACHMENT:
Gift Receipt Form

REFERENCE:
LHHPP 45-01 Gift Fund Management
Volunteer Services Policy C 2.0, In-kind Donations
San Francisco Administrative Code Section 10.100-201
San Francisco Administrative Code Section 10.100-305
San Francisco Administrative Code Section 67.29-6

Revised: 22/01/11
Original adoption: 12/09/25 (Year/Month/Day)

EMERGENCY RESPONSE PLAN

POLICY:

1. The immediate priorities of Laguna Honda Hospital and Rehabilitation Center (LHH) during a disaster are:

    a. Protection of lives

    b. Stabilization of the incident, and

    c. Protection of property and the environment.

2. LHH shall coordinate emergency response with the Department of Public Health (DPH) and, communicate status and resource needs or requests throughout any major event to the Department Operations Center (DOC).

PURPOSE:

1. The purpose of this plan is to serve as a guide for a rapid, effective, and coordinated response to any event resulting in a disruption of normal operations at LHH.

2. The purpose of an effective response will be to provide continued, quality service to residents, maintain essential internal and external communications, manage the use of resources; facilitate recovery efforts; and reduce the impact of the event.

PROCEDURE:

1. Activating the Hospital Incident Command System (HICS)

a. If an emergency situation affects the normal operation of the facility, the employee who discovers the situation shall immediately report it to ~~his or her~~their supervisor. The supervisor shall notify the Chief Executive Officer (CEO) or Administrator on Duty (AOD) of the major event that adversely affects the facility's ability to deliver care in the usual and customary manner, or to an accepted standard.

b. The CEO or AOD shall activate NHICS as needed and either assume or designate the role of Incident Commander.

c. If the CEO or AOD cannot be reached, the Operations Nurse Manager shall assume the role of Acting Incident Commander and assign someone to notify the following, in the order listed:

    i. Chief Operations Officer (COO)

    ii. Chief Medical Officer (CMO)

iii. Chief Nursing Officer (CNO)

iv. Quality Management Director

d. The first person to be reached on the above list shall assume or delegate the position of Incident Commander. Staff qualified to serve as the Incident Commander are those who have completed minimum training, which includes ICS 100, 200, 700 as well as additional NHICS training, and whom are deemed by the CEO or AOD to be qualified to manage the specific incident. A list of staff with this level of training can be found in Section A3 Emergency Resources and Maps and shall be updated quarterly by the Emergency Management Coordinator.

e. If the designated Incident Commander is not on site when HICS is initiated, the Operations Nurse Manager shall serve as Acting Incident Commander who shall serve until the designated Incident Commander arrives to relieve them.

f. NHICS roles are activated at the discretion of the Incident Commander for emergency incidents or planned events with the number of positions activated scalable to the situation. The Incident Commander is the only position ALWAYS activated and shall assume responsibilities of any role(s) not activated.

g. An incident may be initiated from LHH or the ~~hospital~~ facility may be informed of a city-wide incident through external notification by EMS Duty Officer or DPH Departmental Operation Center.

h. Whenever HICS is activated, all department and neighborhood managers or designees shall assess the status of their area using the Department Operating Status Report (DOSR), (see Appendix A), which shall be faxed to the Command Center at ~~415-504-8313, or~~415-504-8313 or delivered to the nearest~~–~~ DOSR collection bin within 15 minutes of HICS activation. The DOSR collection bins are in the following locations:

i. B102

ii. Clinic Registration Area

iii. Cadet's desk at the Pavilion main entrance

iv. Nursing Office

2. Notifications

a. Whether an incident is internal or external to LHH, the sequence of notifications in Table 1 shall be followed once HICS is activated.

Table 1: INTERNAL NOTIFICATION PROCESS		
PERSON INITIATING	**CONTACT PERSONS**	**COMMUNICATION**
Incident Commander	Nursing Office Staff at 4-2999	State message to be announced such as "Attention: HICS has been activated due to_____. Complete your DOSRs now."
Nursing Office Staff	Facility Occupants	Announce on the overhead Public Address (PA) system as directed by the Incident Commander
Incident Commander	S.F. Sheriff Duty Officer On-Call Medical Staff	Inform of situation.
Incident Commander	Executive Staff	Using DPH Alert system (Everbridge), notify the executive team that HICS has been activated and why.
Executive Staff	Department Managers	Follow Department Emergency Plan
Incident Commander or Emergency Manager	DPH Emergency Preparedness & Response On-Call	Notify on-call Manager that HICS is activated, reason for activation, and if there are any immediate needs.

b. Additional notifications may be sent from the command center to all employees or subgroups of employees using the DPH Alert system.

c. Whenever an incident is anticipated to impact, or require assistance from, other agencies or facilities, the CEO, AOD, or Incident Commander shall notify the DPH Emergency Response & Preparedness branch, who can notify the Director of Health and the DEM Duty Officer that Laguna Honda has activated HICS.

3. Communications Plan

a. Communication shall be maintained with DPH throughout large scale incidents in order to verify status, prioritize objectives, share resources, and coordinate city-wide needs.

b. The Liaison Officer or Incident Commander shall establish communications with the EOC and/or the DPH DOC, if activated.

c. If the DOC is not activated, communications shall be established with DPH PHEPR , by calling the 24/7 on-call phone number~~during normal business hours~~.

d. An emergency contact list, including key Laguna Honda contacts and external agencies is available in the command center and as Appendix B.

e. The ReddiNet system shall be used to receive information from EMS, DPH, and other health facilities during multiple casualty incidents (MCIs) affecting the San Francisco health care system.

f. The Public Information Officer or Incident Commander shall maintain communications and provide regular updates to the Laguna Honda community, including employees, residents, and resident families.

g. Any requests for information coming from the media shall be forwarded to the DPH Public Information Officer. No Laguna Honda employee shall make a statement to the media.

h. In the event that regular communications systems are unavailable, a variety of back-up communication methods are available at the discretion of the Incident Commander:

   i. Radios are available in the command center, Nursing Office, and offices for the CEO, COO, Sheriff, Emergency Management Coordinator, and Health at Home.

   ii. A Mayor's Emergency Telephone System (METS) phone is available in the command center for direct contact with city emergency services officials. The METS system is also connected to the State of California's satellite telephone system for direct communication with the Governor's Office of Emergency Services in Sacramento, as well as the emergency operations centers of surrounding counties.

   iii. Messengers shall be used if all communication devices have failed, or as needed to augment communication devices.

4. **Off-Duty Staff Response**

a. All staff are mandated disaster service workers.

b. Off duty staff are expected to:

   i. First assure their own safety and that of their family

   ii. Wait to be called back to work or report for the next scheduled shift unless required to report immediately per the departmental emergency plan.

iii. Listen to the radio in case the phone lines are down (Radio stations KNBR 680, KGO 810, or KCBS 740)

c. Staff are advised to check road conditions and radio announcements before traveling. The city may also assist staff to and from their assigned locations in the event that roads and bridges are compromised, as announced on radio and other means available.

d. The Incident Commander shall activate staff to NHICS positions according to the needs of the response.

e. Additional staff may be called to either their regular duties or to the labor pool. Each department manager/designee leads the call back process and response according to their Departmental Procedure. If the department manager or designee is not available, the Incident Commander or Logistics Section Chief may initiate call back of any staff deemed necessary for the response.

~~2.~~5. ~~Use of Volunteers~~ Staffing & Management of Volunteers

a. **Volunteer Staffing during Emergencies or Disaster**

i. LHH volunteer staffing is designed to be flexible during periods of increased demand or other intermittent challenges

ii. During any emergency or disaster where additional or alternative staffing is required to sustain hospital operations, activated according to LHHPP 70-03 Emergency Response Plan, and under one or more of the following circumstances:

- Activation of the DPH Emergency Operations Plan
- Activation (partial or full) of the DPH Departmental Operations Center (DOC) for an emergency response
- Staff absenteeism is 20% or more than anticipated staffing for hospital
- When emergency preparedness response activities exceed staffing capabilities
- Damage or inoperability of key facility, facilities impedes daily operations

b. **Management of Staff - Including Volunteer Healthcare Professionals at LHH during a Disaster**

i. ~~LHH has a pool of volunteers who provide various levels of day to day assistance through the Volunteer Coordinators. Volunteers frequently assist with resident transport and this is their anticipated primary role during an~~

~~incident or event.~~ During a major event, volunteers will assemble under the direction of their unit supervisor. Volunteers must be properly identified and have their credentials verified before being assigned to assist in any area.

ii. **Licensed Independent Practitioners:**

- In the event that the LHH Emergency Response Plan has been activated AND the Hospital is unable to handle the immediate patient care needs, volunteer health care professional(s) who are licensed independent practitioners may be granted Disaster Privileges and assigned disaster responsibilities by XXXXXXX?
- Before a volunteer licensed independent practitioner is considered eligible for consideration for disaster privileges, they must present valid government issued identification (for example, a driver's license or passport and at least one of the following:
  - • A current picture identification card from a healthcare organization that clearly identifies professional designation;
  - • A current license to practice
  - • Primary source verification of licensure
  - • Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
  - • Written attestation to the Chief of Staff or their designee by a licensed independent practitioner currently privileged by LHH or by a staff member of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

iii. **Tracking Staff & Volunteers at LHH during a disaster**

- During Actual emergency HICS Activations, Department Managers and Supervisors are responsible tracking the location of all on duty staff & assigned volunteers working for their department. Using normal departmental time-keeping documents, attendance should be checked no less than every two (2) hours, and when directed by the Incident Command Center so that appropriate badge access auditing or other search measures can be coordinated as soon as possible.
-

~~b. Calls to volunteers shall be made as needed through the Volunteer Coordinators.~~

~~c.~~ ~~New volunteers who offer assistance during an emergency incident shall be screened according to the usual volunteer screening processes and may only work in roles usually assigned to volunteers.~~

~~3.~~6. Equipment and Supplies

Equipment and supplies to support a safe and effective staff response are maintained by the Department of Workplace Safety and Environmental Management (WSEM), Materials Management, Nutrition Services, and the Pharmacy. Table 2 lists critical equipment and supplies along with their storage locations.

Table 2: Emergency Equipment and Supply Locations

EMERGENCY EQUIPMENT/SUPPLY	STORAGE LOCATION
Seven days' worth of food for 2000 people	Kitchen
600,000 gallons potable water	Water tanks east of facility
266 gallons of bottled water	Kitchen
Par level of linen	Clean linen storage room in S1
Evacuation equipment	H2 emergency storage
Respirators and cartridges	H2 emergency storage
Emergency lighting	H2 emergency storage and each neighborhood/department
Personal patient care supplies	H2 Central Supply/Warehouse
Tent	Container in gravel parking lot
Cots (55)	Container in gravel parking lot

~~4.~~7. Shelter in Place Plan

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

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

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

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

Response Measure
Identify nature of incident and determine necessary level of response and protection.
Coordinate safety and security with law enforcement entities as appropriate.
Implement the following activities: • Close air vents, windows, and doors. • Facilities department to shut down hospital Heating, Ventilation and Air Conditioning Unit (HVAC)
Notify residents, employees, visitors and vendors as to nature of the danger and reason for the shelter-in-place.
Assess capabilities and identify personnel resource requirements and staff availability.
Develop and implement public-information plans for employees and the media to provide information on disease recognition, necessary infection-control measures, treatments, and home-care/after-care instructions.

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

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

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

8. ~~5.~~ Contactor Contact Information

All contracts and ~~their~~ associated contact information for entities providing services to LHH can be found in Appendix C and are maintained in two areas:

- Within four purple ~~binders~~binders located in the Administration Suite.
- On the DPH LHH HICS 2022 SharePoint page
  - The SharePoint software will automatically send out an imminent expiration reminder to the department that holds the contract

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

REFERENCE:
Regulatory References: California Occupational Safety and Health Standards, California Code of Regulations (CCR), Title 8, Section 3220; and Licensing and Certification of Health Facilities, California Code of Regulations (CCR), Title 22, Sections 70741 and 72551; and the Standardized Emergency Management System (SEMS), CCR Title 19, Division 2.

