List of Hospital-wide/Departmental Policies and Procedures for JCC for Approval on August 8, 2023

	New Hospital-wide Policies and Procedures				Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
New	_LHHPP	20-14	Leave of Absence and Bed Hold	New policy	Yes

	Revised Hospital-wide Policies and Procedures				Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
Revision	_LHHPP	01-04	Committees - Mandated	1. Replaced "The facility" with LHH 2. Deleted "Meeting minutes shall be submitted to the Secretary of the Medical Executive Committee as stated in the Medical Staff By-laws"	
Revision	_LHHPP	01-11	Standard Formatting Template for Policies and Procedures	1. Place Laguna Honda Hospital with LHH 2. Added "Ensure reference links are active and correct" under 8. References 3. Removed "Deletion Date" references from 9. Dates	
Revision	_LHHPP	01-13	Fraud, Waste and Abuse	1. Moved Policy Statement #2 to #1. 2. Add LHH compliance Committee with LHH's Compliance Office. 3. Added Service areas implementing corrective action plans shall provide periodic reports to the LHH Compliance Committee.	
Revision	_LHHPP	20-06	Out on Pass	1. Renamed from " Leave of Absence (LOA)" to "Out on Pass". 2. Removed all content for "Leave of Absence (LOA) and Bed Hold" placed in new policy 20-14.	Yes
Revision	_LHHPP	22-07-A01	Restraint Free Environment	1. Added "If there is a change of condition of the resident or change in the device being used" to restraints consents shall be updated annually. 2. Added "for the least amount of time" to utilizing the least restrictive device 3. Replace Resident Care Team with Ordering Provider to obtain consent. 4. Added release and document every 4 hours or sooner according to the resident need throughout the policy.	Yes
Revision	_LHHPP	22-01_A02	Physical Restraints - Acute Units	1. Removed chemical restraint 2. Added guidance for what to do if a patient becomes violent or self-destructive 3. Changed from q4h to per unit protocol 4. Removed chemical restraints bullet per mock survey feedback. 5. Added guidance for what to do if a patient becomes violent or self-destructive per mock survey feedback. 6. Changed vital signs check from q4h to per unit protocol, which is q4h on acute medical and qshift on acute rehab	Yes
Revision	_LHHPP	22-13	Bed Rail Use	1. Updated LHHPP 22-07 name to reflect the new policy name. 2. Added bed rail safety assessment to Procedure 3. Added consent will be renewed annually at minimum. 4. Deleted Appendix A	Yes
Revision	_LHHPP	23-01	Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)	1. Added representative to resident and family references throughout policy 2. Added LHH is to develop and implement person-centered care plans for each resident that is consistent to resident rights and to mee the resident's needs. 3. Added Culture, Cultural Competency and Trauma-informed care to definitions. 4. Added nurse, physician, MDS coordinator, and social worker must be present during RCT. 5. Added Social Services Psychosocial Assessment to Admission Assessments 6. Added if the resident is unable to attend, a representative is required to attend on their behalf. 7. Added care planning process, comprehensive care plan development process, Resident specific interventions , individualized interventions for trauma survivors and resident and/or representative notification to 4. Comprehensive Care Plan section	Yes
Revision	_LHHPP	25-07	Antimicrobial Stewardship Program	1. Deleted "Reviews prescribing patterns" 2. Added "d.e.Presents data prescribing outcomes of vancomycin per pharmacy program to the Pharmacy and Therapeutics Committee every 6 months"	Yes

Revision	_LHHPP	25-10	Use of Psychotropic Medications	1. Added "Care teams shall be responsible for monitoring for potential side effects of psychotropic medications in the antipsychotic class:" 2. Added "Physicians will perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications: Within the first 30 days of admission (if new to LHH) or within the first 30 days of starting or discontinuing an antipsychotic medication at LHH" and "Every 6 months while on an antipsychotic" and "When clinically indicated" 3. Added "Nurses will document in their care plans monitoring for symptoms of tardive dyskinesia and develop an individualized care plan for any resident with tardive dyskinesia" 4. Added "The Unit Based Quality Assurance and Performance Improvement (QAPI) for psychotropic medications will review of side effects, including tardive dyskinesia, for residents on antipsychotics"	Yes
Revision	_LHHPP	27-04	Special Respiratory Therapy Equipment	1. Updated "Respiratory Therapy Department Manager" with "Clinical Support Manager"	
Revision	_LHHPP	55-01	Payor Eligibility, Certification and Coverage	1. Updated UM Nurse tracks the patients admitted to PMA acute and PMR. 2. Updated Charge Nurse/designee with RAI specialist 3. Added UM Nurse will complete the Pre-Admission Screening Resident Review (PASRR) prior to admission or readmission to PMA and PMR back to LHH SNF. 4. Added if resident/representative is unable to sign NOMNC and/or SNFABN, the UM nurse will indicate and date the signature area.	Yes
Revision	_LHHPP	73-08	Hearing Conservation Program	1. Added Cal/OSHA decibels permissible exposure limit details 2. Updated sound level monitoring table 3. Added Nutrition Services Department staff were placed into the Hearing Conservation Program and Facility Services were not. 4. Added "Administrative controls for Facility Services workers include signs to warn of high noise levels, and rotation of staff through different parts of our campus" 5. Added Work with operation of loud equipment to 3. Hearing Protection 6. Added use of eyeglasses interferes with the seal of ear muffs so special eyeglasses or contacts must be worn. 7. Added training records will be maintained for minimum of 2 years.	
Revision	_LHHPP	73-09	Respiratory Protection Program (RPP)	1. Added "and to ensure respirator wearers are adequately trained and equipped to safely select, use and maintain respiratory protective equipment" to Purpose 2. Updated Program Scope to include registry staff and volunteers and does not typically apply to administrative and other departments that do not interact with residents. 3. Updated airborne isolation room with airborne infection isolation room (AIIR) 4. Added "During periods of ATD epidemics, such as Covid-19, all LHH staff (including all registry nurses) that potentially are in contact with our residents are to be included in the RPP, assigned an N-95 respirator, and may be required to wear it for any of the above functions." 5. Updated Tasks Requiring Respiratory use and Selected Respirators table 6. Added "The use of powered air purifying respirators (PAPR) may be restricted during periods of ATD epidemics, such as Covid-19. In such cases, an N95 respirator shall be substituted for each PAPR" 7. Updated Training section with annual training and conceptual training 8. Added "Loose fitting PAPR does not require a fit test but does require documented training regarding use." and qualitative fit section 9. Added "according to manufacturer's instructions and schedules. 10. Added mentions of Covid-19 Mitigation plan for additional guidance 11. Updated training records with records will be maintained for the duration of employment plus 5 years and fit test records will be the duration of employment plus 30 years. 12. Updated Appendix A	
Revision	_LHHPP	75-01	75-01 LHH 2022-2023 Security Management Plan_101320	Updated with 2022-2023 Plan	
Revision	_LHHPP	75-02	Public Access and Night Security	1. Updated office hours with during business hours 2. Added "Are there any weapons involved" to list of information provided to Sheriffs	

			List of Hospital-wide/Departmental Policies and Procedures for JCC for Approval on August 8, 2023		
Revision	_LHHPP	75-03	Disorderly or Disruptive Visitors	1. Added contract security provider to policy 2. Added verbal de-escalation to policy	
Revision	_LHHPP	75-04	Stat Calls for Sheriff's Assistance	1. Updated SFSD with SFSO	
Revision	_LHHPP	75-06	Dr. Grey Code	1. Updated SFSD with SFSO 2. Removed code 33 announcement, all on-site sheriff staff will immediately respond to the location 3. Remove code 4 announcement when situation has been stabilized	
Revision	_LHHPP	75-07	Theft and Lost Property	1. Updated SFSD with SFSO 2. Updated policy to include "to report missing property due to theft" 3. Removed "Items determined by Administration staff to be of more than normal value shall be turned over" in 1. Lost and Found Items	Yes
Revision	_LHHPP	75-09	Reporting Vehicular Accidents	1. Updated SFSD with SFSO 2. Removed "Hospital Operator's Emergency Line" 3. Replaced SFGH with ZSFG	
Revision	_LHHPP	75-10	Security Services Standards Operating Procedures	1. Replaced patients with residents 2. Added SFSO and the contract staff throughout the policy 3. replace security provider's leadership with SFSO Unit Commander or SFSO Watch Commander 4. Added response time to documents 5. Removed "Record all emergency and non-emergency service calls coming into the SOC"	
Revision	_LHHPP	75-10	Appendix A: Threats and Violence in the Workplace: Prevention and Management Guidelines	1. Minor grammar updates 2. Updated patients with residents 3. Replace contract security provider with SFSO. 4. Added mentions of low-risk through out document	
Revision	_LHHPP	75-10	Appendix B: Reporting Details for Threats or Acts of Violence	Added mentions of low-risk through out document	
Revision	_LHHPP	75-10	Appendix C Threat Management Incident Flow Chart	Updated Revised Date	
Revision	_LHHPP	75-10	Appendix D: Threat Management Assessment Grid	Minor grammar updates	
Revision	_LHHPP	75-10	Appendix F: Patrol Procedures	1. Added SFSO 2. Added race, gender and religious affiliation are NOT considers suspicious 3. Added parking violation to Exterior and Vehicle Patrol	
Revision	_LHHPP	75-10	Appendix G: Security Incident Report Writing and Investigation	1. Added SFSO 2. Added Watch Commander and Shift Supervisor	
Revision	_LHHPP	75-10	Appendix H: Visitors Screening Process	1. Replaced contract security provider with Sheriff's office staff	
Revision	_LHHPP	75-10	Appendix I Arrest Procedure	1. Minor grammar updates 2. Replace SFSD with SFSO	
Revision	_LHHPP	75-10	Appendix J Laguna Honda Hospital and Rehabilitation Center Security Training Program	1. Replaces contract security with SFSO 2. Updated training program with time of 6 weeks 3. Added contract security provider will receive training from their Account Manager 4. Updated Department of Education and Training will audit training compliance.	
Revision	_LHHPP	75-10	Appendix K Enforcement of the Smoking Policy	1. Minor grammar updates 2. Added attempts to redirect focus and intentions with clear instructions to If the smoker refused to extinguish their items.	
Revision	_LHHPP	75-10	Appendix L: Response to Internal and External Emergency Disasters	1. Replace contract security staff with SFSO 2. Minor grammar updates 3. Added contract Security Account Manager shall be notified to request additional staff under 4.0 Emergency Security Operations	

Status	Dept.	Policy #	Title	Notes	
Revision	_LHHPP	75-10	Appendix M: Security Service Department Job Descriptions	1. Replaced SFSD with SFSO 2. Added Contract Security Provider account Manager 3. Replaced patients with residents 4. Added SFSO Watch Commander 5. Added Cadets 6. Updated Security Systems with DPH Security Maintenance Planner 7. Replace security operation center with Sheriff's Operations Center, SOC	
Revision	_LHHPP	75-10	Appendix N: Identification of Employee, Patients/Residents and Volunteers	1. Minor grammar updates 2. Added race, gender, and religious affiliation are NOT considered suspicious 3. Updated Security Department with Sheriff's Operations Center	
Revision	_LHHPP	75-10	Appendix O: Personal Safety and Cash Escorts	1. Added SFSO 2. Added 15-minute lead time for escort requests	
Revision	_LHHPP	75-10	Appendix P: Security Operations Center	1. Minor grammar updates 2. replace contract security provider with SFSO 3. Updated notify Nursing Operations instead of Operator Services	
Revision	_LHHPP	75-10	Appendix Q: Security Response Call Procedures	1. Added SFSO an appropriate greetings for SOC phone calls 2. Updated contract security provider's leadership with SFSO Watch Commander 3. Replace patient with residents 4. Updated SFSO will persuade the resident to return and notify Nursing Operations for assist instead of contract security staff will return patient to unit	
Revision	_LHHPP	75-10	Appendix R: Significant Security Event Notification	1. Replaced contract security provider with SFSO 2. Updated $1000 with $950 for Facility Property Theft	
Revision	_LHHPP	75-10	Appendix S: Victims of Violent Crime Protection Plan	1. Replaced contract security provider with SFSO 2. Replaced patient with resident 3. Added SFSO Watch Commander 4. Replaced large crowds forming with any disruptions to resident-care and employee safety.	
Revision	_LHHPP	75-11	Public Access and Defined Restricted Areas	1. Added SFSO 2. Removed during business hours visitors shall be directed to the Administration office for further assistance 3. Updated Staff shall not interfere with anyone's presence with all staff can contribute to a safe and secure environment. 4. Added race, gender, and religious affiliation are NOT considered suspicious.	
Revision	_LHHPP	75-12	Firearms, Dangerous Weapons and Contraband Policy	1. Replaced patients with residents 2. Replaced DPH with LHH 3. Replaced contract security staff with SFSO 4. Updated UO form with appropriate report for reporting 5. Added SFSO will take possession of the contraband	
Revision	_LHHPP	75-14	Safety Support for LHH Patient/Resident	1. Added SFO 2. Added interventions techniques that align with Non-Violent Crisis Intervention, CPI	

Deleted Hospital-wide Policies and Procedures					Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
Deletion	_LHHPP	75-13	Inpatient Patients in Custody	Request to delete.	

Deleted Outpatient Clinic Services Policies and Procedures					Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
Deletion	OP Clinic	C3	Cleaning of Medical Instruments Prior to Disinfection or Sterilization	Request to delete	
Deletion	OP Clinic	C4	High-Level Chemical Disinfection	Request to delete	
Deletion	OP Clinic	C5	Flexible Nasopharyngeal Laryngoscope	Request to delete	

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New Food and Nutrition Services Policies and Procedures					Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
New	FNS	1.01	Food and Nutrition Services (FNS) Scope of Services	New policy	Yes

Revised Nursing Services Policies and Procedures					Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
Revision	Nursing	A 2.0 Attachment 2	BRN Standards	Updated to most current Scope of Practice	
Revision	Nursing	D2 3.0 Attached 1a	Skills Checklist for Portable Tub/Shower Trolley	Remove competency from policy (this is available elsewhere)	
Revision	Nursing	E 5.0 AND Appendix 1	Enteral Tube Feeding Management	Removed labeling bed number for formula feedings.	Yes
Revision	Nursing	G 7.0	Obtaining, Recording and Evaluating Weights	Updated weight cadence from every first weekend to the 7th of each month.	Yes
Revision	Nursing	J 8.0	Blood Product Administration	1. New policy to state that blood transfusion consent forms shall remain effective for up to 12 months. 2. Updated policy to remove items covered by DPH policy. This policy will be specific for LHH procedures. 3. Added to obtain vital signs at completion of transfusion. 4. Removed duplicates from DPH appendices.	Yes
Revision	Nursing	M 15.0 Attachment 1	Portable Bed Alarm Skills Checklist	Remove competency/appendix (this can be uploaded elsewhere)	Yes
Revision	Nursing	NA	Nursing Educational Programs	Added "Records are then submitted to Human Resources for record keeping in the employees file."	Yes
Revision	Nursing	J 2.5	Monitoring Behavior and the Effects of Psychotropic Medications	1. Updated "staff will observe every shift for presence of target behavior" with "CNA/PCA will observe for presence of target behavior and will report to licensed nurse" 2. Added physician will place an order for target behaviors to monitor and nursing care plans should include target behaviors including individualized nonpharmacological interventions and any side effects 3. Added "The EHR flow sheet will be used to monitor medication prescribed to induce sleep when ordered by the physician. If resident is on sleeping aid, nursing shall document on the LHH Nursing Weekly Summary" 4. Added "The licensed nurse will collaborate with CNA/PCA and other members of the RCT team to identify and document target behavior triggers, side effect and effectiveness of interventions" 5. Added "Flowsheet documentation across units will be reviewed by the LHH Psychotropic Subcommittee & QM on a regular cadence to identify inconsistencies and identify opportuneness to ensure consistent and appropriate documentation.	Yes

Revised Pharmacy Services Policies and Procedures					Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
Revision	Pharmacy	06.01.01	Psychotropic Medication	1. Added side effects and adverse consequences to adequate monitoring	Yes

Revised Medical Services Policies and Procedures					Priority
Status	**Dept.**	**Policy #**	**Title**	**Notes**	
Revision	Medical Services	D01-05	Psychotropic Medication Management	1. Added side effects and adverse consequences to adequate monitoring	Yes

New Hospital-wide Policies and Procedures

LEAVE OF ABSENCE AND BED HOLD

POLICY:

The facility shall submit claims for resident bed hold days based on allowable reimbursement.

PURPOSE:

1. To accurately track and monitor residents discharged to acute facilities.

2. To accurately track and monitor residents Out on Pass (OOP).

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

DEFINITION:

1. Bed Hold: When resident is transferred from a skilled nursing facility (SNF) to a general acute care hospital, which may be either Laguna Honda Hospital and Rehabilitation Center (LHH) or an outside hospital, the SNF shall afford the resident a bed hold of up to seven (7) days.

2. Out on Pass: A planned absence of a resident from LHH authorized by a physician's order, which may extend past midnight.

3. Leaving Hospital Against Medical Advice (AMA): A resident is discharged AMA when he/she leaves LHH against the advice of the physician.

4. Absent Without Leave (AWOL): A resident who leaves LHH without notification or without an approved LOA.

5. Bed Reservation: 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.

BACKGROUND:

1. 42 CFR §483.15 – When a skilled nursing facility transfers to an acute care facility, including LHH acute unit, ~~or the resident goes on a therapeutic leave,~~ the 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. <u>When the</u>

resident goes on a therapeutic leave, the facility must provide a ~~notificaiton~~notification of the facility's bed hold policy.

2. A resident who is receiving Medicare Part A Skilled Nursing Facility (SNF) benefits is permitted to a Leave of Absence (LOA) 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.

3. 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:

    a. 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:

        i. 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.

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

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

        iv. 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 the full complement of leave days (18 days per calendar year).

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

4. For LOA due to acute care hospitalization:

    a. The LHH Patient Flow Coordinator shall coordinate both the LOA and bed reservation procedures in conjunction with Admissions and Eligibility (A&E) department and the neighborhood physician representing the neighborhood RCT.

        i. 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.

    b. Medi-Cal and some insurances pay for up to seven days of LOA due to acute hospitalization. LOAs greater than seven days requires the ~~reisdent~~resident to be

discharged from the SNF. Further clarification regarding insurance coverage shall be routed to Utilization Management.

c. A resident whose hospitalization exceeds the LOA period 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.

PROCEDURE:

1. **Notification of LOA Policy**

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

   b. Nursing shall provide the bed hold information and Notice of Proposed 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.

   c. The Medical Social Worker (MSW) shall provide the bed hold information to the resident, their family member, or legal representative prior to the scheduled LOA (day/overnight/weekend).

2. **Process for LOA/Bed Hold**

   a. An order from the Physician for a LOA for day/overnight/weekend and for sending out to another facility (ED/PES/Acute Care) shall be written in the electronic health record (EHR) for each occurrence. The LOA order will have a specific date and duration. The Physician and the Licensed Nurse shall follow the process as specified in the EHR.

   b. For ~~all~~ LOAs to an acute level of care or out on pass, the Notice of Bed Hold Policy and form shall be provided to the resident and/or representative.

   c. LOA-admitted to Acute Care Hospital from ED/PES

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

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

d. 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 transferring 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. Nursing Operation will ensure that the notices are provided to the resident, family member or legal representative.

3. **Census Management**

a. Nursing Department is responsible for census management which is done in the electronic health record (EHR).

4. **Bed Hold**

a. Requirements for bed hold for acute hospitalization:

i. A physician's order ~~that the resident is discharged and that the resident is at the acute care hospital~~to transfer the resident to an acute care hospital.

ii. The day of departure from SNF is counted as day 1 of bed hold; the day of return is not counted.

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

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

v. LHH claims must identify the inclusive date of the bed hold.

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

i. 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.

c. 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.

5. **Requirements for LOA (Out on Pass)/~~Bed Hold~~**

~~a. The day of departure from SNF is counted as day 1 of the leave and the day of return is not counted as a leave day.~~

~~b.~~a.   A bed shall be held during a resident's authorized LOA/OOP.

c.b.   A current physician's order for LOA/OOP is required.

d.c.   LHH will not be reimbursed for bed hold in the event a resident is discharged within 24 hours of return from LOA/OOP.

e. 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:

   i. Maximum time period: 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:

   •   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.

   •   At least five days of SNF inpatient care must be provided between each approved LOA/Pass.

   •   Maximum of 73 days per calendar year for developmentally disabled recipients.

   •   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.

   •   The return from LOA/bed hold must not be followed by discharge within 24 hours.

   ii.i. LHH will not receive reimbursement for any LOA days exceeding the maximum number of leave days per calendar year.

f.d. Medicare does not provide for bed hold reimbursement.

6. Status of Residents Without an Approved LOA

a. Against Medical Advice (AMA)

   i.   A resident who leaves LHH against medical advice is considered AMA and shall be discharged.
   ii. If possible, resident shall be asked to sign the AMA form where indicated.

   iii. Physician writes AMA discharge order.

   iv. LHH will not hold the resident's bed.

b.   AWOL Elopements

i.   A resident who leaves without notification or without an approved order is considered AWOL.

i.

ii.   A resident who goes AWOL past midnight ~~may~~ shall result in a discharge from the facility. LHH is not permitted to place a bed hold for a resident who is not on an approved leave of absence or out on pass order.

iii.   Physician writes discharge order: Discharged – AWOL.

iv.   The nurse shall complete an Unusual Occurrence report.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-06 Out on Pass
LHHPP 20-07 Against Medical Advice
Medi-Cal Provider Manual Part 2 Billing and Policy for Long Term Care related to LOA and Bed Hold
State Operations Manual related to Notice of bed-hold and return and Permitting residents to return to facility

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

Previously numbered LHHPP 20-02.

Revision Hospital-wide Policies and Procedures

COMMITTEES – MANDATED

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall establish Committees that are mandated by law or regulation.

PURPOSE:

To comply with regulatory requirements and assure effective operation of LHH committees.