Revised: 14/11/25, 17/05/09, 18/03/13, 19/05/14, 19/09/10, 20/03/17 (Year/Month/Day)
Original Adoption: 13/05/28

DEPARTMENT OPERATING STATUS REPORT

COMPLETE THIS FORM IMMEDIATELY FOR ALL DISASTER / EMERGENCY NOTIFICATIONS & PROVIDE TO THE COMMAND CENTER (Fax: 415-504-8313)

Date: _____ Time notified of emergency/disaster activation ____:____ Time report completed ____:____ Time report received at Command Center ____:____

Department: _____ Location: _____ Telephone: _____

Contact Person _____ Title _____ Contact by phone _____ Pager _____

If no residents in your area, skip to Section 2 **SECTION 1 – RESIDENTS**	**SECTION 2 – STAFFING**	Resident Units, Clinic, Rehab Only **SECTION 3 – CRITICAL RESOURCES**
Current Census in Department: Number of residents accounted for Have any residents been injured? ☐ Yes ☐ No Please list on the back of this form names of any injured or missing residents. Indicate type of injury or location/ likely whereabouts as applicable. Any anticipated Resident condition changes or problems resulting from this event? ☐ Yes ☐ No # of Patients eligible for discharge # of Patients eligible for Transfer	**Current Staffing in department (on duty)** RN# LVN# CNA/PCA# HHA# MD# EVS# Unit Clerk# FSW# HIS# AT# SW# Other staff: (List title and number of staff) ***Complete staff name and title on next page*** Total Staff: Any injuries to staff? ☐ Yes ☐ No If "Yes", list number of injuries by severity: Minor Delayed Immediate Expired Number of staff available for Labor Pool:	Open/Available Beds # Open/Available Negative Pressure Rooms# Open/Available Gurneys # Open/Available Wheelchairs # Available Portable O2 # Full #Partially Full Other Available Space, Equipment and Supplies

Please use back of form for additional information as needed

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

Employee Name	Classification

Appendix B: Emergency Contact List

Agency or Individual	Phone	Pager	Email
Director of Health	415-554-2525		
SFHN Director	415-554-2711		
DEM Duty Officer	415-260-2591	415-327-0543	
PHEPR ~~Director~~On-Call Manager	415-802-7358		
~~DPH Emergency Response Line~~Emergency Prepar	~~415-558-5949~~		Phepr.dph@sfdph.org
DPH DOC	DOC will provide number upon activation~~Varies – call above number~~		
DPH Communicable Disease Urgent Reporting Line	415-554-2830		
ZSFG Incident Commander	628-206-9680		
ZSFG AOD	628-206-3519	413-327-0259	
ZSFG Emergency Prep Coord	415-694-9488 text/voice		
IT On Call Engineer			
IT MOD			
EOC Turk Street	415-487-5000		
SFSD – Sheriff	415-759-2319		
CDPH L&C District Office	415-554-0353		
Ombudsman	415-751-9788		

Appendix C: Contractor Contact List

LHH Contract Owner	Categories	Vendor Name	Title	Supplier Contact Name	Phone Number	Email
Carton-Wade, Jennifer (DPH)	Activities	Some Things Fishy	Aquarium Maintenance Services	Ric Boschert	408-836-7761	nicefishtanks@yahoo.com
Carton-Wade, Jennifer (DPH)	Activities	Eldergivers	Eldergivers	Mark Campbell	415-215-3659	mark@artwithelders.org
Carton-Wade, Jennifer (DPH)	Activities	Medical Clown Project, Inc.	Medical Clown Project	Calvin Kai Ku	510-919-8310	ckaiku@medicalclownproject.org
Carton-Wade, Jennifer (DPH)	Activities	Community Music Center	Spanish Speaking Choir	Sylvia Sherman	415-647-6015 x172	ssherman@sfcmc.org
Carton-Wade, Jennifer (DPH)	Administration	National Research Corporation	Patient and Workforce Surveys	Molly Preston	800-388-4264	mpreston@nrchealth.com
Sangha, Baljeet (DPH)	Administration	Moss Adams, LLC	Consultant Services	Ryan Joyner	404-285-5183	ryan.joyner@mossadams.com
Sangha, Baljeet (DPH)	Administration	HMA, Inc	Consultant Services - CMS Certification	Rob Ross	845-325-2986	rross@healthmanagement.com
Sangha, Baljeet (DPH)	Administration	HSAG	Consulting and Assessment Services	Barbara Averyt	602-327-2522	baveryt@hsag.com
Sur, Matthew (DPH)	Administration	Toyon	Reimbursement Services	Carrie Yee	888-514-9312	carrie.yee@toyonassociates.com
Shuyan Wu (DPH)	Environmental Services	Stericycle, Inc	Document Destruction - Shred-It	Victor Mainor	415-960-6530	victor.mainor@stericycle.com
Shuyan Wu (DPH)	Environmental Services	Stericycle	Medical Waste Management	Fernando Campos	510-324-6469	fernando.campos@stericycle.com

Shuyan Wu (DPH)	Environmental Services	Agurto Corporation dba Pestec	Pest Control	Luis Agurto	415-671-0300	luis@pestecipm.com
Shuyan Wu (DPH)	Environmental Services	Waxie Sanitary Supplies	EVS cleaning Supplies	Ivan Lopez	510-710-9781	ilopez@waxie.com
Shuyan Wu (DPH)	Environmental Services	Emerald Textile Services LLC	Linen Service	Sherry Lee	209-918-1185	slee@emeraldus.com
Shuyan Wu (DPH)	Environmental Services	Recology Sunset Scavenger Company	Refuse Collection & Recycling	Marc Valentine	415-330-1315	mvalentine@recology.com
Shuyan Wu (DPH)	Environmental Services	Fanta Deluxe Cleaners	Dry Cleaning Services	Joseph Park	415-495-7788	pagingjoseph@gmail.com
Shuyan Wu (DPH)	Environmental Services	COIT Cleaning & Restoration	Blinds and Shades installating and repaire	Ellison Penos	650-826-1394	ellison.penos@coit.com
Shuyan Wu (DPH)	Environmental Services	Banner Uniform Center	Uniform and Related Ancillary Items	Frank Skubal	415-771-5593	frank@banneruniform.com
Shuyan Wu (DPH)	Environmental Services	Beck's Shoes	Foodwear	Brian Baumert	831-345-9305	bnbaumert@beckshoes.com
Shuyan Wu (DPH)	Environmental Services	Cole Supply	Cleaning supply	Michelle Stringer	925-876-1565	mstringer@colesupply.com
Hoffman, Samuel (DPH)	Equipment	Konica Minolta	Equipment Maintenance	Jane Uong	408-387-2335	juong@kmbs.konicaminolta.us
Kenyon, Diana (DPH)	Facilities	ABCO Mechanical Contractor	Air Duct Maintenance Services	Nick Lanthier	415.648.7135	nick@abcoair.com
Kenyon, Diana (DPH)	Facilities	Hill Rom	Hill Rom Bed Maintenance	Dan Murphy	509.319.4054	Daniel_Murphy@baxter.com
Kenyon, Diana (DPH)	Facilities	Garrett Callahan	Boiler Chemicals	Mike Bauman	650-201-3096	mbauman@g-c.com
Kenyon, Diana (DPH)	Facilities	Rubecon General Contracting	Door, Gate, Modular Furnishing, Carpentry,	Rudy Rodriguez	415.987.0500	rudy@rubecon.com

			Fire Rated Door Services			
Kenyon, Diana (DPH)	Facilities	Thyssen Krupp	Elevator Repair and Maintenance	Joseph Charne	415-544-8150	Joseph.Charne@tkelevator.com
Kenyon, Diana (DPH)	Facilities	International Fire	Fire Extinguishers and Pump Maintenance	Karl Reed	415-643-1767	karl.fireprotection@gmail.com
Kenyon, Diana (DPH)	Facilities	Johnson Controls, Inc.	HVAC	Andrew Aguero	510-600-5175	andrew.n.aguero@jci.com
Kenyon, Diana (DPH)	Facilities	West-Com	Maintenance	Tiffany Kraft	707-428-5902	tkraft@westcomtv.com
Kenyon, Diana (DPH)	Facilities	Union Rolling Door	Rolling Door Services and Maintenance	Carlo Doyle	415-789-3899	carlo@union-door.com
Kenyon, Diana (DPH)	Facilities	Emerson Digital Cold Chain, Inc.	Temperature Control	Jonathan Ganak	425-419-7085	jonathan.ganak@emerson.com
Kenyon, Diana (DPH)	Fire Alarm	Johnson Controls	Fire Alarm Maintenance	Andrew Aguero	510-600-5175	andrew.n.aguero@jci.com
Lavarreda, Elvis (DPH)	Food and Nutrition Services	Bay Cities Product Inc	Food Service Distribution and Procurement - Bay Cities (Milk and Dairy)	Tina Swearengin	510-346-4943	tina@baycitiesproduce.com
Lavarreda, Elvis (DPH)	Food and Nutrition Services	Bay Cities Produce Inc	Food Service Distribution and Procurement - Bay Cities (Produce)	Tina Swearengin	510-346-4943	tina@baycitiesproduce.com
Lavarreda, Elvis (DPH)	Food and Nutrition Services	Blossom Foods	Food Service Distribution and	Sue Adams	510-893-3244	1Sueadams@gmail.com

			Procurement - Blossom Foods - Premade Meals			
Lavarreda, Elvis (DPH)	Food and Nutrition Services	Fresh & Ready	Food Service Distribution and Procurement - Grab-N-Go	Arthur Gulumain	818-433-6746	
Lavarreda, Elvis (DPH)	Food and Nutrition Services	IVSF Catering	Food Service Distribution and Procurement - IVSF	Jason Angeles	415-830-0095	
Lavarreda, Elvis (DPH)	Food and Nutrition Services	San Francisco Supply Master Inc.	Food Service Distribution and Procurement - SF Supply Master	Ryan Framan	415-642-0700	ryan@sfsupplymaster.com
Lavarreda, Elvis (DPH)	Food and Nutrition Services	US Foods, Inc	Food Service Distribution and Procurement - US Foods	Daniel Murray	800-682-1281	ncacustomerservice@usfoods.com
Lavarreda, Elvis (DPH)	Food and Nutrition Services	Bimbo Bakeries USA	Fresh Bread and Dinner Rolls	Franko	510-333-2217	
Lavarreda, Elvis (DPH)	Food and Nutrition Services	Banner Uniform Center	Uniform and Related Ancillary Items	Frank Skubal	415-771-5593	frank@banneruniform.com
Lovko-Premeau, Diane (DPH)	H.I.M.S.	GRM Information Management Services LLC	Document Storage Service	Michael Vlahos	800-932-3006	www.grmdocumentmanagement.com
Lovko-Premeau, Diane (DPH)	H.I.M.S.	VRC Companies LLC	Medical Record Retrieval and	Sonya Brousil	702-410-9591	sbrousil@vrcnetwork.com

			Reproduction			
Lovko-Premeau, Diane (DPH)	H.I.M.S.	ACCESS (Previously DELIVEREX)	Medical Record Storage	Karen Clements	888-869-2767	Karen.Clements@accesscorp.com
Cozzi, Gary (DPH)	Laboratory	Registry Network Inc	Laboratory Staffing			
Hoffman, Samuel (DPH)	Medical and Industrial Gas	Airgas	Medical and Industrial Gas	Victor Trotter	916-205-8773	
Fong, Doug (DPH)	Medical Equipment	AeroScout, LLC	AeroScout			
Hoffman, Samuel (DPH)	Medical Equipment	Baxter Healthcare Corporation	Equipment Maintenance Service	Lawrence Jones	619-734-5233	lawrence_jones@baxter.com
Hoffman, Samuel (DPH)	Medical Equipment	KCI USA Inc	Equipment Rental	Anthony Maduena	510-292-0315	amaduena@mmm.com
Hoffman, Samuel (DPH)	Medical Equipment	Agiliti Health Vizient	Medical Equipment Management	Peter Galley	916-540-6066	Peter.Galley@agilitihealth.com
Kenyon, Diana (DPH)	Medical Equipment	Stryker	Stryker Bed Maintenance	Kelsy Bucklew	317-703-9607	kelsy.bucklew@stryker.com
Hoo, Lisa (DPH)	Medical Services	Bay Area Communication Access	American Sign Language Interpreting Services	Arnita Dobbins	415-356-0405	bacareg@bacainterp.com
Lee, Christina (DPH)	Medical Services	Regents of the University of California (UCSF)	Outpatient Clinical Services & Dental Services			
Hoffman, Samuel (DPH)	Medical Supplies	Medline Industries	Medline Supply	Brian Lee	925-290-9497	bjlee@medline.com
Hoffman, Samuel (DPH)	Medical Supplies	SF Supply Master	Cleaning supply and Food Serving Supply	Customer Service	415-642-0700	order@sfsupplymaster.com
Hoffman, Samuel (DPH)	Medical Supplies	Cardinal Health	Medical Supplies	Keri Smith	510-570-6594	keri.smith01@cardinalhealth.com

Hoffman, Samuel (DPH)	Medical Supplies	Performance Health	Medical Supplies	Cindy Nguyen	408-609-4894	cindy.nguyen@performancehelath.com
Hoffman, Samuel (DPH)	Medical Supplies	Nestle Ready ReFresh	Bottled Water	Customer Service	844-855-4596	
Antoc, Maria Roella (DPH)	Nursing	Cross Country Staffing	Medical Staffing			
Antoc, Maria Roella (DPH)	Nursing	Tryfacta, Inc.	Medical Staffing	Adesh Tyagi	408-893-5500 517-273-4547	adesh.tyagi@tryfacta.com
Fouts, Michelle	Pharmacy	Technical Safety Services TSS	Sterile Room Testing	Grant Ono	510-845-5591	GOno@techsafety.com
Fouts, Michelle	Pharmacy	Parata	Auto Packaging Machine Service and Supplies	Teresa Rasmussen	866-559-0968	TRasmussen@parata.com
Fouts, Michelle	Pharmacy	FFF	Vaccinations	Diane Santos	800-843-7477	DSantos@fffenterprises.com
Fouts, Michelle	Pharmacy	Alta Medical	Sterility testing equipment	Ty Rudell	415-215-9599	Ty@altamedspec.com
Fouts, Michelle	Pharmacy	JMI Sourcing	Auto Packaging Supplies	Jennifer Varma	415-939-5221	VarmaJennifer@gmail.com
Fouts, Michelle	Pharmacy	Fisher Healthcare	Pharmacy supplies	Julian Barber	442-287-5293	Julian.barber@thermofisher.com
Fouts, Michelle	Pharmacy	GlaxoSmith Kline	Vaccinations	Sarah Rauh	415-470-2533	Sarah.e.rauh@gsk.com
Fouts, Michelle	Pharmacy	CME	Pharmacy supplies	Heather Pfeiffer	415-744-4476	hpfeiffer@cmecorp.com
Fouts, Michelle	Pharmacy	Muscolino	Pharmacy inventory	Ray Parsons	940-577-5241	Ray.Parsons@picsinv.com
Fouts, Michelle (DPH)	Pharmacy	Nor-Cal Medical Temps	Pharmacy Staffing	Bryan Medlin	415-459-5211	bpmedlin@norcalmedtemps.com

Fouts, Michelle (DPH)	Pharmacy	Soliant Health, Inc	Pharmacy Staffing	Meckal Rogers	813-749-5268	Meckal.Rogers@soliant.com
Fouts, Michelle (DPH)	Pharmacy	Omnicell	Supplies	Al-x Gonzalez	650-251-6039	Al-x.gonzalez@omnicell.com
Blanco, Irin (DPH)	Technology	Change Healthcare (CERME, InterQual)	Software Maintenance - Workforce Management			
Fouts, Michelle (DPH)	Technology	McKesson Technologies, Inc.	Technology Services	Cristina Lizarraga	916-284-6315	cristina.lizarraga@mckesson.com
Lavarreda, Elvis (DPH)	Technology	The CBORD Group, Inc	Food Software License	Jim Mitchel	607-330-3925	
Lovko-Premeau, Diane (DPH)	Technology	Nuance Communication Inc	Nuance's Clintegrity System Licenses	Jeanne Nauman	866-383-9031	jeanne.nauman@nuance.com
Rudolph, Heather (DPH	Therapy - OT/PT/SLP	Preferred Health Care Registry, Inc	Rehab Staffing	Peyton Pyburn	858-429-7990	peytom@mypreferred.com
Rudolph, Heather (DPH	Therapy - OT/PT/SLP	Supplemental Health Care	Rehab Staffing	Morgan Mason	469-708-4005	mmason@shccares.com
Rudolph, Heather (DPH	Therapy - OT/PT/SLP	Hearing & Speech Center of Northern California	Speech Therpay Third Party	Emily Smith	(415) 921-7658	esmith@speechhearing.org
Hnin, Aye (DPH)	Transfer/Transportation	Capital Transit	Medical Transportation - Capital Transit	Shiraz Mir	(916) 470-0476	shirazmir916@gmail.com
Hnin, Aye (DPH)	Transfer/Transportation	Semax	Medical Transportation - Semax	Helen Basson	(415) 439-9836	semaxtrans@gmail.com

Revised Activity Therapy Policies and Procedures

SCOPE OF SERVICES

POLICY:

The Activity Therapy Department provides a wide range of services and activity options to enhance resident quality of life, skill development and independence. This includes providing individualized opportunities for meaningful engagement and participation for residents with dementia.

PURPOSE:

To provide Laguna Honda Hospital residents opportunities for self improvementself-improvement, leisure and meaningful engagement and connections to the community.

PROCEDURE:

Activity therapy services are an integral part of the rehabilitation and skilled nursing services at Laguna Honda Hospital. Services include but are not limited to:

1. Neighborhood based services which engages the interdisciplinary team to provide -(See Activity Therapy Policy and Procedure File D1: File P1-0 Activity Calendars)
   a. Social opportunities
   a.b. Musical entertainment
   b.c. Educational opportunities
   c.d. Creative expression
   d.e. Religious referrals and expression
   e.f. Exercise activities
   f.g. Community connections
   g.h. Outdoor experiences

2. Individualized activities adapted for each resident's needs, including activities for residents with advanced dementia. May include:
   a. Social engagement
   b. Daily living activities
   c. Games or puzzles
   d. Spending time in the garden or outdoors
   e. Personalized music or other entertainment the resident enjoys

2.3. Evening and Weekend divisional activities (See Activity Therapy Policy and Procedure File D2 C2: Tracking of Resident Participation Hospital-Wide Activity Attendance Record)

3.4. Support to the residents council Residents' Council (See Hospital Wide Policy and Procedure File 22-06: Residents' Council)

4.5. Wellness Center recreational activities (activities (See Hospital Wide Policy and Procedure File 28-03: Aquatic Services)

5.6. Therapeutic farm and garden activities (See Hospital Wide Policy and Procedure File 28-02: The Farm and Therapeutic Gardens and Animal Control 76-03)

6.7. Therapeutic outings in collaboration with nursing services (See Hospital Wide Policy and Procedure File 28-01 and Activity Therapy Policy and Procedure File D2P7: Community Outing Program)

7. A documentation process which includes assessment, care plans, reviews, participation and the MDS. (See Activity Therapy Policy and Procedure File D1: Medical Record Documentation, D2-0 Tracking of Resident Participation, D4 Quarterly Progress Note Format, C1: Medical Record Documentation)
8.

RESIDENTS WITH DEMENTIA

Activities for residents with dementia are customized to the individual so that they are meaningful. Through comprehensive care assessments, LHH staff learn as much as possible about the resident's preferences and pursuits prior to their arrival at LHH. This includes but is not limited to work history, hobbies, and physical activity preferences. The focus is on the resident, and not the condition. The goal is to offer more simple, brief individualized activities and less structured group activities to promote and maintain existing skills. Activities shall include but are not limited to large and small motor activities, cognitive, sensory stimulation, and socialization.

EXAMPLES OF ACTIVITES FOR RESIDENTS WITH DEMENTIA

1. Large motor activities: outdoor strolls in the garden, dance parties, Sit and Be Fit group exercise, balloon, or beach ball toss
2. Small motor activities: Fiddle Boxes, untying knots, fabric boxes, arts and crafts
3. Cognitive activities: reminiscing, memory with pictures (of families, familiar objects), card games (e.g., Blackjack)
4. Sensory stimulation: fabric boxes, music/music appreciation, smelling of essential oils, putting lotion on hands,
5. Socialization: dance parties, music appreciation, reminiscing, community meetings

Activities preferences for residents with dementia, as well as all residents at LHH, shall be reassessed quarterly, annually, and as needed with appropriate updating of care plans.

REFERENCES:
Activity Therapy Policy and Procedure File P1: Activity Calendars
Activity Therapy Policy and Procedure File D2: Tracking of Resident Participation
Hospital Wide Policy and Procedure FileHWPP 22-06: Residents' Council
HWPP 22-14: Resident Activities
Hospital Wide Policy and Procedure File 28-03: Aquatic Services
HWPP Hospital Wide Policy and Procedure File 28-01: Community Outing Program
HWPP Hospital Wide Policy and Procedure File 28-02: The Farm and Therapeutic Gardens
HWPP Hospital Wide Policy and Procedure File 28-03: Aquatic Services
HWPP Hospital Wide Policy and Procedure File 76-03: Animal Control
Activity Therapy Policy and Procedure File P2: Community Outing Program
Activity Therapy Policy and Procedure File D1: Medical Record Documentation
Activity Therapy Policy and Procedure File D2: Tracking of Resident Participation
Activity Therapy Policy and Procedure File P1: Activity Calendars
Activity Therapy Policy and Procedure File P2: Community Outing Program

ATTACHMENTS:
None

Most recent review: 3/20/2023, 6/25/20186/25/2018, 5/5/2015
Revised: 10/12/2010, 8/29/2013, 8/29/2014

Adopted: 6/1/1999

New Food and Nutrition Services Policies and Procedures

1.01 Food and Nutrition Services (FNS) Scope of Services

Established and Revised: 5/2023

Pending JCC Approval: 06/2023

Reviewed: 5/2023

Policy: The Food and Nutrition Services Department directs daily kitchen operation and clinical nutrition services to provide facility-wide dining services and nutrition care to all residents.

Purpose: To provide safe, satisfying and nutritionally adequate food based on the individual needs of the residents at Laguna Honda Hospital (LHH). There will be adequate qualified staff, space, equipment and supplies to support uninterrupted and organized dietary services. This policy states the general scope of services for which the FNS department is responsible.

Definition: The resident is a resident, patient, or client receiving care or services from Laguna Honda Hospital.

Procedure:

1. The FNS Provide meal service based on departmental policy 1.83 Resident Meal Service, while a bedtime snack shall be offered through Nursing Service, unless otherwise indicated in writing by the resident's licensed healthcare practitioner acting within the scope of his or her professional licensure.
2. No more than 14 hours shall elapse between the evening meal and breakfast of the following day (See attached Meal Schedule)

Personnel – General

1. The FNS department will have an adequate number of staff to provide for the nutritional needs of the residents and to maintain the food service areas.
2. Food and nutrition services staff will be on duty to allow the kitchen to be open during hours of operation.
3. A clearly written job description for each position will be on file and available for staff to review.
4. A record shall be maintained of the number of persons by job title employed full or part-time in dietetic services and the number of hours each works weekly.
5. Food and nutrition services staff will be oriented and trained to perform assigned duties and will be expected to participate in departmental or facility-wide in-service training programs. These programs may be conducted in-person or via the Electronic Learning Management system.
6. A FNS employee should not be assigned duties outside the department, except in an emergency. These duties shall not interfere with the sanitation, safety or time required for dietetic work assignments.
7. The Food Service Director directs daily kitchen operation and is responsible for all aspects of dining services.

8. The Chief Clinical Dietitian directs clinical nutrition services and is responsible for all aspects of nutrition care.

Space/Equipment/Supplies

1. There will be adequate space to conduct daily food service operation.
2. The dietetic service area shall be ventilated in a manner that will maintain comfortable working conditions.
3. Adequate supplies and equipment for food service operation shall be available to meet the needs of the hospital. Their condition shall be inspected as part of the Production Sanitation Inspection. These include all utensils, counters, shelves and equipment. They shall be clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas. Any plasticware, china and glassware that is unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded immediately when identified.
4. The FNS department will coordinate with the Facility department to perform routine preventative maintenance for all fixed and mobile equipment in the dietetic service area to assure sanitary and safe operation.
5. Menu management system, i.e. CBORD, is used to prepare and manage menus, resident's dietary records and preferences.

Revised Nursing Services Policies and Procedures

NURSING SERVICES: ORGANIZATION, AUTHORITY/RESPONSIBILITY AND OPERATIONS

POLICY:

The operational units of Nursing Services include skilled nursing, medical acute, and rehabilitation acute care. LHH Nursing Services shall be organized, staffed, equipped, and supplied to meet the needs of the residents of LHH.

PURPOSE:

To describe and communicate LHH Nursing Services structure, authority, responsibility, and operations.

RELEVANT DATA:

1. The Chief Nursing Officer (CNO) or designee:

   a. Holds an active Registered Nurse license and is employed by ~~by~~ SFDPH as the CNO on a full-time basis, defined as 40 or more hours per week,

   b. Actively participates in the organization's leadership functions with the Governing Body, Medical Staff, Hospital Management, and Clinical Leaders in the Hospital's decision-making structures and processes;

   c. Ensures the continuous and timely availability of nursing services to residents;

   d. Ensures that Nursing Practice Guidelines and Nursing Policies and Procedures are consistent with current evidence-based practice and nationally recognized professional standards;

   e. Implements the findings of current research from nursing and other literature into policies and procedures that govern the provision of nursing care;

   f. Ensures that Nursing Services staff carry out applicable processes in resident care and organization wide functions;

   g. Assigns responsibility for individuals or groups of nursing staff members to act on improving the performance of Nursing Services through the implementation of an effective, ongoing program to measure, assess, and improve the quality of nursing care delivered to residents;

   h. Participates with leadership from the Governing Body, Medical Staff, Hospital Management, and other Clinical Leaders in planning, promoting, and conducting organization wide performance improvement activities;

   i. Collaborates with other hospital leaders in designing and providing patient care programs, services, policies, and procedures that describe how residents' nursing care needs are assessed, evaluated, and met;

   j. Develops and implements the organization plan for providing nursing care to those residents requiring nursing care;

   k. Participates with hospital leaders in providing for a sufficient number of appropriately qualified nursing staff to care for residents; and

l. Manages the Nursing Services' portion of the hospital budget.

m. May serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents.

ORGANIZATION

LHH Nursing Services are provided within a decentralized organizational structure. (See Appendix A "Nursing Organizational Chart")

The Nursing Services Administration includes the following personnel:

- Chief Nursing Officer
- Nursing Directors
- Nursing Operations Supervisors
- Shift Supervisors
- Nurse Managers
- Nursing Leadership which supports nursing management and/or resident care functions (e.g., Advanced Practice Nurses, Clinical Nurse Specialists, ~~Clinical Resource Nurses, Clinical Resource CNA~~, MDS-RAI Program Coordinators, MDS Coordinators, Informatics Nurses, Nurse Recruiter, Nursing Orientation Coordinator, and ~~Clinical~~ Nurse Educators)

All areas providing Nursing Care/Service are represented at the Nursing Executive Committee (NEC) that is chaired by the CNO/designee.

AUTHORITY/RESPONSIBILITY

All areas providing Nursing Services are accountable to the Chief Nursing Officer for Nursing Practice Guidelines, Nursing Policies & Procedures, and Nursing Performance Improvement Programs.

1. Authority for Nursing Services is specified in the job descriptions of the nursing leadership staff.

2. The CNO is usually present in the hospital during business hours Monday through Friday. When the CNO is not present, she/he will designate a Nursing Administrator Director to assume overall responsibility for the operation of Nursing Services. The Nursing Operations Supervisor assumes all responsibility on evening and night shifts, weekends, and holidays.

3. The Nursing Directors are usually present in the hospital during business hours Monday through Friday. Each is responsible for making arrangements for administrative coverage for their divisional/unit operations in the event of their absence.