PROCEDURE:

1. ~~The facility~~LHH shall have at least the following committees: Infection Prevention and Control, Pharmacy and Therapeutics, and Performance Improvement and Patient Safety (PIPS) as required by State and Federal regulation, and other committees as written in the Medical Staff By-laws.

2. The committees shall be composed of membership from the areas of administration, medicine, nursing, pharmacy and other representatives as required by regulation and written in the Medical Staff By-laws.

3. The Infection Control Committee, Pharmacy and Therapeutics and PIPS shall meet at least quarterly. The PIPS Committee shall review LHH policies and procedures at a minimum annually. Medical staff committees shall meet as frequently as written in the Medical Staff By-laws.

4. Minutes of all committees shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed, and action(s) taken. ~~Meeting minutes shall be submitted to the Secretary of the Medical Executive Committee as stated in the Medical Staff By-laws.~~

5. Functions of the respective committees shall be outlined in policies and procedures and or described in the Medical Staff By-laws.

ATTACHMENT:
None.

REFERENCE:
Medical Staff By-laws, Title 22

Revised: 2007/12/04, 2009/10/27, 2016/01/12, 2020/09/08 (Year/Month/Day)
Original adoption: 1992/05/20

STANDARD FORMATTING TEMPLATE FOR POLICIES AND PROCEDURES

POLICY:

A standardized formatting template shall be followed in developing and revising Laguna Honda Hospital and Rehabilitation Center (LHH) policies and procedures.

PURPOSE:

To provide consistency in formatting ~~Laguna Honda Hospital~~LHH policies and procedures (LHHPP).

PROCEDURE:

1. **Page Set-Up**

    a. Open word document and apply the following setting:

        i. Header and Footer – 0.5"
        ii. Margins – 1" Top, 1" Bottom, 1" Right, 1" Left
        iii. Orientation – Portrait

2. **Headers and Footers**

    a. Under view setting click on Header and Footer and apply the following format to your Header:

        i. Arial 10 Font
        ii. Apply a bottom border by using the grid from your toolbar.
        iii. Center the header contents so that comparable blank space remains at the top and at the bottom of the Header to accommodate Headers with extensive content.

    b. Under view setting click on Header and Footer and apply the following format to your Footer:

        i. Arial 10 Font
        ii. Apply top border by using the grid from your toolbar.
        iii. Insert Auto Text Menu – Insert Page X of Y

    c. Keep the footer and header aligned.

    d. Titles or description of headers and footers

      i.   Top left: Indicate the file number and title of the LHHPP; ensure the file number is correct, especially for renumbered LHHPP.

      ii.   Top right: Indicate New, Revised, or Deleted and the date of approval by the Joint Conference Committee (JCC).

      iii. Bottom left: Specify Laguna Honda Hospital-wide Policies and Procedures

      iv. Bottom right: Specify page numbers

3. Title

    a. Apply the following format options to the Title (Name of a Policy or a Procedure):

      i.   Arial 14 Font

      ii.   All Caps

      iii. Bold

      iv. Left Alignment

    b. Use the singular noun form to title sections of the policy and procedure (e.g. Policy, Purpose, Procedure, Header and Footer, Attachment, Appendix, and Reference).

4. Policy, Purpose and Procedure

    a. The Policy statement shall be stated at the beginning of each LHHPP, followed by the Purpose statement.

    b. If more than one Policy and Purpose statements are stated, they shall be numbered.

    c. The Procedure section describes the steps for carrying out the policy (or policies) and meeting the purpose statement(s).

5. Body Content

    a. Apply the following format options to the Body:

      i.   Arial 12 Font

      ii.   Justified Alignment

    b. Sections in the body (i.e. POLICY, PURPOSE, PROCEDURE, ATTACHMENT/APPENDIX, REFERENCE) are formatted as follows:

      i.   Arial 12 Font

      ii.   All Caps

      iii. Bold

      iv. Left Alignment

c. Subjects in the body (i.e. Page Set-Up, Headers and Footers, Title Content, etc.) are formatted as follows:

i. Arial 12 Font
ii. Bold (when applicable, with the exception of Subjects that are in the form of a paragraph or multiple sentences).

6. Bullets and Numbering

a. The Procedure section shall apply the following listing format:

i. Outline Numbered: 1., a., i, ●, ●

b. Apply Bold Setting to Subjects (primary listing 1., 2., 3., etc.) when applicable.

7. Attachments/Appendices

a. List Attachments and/or Appendices in ascending order. Indicate None if there are no attachments.

b. Whenever possible, insert the appendices into the MS Word version of the policy/procedure as MS Word text or as an image. Otherwise, submit the appendices as separate MS Word documents along with the policy/procedure.

c. Ensure Attachments/Appendices are correctly identified.

8. References

a. List references in numeric order when the reference relates to a policy number, otherwise list in ascending order. Indicate *None* if there are no references.

i. Check all policy numbers used as references to ensure their accuracy.

b. Ensure References are correctly identified.

b.c.   Ensure reference links are active and correct.

9. Dates: New, Revised and , Deleted, Original Adoption

a. Date format to be used is (Year, Month, Day)

b. New, Revised and, Re-numbered and Deleted date(s)

i. Indicate New or, Revised, or Deleted at the top right corner of the policy and procedure.

ii. ~~Beginning December 3, 2010, the~~The new and revised ~~, revised, and deleted~~ date reflects ~~the date when the JCC approved the new, revised, or deleted the LHHPP.~~ the JCC approval date

iii. At the end of the LHHPP, indicate N/A for a new policy and procedure

iv. List the dates of all prior LHHPP revision(s).

v. When a LHHPP is re-numbered, specify the old and new LHHPP number next to the revision date.

vi. Do not delete any dates that have previously been listed.

c. Original adoption date

i. This date reflects the date when the LHHPP was first approved or when the policy and procedure was first implemented.

ii. This date does not change.

10. Proofreading

a. Proofread document in its entirety for typographical and formatting errors.

b. Spell out abbreviations that are not previously spelled out in the file.

11. Finalizing the Document

a. Spacing issues:

i. Align each indented listing with the previous listing to keep consistency in the document (Reference spacing above).

ii. If you are having issues with spacing at the bottom of a page, such as too much space above the Footer, try the following:

- Highlight the area
- Right Click
- Select Paragraph
- Uncheck Window/orphan control option

ATTACHMENT:
None

REFERENCE:
None

Revised: 11/09/27, 13/09/24, 15/07/14, 20/10/13 (Year/Month/Day)
Original adoption: 10/12/03

FRAUD, WASTE, AND ABUSE

POLICY:

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

~~1.~~2. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to prevent and detect fraud, waste, and abuse. LHH endeavors to train and educate staff to recognize potential problem areas and to use the internal mechanisms available to report suspected problems. This policy describes ways in which LHH can detect and prevent fraud, waste, and abuse, and the avenues through which to report a suspected violation.

~~2.1.   LHH staff shall not engage in any activity that constitutes fraud, waste, and/or abuse. LHH staff shall comply with state and federal laws, including the False Claims Act and the California False Claims Act related to the prevention of fraud, waste, and abuse. In addition, LHH staff shall comply with the San Francisco Department of Public Health's (DPH) Code of Conduct and DPH wide and LHH specific compliance policies.~~

PURPOSE:

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

DEFINITIONS:

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

2. **"Claim"** includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded. (31 U.S. Code § 3729)

3. **"The California False Claims Act (CFCA)"** is the state law that prohibits any person

or entity from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval, or knowingly making, using, or causing to be made or use a false record or statement material to a false or fraudulent claim. (Cal. Govt. Code §12650 et seq.)

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

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

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

PROCEDURE:

1. Preventing and Detecting Fraud, Waste, and Abuse

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

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

   c. Mistakes or errors on bills that result in overpayments are returned in accordance with applicable laws and corrective action plans are enacted when problems are identified. LHH's Compliance Officer and the LHH Compliance Committee monitors the implementation of corrective action plans. Service areas implementing corrective action plans shall provide periodic reports to the LHH Compliance Committee.

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

2. Reporting Fraud, Waste, and Abuse

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

   b. LHH staff have a variety of internal reporting options to resolve concerns related

to fraud, waste or abuse. Any concern may be reported to an immediate

supervisor, manager, and LHH's Compliance Officer. Individuals may alternatively contact the OCPA Compliance and Privacy Hotline by telephone at 855-729-6040, or by email at compliance.privacy@sfdph.org. All staff may anonymously report known or suspected violations.

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

3. Investigation of Fraud, Waste, and Abuse

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

4. Prohibition on Retaliation against Whistleblowers

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

5. Enforcement of Policy

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

ATTACHMENT:
None.

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

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

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

POLICY~~:~~

~~A leave of absence (LOA) may be granted to a resident of~~**POLICY:**

1. It is the policy Laguna Honda Hospital and Rehabilitation Center (LHH) ~~in accordance with the resident's individual plan of care and for the reasons outlined below~~to meet residents' physical and psychosocial needs to go out on pass (OOP). The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights.

    a. ~~Therapeutic Leave - for purposes other than required hospitalization based on~~ Residents who wish to leave the ~~resident's plan~~grounds of ~~care.~~

    i. ~~Scheduled appointments (Clinic/Dialysis, OR/IR/Cath Lab)~~

2. ~~Out on Pass (day/overnight/weekend) - Absences for purposes other than required hospitalization which~~LHH shall ~~be~~ have written orders from their attending physician and appropriate ~~to the physical and mental well-being of~~pass medications.

    b. ~~Determining if an OOP is appropriate for~~ the resident. ~~It~~ is the responsibility of ~~the~~ unit Resident Care Team (RCT) and may be granted ~~for, but is not limited to, the following~~ in accordance with the resident's plan of care~~:~~

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

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

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

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

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.~~3. ~~The bed hold is limited to maximum of seven days per acute hospitalization~~.

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~~

5. To comply~~residents~~ 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. ~~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.~~
the opportunity to participate

3. ~~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~~family and community life in ~~accordance with the individual resident care plan and appropriate to the physical and mental~~ways that support well-being ~~of the patient.~~
   and optimal functioning

   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.~~

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. 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.

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.

PROCEDURE:

1. **Notification of ~~LOA~~Out on Pass Policy**

    a. Upon admission, LHH Admissions & Eligibility department (A&E ~~provides the~~) and Social Services shall provide each newly admitted resident~~, or family member, or legal representative~~/surrogate decision maker (SDM) with ~~the California Standard Admission Agreement which includes written~~ information regarding ~~LOA acute hospitalization.~~
        the Out on Pass
    b. ~~Nursing~~ provides bed hold information and Notice of Proposed 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.

    c. MSW will provide the bed hold information to the resident, their family member, or legal representative 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.

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

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

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

   c. ~~The 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 transferring 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.~~

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

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

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

   g. ~~LHH claims must identify the inclusive date of the LOA.~~

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

      i. ~~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.~~

   ~~i.~~a. ~~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.~~.

~~5.~~2.   Request for ~~OOP~~ an Out on Pass and the Pass Order Form

   a. A ~~SDM~~resident and/or Surrogate Decision Maker (SDM) or representative may request a pass from the physician at least 2 business days prior to the planned OOP.