4. Individuals in nursing administrative/nursing leadership positions are knowledgeable about hospital/nursing services goals and objectives, hospital/nursing organizational structure, hospital/nursing policies and procedures, nursing staff job descriptions, staffing methodologies, scope of services provided by each nursing unit, and mechanisms for monitoring/evaluating the quality and appropriateness of resident care.

OPERATIONS

A. INTEGRATION

1. The Nursing Directors, Nursing Operations Supervisors, Clinical Nurse Specialists, Advanced Practice Nurses, MDS/RAI Program Coordinators, Chair of the Nurse Managers Council, and Director of Quality Management are members of the Nursing Executive Committee.
2. Nursing Services administrative staff (listed as above) participate with other hospital leaders in the decision-making of structures and processes.
3. Nursing Services are represented and participate on hospital, medical staff, and nursing committees.
4. The NEC may appoint Task Forces and Ad Hoc Committees when needed to accomplish specific projects or goals.

B. MANAGEMENT FUNCTIONS

1. Structure:

The Nursing Services organizational structure, delineating lines of authority and accountability, is displayed graphically in the Nursing Organizational Chart (See Appendix A). Other documents describing authority, accountability, and communication within the department are located in job descriptions and in policy/procedure statements.

2. Personnel Policies and Procedures:

Nursing Services works within the framework of personnel policies/procedures set forth by the Human Resource Services Department that have been developed and reviewed with input and involvement of the Hospital Executive Committee.

The CNO and members of the NEC are responsible for the identification of qualifications required for each classification of nursing positions. The CNO, in collaboration with the Director of Nursing Operations, Nurse Recruiter, and a representative from Human Resources, has the authority to make decisions with regard to employment, deployment, and assignment of nursing staff.
Employment activities and placement of nursing personnel are coordinated with the Human Resource Services Department through the Nurse Recruiter or designee.

The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.

3. Nursing Policies & Procedures, Criteria/Indicators:

Nursing Services Policies and Procedures are reviewed and approved by the NEC. Performance criteria are derived from job descriptions and policies/procedures. Individual nursing performance criteria are evaluated through criteria-based performance appraisals annually. Quality improvement indicators are used to measure, assess, evaluate, and improve the quality of Nursing Services. Quality improvement activities are reported to the Nursing Quality Improvement Coordinating Committee.

4. Nursing Executive Committee (NEC):

a. The Nursing Executive Committee is the decision-making body relating to Nursing Services at LHH. The goals of the NEC are:

i. to set policy for Nursing Services;

ii. to define the mission, philosophy, and goals for nursing at LHH;

iii. to approve Hospital Policies and Procedures that affect nursing services and care delivery;

iv. to promote communication throughout all levels of Nursing Management across the organization;

v. to oversee nursing practice throughout the organization;

vi. to discuss innovations in nursing care delivery and management systems;

vii. to discuss and promote interdepartmental and institutional relation.

b. Members of the Nursing Executive Committee are:

i. Chief Nursing Officer (Chair)

ii. Nursing Directors

iii. Chair of Nurse Manager Council

iv. Operations Supervisors

v. Clinical Nurse Specialists

vi. Bed Control Coordinator

c. The Chief Nursing Officer and a Nurse Manager co-chair the Nursing Executive Committee. The NEC meets once a month. An agenda is prepared and a permanent record of proceedings is maintained.

5. Licensing and Certification:

Nursing Services participates in the Licensing and Certification Survey with DHS. Nursing administrative staff has knowledge of the Title 22 Regulations and other regulatory standards.

6. Licensure:

a. Nursing Services complies with Title 22 and other regulatory requirements regarding staff licensure and certification requirements.

b. Nursing Services hires Registered Nurses, Licensed Vocational Nurses/Licensed Psychiatric Technicians, and Certified Nurse Assistants who are licensed or certified to practice in the State of California. The process for verifying and monitoring current licensure or certification status is written and available for review. Human Resource Services (HRS) Department has the responsibility of verifying and ongoing maintenance and monitoring of all personnel licenses. HRS collaborates with the Nursing Department through the Director of Nursing Operations or designee to ensure that the system of ongoing license monitoring is achieved.

c. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.

d. Temporary Agency Nurses (e.g. Nurse Registries) are required to show their license to the Nursing Supervisor/NAOD or designee on her/his initial shift. The responsibility for verifying licensure and ongoing maintenance rests with the employing agency per the Temporary Services Contract language.

7. Competency Assessment Program:

a. The competency of all Registered Nurses, Licensed Vocational Nurses, Certified Nursing Assistants, and other nursing personnel is evaluated at the time of hire, at the end of the probationary period, and annually thereafter. Evaluations for nursing personnel involved in direct patient care activities are criteria-based and related to performance criteria specified in the individual's job description.

b. Employees from temporary help agencies (e.g. Nurse Registries) are evaluated by the unit Nurse Manager or designee, with input from nursing staff, following their initial shift and annually thereafter if the assignment is for an extended period of time.

8. Job Descriptions:

a. The job description for each nursing classification delineates functions, responsibilities, and qualifications of the position. Job descriptions are reviewed and revised when necessary to reflect changing job requirements. They are maintained in the nursing office and by Human Resource Services Department.

b. Job descriptions are available to nursing personnel at the time they are hired and when requested.

c. Appropriate staff will demonstrate competence in cardiopulmonary resuscitation (CPR) basic life support (BLS) issued by the American Heart Association (AHA) in compliance with the California Code of Regulations: Title 22, and according to established standards of the AHA.

i. Competence must be demonstrated by direct care providers such as LHH Registered Nurses (includes staff nurses, nurse managers, nursing directors, clinical nurse specialists, educators, supervisors, and nursing directors), Licensed Vocational Nurses (LVNs), Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Respiratory Care Practitioners.

ii. CPR training is provided at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) monthly, while taking into consideration the availability of on-campus BLS instructors. AHA Standards are used to evaluate levels of competency.

iii. Prospective employees are expected to show proof of current CPR certification from the AHA prior to being considered for employment in any class requiring CPR/BLS as a minimum qualification. Current BLS cards will be submitted as part of the hiring packet/process. Copies of AHA eCards are also acceptable, as long as they are able to be verified using the AHA eCard verification system.

iv. Staff with no evidence of valid CPR certification and no valid documentation of physical disability are unable to work until proof of current certification is presented to their manager/supervisor.

9. Staffing:

a. Nursing Services plans for and implements staffing requirements according to

staffing guidelines, policies, legislative requirements, and budgetary considerations.

b. Each nursing area specifically plans for staffing assignments based on staff competencies, resident/client care needs, the care delivery system, and volume indicators.

c. Skilled nursing areas are budgeted according to Hours Per Patient Day (HPPD).

10. Nursing Process, Plan of Care, and Documentation:

Nursing contributes to the inpatient interdisciplinary plan of care and documents resident assessment, planning, intervention, and evaluation as defined in policies/procedures.

11. Education/Training Programs:

a. Education/training programs for nursing services staff are ongoing and designed to augment knowledge of pertinent developments in resident care and to maintain current competence.

b. The scope and complexity of the program is based on the educational needs of nursing staff. Educational needs are identified through monitoring and evaluation activities, annual competency evaluation, and needs assessment surveys.

c. Nursing collaborates with the Department of Education and Training in development and coordination of nursing hospital orientation activities and required training.

12. Quality Assessment and Performance Improvement:

Nursing Services has a planned and systematic process for monitoring and evaluating the quality and appropriateness of resident care and for resolving identified problems. Nursing services follows the process outlined in LHHPP 60-01 Quality Assurance Performance Improvement (QAPI). The process selected is FOCUS P-D-C-A and is coordinated through the Nursing Quality Improvement Council (NQIC). This committee reports to the Hospital Performance Improvement Committee.

13. Interdepartmental Relationship:

Nursing Services work collaboratively with other hospital departments and disciplines to promote quality resident care. Policies and procedures are developed collaboratively with other disciplines for the provision of an interdisciplinary approach to resident care.

ATTACHMENTS:

Appendix A: Nursing Organizational Chart

REFERENCE:

California Code of Regulations: Title 22
https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I6F56A7E1D4B611DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

Date Adopted: 2007/10

Revised: 2022/07/12, 2022/12/13

Reviewed: 2022/12/13

Approved: 2022/12/13

NURSING CLINICAL COMPETENCY PROGRAM

POLICIES:

1. Nursing administration, supervisors, and nurse managers are responsible for assuring competent nursing practice at LHH.

2. Registered nurses are responsible and accountable for assuring their own clinical competence as elaborated in the California Nurse Practice Act and as consistent with the American Nurses Association's Code of Ethics for Nurses.

3. Licensed vocational nurses are responsible and accountable for assuring their own clinical competence consistent with scope of practice set by the California Boards of Vocational Nursing and Psychiatric Technician (BVNPT).

4. Certified nurse assistants and home health aides are responsible and accountable for assuring their own clinical competence consistent with certification set by the California Department of Public Health Licensing and Certification Program.

5. The Nurse Recruiter collaborates with Human Resources to recruit and hire qualified nursing personnel.

6. The Nursing Orientation Coordinator, Nurse Educator, ~~Education Coordinator~~, Charge nurse, and/or preceptor provide competency-based orientation and evaluation of new nursing employees.

5. The Nursing Orientation Coordinator and/or charge nurse will assign orienting RNs and LVNs to an experienced, competent licensed nurse preceptor for the duration of the orientation program. The Nurse Manager and/or charge Nurse will assign experienced, competent CNAs to precept the new CNAs, PCAs, or HHAs.

6. Upon completion of orientation and throughout the employee's employment, the Nurse Managers and supervisors, with the support of Department of Education and Training (DET) Nurse Educators and Advanced Practice Nurses, provide ongoing competency evaluations.

7. DET shall conduct a biannual review revision of the topics of its in-service training program to the Nursing Executive Committee (NEC) for review. After approval from NEC, the proposed in-service training program will be sent to Performance Improvement and Patient Safety Committee for a final review. Thereafter it will be sent to CDPH for approval. This process is to ensure that topics are relevant to the facility and its needs.

~~8.~~ DET and Quality Management will collaborate on abuse in-services and trainings to ensure that gaps in knowledge of abuse prevention are addressed. ~~In addition, prior to the start of each abuse Inservice, a pre-test will be administered to assess the current state of learners' abuse prevention knowledge.~~

9. Annual performance appraisals will include a competency to assess knowledge of employee's abuse prevention.

10. On all shifts, immediate needs for clinical training to assure safe practice are routed through the nurse manager, if present, nursing operations or the clinical resource nurse, who have access to educational materials and can assist in coordinating 1:1 coaching. An experienced, competent clinician may also be asked to assist with the instruction.

PURPOSE:

To ensure that LHH nursing employees are competent to provide care and services in accordance with current standards and within their scope of practice**.**

DEFINITION:

Competency is defined as the employee's ability to perform a particular job or function or skill in a specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, and demonstration of skills and behaviors.

PROCEDURES:

A. Clinical nursing staff (RNs, LVNs, CNAs, PCAs, and HHAs) competency includes:

1. Maintaining a current and active license and/or certification to practice.

2. Updating and maintaining skills and knowledge through:

   a. Classroom-based review and demonstration of procedure prior to actual practice.
   b. Review of video tapes, CDs and web-based training programs.
   c. Review of procedures using resources such as policy and procedure manuals, current clinical practice guidelines or other approved written materials, such as textbooks and current articles.
   d. Demonstration/ return demonstration or actual practice guided by a competent and experienced clinician at the bedside.
   e. Participation in general, program-based or unit-based education.

3. Participating in formal needs assessment process to identify individual learning needs.

4. Participating in LHH mandatory annual trainings and other training programs.

5. Attending continuing education conferences and professional seminars to remain clinically relevant, and as required for recertification (CNA, PCA, HHA.) or re-licensure (RN / LVN).

6. Maintaining BLS (CPR) current certification as required by job description. ~~for RNs, LVNs, and PCAs~~.

7. Participating in the performance appraisal process, including self-appraisal to evaluate clinical practice and to identify areas of practice for professional development.

B. Nurse Manager/~~Nursing Program Director~~

ROLE: Ensures clinical staff competency which includes:

1. Communicates job expectations to staff.

2. Collaborates with Nursing ~~Education~~ Orientation Coordinator to provide new staff with neighborhood or program-specific orientation.

3. Completes probationary performance evaluation ~~together~~ with input from Nursing Orientation Coordinator and/or Nurse Educator, preceptors, and/or mentors for new nursing staff. ~~with inputs from Nurse Managers, preceptors, and/or mentors.~~

4. Completes ongoing performance evaluation in collaboration with human resources, including annual and intermittent competency evaluations, recommendations for development, training and progressive discipline up to and including separation of employees unable to meet job expectations. An action plan will be developed for employees who are not meeting standards and/or competency(ies).

5. Encourages and supports employees' self-development and independent learning efforts.

6. Schedules nursing staff to regularly participate in annual and ongoing training.

7. Ensures resident -specific neighborhood training as needed.

8. Maintains documentation of competency assessment.

C. Clinical Nurse Specialist

ROLE: Supports competency development which includes:

1. Participates in interdisciplinary committees and performance improvement teams to:
   a. assess program needs in clinical areas,
   b. develop related program or interventions for individual residents,
   c. evaluate processes that support or detract from nursing practice and performance.

2. Provides consultation to enhance competent clinical practice.

3. Participates with quality improvement and interdisciplinary committees in analyzing resident outcome data in order to link competency training with desired resident outcomes.