   ~~a.~~b.   An ~~. Such residents will be assessed by the~~ RCT ~~in arranging for pass privilege.~~is needed in order to evaluate the specific parameters for a request. A new RCT is valid for up to 90 days for a given type of OOP request if all parameters are exactly the same. A new RCT is needed if ANY of the parameters are different.

   ~~b.~~c.   An OOP order ~~from~~for each request by the physician shall be written in the EHR with medications if appropriate. ~~~~A standing physician order cannot be made by a physician.

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

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

e.f. The RCT shall ~~advise~~advice the resident concerning failure to return by ~~midnight~~the agreed upon duration of the scheduled return date and time may result in discharge from LHH if ~~a pass~~an extension is not obtained from the Physician.

f.g. The Medical Social Worker (MSW) will review and provide the bed hold policy and form to the resident, SDM and/or representative.

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

3. ~~LHH~~Documentation

a. Each request will ~~not~~ be ~~reimbursed from bed hold in~~ evaluated on the ~~event~~resident's current medical, physical, and mental health condition at the time the request is made to the RCT.

b.   Each evaluation will take into consideration and document the following:

   i.   Indication (**i.e.,** "having lunch with mother improves mood")

   ii.   Destination

   iii.   Who are they going with

   iv.   Duration/timing of OOP (typical duration ≤4 hours, exceptions should have documented justification)

   v.   Benefits of OOP

   vi.   Risks of leave, including specific notation if risks for:

   - Elopement risk

   - Challenges with safe decision making

   - Depression / safety risk

- Contraband

- Substance use disorder risk

- Prior non-compliance with OOP parameters

- Other (i.e., medical risk, psychiatric risk, etc.)

vii.   If benefits outweigh risks, list specific mitigation strategies:

- Accompanied by a person who is responsible

- Family is aware of risks

- Able to demonstrate teach-back with strategies shared

- Family is responsive and collaborative with the RCT

viii.   If the risks outweigh the benefit of the OOP, document reason(s) for declining OOP

ix.   Medication safety planning during OOP, including plan for education on administration

- Determine what education will be provided (by whom and to whom)

- Determine when education will be provided

- Determine what medications will be required and ordered for a safe OOP

x.   Other caregiver safety education and planning (i.e., car transfers).

xi.   Documented counseling of resident/SDM that being out past the scheduled parameters of the leave will result in discharge as Against Medical Advice (AMA).

xii.   Notes: A new RCT is valid for up to 90 days for a given type of leave of absence request if all parameters are exactly the same. A new RCT meeting is needed if ANY of the parameters above is different or if a change in condition. (For example, if a resident returned from last OOP with concerning medical condition, behaviors, or contraband.)

4. Resident Education prior to OOP

a. Nursing discharged within 24 hours of return from an overnight OOPstaff shall provide education to the resident prior to going OOP. The education shall include:

   i.   Review and verification of the RCT note and OOP order.

   ii.   Medication education on administration, confirmation of medication teach-back, and signature obtained for receipt of medication supply.

      • If resident does not demonstrate competency with meds, they are not allowed the OOP privilege.

   iii. Provision of written handout or instructions to resident (medication, treatment) prior to OOP. Use the "education" material in EHR.

   iv.   Instructions on special equipment (i.e., insulin pump, splints, etc.)/ special circumstances.

b. If nursing is concerned that resident condition is not safe for OOP:
   i.   Notify on-call physician and document in EHR.

   ii.   Physician will evaluate immediately and document in the EHR.

   iii. Physician will cancel the OOP order if decision is determined to not permit OOP.

   h.iv. Nursing staff not to release resident for out on pass until the physician evaluation occurs.

6.5.   Census Management

a. The Licensed Nurse/Unit Coordinator shall complete the OOP information in Unit Manager in EHR.HER under Leave of Absence (LOA). 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 from LOA, the Licensed Nurse/Unit Coordinator shall update the LOA to discharge.

7.6.   Compliance/Adherence with Pass Privilege

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

   i.   When leaving on passOOP and on returning from passOOP, residents and/or SDM shall check in and out with the nursing staff on the caretheir home 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).~~in the EHR.

- 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~~Residents who are going ~~out on pass~~OOP 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~~/~~or SDM with the ~~(~~RCT and, if appropriate, development of an interdisciplinary care plan addressing the problem.

- ~~Residents who remain OOP longer than~~Continued non-adherence or non-compliance or if a resident leaves the ~~duration~~ facility without an OOP order or in a manner inconsistent with the specified ~~by~~OOP parameters, the physician shall discharge the resident as Against Medical Advice (AMA).

iii. Residents who remain OOP in a manner outside of the specified order parameters or residents who can understand the risks of leaving the hospital grounds and who leave the hospital grounds without ~~a pass~~an OOP order shall be considered an elopement and may be subject to discharge AMA.

b. If a resident has not returned as expected, the nursing staff shall attempt to contact the resident and/or SDM. The LN shall document attempts in the EHR to contact the resident and/or SDM.

7. Extension of an OOP Order

~~b.~~a. Extension/Re-order of an 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~~SDM and the Nursing Unit Staff or Physician.

iii.   ~~Therapeutic LOA.~~

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

b.   The Physician ~~documents~~shall document the reason for the extension of ~~OOP~~the LOA in the EHR.

c.   If an extension occurs, the RCT shall meet to evaluate the appropriateness of the extension and document counseling with the resident/SDM about the need to follow LOA order parameters.

8. Nursing Evaluation upon Return from OOP

a.   Nursing staff shall complete an evaluation of the resident withing one hour of returning and completion of EHR documentation following the existing standard work (Resident Returning from an Out on Pass).

b.   At ~~medical record~~a minimum, staff to examine for the following:

i.   Customary routine.

ii.   Cognitive patterns.

iii.   Communication.

iv.   Vision.

v.   Mood and behavior patterns.

vi.   Psychological well-being.

vii.   Physical functioning and structural problems.

viii.   Continence.

ix.   Disease diagnosis and health conditions.

x.   Dental and nutritional status.

xi.   Skin Conditions.

xii.   Medications.

~~c.~~xiii.   Special treatments and procedures.

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

None.

REFERENCE:
LHHPP 20-07 Against Medical Advice
LHHPP 20-14 Leave of Absence and Bed Hold
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, 23/06/13 (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~~

02

_____

Restraint Free Environment

POLICY:

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

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

3. The restraint consent form shall be updated annually, if there is a change in condition of the resident or change in the device being used.

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

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

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

PURPOSE:

To assure resident freedom from physical restraints, and if necessary to utilize the least restrictive device only for the least amount of time when other less restrictive have been ineffective to provide safety.

DEFINITIONS:

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

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

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

a. The bed rail keeps a resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently.

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

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

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

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

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

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

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

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

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

Compliance Guidelines

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

2. Assessments shall be conducted by following the below steps:

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

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

    - Decline in physical functioning
    - Decreased muscle condition
    - Contractures
    - Increased risk for infection
    - Pressure ulcers/injuries
    - Delirium
    - Agitation
    - Incontinence
    - Accidents such as falls, strangulation, or entrapment
    - Loss of autonomy and dignity
    - Withdrawal or reduced social contact

PROCEDURE:

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

    a. Before applying a new restraint:

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

            - RTC will discuss:
                - Circumstances leading to the use of restraints and what alternative interventions were tried first
                    o Alternative interventions may include, but are not limited to: diversionary activities, 1:1 resident care, repositioning, pain management, reorientation to surroundings, or administration of

prescribed medications

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

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

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

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

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

- Type of restraint and duration of use.

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

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

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

   i.   Nursing will update the resident's care plan after RCT discussion:

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

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

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

- Interventions (restorative) to address potential functional decline.

- Interventions to remain free from injury while restrained, release and document every 4 hours or sooner according to the resident need.

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

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

 d. For continued restraint use:

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

  ii. Discussion shall include:

- Resident's response to restraint being used.

- Possible alternatives other than current restraint to be used.

- Referrals to ancillary departments, as appropriate.

- Continuation of restraint use must be renewed via EHR.

DOCUMENTATION

1. Staff will provide ongoing monitoring and evaluation for the continued use of a physical restraint, release and document every 4 hours or sooner according to resident need.

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

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

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

 c. Monitoring and supervision are to be documented via EHR on the following: See Standard work for procedures in regards to restraint documentation.

 d. Monitoring will include:

  i. Proper placement of restraint as ordered
  ii. Release of restraint for:
  iii. ROM to the restrained extremity(ies) while awake if used

      iv.   Turning and repositioning
      v.   Hydration/meals
      vi.   Hygiene/elimination

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

2. Staff Training

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

     i.   Methods to reduce and eliminate restraint use;

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

     iii.   Use of non-physical intervention skills;

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

     v.   Safe application of physical restraints;

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

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

ATTACHMENT:
None

REFERENCE:
LHHPP 22-13 Bed Rail Use
LHHPP 24-13 Falls
State Operations Manual Appendix PP - Survey Protocol, Regulations and Interpretive
    Guidelines for Long Term Care (Rev. 173, 11-222017)

Revised: 97/04/15, 00/01/27, 02/09/06, 08/08/08, 09/01/13, 09/08/21, 10/09/24, 10/11/10, 16/01/12, 17/09/12, 19/03/12, 20/01/14, 21/10/12, 22/08/31, 22/12/13, 23/05/09 (Year/Month/Day)
Original adoption: 96/07/15

PHYSICAL RESTRAINTS - ACUTE UNITS

POLICY:

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

PURPOSE:

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

OVERVIEW:

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

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

DEFINITIONS

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

Methods:

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

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

EXCLUSIONS

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

- **Mechanical Support:** devices used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without

the use of such a mechanical support is not considered a restraint. Abdominal binders used as abdominal support post-operatively or to promote mobilization (e.g., prevention of orthostatic hypotension or pain) are not restraints.

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

PROCEDURE:

1. **Restraint Practice Specifications**

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

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

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

2. **Restraint Application**

a. The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, staff member, or others from harm.
b. The physical restraint application procedure involves all of the following components:

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

c. Restraint consent

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

3. Restraint application orders

a. Physician order is required for all restraints when:

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

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

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

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

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

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

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

h. The Physician must evaluate:

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

4. Monitoring and Provision of Care

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

5. Documentation Requirements

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

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

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

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

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

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

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

6. Modification to Care Plan

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

b. Care plan components include:

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

7. Discontinuation, Reapplication and Temporary Release/Interruption

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

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

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

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

8. Considerations

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

and thought processes may also result. Humiliation, fear, anger and a decreased sense of self-esteem may occur.

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

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

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

9. **Education**

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

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

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

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

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

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

CROSS REFERENCE:
27-07 Physical Restraints/Skilled Units

60-03 Incidents Reportable to the State of California
60-12 Review of Sentinel Events (Applicable to Acute Care Units Only)
REFERENCE:

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

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

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

BED RAIL USE

POLICY:

1. Prior to bed rail use, <u>Resident Care Team</u> 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~~ <u>Restraint Free Environment</u> 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 CARE PLAN (RCP), RESIDENT CARE TEAM (RCT)
& RESIDENT CARE CONFERENCE (RCC)

POLICY:

1. An interdisciplinary Resident Care Team (RCT), in conjunction with the resident, resident's family, or surrogate decision-maker shall develop a Bbaseline Pplan of Ccare within 48 hours of the resident's admission. It shall include instructions needed to provide effective and person-centered care of the resident, and shall at a minimum include: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and if applicable, PASARR recommendation(s).