~~D.~~ Nursing Orientation Coordinator and ~~,~~ Nurse educators~~, and Education Coordinators~~

ROLE: Supports staff competency which includes:

1. Ensures nursing orientees (whether CNA, PCA, HHA, LVN, RN, CNS, NM, Nursing Supervisor or Nursing Director) meet standards for clinical competency consistent with their scope of practice and job description.

2. Participates in the assessment of educational needs required for the job and setting in collaboration with LHH Performance Improvement Teams (PITs), Nursing QI Program, committees and department managers.

3. Develops, implements and evaluates nursing orientation and training programs for nursing staff, as outlined in the Nursing Educational Programs Policy A ~~3.~~0 6.0. Programs are based on CDPH approved orientation program, assessed needs, core competencies, quality improvement findings, and evaluation of learner and/or resident outcomes.

4. Participates in the development of nursing practice standards.

5. Participates with quality improvement and interdisciplinary committees in analyzing resident outcome data in order to link competency training with desired resident outcomes.

6. Ensures Licensed Nurses will complete a Point of Care Test (POCT) Training on Accu-check (glucocheck) device initially during orientation, six (6) months post orientation, and then annually thereafter, under the guidance of the POCT Coordinator.

REFERENCES:

California Nurse Practice Act, Standards of Competent Performance
Excerpt from California Code of Regulations, Title 16 - Chapter 14

CROSS REFERENCES:

Hospitalwide Policy and Procedure
01-03 Hospital Organization
80-03 Employee and Volunteer Orientation
80-05 Staff Development
80-12 Staff Competency

Nursing Policy and Procedure
A 6.0 Orientation of Nursing Personnel

Human Resources Policy for the Developmental Plan/Disciplinary Action.

ATTACHMENT:

California Code of Regulations Standards of Competent Performance for RNs.

Adopted: 12/2007

Revised: 2012/05/22; 2021/02/09, 2022/12/13

Reviewed: 2022/12/13

Approved: 2022/12/13

ORIENTATION OF NURSING PERSONNEL

POLICY:

1. All nursing staff employees are oriented to their job performance expectations and pertinent organizational and divisional policies and procedures prior to independent performance. Successful completion of orientation is required to pass the probationary period.

2. The Nursing Orientation program is developed by the Department of Education and Training (DET) in coordination with many other clinical departments, such as the Department of Public Health Occupational Safety & Health (OSH) and Laguna Honda Hospital (LHH) Human Resources.

3. The orientation program consists of:

    a. Didactic orientation to facility attributes, policies, procedures, regulations and specific job description.

    b. Clinical experiences guided and supervised by the Nurse Managers, Nurse Educators, Clinical Nurse Specialists, preceptors, and mentors.

    c. Documentation that objectively reflects job competencies, as well as provides a method for performance appraisal or competency to assess knowledge acquisition and evaluating performance.

4. Successful completion of the Nursing Orientation Program is achieved when assessment of performance indicates that the orientee is competent to perform duties of the job description, as evidenced by the demonstration of job-related skills and completion of other learning activities.

5. Successful orientees will demonstrate the following:

    a. The Certified Nursing Assistant (CNA), Patient Care Assistant (PCA), or Home Health Aide (HHA) orientee will complete: a Skills Demonstration Competency Checklist including equipment and technologies, a Mealtime Competency Evaluation, a signed proof of having read the Patients Bill of Rights, a post test and an evaluation of the orientation, as well as other assignments made by the Nursing Orientation Coordinator and/or Nurse Educators.

    b. The licensed orientee {Registered Nurse (RN) or Licensed Vocational Nurse (LVN)} will complete the above plus a Competency Evaluation in Physical Assessment, a Medications Administration Competency Evaluation, Nutrition Competency Evaluation and Point of Care Tes (POCT) training on use of the Accu-check (glucometer) and Occult Blood testing In addition, the orientee will also complete exercises on the Management of Sharps, Using Information Resources Page and other assignments given by the Nursing Orientation Coordinator and/or designee.

6. The orientee will be given the opportunity to complete the Orientation Program in an environment that is conducive to learning. A designated period of time for the CNA, PCA, HHA and for licensed staff will be allotted for the orientation to identify learning needs, obtain experiences, demonstrate knowledge and skills, and receive an evaluation of performance.

~~7.~~ The orientee shall receive ~~Abuse~~ training on prevention of Abuse, Neglect, and Exploitation. ~~Prior to the start of the abuse training, a pre-test will be administered to assess the current state of learners'~~

~~abuse prevention knowledge. Comparison of the pre- and post-tests can help assess the effectiveness of the training.~~

8. If the orientee has not completed all of the competencies within the time allotted, and the assessment indicates that the orientee is not yet competent to perform duties of the job description, as evidenced by the demonstration of job-related skills and completion of other learning activities ~~that they may not be achieved,~~ the need for an extension of orientaton will be evaluated. The length of the extension of orientation will be determined by the ~~Nurse Manager and/or~~ Nursing Orientation Coordinator in consultation with the Nursing Director, Nurse Manager, Nurse Educator and/or preceptor/mentor. Notification will be ~~given~~ provided to the DET Nursing Director and/or to the Chief Nursing Officer.

PURPOSE:

To provide an orientation program to newly hired nursing staff who provide or supervise direct patient care, and to staff who function in roles of consultation.

PROCEDURE:

A. **Ongoing Assessment and Documentation**

1. Classroom time will be provided for didactic teaching according to job description.

2. Clinical experiences are provided so that performance assessments which address the criteria-based objectives will be observed, practiced, and demonstrated by the orientee.

3. The orientee's ability to perform specific skills will be documented on the Orientation Checklist by those who observe the orientee's performance or provide instruction, as designated by the Orientation Coordinator.

4. The Nurse Manager and/or preceptor will discuss with the orientee specific skills required and whether criteria are met by the orientee and assess need for further training. The orientee and Nursing Orientation Coordinator will review the documentation together.

B. Unmet Competencies

If the orientee has specific learning needs that requires additional orientation time, efforts will be made to address those needs. The Nursing Orientation Coordinator will be informed by the Nurse Manager if the orientee is unable to meet criteria/skills required.

1. A collaborative team of the Nurse Manager, Nursing Orientation Coordinator and/or Nurse Educators will write a developmental plan to assist the orientee to meet required program objectives.

2. The developmental plan will be outlined in writing and attached to the documents for orientation completion for the individual orientee.

3. In a conference, the orientee will be advised by the Nurse Manager, Nursing Orientation Coordinator and /or Nurse Educator as to performance expectations, the developmental plan, and the target date for the completion of the plan.

4. The Developmental Plan will be signed by those participating in the conference.

5. If, at the end of the designated time, the orientee has not met job expectations as defined by the Initial Orientation Checklists and the Developmental Plan, termination of employment will be recommended to Human Resources.

C. Orientation Program

An orientation program will be provided for the following categories of nursing and affiliated staff:

1428 Unit Clerk

2583 Home Health Aide

2302 Certified Nursing Assistant

2303 Patient Care Assistant

2312 Licensed Vocational Nurse

2320 Registered Nurse

Leadership orientation will be given to staff that are new to Laguna Honda Hospital:

2320 Acting Nurse Manager, Nurse Educator
2322 Nurse Manager
2323 Clinical Nurse Specialist
2324 Nursing Supervisor or Nursing Director
0941 Chief Nursing Officer, Hospital Associate Administrator

CROSS REFERENCES:

NONE

ATTACHMENT/APPENDIX:

NONE

Adopted: 1/2006

Revised: 2007/10, 2012/05/22; 201/01/13; 2021/02/09; 2022/12/13

Reviewed: 2022/12/13

Approved: 2022/12/13

Revised: 2022/12/13

RESTORATIVE NURSING CARE

POLICY:

1. Restorative nursing care is carried out by ~~Restorative Nurse~~~~Restorative LN~~~~Therapy Aides (TA),~~ Certified Nursing Assistants (CNA) and Patient Care Assistants (PCA), and/or other trained staff under the direction and supervision of a licensed nurse (LN).

2. Staff who have been trained in restorative nursing care interventions can implement and document restorative interventions.

~~3. Group restorative activities are limited to no more than 1:4 staff to residents.~~

~~4.~~3. A resident may participate concurrently in restorative nursing care, the Restorative Nursing Program, or Skilled Rehabilitation Therapy if deemed therapeutic and beneficial in maximizing the resident's functional status.

~~5. Restorative treatments are reviewed monthly and as needed by the LN and quarterly by the Resident Care Team (RCT).~~

~~6.~~4. Any member of the RCT may recommend to a LN or physician that a resident be evaluated for restorative care.

~~7.~~5. Restorative nursing care does not require a physician's order and can be initiated by a licensed nurse. However, for residents with complex clinical conditions such as fractures or severe contractures, a consultation with a physician and/or licensed rehabilitation therapist may be appropriate.

~~8.~~6. Residents are referred to the Restorative Nursing Program by rehabilitation therapists.

~~9.~~7. If resident exhibits ~~aa~~ lack of progress, a decline, or the achievement of goals~~, is noted in the unit's weekly summaries or the Restorative Nursing Program's quarterly summaries,~~ the treatments or program may be reevaluated for discontinuation or modification to be more appropriate for the resident.

PURPOSE:

To define and describe treatments provided to residents to maintain, and/or improve to their highest level of range of motion (ROM), mobility status, functional independence and ADLs, and prevent declines unless clinically unavoidable.

BACKGROUND:

A. Skilled Rehabilitation Therapy: rehabilitation therapy that is provided by a licensed therapist such as Physical Therapist (PT), Occupational Therapist (OT), and Speech Language Pathologist (SLP).

B. Restorative Nursing Care:

1. Nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible
2. Focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

~~3. Directed toward the conservation of resident's abilities, restoration of maximal levels of function and independence, promotion of quality of life, adaptation to an altered life style, and prevention of deterioration and complications of disability.~~
~~4. Planned, implemented and facilitated by the RCT to achieve the best individual outcomes.~~
~~5.~~3. Licensed Nurses provide direction, oversight and follow up for restorative nursing interventions performed regularly by C~~-RNAs, C~~NAs/PCAs and other trained staff, with or without consultation by a licensed therapist.
4. The exercises, treatments or activities are individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.
~~6.~~5. Restorative nursing care should be provided for at least 15 minutes daily for at least 6 of 7 days per week to qualify as restorative.

C. Restorative Care Components

1. **Technique:** Restorative activities provided by nursing staff and trained staff.
   a. **Active Range of Motion (AROM)**: exercises performed by the resident, with cueing, supervision, or physical assist by staff. Includes AROM and active-assisted range of motion (AAROM).
      i. **AROM**: performance of an exercise to move a joint without any assistance or effort of another person to move the muscles surrounding the joint.
      ii. **AAROM**: the use of the muscles surrounding the joint to perform the exercise but requires some help from the staff or equipment.
   b. **Passive Range of Motion (PROM)**: provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. PROM is the movement of a joint through the range of motion with no effort from the patient.
   c. **Splint or Brace Assistance**: provision of:
      i. verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
      ii. a scheduled program of applying and removing a splint or brace.
2. **Training and Skill Practice:** Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.
   a. Amputation or Prosthesis Care: activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses.
   b. Activities of Daily (ADL) Training
      i. **Bed Mobility**: activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning self in bed.
      ii. **Transfer**: activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
      iii. **Walking**: activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
      iv. **Dressing and/or Grooming**: activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks with or without assistive devices.
      v. **Eating and/or Swallowing**: activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids with or without assistive devices, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

c. **Communication**: activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

d. Bowel and Bladder Training:

i. Urinary Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern targeted at decreasing or resolving incontinence (ex: bladder rehabilitation or retraining, prompted voiding, and habit training or scheduled voiding)

ii. Bowel Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern targeted at maintaining bowel continence.

~~**C. Restorative Nursing Program**:~~

~~1. The Restorative Nursing Program is provided regularly by TAs under the supervision of a LN with treatments recommended by a licensed rehabilitation therapist and requires an initial consult request from the physician.~~

~~2. TAs provide restorative treatment in the wellness gym, on the neighborhoods (unit-based) and in the aquatics pool, under the supervision of a LN with initial recommendations and follow up consultations provided by the licensed therapist. Restorative therapy is reviewed quarterly and as needed for modifications and/or discharge by the LN and/or the RCT.~~

~~a. Wellness gym: Restorative treatment in the wellness gym utilizes specialized equipment~~

~~b. Neighborhood (unit-based) restorative programs: depending on the medical or physiological complexity of the resident, the restorative program can be done one-to-one or in a small group.~~

~~c. Aquatics: This restorative program can be used for residents who may not tolerate therapy on land due to pain or other movement issues. The licensed therapist may be present for all sessions of this type of programming (refer to LHH PP 28-03 Aquatic Services).~~

	~~**RESTORATIVE NURSING CARE**~~	
	~~**RESTORATIVE NURSING CARE**~~	~~**RESTORATIVE NURSING PROGRAM**~~
~~**STAFF**~~	~~LN, CNA/PCA, AT~~	~~TA~~
~~**PLAN OF CARE**~~	~~Determined by LN~~	~~Recommended by licensed rehabilitation therapist~~
~~**TREATMENTS**~~	~~Can be safely carried out by nursing staff or trained staff~~	~~Complex treatments or specialized equipment~~
~~**LOCATION**~~	~~On unit~~	~~Wellness gym, on unit, aquatics~~
~~**COMPONENTS**~~	~~AROM, PROM, splint/brace assistance, amputation/prosthesis care, bed mobility, transfer, walking, dressing/grooming, eating/swallowing, communication, bowel/bladder training~~	~~AROM, PROM, splint/brace assistance, amputation/prosthesis care, bed mobility, transfer, walking~~

~~**D.**~~**A. Restorative Care Components**

~~1. **Technique:** Restorative activities provided by nursing staff and trained staff.~~

a. **Active Range of Motion (AROM)**: exercises performed by the resident, with cueing, supervision, or physical assist by staff. Includes AROM and active-assisted range of motion (AAROM).
   i. **AROM**: performance of an exercise to move a joint without any assistance or effort of another person to move the muscles surrounding the joint.
   ii.i. **AAROM**: the use of the muscles surrounding the joint to perform the exercise but requires some help from the staff or equipment.

b.a. **Passive Range of Motion (PROM)**: provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. PROM is the movement of a joint through the range of motion with no effort from the patient.

c.a. **Splint or Brace Assistance**: provision of:
   i. verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
   ii.i. a scheduled program of applying and removing a splint or brace.

2.1. Training and Skill Practice: Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

a. Amputation or Prosthesis Care: activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses.

b.a. Activities of Daily (ADL) Training
   i. **Bed Mobility**: activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning self in bed.
   ii.i. **Transfer**: activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
   iii.i. **Walking**: activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
   iv.i. **Dressing and/or Grooming**: activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks with or without assistive devices.
   v.i. **Eating and/or Swallowing**: activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids with or without assistive devices, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

c.a. **Communication**: activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

d.a. Bowel and Bladder Training:
   i. Urinary Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern targeted at decreasing or resolving incontinence (ex: bladder rehabilitation or retraining, prompted voiding, and habit training or scheduled voiding)
   ii.i. Bowel Toileting Program: implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern targeted at maintaining bowel continence.

PROCEDURE:

A. Assessment for restorative nursing needs

1. Residents may have restorative needs under the following conditions:
   - **a.** Observed decline, change of condition or quality measure triggered through assessments that may include Minimum Data Set (MDS) assessments, Care Area Assessments (CAA) or Certification and Survey Provide Enhanced Reports (CASPER)
   - **b.** Recommended by therapy
   - c. Triggering event (e.g., falls, pressure ulcer, weight loss, choking event, etc.)
   - d. Functional decline, maintenance need, or potential for functional improvement identified by methods including physician assessment, nursing admission assessment and weekly summaries.
2. Discontinuation criteria for restorative services
   - a. Goals have been met
   - b. Resident is unable to meet established goals or has declined
   - c. Resident requires skilled therapy
   - d. Resident is unwilling to participate or attend

~~1. The minimum data set (MDS) and Resident Assessment Instrument (RAI) process are the baseline functional assessment for restorative nursing.~~
~~2. Registered nurses (RN) assess restorative needs at the time of admission, weekly, quarterly, annually, and with significant change of condition.~~
~~3. Assessment includes any of the following that apply:~~
- ~~a. Functional activities in which the resident has recently declined.~~
- ~~b. Functional activities in which the resident believes there is potential for increased independence or a need for maintenance to prevent decline.~~
- ~~c. Activities in which the nurse, licensed therapist, physician, or other member of the interdisciplinary team identifies that the resident has potential for improvement or a need for maintenance to prevent decline.~~
- ~~d. Consideration of conditions that commonly cause functional decline such as stroke, Parkinson's Disease, Multiple Sclerosis, peripheral neuropathy, Muscular Dystrophy, spinal cord injury, or coma.~~
- ~~e. Review of data that contributes to the assessment process such as the MDS, the Care Area Assessments (CAA), Certification and Survey Provider Enhanced Reports (CASPER), and assessment or progress notes from any clinical discipline.~~
- ~~f. If the resident has a progressive illness/condition in which a decline in function is anticipated and the restoration in function is not realistic, and/or has goals of care that are primarily focused on comfort measures, restorative interventions may be utilized for preservation of function.~~

B. Restorative Nursing Care

Laguna Honda Hospital (LHH) provides restorative nursing care through 2 modalities:

1. **Restorative Nursing Program**:
   - a. Physician places a rehabilitation consult order. If the resident has a restorative need, the rehabilitation therapist may refer the resident to the Restorative Nursing Program.
   - b. Initial treatments are recommended by a rehabilitation therapist and provided by CNAs/PCAs under the supervision of the restorative LN. Treatments may be adjusted as needed by ~~restorative nurse~~restorative LN or by follow up consultations with rehabilitation therapist.
   - c. Services include: AROM, PROM, splint/brace assistance, amputation/prothesis care, bed mobility, transfer, walking, eating
   - d. Group restorative activities are limited to no more than 1:4 staff to residents.
   - e. Treatments may include the use of specialized equipment including theraband, pedal exerciser, theraputty, weights, and peg boards.
   - f. Discharge criteria in addition to those outlined above include stabilization of functional performance so that Unit Restorative Care can assume restorative treatments for maintenance

g. Reevaluation criteria include significant change of condition and acute hospitalization >24 hours.

2. **Unit Restorative Care**:
   a. Treatments developed by unit LN and provided by unit PCAs under the supervision of the unit LN
   b. Services include all restorative care components

C. Documentation

1. Care plans
   a. Restorative care plans, goals and interventions are developed utilizing assessment data, involving input from interdisciplinary or clinical services (e.g., skilled therapy), and including resident-centered, individualized treatments and interventions.
      i. **Restorative Nursing Program**: care plan initiated and maintained by ~~restorative nurse~~restorative LN
      ii. **Unit Restorative Care**: care plan initiated and maintained by unit nurse
   b. Care plans developed by other disciplines are appropriate to use for nursing restorative programs with the agreement of the discipline and by identifying nursing as one of the responsible services (e.g., Residents with individualized feeding plans written by the SLP are often restorative in nature and require nursing implementation).
   Individualized feeding plans for thickened liquids or special diet only are not appropriate for restorative nursing care.
   c.
2. Restorative documentation in the electronic health record (EHR)
   a. The licensed nurse indicates the restorative intervention(s) to perform in the EHR.
   b. The CNA/PCA documents in the EHR, the completion of restorative interventions and the total number of minutes spent doing the activity per restorative component, except for bladder and bowel training.
   c. Observations of problems, reasons for not performing or participating in restorative interventions, or resident complaints during restorative care are reported to the licensed nurse and documented in the EHR (i.e., dizziness, pain, shortness of breath, resident refusal, etc.).
   d. Restorative Nursing Program:
      i. CNAs/PCAs schedule restorative appointments in the EHR and document attendance.
      ii. CNAs/PCAs will document and communicate any unusual occurrences, significant resident problems or significant changes to the ~~restorative nurse~~restorative LN.
3. Evaluation
   a. Periodic evaluation of restorative activities is demonstrated by routine documentation in summaries and resident care conference (RCC) notes.
   b. The nurse evaluates the effectiveness of the restorative treatments by documenting the progress towards restorative goals and describing the resident's related clinical status or changes to the interventions or goals as needed.
      i. Restorative Nursing Program
         1. CNAs/PCAs are responsible for weekly summaries that must be reviewed and co-signed by the restorative LN. The note will include ~~res~~restorative LNany changes in performance, participation or changes in clinical status identified during Restorative Nursing Program session.
         2. CNAs/PCAs may initiate a monthly summary that must be reviewed and co-signed by the ~~restorative nurse~~restorative LN. The note will include progress towards goals, activities provided, the response to treatment, level of assistance and functional status. Documentation should reflect how the resident responds to the program in relation to behavior (e.g., refusal, anxious, combative, etc.), along with physical response (e.g., fatigue level, attention, distractibility, etc.). ~~Restorative~~

nurseRestorative LN evaluates the care plan effectiveness, and initiates any changes in treatment, interventions, or goals as needed.

ii. Unit Restorative Care

1. Unit nurse is responsible for summaries and evaluating the care plan effectiveness weekly.

4. MDS

a. The MDS coordinator completes section O, "Nursing rehabilitation/ restorative care" of the MDS to indicate the number of days the restorative techniques or practices were provided for equal to or greater than 15 minutes per day in the last 7 days.

The MDS coordinator records bladder retraining and scheduled toileting in section H0200 Urinary Toileting Program.

b.

B. Planning restorative care

1. Using the assessment data, a plan of care is developed with restorative component treatments individualized to the resident.
   - **a.** The LN develops a care plan:
     - **i.** Problem statements are determined by the functional assessment and are generally functionally oriented.
     - **ii.** Goals must be specific, measurable, and time oriented. Both maintenance and improvement goals are appropriate for restorative nursing.
   - **b.** Restorative care: Informal consultation is often useful with the interdisciplinary team and clinical services such as PT, OT, or SLP for care planning and decision making related to restorative nursing.
   - **c.** Restorative Nursing Program: rehab consult to the Restorative Nursing Program includes recommended treatments that the LN will incorporate into the care plan. The unit physician will place a Rehab Consult if a Restorative Nursing Program need is identified, so that the resident may be evaluated initially by a licensed rehabilitation therapist.
2. All restorative minutes may be counted in section O of the MDS, regardless if they are provided as part of restorative care or the Restorative Nursing Program.

C. Documentation

1. Weekly Summary by the unit LN and Quarterly Summary by Restorative Nursing Program RN:

a. For all residents receiving restorative nursing care or participating in the restorative nursing program, the nurse evaluates the effectiveness of the restorative treatments by documenting the progress toward or away from restorative goals, and describing the resident's related clinical status or changes to the interventions or goals as needed. (e.g., "Restorative goal of ambulating 60 feet BID with 1 assist and gait belt has been met. Goal increased to 60 feet TID").

i. Periodic evaluation of restorative activities is demonstrated by routine documentation in the summaries and RCT notes. Progress toward or away from the restorative goal is documented followed by reason and/or modifications to the interventions or goals.

ii. Resident and staff teaching related to the restorative program.

iii. Consultation with the interdisciplinary team and therapies, as needed, to modify the program.

iv. Consultation with ancillary services, interdisciplinary team members, and/ or a Clinical Nurse Specialist or Clinical Resource Nurse trained in restorative assessment and programming when the need for initial or additional staff development is identified.

b. The TA may initiate a Quarterly Summary for the Restorative Nursing Program that must be reviewed and co-signed by the RN.

2. Care Plan:

~~a. The unit's LN responsible for the restorative nursing care problems, goals and interventions.~~
~~b. The Restorative Nursing Program's RN responsible for the restorative nursing program problems, goals and interventions.~~
~~c. Collaboration with RCT members or the resident as needed to determine the resident's preferences and choices.~~
~~d. Care plans developed by other disciplines are appropriate to use for nursing restorative programs with the agreement of the discipline and by identifying nursing as one of the responsible services (e.g., Residents with individualized feeding plans written by the SLP are often restorative in nature and require nursing implementation).~~
~~e. Individualized feeding plans for thickened liquids or special diet only are not appropriate for restorative nursing care.~~

~~3. Minimum Data Set (MDS):~~

~~a. The MDS coordinator completes section O, "Nursing rehabilitation/ restorative care" of the MDS to indicate the number of days the restorative techniques or practices were provided for equal to or greater than 15 minutes per day in the last 7 days.~~
~~b. The MDS coordinator records bladder retraining and scheduled toileting in section H0200 Urinary Toileting Program.~~

~~4. Electronic Health Record (EHR) ADL and Restorative Documentation:~~

~~a. The licensed nurse indicates the restorative intervention(s) to perform in the EHR.~~
~~b. The CNA/PCA/TA documents in the EHR, the completion of restorative interventions and the total number of minutes spent doing the activity per restorative component, except for bladder and bowel training.~~
~~c. Observations of problems, reasons for not performing or participating in restorative interventions, or resident complaints during restorative care are reported to the licensed nurse and documented in the EHR (i.e., dizziness, pain, shortness of breath, resident refusal, etc.).~~
~~d. Restorative Nursing Program:~~
~~i. TAs will document in a note at least quarterly at a minimum, the resident's progress towards goals, the response to treatment and functional status. The documentation may compare the previous quarter's note for any changes. Documentation should reflect how the resident responds to the program in relation to behavior (e.g., refusal, anxious, combative, etc.), along with physical response (e.g., fatigue level, attention, distractibility, etc.). Content may include:~~
~~1. Activity provided~~
~~2. The specific distance or repetitions~~
~~3. Use of assistive devices~~
~~4. Resident response to activity (endurance and tolerance level)~~
~~5. Amount of assistance needed and why (i.e., verbal cues, stand by assist of one, moderate assist of one, etc.)~~
~~6. Outcomes, progress or lack of progress~~
~~ii. The TA will document and communicate any unusual occurrences, significant resident problems or significant changes to the Restorative Nursing Program Nurse Manager and RN.~~

APPENDIX:

NONE

REFERENCES:

CMS's RAI Version 3.0 Manual v1.17.1 (2019).
Medicare and Medicaid requirements for participation for Long Term care facilities (2017)

CROSS REFERENCES:

Nursing Policies and Procedures
- C 3.0 Documentation of Resident Care/Status by Licensed Nurse
- C 3.2 Documentation of Resident Care by Nursing Assistant
- D1 2.0 Resident Activities of Daily Living
- D5 2.0 Limb Care following Amputation
- D5 4.0 Arm Sling
- D5 5.0 Application and Management of Braces
- D6 2.0 Transfer Techniques
- D6 3.0 Range of Motion Exercise
- D6 4.0 Positioning and Alignment in Bed and Chair
- D6 5.0 Ambulation
- E1.0 Oral Management of Nutritional Needs
- F1.0 Assistance with Elimination
- F2.0 Assessment and Management of Urinary Incontinence
- F3.0 Assessment and Management of Bowel Functions
- F4.0 Application and Management of Condom Catheters
- F6.0 Colostomy Management

Hospitalwide Policies and Procedures
- LHPP 26-02 Management of Dysphagia and Aspiration Risk
- LHPP 27-02 Referrals for Rehabilitation Services
- ~~LHPP 28-03 Aquatic Services~~

Original: 2001/12

Revised: 2008/09; 2015/03/10; 2019/09/10; 2022/10/11

Reviewed: 2022/10/11

Approved: 2022/10/11

OBTAINING, RECORDING AND EVALUATING RESIDENTS WEIGHTS

POLICY:

1. Any nursing staff except for Home Health Aide may obtain residents' weights.

2. All residents will be weighed on admission/readmission, then monthly or per physician order, and as clinically indicated. Should obtaining weights have a negative impact on the resident's comfort causing undue pain or stress, the weight will not be taken and the reason will be documented.