2. The RCT, in conjunction with the resident, resident's family, or surrogate decision-maker or representative, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a timeframes table to meet the resident's medical, nursing, and mental healthpsychosocial needs, if appropriate.

3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes.

4. The resident, family, significant other(s) and/or representativeconservator shall be part of the development and implementation of his or her person-centered plan of care.

5. CMost care problems require various professional disciplines working together in planning, implementing and evaluating goals and interventions. The RCT may care plan together in formal resident care meetings, in smaller less formal settings, in discussions over the telephone or by written communication.

6. A Resident Care Conference (RCC) shall be conducted with the scheduled completion of an admission, quarterly, annually and/or with a significant change in condition.

7. Special Review (SR) RCC's shall be held when the review of specific care issues is clinically indicated.

8. Stable, ongoing resident needs and resident preferences are addressed on the Baseline Care Plan in the electronic health record (EHR)). Unstable, alterable problems that require a more goal directed approach are addressed on the RCP in the EHR. Together they comprise the resident's care plan.

9. Care Area Assessment (CAA) that are triggered during completion of the comprehensive MDS requires evaluation and discussion from the resident, family, significant others and/ or conservator and/or representative, and RCT to develop

~~whether or not~~ a comprehensive care plan ~~needs to be developed~~ for the triggered care areas.

PURPOSE:

It is the policy of LHH to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments. To promote the resident's highest possible physical, mental and psychosocial well-being.

DEFINITION:

Resident's goal: The resident's desired outcomes and preferences for admission, which guide decision making during care planning.

Interventions: Actions, treatments, procedures, or activities designed to meet an objective.

Measurable: The ability to be evaluated or quantified.

Objective: A statement describing the results to be achieved to meet the resident's goals.

Person-centered care: ~~T~~ ~~means~~ to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

"Culture" is the conceptual system that structures the way people view the world – it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

"Cultural Competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.

PROCEDURE:

1. **The Resident Care Team**

    a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include:

        i.   Nurse Managers (or designee) — Facilitator of RCC

        ii. Licensed Nurse

        iii. Nursing Assistant

        iv. Attending Physician

        v.   Medical Social Worker

        vi. MDS Coordinator

        vii. Activity Therapist

        viii. Registered Dietitian

    b. The resident, family and/or representative, significant other(s) and/or conservator shall be part of the development and implementation of his or her person-centered plan of care, including but not limited to:

        i.   The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

        ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

        iii. The right to be informed, in advance, of changes to the plan of care.

        iv. The right to receive the services and/or items included in the plan of care.

        v.   The right to see the care plan., including the right to sign after significant changes to the plan of care.

c. In the event a special review meeting is necessary, the following disciplines must be present: physician/MD, coordinator, social worker, dietician, (appropriate members of other disciplines attend with reasonable notice and with reasonable notice). The remaining RCT members shall be notified of any care plan changes, including the resident and/or representative., family, significant other(s) and/or conservator .

d. Consultative Members may be part of the RCT if actively involved in the care of the resident and may include as appropriate:

- Chaplaincy

- Clinical Nurse Specialist

- LHH Psychiatry providers (Psychiatrist/Psychologist/Behavioral Health Clinician/mental health or substance treatment counselor)

- Occupational Therapist

- Quality Management

- Pharmacy

- Rehabilitation Services

- Dietary Technicians

- Peer Mentors

- Ombudsmen

- Any other consultants as needed

e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP.

f. The RCT shall incorporate the resident's personal and cultural preferences in developing goals of care, and address the resident's care needs through assessments such as:

i. Minimum Data Set (See LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set)

ii. Admission assessments including but not limited to:

- Physician History and Physical

- Resident Social History Assessment

- Nutrition Screening and Assessment

- Admission Nursing Assessment

- Comprehensive Pain Assessment

- Behavioral Risk Assessment

- Discharge Assessment

- Pressure Ulcer Risk Assessment

- Activity Therapy Assessment

- RCT Pre and Post Elopement Event (Cross Reference LHHPP 24-22 Code Green Protocol)

- Bed Rail Order (if appropriate)

- Smoking Assessment and Plan of Care

- Social Services Psychosocial Assessment

2. Resident Care Conferences

a. The RCC shall serve as the forum for interdisciplinary development and review of the care plan. Care plan review shall be done:
   i. On a quarterly schedule with the MDS

   ii. With discharge planning

   iii. Within 14 – 21 days of relocation to another unit in LHH

   iv. Special Review(s)

   - Comprehensive MDS with CAA

   - Within seven days of new admission

   - Annually

   - Significant change in resident condition

b. RCT members shall conduct their assessments and prepare for prior to the RCC. This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident.

c. The RCT shall facilitate the inclusion of the resident and/or resident representative. The resident and/or surrogate decision-maker representative shall be informed of the meeting, date and time. The resident shall be invited and encouraged to attend the RCC, unless contraindicated by the resident's condition. If the resident is unable to attend, a representative is required to attend on behalf of the resident.

   i. The social worker shall contact the surrogate/conservator representative about the meeting date and time.

   ii. The resident or/surrogate representative shall have the opportunity to express concerns and preferences during the RCC.

d. The nursing assistant and assigned licensed nurse shall be present, or provide information if unable to attend, at the RCC and consultants shall be invited as appropriate.

e. The RCT Interdisciplinary Team Conference Note in the EHR shall be completed for each RCC.

3. Baseline Care Plan

a. Shall be initiated by nursing within eight hours on the day of admission.

b. Shall be completed and implemented within 48 hours of a resident's admission.

c. The baseline care plan shall address the resident's immediate needs for safety, management of risks, and medical attention, including but not limited to the minimum healthcare information necessary to properly care for the resident as outlined in policy statement #1.

d. The baseline care plan shall reflect the resident's stated goals and objectives, and include interventions that address his or her current needs.

   i. It shall be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

   ii. The baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care shall dictate that it shall also reflect changes to approaches, as necessary, resulting

from significant changes in condition or needs, occurring prior to development of the comprehensive care plan.

    iii.   LHH staff shall implement the interventions to assist the resident to achieve care plan goals and objectives.

e.   Is reviewed with the resident and/or ~~authorized resident~~ representative, in their preferred language, no later than seven days after admission.

f.   LHH shall provide the resident and/or resident representative with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary shall include:

    i.   Initial goals for the resident;

    ii.   A list of current medication and dietary instructions; and

    iii.   Services and treatments that shall be administered by LHH.

g.   Problems identified by the Resident Assessment Instrument (RAI), shall be care planned within seven days of the completion of the comprehensive assessment.

4. Comprehensive Care Plan

a.   The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed.

b.   ~~LHH shall develop and implement a comprehensive person-centered care plan within seven days of completion of the comprehensive assessment.~~ The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.

~~a.~~

~~b.~~c.   The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, specifically in the CAA.

i.   The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

ii.   Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.

i.iii. Identify concerns in the CAA that may warrant interventions.

ii.iv.   Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well- being in the context of the resident's condition, choices, and preferences for interventions.

iii.v.   Address other important considerations, such as advanced care planning and palliative care.

vi.   Describe any specialized services or specialized rehabilitative services tor specialized rehabilitative services LHH shall provide as a result of the PASARR recommendations.

vii.   Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.

viii.   Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

ix.   The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

iv.

c.d.   In consultation with the resident and/or the resident's representative, the comprehensive care plan shall describe:

i. The resident's goals for admission and desired outcomes.

ii. The resident's preference and potential for future discharge. LHH shall document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

iii. Discharge plans in the comprehensive care plan, as appropriate.

e.   The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:

i.   The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan.
ii.   A registered nurse with responsibility for the resident.
iii.   A nurse aide with responsibility for the resident.
iv.   A member of the food and nutrition services staff.
v.   The resident and the resident's representative, to the extent practicable.
vi.   Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:
   • The RAI Coordinator.
   • Activities Director/Staff.
   • Social Services Director/Social Worker.
   • Licensed therapists.
   • Family members, surrogate, or others desired by the resident.
   • Administration.
   • Discharge Coordinator.
   • Mental health professional.
   • Chaplain.

f.   The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

g.   The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative.

h.   Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

5. Identifying and Writing the Problem Statement

a. Problems, needs, strengths, and preferences are identified by members of the RCT and the resident as a result of careful, comprehensive, and ongoing assessments.

b. Problem statements are resident focused and not staff focused.

c. The statement may, but does not require the reason for the problem, (i.e. what the problem is related to "R/T").

d. The statement may include some, but not all, of the common observable signs and be described as "As Evidenced by (AEB)".

d. Problems with the same root cause or same interventions may, but are not required to, be grouped together.

6. **Determining the Goal Statement**

a. The goal statement indicates the outcome desired by the resident or surrogate decision-makerrepresentative and aims at promoting or maintaining the resident's highest practicable physical, mental, and psycho-social well-being.

b. Goals must be realistic, specific, reflect the problem, measurable, and have a target date.

7. **Developing Interventions**

a. Interventions can address how to minimize the risk of problem(s), address resident's preferences, and meet the resident's goals.answer the questions:

i. "What can the team do to minimize the risk of a problem developing?"

i. "What can be done to address the resident's preferences?"

i. "How can the resident's goal be met?"

b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions.

c. Interventions reflect standards of current professional practice.

8. **Evaluating Effectiveness of the Care Plan**

a. Evaluation of the care plan requires accurate knowledge and analysis of the resident's present status and is documented in the summary notes.

b. There is evidence that the goal has been met or that there is progress towards the goal. The progress of the goal is based on the following:

    i.   If there is evidence or progress towards the outcome desired by the resident or ~~surrogate decision-maker~~representative.

    ii.   If the evaluation indicates that the goal is not being met, the RCT shall determine the cause for the lack of progress and make the necessary changes.

  c. Consideration by the RCT should include:

    i.   Identification of the problem. Is it an accurate reflection of resident's present status?

    ii.   Measurable and realistic goals.

    iii.   Appropriate interventions for each goal.

    ~~What else can be done?~~

    ~~v.~~iv.   Additional information as appropriate.

  d. The evaluation of the effectiveness of the care plan is documented in the EHR under:

    i.   The ~~RCT summary note~~Team Conference note

    ii.   The Nnursing Wweekly~~/monthly~~ Ssummary

    iii.   Discipline specific progress notes ~~in the electronic health record~~\

9. **Behavioral Plans are a part of the Resident's Plan of Care and documented in the EHR**

  a. These plans are developed by the interdisciplinary RCT members. Plan development may require specialized behavioral planning meetings. Planning discussion is documented by a summary special review meeting note.

  b. These plans are drafted by team members, most often the ~~Social Worker~~Nursing, in consultation with a LHH Psychiatry provider, and/or consultation with other key team members on different shifts.

  c. The RCT is to discuss behavioral plans with the resident and/or the resident's surrogate decision-maker when appropriate.

  d. Behavioral Plans are revised as needed and discontinued when the target behavior no longer poses a problem.

e. Behaviors identified for modification shall be clearly described, noted and tracked in the Behavior Monitoring Record (BMR).