3. Residents are weighed by the receiving neighborhood upon relocation.

4. Reweighs are performed each time the weight varies from the previous weight by five or more pounds (2.27 kilograms or more) that is not otherwise explained in the plan of care (e.g., planned weight loss).

5. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.

6. Monthly weights shall be obtained within the first 7 days of the month.

PURPOSE:

To obtain accurate weight measurements and identify unintended weight changes to facilitate effective care planning.

PROCEDURE:

A. Obtaining Weights

1. Check previous weight prior to weighing resident to immediately identify any potential discrepancy.

2. To obtain accurate weight, weigh resident in the day shift at a consistent time and have resident wear consistent clothing and/or devices.

3. Resident will be weighed using the same scale, clothing, and/or linen with each reweigh.

   a. Use the scale's manufacturer's instructions for steps to balance and measure the resident. Instructions are attached to the scale or available in the Central Supply Room (CSR)
   b. If the manufacturer's instructions are not readily available, contact Facility Services.
   c. Improperly functioning scales are reported to Facility Services through a work order.

4. Immediately prior to weighing resident, staff shall zero the scale.

B. Reweighing

1. If there is a weight change greater than 5 pounds (+/-), immediately reweigh resident.

2. Continue to reweigh resident daily for the next 2 consecutive days.

C. Frequency of Weights

1. On admission/readmission, nursing will obtain resident weights on the day of admission/readmission.

2. Residents shall be weighed weekly for 4 weeks after admission, then monthly, unless otherwise prescribed by physician.

3. Nursing will weigh resident for a significant change in condition, change in food intake, and other evidence of altered nutritional status or fluid and electrolyte imbalance.

D. Reporting

1. Weights must be reported to the licensed nurse during the shift it was obtained

2. If the weight variation is greater than or less than five pounds (2.27 kilograms) and is unanticipated weight change, the licensed nurse notifies the physician and dietitian.

3. The nurse reports unintended weight loss or gain to the dietitian and physician:
   a. 5% or greater over 30 days
   b. 7.5% or greater over 90 days
   c. 10% or greater over 180 days

4. The licensed nurse will notify the MDS Coordinator or Nurse Manager to include resident with significant weight change on the list of resident's for discussion at the next Resident Care Team meeting.

E. Documentation

1. The type of scale (e.g., wheelchair or floor scale, EZ-Lift scale, or electronic bed scale) to be used is noted in the electronic health record.

2. Nursing Staff documents all weights, in kilograms, on the resident's electronic health record.

3. Licensed nurse will document on the electronic health record the assessment and actions taken for unintended weight changes.

REFERENCES

NONE

CROSS REFERENCES:

Nursing Policy and Procedure
G 4.0 Measuring the Resident's Height and Weight

ATTACHMENT/APPENDIX:

NONE

Revised: 2018/01/09, 2019/03/12, 2019/09/10

Reviewed: 2019/09/10

Approved: 2019/09/10

NURSING EDUCATIONAL PROGRAMS

BACKGROUND:

1. Educational needs assessments direct the educational planning efforts including evaluation of nursing care, feedback from quality management, resident population or care trends, performance appraisals, and plans of correction from regulatory bodies.

2. Department of Education and Training (DET), in collaboration with Human Resources, provides orientation for new nursing employees and collaborates with Human Resources for hospital-wide orientation.

3. Department of Education and Training (DET) provides ongoing education and staff development for all Nursing Department employees to improve nursing practice and to enhance resident care outcomes.

4. Instructors include clinical educators (~~CNAs, PCAs~~, LVNs, RNs and Advanced Practice RNs) who design and implement formal education programs and unit-based training.

5. Department of Education and Training (DET) provides training in-services as required by Title 22.

6. Nursing in-service education is conducted on all shifts under the supervision of a Director of Staff Development. As required by Title 22, Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) are provided with a minimum of 24 hours of live in-service education each year during work time.

7. Department of Education and Training (DET) maintains relationships with local colleges and universities to collaborate on various programs that meet the needs of Laguna Honda Hospital (LHH) staff and the community.

PROGRAM ELEMENTS:

A. Orientation

See NPP A 6.0 for a detailed description of LHH Department of Education and Training orientation program and related policies and procedures.

B. In-service and Continuing Education

1. Nursing Education ~~is~~ may be accomplished in various milieus including continuing education courses, Skills Days, and in collaboration with local colleges, universities, and other community organizations.

~~Crisis Prevention Institute's Responding and Intervening During a Non-Violent Crisis training for all LHH staff, as well as computer training for nursing staff are coordinated by and/or provided by Department of Education and Training staff.~~

2. Nursing in-service education is conducted on all shifts under the supervision of a Director of Staff Development. As required by Title 22, Certified Nursing Assistants (CNAs), Patient Care Assistants (PCAs), and Home Health Aides (HHAs) are provided with a minimum of 24 hours of live in-service education each year during work time.

~~2.~~

~~3.~~ 3. Department of Education and Training (DET) provides individualized training for nursing employees, as needed, for developmental plans formulated by Nurse Managers or Nurse Supervisors to improve the employee's performance.

C. Nursing Affiliations

Refer to NPP A5.0 Nursing Educational Affiliations (Student Placements)

D. Record Keeping

The Department of Education and Training maintains:

1. Current CNA and Board of Registered Nursing (BRN) continuing education provider numbers.
2. Current Director of Staff Development certification as appropriate for each nursing educator.
3. Program approvals from CDPH for CNA, PCA, and HHA orientation and in-services.
4. Records of all courses provided will include lesson plans, outlines, sign-in sheets, sample evaluations and posttests as documentation that learning has occurred. (Kept for a period of four years).
5. Orientation records (Kept for a period of 10 years).
6. Annual education calendar of all classes and in-services are provided by Department of Education and Training.
7. In-service records and orientation records (hard copy and digital) will be stored at LHH DET, Room A300, Administration Building, 375 Laguna Honda Blvd, San Francisco, CA 94116.
8. LHH DET Nurse Director and/or designee will be responsible for record keeping.

CROSS REFERENCES:

Hospitalwide Policies & Procedures
80-05 Staff Development

Nursing Policies & Procedures
A 6.0 Orientation of Nursing Personnel
A 5.0 Nursing Educational Affiliations
A 4.0 Nursing Competency Program

Adopted: 2000; 5/2012 as Nursing Policy & Procedure

Revised: 2002/08, 2007/10, 2012/05/22; 2014/07/27; 2021/02/09; 2022/05/10

Approved: 2022/05/10

Deletion Nursing Services Policies and Procedures

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring, and documenting medications consistent with their scope of practice.

    a. Only an RN may administer intravenous (IV) medications, whether by IV piggyback or IV push.
    b. The LVN may administer medications per LVN scope of practice, except for IV medications.
    c. The Certified Nursing Assistant/Patient Care Assistant (CNA/PCA) may, under the supervision of Licensed Nurses (LN), administer the following: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.
        - Exception: Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications, require a physician's order which includes:
    a. Medication name/agent
    b. Dose
    c. Frequency
    d. Route of administration
    e. Indication for use.
        - If indication for use is not on order, consult with ordering physician.
3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a LHH physician, and shall not be kept at bedside.

4. LN will follow the "6 Rights" of medication administration:
    a. Right resident
    b. Right drug
    c. Right dose
    d. Right time
    e. Right route
    f. Right documentation

5. Bar Code Medication Administration (BCMA) is not a substitute for the LN performing an independent check of the 6 Rights of medication administration.

6. Resident arm bands should only be scanned if the arm band is secured on the resident. Arm bands should be replaced if worn, torn, or do not scan.

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

8. The LN will prepare medications at the resident's side (i.e., If resident is in bed, preparation will be at bedside, if resident is in great room, they may receive at chair side).

9. The LN will prepare medication(s) at the time just prior to administration. Do not prepare medications prior to administration or store out of the package.

10. LHH does not allow medication to be separated from the original package and stored for administration at later time, this is considered pre-pouring.

~~11. Narcotic (opioid) medication administration will have a two LN independent check of administration and each LN will document in EHR.~~

~~12.~~11. IV medications are only prepared by RN for emergency situations and must be labeled with resident name, date and time of preparation, medication name, strength, amount, and name of the person preparing.

~~13.~~12. Medication delivered via transdermal route must have date, time, and LN's initials. Before application of new patch, old transdermal patch must be removed.

~~14.~~13. Medication times are standardized in the Electronic Health Record (EHR). Medication administration times may be modified to accommodate clinical need or resident's preferences. The LN will notify pharmacy via the EHR with medication administration time change request.

~~15.~~14. The safe administration of psychotropic, hazardous, high risk/high alert medications, and reporting of Adverse Drug Reactions (ADR) will be followed as outlined in other LHH policies and procedures.

~~16.~~15. Medications may not be added to any food or liquid for the purpose of disguising the medication, unless informed consent has been granted by the resident or the surrogate decision maker.

~~17.~~16. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container, including crushed, dissolved, or disguised medications. Non-hazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.

~~18.~~17. Partial doses of controlled substances being pulled from Omnicell must be pulled at time of administration with witness and immediately wasted with co-signer/other LN at the time of retrieval from Omnicell.

a. 2nd LN shall witness when the medication is still in the sealed packaging, and the actual wasting of the partial dose.
b. Partial doses should not be placed in medication cart for administration at later time.

~~19.~~18. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

~~20.~~19. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

~~21.~~20. Oral medications that are safe to be crushed can be crushed at the discretion of the LN.

~~22.~~21. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications, and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

~~23.~~22. A provider order must be obtained for medications to be mixed with pudding.

~~24.~~23. Medications mixed with food mediums (e.g., apple sauce, pudding) must have the food medium dated, timed and discarded at the end of each medication pass.

~~25.~~24. It is the legal and ethical responsibility of the LN to prevent and report medication errors.

~~26.~~25. Topical creams and ointments that are ordered "until healed" can be discontinued by the LN via an order in the EHR, and ordered "per protocol, co-sign required".

~~27.~~26. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.

~~28.~~27. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of nasal naloxone, rescue inhalers, and other documented, approved rescue medications if ordered. If an approved medication is to be stored at the bedside, the resident must be assessed for their ability to ensure that the medication is stored safely.

~~29.~~28. Residents who request to self-administer medications must be assessed by Resident Care Team (RCT), and determined to be able to safely self-administer medications.

~~30.~~29. Herbal supplements are not medications. Please see Herbal Supplement Policy for guidance around ordering, use, and storage of herbal supplements.

~~31.~~30. All medications for self-administration will be stored securely by nursing, with the exception of nasal naloxone, rescue inhalers, or other documented approved rescue medications.

RELEVANT DATA & DEFINITIONS:

BCMA: Bar Code Medication Administration
eMAR: Electronic Medication Administration Record/MAR: Medication Administration Record
EHR: Electronic Health Record
WOW: Workstation on Wheels

CRITICAL POINTS:

A. SIX RIGHTS OF MEDICATION ADMINISTRATION

1. RIGHT RESIDENT
    - Two forms of identification are mandatory.
        - Verify identity of resident using any of the following two methods:
            - Successful scan of identification band, only if arm band is on the resident, or successful scan of identification card for the resident who meets criteria (See appendix II)
            - Resident is able to state his/her first and last name (Ask for first and last name without prompting)
            - Resident Medication Profile Photograph matches the resident image in the EHR.
            - Resident is able to state date of birth (Ask without prompting.)
            - In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.
            - Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

2. RIGHT DRUG
    - Review eMAR for drug/medication ordered
    - Review resident allergies to medications or any other contraindication
    - Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.

- Checks or verifies information about medication using one or more of the following references, when needed:
  - Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline
- Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

3. RIGHT DOSE
   - Review eMAR for dose of drug/medication ordered
   - Check medication label and confirm accuracy of dose with eMAR

4. RIGHT TIME
   - Review eMAR for medication administration time
     - Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin, and any medication ordered more often than every 4 hours will be administered within 30 minutes before or after schedule time.
     - All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.
     - See Appendix I for routine medication times and abbreviations.
     - Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix I.

5. RIGHT ROUTE
   - Review routes of administration
     - Aerosol/Nebulizer: Refer to NPP J 1.3
     - Enteral Tube Drug Administration: Refer to NPP E 5.0
     - Eye/Ear/Nose Instillations: Refer to J 1.4
   - IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: http://in-sfghweb01/Nursing/Documents/PushMedicationGuidelines.pdf

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

B. OVERRIDE OF MEDICATION ADMINISTRATION

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

C. TWO LN INDEPENDENT CHECK OF MEDICATIONS:

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

D. CRUSHING MEDICATIONS FOR ORAL ADMINISTRATION

1. Crushing medications is based on nursing judgement and resident care plan.

2. Do not crush hazardous, enteric, sustained release or medications labeled “do not crush.”

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

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

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

6. Medications which are to be crushed for administration, must be given individually and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food), unless pharmacy has reviewed the medications for safety and efficacy, and pharmacy has documented that it is safe to mix crushed medications together and the physician has placed an order for crushing and combining the medications.

7. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:
    a. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.
    b. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)
    c. If using pudding as the food medium to administer medications, a physician order is required for the pudding.
    d. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

E. HAZARDOUS MEDICATIONS

1. Special precautions need to be applied when preparing and handling and disposing of hazardous medication. (Refer to Hazardous Drugs Management LHHPP 25-05).

2. Instructions for administering the medication can be found in administration instructions on the MAR.

F. PHYSICIAN ORDER

1. LNs may accept telephone orders from an authorized prescriber (Refer to LHHPP 25-03) and will confirm resident’s medication allergies with prescriber and read back the order entered into the EHR for accuracy with the physician. Verbal orders should only be taken during emergent situations when provider is unable to enter the order due to care being provided to resident.

2. STAT medication orders are processed immediately and administered no later than four hours after the order was written.

3. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.

PURPOSE:

Medications will be competently and safely administered

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.

2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.
    a. Pull those resident's cassettes from medication cart and place on top of WOW, or bring med cart inside med room if space permits.
        i. Ensure each cassette is labeled with the correct resident name.
        ii. Do not overcrowd the WOW with too many cassettes.
    b. Bring WOW with the resident(s) medication cassette(s) into the medication room.
        i. If using medication cart with computer screen attached, bring the entire cart into the medication room.
    c. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.
    d. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.
        i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.
    e. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.
    f. Repeat this for each resident that need medication(s) removed if needed.
    g. Return to medication cart with WOW and cassettes and put cassettes in medication cart.
        i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette, and immediately followed by placing cassettes in medication cart.

3. Log into the EHR and review the medications which will be administered. Remove those medications from resident’s cassette and place on top of WOW. Bring the WOW with only the medications to be administered and needed supplies to the resident’s side.

4. Confirm with the resident that they are ready to receive their medications in the location they are located if they are not in their room, such as the great room.

5. Scan the arm band of resident to correctly identify resident and open their MAR.
    a. If the resident is wearing their arm band, this will serve as ~~is~~ one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.
    b. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.
    c. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

6. Scan medication(s) barcode(s) at bedside/chairside.

7. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights.

8. Immediately prepare medication(s), if appropriate. (e.g., crush), and administer medication(s).

    a. If this is the first dose being given, document that the “1st dose” resident education has been performed as appropriate.

9. Remain with the resident until all medications have been taken.

    a. Never leave medications at the bedside/chairside.

10. Document in real time in the EHR medication(s) given, not given, etc.

11. Log out of the EHR. If medication cassette was brought to bedside, disinfect it and return the cassette to the medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

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

2. Do not add medication directly to an enteral feeding formula.

3. **Prior to administering the medication, stop the feeding and flush the tube with at least 15 mL of water.**

4. Dissolve the tablets, or dilute the medication in at least 30 mL of water, to sufficiently allow for medication to pass through the tube.

5. **Each medication should be administered separately. After each medication flush the tube with 15 mL of water.**

6. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

7. Give medication at the appropriate time in relation to feeding.

    a. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).
    b. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.
    c. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

8. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication, and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

9. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication(s) is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid regulation, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document the amount of the flush used for medication administration in the flowsheet.

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. Narcotic medication administration may happen after performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:
    i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.
    ii. Request the resident to repeat a sentence such as “no, ifs, ands, or buts,” to ensure the oral medication have been swallowed.
    iii. .
2. Administration of buprenorphine-naloxone.
    a. Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed..
    b. Buprenorphine administration is as follows:
        i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.
            1. 5-10 minutes for sublingual tablet
            2. 3-8 minutes for film
        ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.
        iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.
    c. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).
        i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

A. Monitor resident

1. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process, and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

2. Whenever the resident’s condition warrants, and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or when there has been a change in the treatment.

3. Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.

B. Administration

1. Refer to Appendix 4, follow Manufacturer’s Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

2. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

3. When using multiple inhaled medications, **wait 5 to 10 minutes between drugs** to get maximum benefit. **NOTE:** If both bronchodilator and a steroid inhaler are prescribed, **use the bronchodilator first**.

4. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

5. Compressor/ Nebulizer (brand name Misty-Fast)

    a. Use with nebulizer face mask, which has medication cup and lid.
    b. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.
    c. Air source
        i. Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced.
        ii. Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.
        iii. For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO_2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.
    d. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

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

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

2. Assess the resident's response to treatment.

SPECIAL CONSIDERATIONS:

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

2. If medication(s) is not given within the time schedule, review "Appendix II: Specific Medication Administration Times and Abbreviations" to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.

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

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

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

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

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

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

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

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

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

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

SHAKING MEDICATIONS OR MIXING A SUSPENSION

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

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. Scan the arm band of resident to correctly identify resident and open their eMAR.
2. Every cardiovascular drug requires vital sign monitoring as outlined below:
    a. Frequency of monitoring:
        i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.
        ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.
    b. Default parameters:
        i. Hold medication for SBP < 105 and/or hold for HR < 55.
        ii. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.
    c. If the physician desires more frequent monitoring they will specify parameters which will be in the EHR.
    d. Whenever the nurse believes per his/her judgement that more frequent monitoring is warranted, they may check vital signs per their scope of practice.
    e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.

3. PRN Cardiovascular Medication Orders
    a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics
    a. Document VS and response to therapy once every shift for duration of therapy.

2. Pain
    a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT-TOSHIFT LN REPORTING

1. During change of shift, hand-off and when reporting to team lead or charge nurse, report:
    a. Any new medications started, indication and monitoring required.
    b. Any suspected Adverse Drug Reactions (ADRs).
    c. If receiving medication that requires monitoring, report clinically relevant data including abnormal VS or laboratory results.
    d. Time or food sensitive medications to be given on incoming shift.
    e. PRNs given at end of shift requiring evaluation of effect.
    f. Refusal of medication.

FENTANYL TRANSDERMAL (PATCH) APPLICATION AND DISPOSAL (Refer to Pharmacy P&P 02.02.02)

1. Application
    a. Don gloves during any time you will be touching patch.
    b. If resident currently has a patch on, remove the old patch before applying a new patch.
    c. Select appropriate site for patch, on flat area, such as chest, back, flank or upper arm. Apply patch to non- irritated, non-irradiated skin.
    d. Clip hair if needed (Do Not shave) prior to applying patch. Avoid use of oils, alcohol, or soaps to surface area as they may affect patch adhesion or drug absorption. Allow skin to dry completely before applying patch.
    e. Peel liner from the back of the patch and press patch firmly to skin using the palm of the hand for at least 30 seconds to obtain seal.
    f. Date and initial patch after application.

2. Document application and location of patch in the eMAR.

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

4. Disposal
    a. Fold the old patch in half so that the adhesive sides are in contact and discard in medication disposal container.
    b. Document disposal on the eMAR.
    c. A waste/witness co-signature is required for a used patch.

SELF-ADMINISTRATION

~~AND BEDSIDE MEDICATION~~

The resident must be assessed by the Resident Care Team (RCT), and determined to be able to safely self-administer medications and re-assessed quarterly and as needed thereafter.~~before medications are kept at bedside.~~The assessment of the residents' ability to self-administer medications and/or herbal supplements will documented in the RCT note, and include input from the resident during this process.

1. Self-Administration

a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration. This assessment must include:
    i. The medications appropriate and safe for self-administration;
    ii. The resident's physical capacity to swallow without difficulty and to open medication bottles;
    iii. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;
    iv. The resident's capability to follow directions and tell time to know when medications need to be taken;
    v. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.
    vi. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.
    vii. The resident's ability to ensure that medication is stored safely and securely.
    Appropriate notation of these determinations must be documented in the resident's medical record and care plan

b. If the resident assessment or re-assessment has determined that a resident cannot safely self-administer a medication this will be communicated to the physician and to the resident ~~a~~.
c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed and the assessment is complete.
d. Orders will be entered in the EHR for medications and herbal supplements.
~~A nursing communication order listing non-formulary herbal supplements will be entered in the EHR.~~
e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.
The resident will prepare and take their own prescribed medications and/or prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. ~~(Unless ordered for bedside by physician as indicated in the care plan.)~~
f. The LN will observe self-~~medication~~ administration preparation at each medication time and answer the resident's questions, or reinforce the teaching as indicated.
g. If the nurse notices the resident is about to make an error, ~~he/she~~the nurse will intervene to

stop the preparation. ~~He/she~~The nurse will also discuss and clarify with the resident the accurate manner of self-~~administering medications~~administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer ~~medications safely~~, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.

h. The LN observing the resident taking the appropriate prescribed medications and/or herbal supplements via self-administration ~~,~~will document ~~in~~ in MAR as 'given' and "self-administered"

i. For self-administration of a rescue medication stored at bedside that was not observed, the resident will report to the LN who will document in the MAR as given and "self-administered" and include a comment of 'patient reported' in the MAR.

i. If a resident fails to report self-administration of a medication despite on-going education, the RCT will re-assess if self-administration is appropriate

~~Residents who self-administer herbal supplements will maintain their supply and will take responsibility for self-administration and safe storage.~~

~~Resident will be instructed to notify physician of changes, additions or discontinuation of herbal supplements.~~

j. Education and training skills will be documented and care planned in the EHR.

The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications~~The resident must be assessed by the Resident Care Team (RCT), and determined to be able to safely self-administer medications and/or ordered and approved herbal supplements. See Herbal Supplements: Formulary and Non-Formulary policy.~~

~~**1. Self-Administration**~~

~~a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration.~~

~~b. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note.~~

~~c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed.~~

~~d. Orders will be entered in the EHR for medications and herbal supplements.~~

~~e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.~~

~~f. The resident will prepare and take their own prescribed medications and/or ordered herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self-administration preparation at each administration time and answer the resident's questions, or reinforce the teaching as indicated.~~

~~g. If the nurse notices the resident is about to make an error, he/she will intervene to stop the preparation. He/she will also discuss and clarify with the resident the accurate manner of self-administration. The RCT will be kept informed of any change in the residents' ability to safely self-administer, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements~~

~~h. The LN observing the resident taking the appropriate prescribed medications and/or ordered herbal supplements, and the LN will document in MAR as given and will note "self-administered".~~

~~i. Education and training skills will be documented and care planned in the EHR.~~

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

a. Prior to providing nasal naloxone, a rescue inhaler or other approved rescue medication at the bedside, the RCT shall determine that the resident can safely self-administer the medication and an appropriate individualized plan of care shall be written.

b. Medication(s) for bedside storage must be safely stored by resident. The Pharmacy will label all bedside medications in appropriate lay-language.

c. The medication used will be recorded in the resident's health record, based on observation or resident self reporting of the medication being administered.

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See LHHPP 73-11 Medical Waste Management Program & LHHPP 25-05 Hazardous Drugs management).
   a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Nonhazardous medications shall be disposed of in the blue and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.
      i. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error, should go in medication waste bin.
      ii. Empty medication cups go in the garbage.
      iii. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.
      iv. The empty spoon can go in the garbage.
      v. If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.
      vi. For residents who are at risk for digging through the garbage, care plan your intervention to attempt to minimize and avoid this behavior.
      vii. Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage.
      viii. Empty packets of powered medications can be thrown in the garbage.

2. The LN must secure narcotics/controlled substances from time of receipt/removal from OmniCell to administration by having in physical possession or securely locked in medication cart.

3. Narcotics/controlled substances that are removed and not administered and/or are only partially administered, shall be immediately wasted in pharmaceutical waste container with witness of a 2nd LN.

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

4. If resident refuses medication, the LN shall return the medication to original package.

   a. A 2nd LN will provide the co-sign in Epic will also witness the waste of the controlled substance in the Omnicell.
   b. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.
      i. This may be done via looking up the IC medication tag through Lexicomp.

   c. 2nd LN shall witness actual wasting of controlled substance medication that was refused by

the resident.
d. Both LNs shall document waste in Omnicell and the MAR.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

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

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

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

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

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

PERSONAL MEDICATION

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

   Personal medications will not be obtained, stored or used by residents. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

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

EXCESS MEDICATIONS

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

ATTACHMENTS:

Appendix I Specific Medication Administration Times

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

Appendix III – LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

REFERENCES:

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LHHPP File: 25-02 Safe Medication Orders
LHHPP File: 25-03 Verbal Telephone Medication Orders
LHHPP File: 25-04 Adverse Drug Reaction Program
LHHPP File: 25-05 Hazardous Drugs Management
LHHPP File: 25-06 Pain Assessment and Management
LHHPP File: 25-08 Management of Parental Nutrition
LHHPP File: 25-10 Use of Psychoactive Medications
LHHPP File: 25-11 Medication Errors and Incompatibilities
LHHPP File: 25-13 Herbal Supplements: Formulary and Non-Formulary
LHHPP File: 72-01 B8 Medication Handling/Dispensing Guidelines: Infection Control Manual
LHHPP File: 73-11 Medical Waste Management Program

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

Nursing P&P C 9.0 Transcription and Processing Orders
Nursing P&P E 5.0 Enteral Tube Management
Nursing P&P J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds

Nursing P&P J 1.3 Aerosol/Nebulizer Medications.
Nursing P&P I 5.0 Oxygen Administration
Nursing P&P J 7.0 Central Venous Access Device Management

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