10. Communication

a. The MDS Coordinator shall identify the scheduled RCC meeting based on the MDS assessments.

a.b.   Nursing (i.e., MDS Coordinator, Nurse Manager or Charge Nurse) shall coordinate all Special Review RCC meeting dates and times.

b.c.   The RCT shall communicate with one another in a timely manner using the EHR, email, and text paging, as needed.

c.d.   The BMR shall be used by nursing to document resident behaviors and reviewed by the RCT to evaluate the resident's response to the behavioral plan.

d.e.   Changes that affect the resident's care or daily routine shall be communicated to the resident or /surrogaterepresentative as soon as possible in the method that is most practical for the resident or representative/surrogate and shall be repeated as needed or provided in writing.

ATTACHMENT:
None.

REFERENCE:
LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)
LHHPP 24-22 Code Green Protocol
MSPP D08-10 Behavioral Management Services by LHH Psychiatry
Long Term Care Survey, June 2006 Edition
42 Code of Federal Regulation (CFR) 483.21(a)(1)-(3) Comprehensive Person-Centered Care Planning, Baseline Care Plans
42 Code of Federal Regulation (CFR) 483.10(c)(2)-(3) Resident Rights – Planning and Implementing Care
Comprehensive User Manual Version 3.0 Resident Assessment Instrument. Chapter 4. CAA Process and Care Planning.

Revised: 01/10/20, 09/10/27, 10/05/25, 16/11/08, 19/03/12, 19/05/14, 19/07/09 (Year/Month/Day)
Original adoption: 92/05/20

ANTIMICROBIAL STEWARDSHIP PROGRAM

PURPOSE:

The purpose of this policy is to provide for an antimicrobial stewardship program (ASP) which aims to optimize appropriate selection of antibiotics, improve patient outcomes, reduce health care costs and antimicrobial resistance, and minimize adverse effects of antimicrobial use.

POLICY:

1. The hospital shall support a robust antimicrobial stewardship program for both acute and skilled nursing units.

2. The antimicrobial stewardship program shall evaluate all antimicrobial prescriptions in the acute care unit and targeted antimicrobial prescriptions on the skilled nursing units.

3. The CDC Core Elements of Antibiotic Stewardship for hospitals and nursing home settings are used as the program framework.

PROCEDURE:

1. **Antimicrobial Stewardship Program Members**

    a. The ASP Team is comprised of physicians (infectious disease consultant, medical staff representative), clinical pharmacists, a representative from nursing, and the infection prevention and control officer.
    b. The ASP team meets regularly with a minimum of 6 meetings/year

2. **Physician:**

    i. Assesses clinical signs and symptoms and laboratory reports to help guide antibiotic(s) choice
    ii.
    iii. Orders antibiotic(s) with an appropriate indication, dosage, and duration of use.

    iv. Obtains necessary cultures and labs if indicated (e.g., urine, blood, sputum, creatinine clearance) prior to first dose of antibiotic(s).

    v. Documents in the medical record rationale for antibiotic therapy and selection of agent(s).

3. **Pharmacist:**

   a. Reviews antibiotic(s) ordered regardless of acute, SNF, or initiated at outside hospital prior to admission.

   b. Monitors and evaluates antimicrobial prescribing for documentation of infection, and rationale for antibiotic(s) ordered

   c. Contacts prescribers to recommend alternative therapy, dosage and/or duration of therapy when appropriate to optimize treatment.

4. **Both the physician and the pharmacist are responsible for the following:**

   i. Appropriate dosing of antimicrobials based on the patient's age, weight, renal function, clinical signs and symptoms, site of infection, causative organism, pharmacokinetics and pharmacodynamics of the drug.

   ii. Routine monitoring of all appropriate laboratory studies, which may include CBC, renal and liver function tests, and drug concentrations.

   iii. Refer to treatment guidelines to determine appropriate length of antimicrobial therapy based on the patient's clinical status, the site of infection, and the causative agent.

5. **Antimicrobial Stewardship Team:**

   a. Shall utilize the most recent standards for antimicrobial stewardship when performing review of antimicrobial use, including but not limited to review of lab results, culture findings, medication orders, progress notes, and medication administration records.

   b. Develops criteria and protocols for monitoring and intervention.

   c. Communicates protocols to medical staff and provides feedback on antibiotic use and antibiotic resistance patterns based on laboratory data to help guide prescribing practices
   ~~Reviews prescribing patterns~~

   d. Reports results of antibiotic use and prescribing practices to Infection Control Committee, Pharmacy and Therapeutics Committee and Performance Improvement Patient Safety (PIPS) Committee.

   e. Presents data prescribing outcomes of vancomycin per pharmacy program to the Pharmacy and Therapeutics Committee every 6 months

ATTACHMENT:
Appendix A: Standards for Evaluating Antimicrobial Use

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

American Hospital Association

American Society of Health-System Pharmacists' (ASHP). A Hospital pharmacist's Guide to Antimicrobial Stewardship programs.2010.
Http://www.ashpadvantage.com/stewardship

Centers for Medicare and Medicaid Services. Infection Prevention, Control, and Immunizations CE Pathway 20054, 10/2022.

Rybak M, Lomaestro B, Rotschafer J et al. Therapeutic monitoring of Vancomycin in adult patients: A consensus review of the American Society of Health-System Pharmacists, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacists. Am J Health-Syst Pharm. 2009; 66:82-98

Dellit T, Owens R, Mcgowen J et al. Infectious Disease Society of America and Society for Health Care Epidemiology America Guidelines for Developing an Institutional Program To Enhance Antimicrobial Stewardship. CID 2007:44 (15 January)

University of California, San Francisco. Antibiotic Management for Critically Ill patients. 2005. http://clinicalpharmacy.ucsf.edu/idmp/guide_home.htm

Revised: 16/11/08, 22/09/07, 22/12/13, 23/07/13 (Year/Month/Day)
Original adoption: 10/12/03

APPENDIX A
Standards for Evaluating Antimicrobial Use

1. Empiric broad-spectrum antibiotics (e.g. carbapenems, fluoroquinolones) are reserved for situations in which narrower-spectrum drugs are likely to fail. Empiric therapy should continue for no more than 3-4 days to prevent adverse effects and resistance.

2. Combination therapies are used for patients who have multi-drug resistant pathogens.

3. Antibiotics are narrowed based on antibiogram, formulary selection, culture results and sensitivities to minimize drug resistance.

4. Serum antibiotic drug levels are drawn to optimize efficacy and prevent toxicities for some antibiotics, including: vancomycin, aminoglycosides.

5. With improvement of the patient's medical condition, IV antibiotics are converted to oral agents to decrease health care costs and length of acute hospital stay. Patients will be discharged back to their previous ward with appropriate oral antimicrobials, if needed.

SPECIAL RESPIRATORY THERAPY EQUIPMENT

POLICY:

Residents who have special respiratory equipment needs shall have such equipment provided in a timely manner regardless of source of payment.

PURPOSE:

1. To provide timely service to the resident;
2. Efficiently utilize city approved vendors; and
3. Invoice and pay the proper parties.

PROCEDURES:

1. Referred Pre-Admits

   a. When the Screening Committee becomes aware, the bed control nurse or designee informs appropriate departments of need for special respiratory equipment. The designated physician, based on judgment regarding medical necessity and without special review or consultation, may submit a requisition for special respiratory therapy equipment to the Respiratory Therapy Department by ordering a sleep study that documents medical necessity.

2. In-House Residents

   a. When the attending physician becomes aware of the need for special respiratory equipment, the physician, without special review or consultation, may submit a requisition to the Respiratory Therapy Department for special respiratory equipment based on the physician's judgment regarding medical necessity by completing the LHPP Form 96-05 (7/00) Requisition for Special Respiratory

   b. A list of all residents using rental respiratory equipment shall be maintained by the Respiratory Therapy department manager.

3. Processing the Requisition

a.   The ~~Respiratory Therapy Department~~Clinical Support Manager ~~and or~~, with assistance from Materials Management ~~designee~~ shall:

   i. procure the equipment (or coordinates with the respiratory therapist who procures the equipment) for installation by the target admission ~~or start date;~~

   ii. manage the vendor's installation of the equipment in the resident's room, by the target admission or start date;

USE OF PSYCHOTROPIC MEDICATIONS

PHILOSOPHY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall continuously monitor each resident's drug/medication regimen to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.

POLICY:

1. Informed consent shall be obtained as described in MSPP D01-05 Psychotropic Medication Management, regardless of indication for use.

2. Resident Care Team (RCT) shall ensure that each resident's drug regimen shall be free from unnecessary psychotropic[1] medication and conform to State and Federal regulations.

3. Non-pharmacological interventions (such as behavioral interventions) shall be the first consideration whenever indicated, instead of, or in addition to, psychotropic medication.

4. Residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record based on diagnostic criteria in Diagnostic and Statistical Manual of Mental Health Disorders (DSM).

5. Residents shall not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed, specific condition that is documented in the clinical record. PRN use of psychotropic medications shall be limited as follows:

   a. PRN non-antipsychotic medications shall be limited to 14 days unless a longer time frame is deemed appropriate by a physician and there is documentation of their rationale and the duration of the PRN order in the medical record.

   b. PRN antipsychotic medications shall be limited to 14 days and may not be renewed unless the attending physician evaluates the resident for the appropriateness of that medication.

6. Psychotropic medications shall never be used for reasons of staff convenience and/or to discipline a resident.

7. Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue or taper the dosage of these drugs.

---

[1] Also known as psychiatric medication.

---

8. Providers will document specific observable and quantifiable target behaviors to be monitored in a ~~t~~Target ~~s~~Symptom order in Epic for any resident on psychotropic medications.

9. Target symptoms are not required when psychotropic medications are used to treat other medical conditions such as seizures, spastic disorders, hiccups, terminal delirium, pain, etc.

10. The licensed nurse is responsible for monitoring the specific target behaviors and documenting in the electronic health record (EHR).

11. Care teams shall be responsible for monitoring for potential side effects of psychotropic medications in the antipsychotic class:
    a. Physicians will perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications:
        i.   Within the first 30 days of admission (if new to LHH) or within the first 30 days of starting or discontinuing an antipsychotic medication at LHH
        ii. Every 6 months while on an antipsychotic
        iii. When clinically indicated
    b. Nurses will document in their care plans monitoring for symptoms of tardive dyskinesia and develop an individualized care plan for any resident with tardive dyskinesia
    c. The Unit Based Quality Assurance and Performance Improvement (QAPI) for psychotropic medications will review of side effects, including tardive dyskinesia, for residents on antipsychotics ~~t~~

~~10.~~

~~11.~~12. The provider is responsible reviewing the target symptom monitoring to inform their assessment of the effectiveness of the psychotropic regimen.

~~12.~~13. Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s).

PURPOSE:

To assure that the use of psychotropic medications is appropriate and justified and that residents and their families or surrogate decision makers (SDMs) are informed about, and consent to utilization of psychotropic medications.

DEFINITION:

"Psychotropic drug": any drug that affects brain activities associated with mental processes and behavior. These include, but are not limited to, anti-anxiety agents, anti-

depressants, anti-psychotics, anti-manic drugs, and sedative-hypnotics.

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

"Behavioral Interventions": individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being.

"Anti-psychotic medication": any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders, per Title of California Regulations, Section 850-857.

PROCEDURE:

1. **Initiation**
   Refer to MSPP D01-05 Psychotropic Medication Management Procedure 1, prior to initiating a resident on psychotropic medication(s).

2. **Informed Consent**
   Refer to MSPP D01-05 Psychotropic Medication Management Procedure 3, for obtaining informed consent.

3. **Emergency use of psychotropic medications**
   Refer to MSPP D01-05 Psychotropic Medication Management Procedure Standard Work on Emergent Medications.

4. **Monitoring and Documentation**
   Refer to Nursing J-02.5 Monitoring Behavior & the Effects of Psychoactive Medications, MSPP D01-05 Psychotropic Medication Management, procedure 1, and Pharmacy Services 6.00 Clinical Pharmacy 06.01.01 Psychotropic Medication Procedure for monitoring residents who are on psychotropic medication(s) and documentation procedures.

ATTACHMENT:
Attachment A: Informed Consent for Psychiatric/Psychotropic Medications

REFERENCE:
MSPP D01-05 Psychoactive Medications
NPP J2.5 Monitoring Behavior and the Effects of Psychoactive Medications
Pharmaceutical Services Policy and Procedure 06.01.00 Medication Regimen Review
Pharmaceutical Services Policy and Procedure 06.01.01 Psychotropic Medication

Appendix PP of the Long Term Care State Operations Manual
Nursing Standard Work on Emergent Medications

Revised: 12/09/25, 13/05/28, 19/05/14, 21/09/14, 23/04/11 (Year/Month/Day)
Original adoption: 12/05/22

PAYOR ELIGIBILITY, CERTIFICATION AND COVERAGE

POLICY:

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

PURPOSE:

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

PROCEDURE:

1. **Provision of Medicare Rights Form**

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

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

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

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

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

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

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

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

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

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

3. **Procedure A – Medicare Part A Coverage**

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

i.   has Part A Medicare eligibility,

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

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

b. Acute Medical Unit

i. The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification.

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

iii. If the patient's admission does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. If the Physician concurs the patient's admission was not medically necessary, the UM Nurse issues the Preadmission or Admission Hospital-Issued Notice of Noncoverage on the day of admission (refer to Appendix A2). The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

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

• Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.

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

    v. When the patient does not meet InterQual Adult Acute Level of Care Criteria for continued stay, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

    vi. The UM Nurse shall refer the case to the UM Committee Chair or Physician advisor as needed. If the UM Chair or Physician advisor concurs the patient needs to be discharged, the UM Nurse shall issue the Hospital-Issued Notice of Noncoverage Noncovered Continued Stay (refer to Appendix A3).

  c. Acute Rehab Unit

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

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

and transmit_the_information.notifies RAI Specialist/designee when PAI is ready for transmission. RAI Specialist or designee notifies UM, Billing, CN/NM/designee when PAI was transmitted. Status of PAI is reviewed during Triple Check meeting.

During an Interrupted Stay (patient was discharged to the acute hospital for an acute medical intervention and is readmitted to the same Acute Rehab Unit prior to the third consecutive midnight after discharge from Acute Rehab Unit), the previous PAI prior to the discharge shall be continued.

    ii. The UM Nurse sends the patient information during PMR Admission and updates as needed (refer to Appendix L3) at each admission of a patient to PMR The UM nurse will use use the of InterQual Adult Acute Rehab Level of Care Criteria started for admissions beginning 02/01/19. If the patient's admission does not meet InterQual Adult Acute Rehab level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review.

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

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

iii.iv.   The UM Nurse will complete the Pre-Admisison Screening Resident Review (PASRR) prior to admission or readmission from PMA and PMR back to LHH SNF.

d. SNFSkilled Nursing

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

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

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

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

- Completes and submits the SNF Physician Certification to the admitting physician for his/her signature of initial certification. Subsequent signatures shall be submitted to the attending/covering physician for continued certification according to the required time frames (see Appendix M3). When Medicare coverage is discontinued, the completed Certification form shall be filed in the EHR. If the form was signed after the due date, the Delayed Physician Medicare Certification needs to be filled out/completed by the Physician (see Appendix M8).

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

- Conducts and documents periodic reviews to determine that the resident continues to meet Medicare Part A SNF coverage and benefits. Reviews

shall be conducted on a weekly basis and no more than ten days shall lapse between reviews.

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

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

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

- The MDS is a clinical assessment tool that is completed by the resident care team and are used to classify resident into payment categories. The two required SNF PPS Assessments are: 5-Day Assessment and the PPS Discharge Assessment. The Interim Payment Assessment (IPA) shall be completed when providers determine the resident has undergone a significant change in condition.

- During an Interrupted Stay (patient was discharged from Part A covered SNF care due to an acute hospitalization and subsequently readmitted to Part A covered SNF care in the same SNF prior to the third consecutive midnight after discharge from the SNF), the previous MDS prior to the discharge shall be continued

vi. Medicare Denial Determination

- When the resident no longer meets Medicare criteria for coverage under Part A benefits; the UM Nurse, as the designated Administrative Officer shall issue the appropriate Notice of Medicare Non-Coverage letter (NOMNC) no later than 2 days before covered services shall end. The UM Nurse shall notify the resident and all appropriate administrative and resident care team members of the resident's non-coverage determination. UM nurses shall document the resident notification on the notice. The UM Nurse must also provide a Detailed Explanation of Skilled Nursing Non-Coverage letter, also known as the Detailed Notice, to the resident or the responsible party, if the resident or responsible party chooses to appeal the Medicare denial determination with the Quality Improvement Organization (QIO). If the patient shall remain in the SNF after Medicare coverage, the SNF Advance Beneficiary Notice of Non-coverage (SNFABN) shall be issued (refer to Appendix M4A, M4B and M1 for the NOMNC, Detailed Notice, and SNFABN) and copies shall be given to Admission and Eligibility Manager/designee. The Admission and Eligibility Manager/designee shall sign as verification of the receipt of the Generic notice.   The UM Nurse obtains the patient's/resident's or

responsible party's signature for NOMNC and/or SNFABN. If the patient or representative is unable to sign the NOMNC and/or SNFABN, the UM nurse will indicate and note the date and time of the notification on the signature area of the form.

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

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

ix. The Utilization Management department shall be notified by the Billing department regarding the outcome of the Intermediary's decision. Any decisions made by the Intermediary that is contrary to the facility's Medicare coverage determination shall be reported and reviewed at the monthly Utilization Management Committee.

x. Medicare Reinstatement (applicable only for SNF stays)

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

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

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

4. Procedure B - Medi-Cal Fee for Service

a. Acute Medical Unit

i.   The Acute Care Admitting Physician enters the order of Admit to Inpatient in the EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification.

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

iii.   If the patient's admission does not meet the InterQual Adult Acute Level of Care Criteria, the UM Nurse shall refer the case to the Physician for Secondary Medical Review. The UM Nurse shall refer the case to the UM Committee Chair or Physician Advisor as needed.

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

- Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.

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

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

b. Acute Rehab Unit

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

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

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

c. SNF

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

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

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

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

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

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

5. Procedure C - SFHP CHN Coverage

a. Acute Medical Unit

    i. The UM Nurse verifies patient's membership with SFHP via SFHP website.

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

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

    iv. The Acute Care Admitting Physician enters the order of Admit to Inpatient in EHR. After this initial order of Admit to Inpatient which includes length of stay, the Physician writes daily progress notes which will serve as continued certification.

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

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

- Enter acute care reviews (Admission, Continued Stay) using InterQual Adult Acute Level of Care Criteria in EHR.

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

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

b. Acute Rehab Unit

i. The UM Nurse verifies patient's membership with SFHP via SFHP website.

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

iii. The UM Nurse notifies SFHP of patient's admission. The UM Nurse enters the patient information in the log of PMR Admission and SFHP Patient List and updates as needed (refer to Appendix L5 and Appendix L2). tracks the admission to PMR.

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

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

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

   c. SNF

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

      ii. The UM Nurse verifies patient's membership with SFHP via SFHP website.

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

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

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

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

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

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

6. Procedure D – SFHP-UCSF Coverage

   a. Acute Rehab Unit

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

      ii. The UM Nurse verifies patient's membership with SFHP via SFHP website.

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

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

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

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

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

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

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

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

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

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

b. SNF

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

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

iii. The UM Nurse verifies patient's membership with SFHP via SFHP website.

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

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

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

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

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

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

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

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

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

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

a. Acute Rehab Unit

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

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

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

iv.   The UM Nurse enters the patient information in the Log of PMR Admission and Anthem Blue Cross Medi-Cal Managed Care Patient List (refer to Appendix L5 and Appendix L6).

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

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

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

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

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

ix.   If the patient is still meeting the InterQual Adult Acute Rehab Level of Care Criteria and denial received from Anthem, the UM Nurse shall discuss case with Anthem Blue Cross UM RN. If no resolution obtained, follow the next step as recommended by Anthem Blue Cross such as peer-to-peer review within 30 days of receiving the denial or appeal the denial.

x.   When the patient is discharged either to the acute hospital or to the community, the UM Nurse notifies Anthem Blue Cross.

b. SNF

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

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

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

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

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

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

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

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

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

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

8. Procedure F – Other Payor Coverage

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

b. The UM Nurse notifies payor/insurance of this admission on the day of admission or soon thereafter and obtain information from the payor of the requirements to obtain coverage for this admission.

c. The UM Nurse enters patient information in the Other Payor List and updates the list as needed (refer to Appendix L7).

d. For any issues, obtain assistance from OMC as necessary.

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

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

ATTACHMENT:
Appendix A2: Preadmission or Admission Hospital-Issued Notice of Noncoverage (HINN/HINN 1)
Appendix A3: HINN Noncovered Continued Stay (HINN 12)
Appendix L2: SFHP Patient List
Appendix L3: Acute Rehab Patient List
Appendix L4: Log of PMA Admission
Appendix L5: Log of PMR Admission
Appendix L6: Anthem Blue Cross Medi-Cal Managed Care
Appendix L7: Other Payor List
Appendix L8: Utilization Review Daily Analysis
Appendix L9: Medi-Cal SNF Log
Appendix M1: SNF Advance Beneficiary Notice of Non-coverage (SNFABN)
Appendix M2a: Benefit Exhaust Letter
Appendix M2b: No Qualifying 3-day Inpatient Hospital Stay
Appendix M3: SNF Physician Certification
Appendix M4A: Notice of Medicare Non-Coverage (NOMNC)
Appendix M4B: The Detailed Notice (Detailed Explanation of Non-Coverage)
Appendix M5: Medicare Information Summary
Appendix M6: Medicare Part A SNF List
Appendix M7: Skilled Nursing Facility Reinstatement
Appendix M8: Delayed Physician Certification

REFERENCE:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c04.pdf
LHHPP 55-02 Processing of Long Term Care TARs
LHHPP 55-03 PASRR

Revised: 11/21/19, 05/08/18, 08/04/17, 10/08/19, 11/09/27, 14/01/28, 14/03/25, 14/07/29, 16/11/08, 20/01/14, 21/04/19, 21/09/14 (Year/Month/Day)
Original Adoption: Est. 1993

HEARING CONSERVATION PROGRAM

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and healthy workplace for all employees.

PURPOSE:

1. To implement procedures for the prevention of noise-induced hearing loss in LHH employees.

2. To comply with the Division of Occupational Safety and Health (Cal/OSHA) standards for the control of occupational noise exposure.

PROCEDURE:

1. Noise Monitoring

   a. Identification of Noise Sources

   The kitchen, (particularly the dish room and tray line area) and the boiler room have been identified as locations where equipment and processes generate a significant amount of noise. Measurements with a sound level meter in these areas have demonstrated that, depending on the amount of time spent in these areas, employees could have time weighted average exposures that exceed the Cal/OSHA regulations- action level90 decibels on the 'A' scale (dBA) permissible exposure limit and of 85 dBA action level.

   b. Personal Dosimetry

   Personal dosimetry has been conducted on representative employees working in the kitchen and the boiler room. Time weighted average noise exposures that were measured are presented in the table below.

Job	8Hr TWA Noise Exposure (dB) in 2017	Sound Level Monitoring (dB) in 2023
Dish Unloader	91	91.5
Dish Loader	86	88.4
Cook (grill)	82	81.8
Cook (steam kettles)	76	76.2
Cold Food Station	72	80.2
Nourishment Delivery	67	N/A
Night Watch Engineer	65	N/A

Based on the monitoring results from 2017, all Nutrition Services Department staff were placed into the Hearing Conservation Program and Facility Services Engineers were not. Based on the monitoring results from 2023, and the fact that Nutrition Services staff are rotated with a maximum of 2 hours at each station, 8-hour TWA noise exposures will be below 85 dB, therefore we removed the Nutrition Services Department from the Hearing Conservation Program. All staff, however, are ~~Based on the monitoring results, the fact that Food Services Workers rotate jobs, and the fact all staff in the Nutrition Services Department move freely around the kitchen through noisy areas, all Nutrition Services staff shall be included in the LHH Hearing Conservation Program. Facility Services Engineers are not anticipated to have exposures that exceed the Cal/OSHA action level, so are not included in the Hearing Conservation Program. They are, however,~~ provided with hearing protection and encouraged to wear it when working in loud environments and/or operating ~~that is available to be worn voluntarily in the boiler room or when operating~~ loud equipme~~nt~~t ~~such as power tools or landscaping equipment~~.

c. Ongoing noise monitoring

Additional noise monitoring shall be conducted any time a new source of noise is introduced into the facility or when there is reason to believe that the noise exposure of an individual or job classification might exceed the Cal/OSHA action level of 85dB. Any employee who has a concern about their noise exposure at work should contact the Department of Workplace Safety and Emergency Management for an evaluation.

2. ~~Audiometric Testing~~

. ~~All employees included in this program shall be provided with audiometric testing on initial hire and annually. This testing shall be provided by the Zuckerberg San Francisco General Hospital (ZSFG) Occupational Health Service (OHS) during work hours on the LHH campus.~~

. ~~Employees shall be informed of the need to avoid high levels of noise for 14 hour prior to their test. This may require use of hearing protection at work on the day of the test.~~

. ~~Audiograms shall be evaluated by the ZSFG OHS audiologist, who shall determine whether there has been a standard threshold shift. IN determining whether or not there has been a standard threshold shift, the audiologist shall use the age correction procedure in Appendix F of the Cal/OSHA Occupational Noise Standard.~~

. ~~If an employee experiences a standard threshold shift:~~

.   ~~The audiologist shall notify the employee and the Director of Workplace Safety and Emergency Management in writing within 21 days of the determination.~~

.   ~~The test may be repeated if there is reason to believe that there was noise exposure during the 14 hours prior to the test.~~

.   ~~The employee may be referred for clinical evaluation.~~

~~18.~~2. Noise Exposure Control

a. The primary sources of noise in the kitchen are the china plates, the dish machine, the tray line, and the exhaust hoods over the steam kettles and grill area. Engineering controls such as sound dampening insulation are not feasible in the kitchen due to the need for sanitation of all surfaces.

b. Administrative controls that have been implemented include the rotation of Food Service workers through different assignments in the tray line and dish room areas, and some rotation of Cooks through various assignments in the production kitchen. Administrative controls for Facility Services workers include signs to warn of high noise levels, and rotation of staff through different parts of our campus. Some employees, however, still spend much of their time in noisy areas.

c. Hearing protection is available to all Nutrition and Facility Services employees to further reduce their noise exposure.

~~19.~~3. Hearing Protection

a. Hearing protection is required for:

i.   Work in the dish room;
Work with operation of loud equipment;
ii.
~~ii.~~iii.   Employees who have experienced a standard threshold shift.

b. Hearing protection is recommended during any work in the kitchen or grill area of the cafeteria, including supervisory work.

c. Two different brands of ear plug and one type of ear muff are available to employees in the Nutrition and Facility Services Departments for hearing protection.

i.   Ear plugs are available out on the work floor for easy access during the work shift.
ii. Ear muffs are provided to individuals who choose to use them. Ear muffs shall be kept in the employee's locker when the employee is not working.

d. Proper use of hearing protective devices (HPDs)

i. Ear Plugs

- With clean hands, hold earplug between thumb and forefinger.

- Roll and progressively compress the entire tapered end of the earplug to a small crease-free cylinder.

- Reach opposite hand over head and gently pull ear upward and outward to open the ear canal.

- When properly inserted, as much of the ear plug as possible should be inside the ear canal for maximum effectiveness.
- Allow ear plug to expand. The end of the ear plug should not be protruding into the outer ear

ii. Ear muffs

- Unfold ear muff and place headband on head.

- Adjust cups up and down until ear is completely inside cup.
- Use of eyeglasses interferes with the seal of the ear muff. Special eyeglasses or contacts must be worn by users requiring both ear muffs and eyeglasses.

20.4. Training

a. All employees included in the Noise Conservation Programthis program shall receive training on initial assignment to a job with noise exposure. The training shall include the following topics:

i. The effects of noise on hearing.;

ii. The purpose of HPDs and when they must be used.;

iii. The advantages and disadvantages of the various types of HPDs and instructions on selection, fitting, use, and care.;

iv. The purpose of audiometric testing and an explanation of the test procedures..

21.5. Recordkeeping

a. For workers with present or past enrollment in our Hearing Conservation Program, their rRecords of audiometric tests and audiometric test rooms shall be maintained by the ZSFG OHS for the duration of their employment of each affected employee.

  b. Records of noise exposure measurement shall be maintained by the Department of Workplace Safety and Emergency Management for a minimum of two years.

  b.c.   Records of training shall be maintained by the LHH Senior Industrial Hygienist for a minimum of 2 years.

  c.d.   Records shall be made available to employees, former employees, any representative designated by an employee, or to Cal/OSHA on request.

ATTACHMENT:
None

REFERENCE:
73-01 Laguna Honda Injury and Illness Prevention Program
CCR Title 8 Subchapter 7, Group 15 Article 105 Sections 5095-5100

<OSHA 29 CFR 1910.95 is the federal standard, intentionally omitted>
Revised: 17/03/14 (Year/Month/Day)
Original adoption: 12/09/25

RESPIRATORY PROTECTION PROGRAM (RPP)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHHaguna Honda) is committed to the protection of employees from workplace hazards by eliminating and/or minimizing hazards with the use of engineering and administrative controls. If engineering and administrative controls are not feasible, or available or capable of to completely eliminatinge hazards posed by airborne contaminants in the workplace, employees will be provided appropriate respiratory protective equipment.

PURPOSE:

The Respiratory Protection Program (RPP) is established to protect employees from potentially hazardous airborne contaminants during the performance of their duties, and to ensure respirator wearers are adequately trained and equipped to safely select, use and maintain respiratory protective equipment.

PROCEDURE:

1. Program Scope

This RPP applies to LHH employees who are required to use respiratory protection on a regular basis and those who may be required to use respiratory protection in the event of a disease outbreak or other emergencyies. Departments at LHH that areJob classifications that are included in the RPP are listed in Appendix A. This RPP also applies to With the exception of Registry Nursing staff and volunteers who are not LHH employees. It does not typically apply , this RPP does not apply to administrative and other departments that do not interact with residents, nor with some contractors, students, volunteers, or other non-LHH staff on site, who are not employees of Laguna Honda, such as Sheriffs and building tenantsresidentsalthough specific decisions may be made for each of these groups on a case-by-case basis.

In some circumstances, Laguna Honda staff may not be required to wear respiratory protection to comply with SFDPH policies, Cal OSHA standards, or CDC Guidelines, but may choose to wear a respirator for an additional level of protection. Such voluntary use is allowed for employees who are otherwise included in the RPP, and have been medically cleared and trained to use a respirator provided by the facility. These employees will be provided with the information provided in Appendix D of the Cal-OSHA Respiratory Protection Standard Title 8, Section 5144 (Appendix B of this document).

An employee who is not covered by this RPP and would like to use a respirator must contact the Department of Workplace Safety and Emergency Management (WSEM) department to be included in the RPP. Employees who are not included in the RPP,

such that they have not been medically cleared and trained, shall not don a respirator while working at the facility.

The following employees who are performing the following tasks may either be required, or may choose to wear respirators and will be included in the RPP:

a. Employees who are directly involved in any of the following resident care activities

    i. Functioning in an airborne infection isolation room (AIIR) with the presence of airborne infectious disease.

    ii. Performing routine tasks in close proximity to residents with a known or suspected infectious disease that can be transmitted via droplet or airborne routes (meeting the definition of aerosol transmissible disease (ATD) according to Title 8 CCR Section 5199).

    iii. Performing high hazard procedures on residents with a known or suspected ATD.

    iv. Performing surge capacity functions with potential exposure to an ATD.

b. Facility Services employees involved in the following activities:

    i. Functioning in an airborne infection isolation room (AIIR) ~~airborne isolation room~~ with the presence of an ATD.

    ii. Performing maintenance work that could result in exposure to an ATD.

    iii. Performing maintenance work that could result in exposure to other airborne contaminants such as hazardous dusts (including lead based paint), mists, oils, gases, and vapors.

    iv. Performing Class III asbestos spill cleanup or other work that may cause the disturbance of Asbestos Containing Material (ACM) or Presumed Asbestos Containing Material (PACM).

    v. Responding to spills or releases of hazardous materials.

c. Pharmacy Technicians

    i. Cleaning up spills of hazardous drugs

    ii. Using bleach to clean compounding areas in the pharmacy.

   d. Other Support Services Employees (Including Environmental Services)

      i. Functioning in an airborne isolation room with the presence of infectious disease agents.

      ii. Performing routine tasks in close proximity to residents with known or suspected ATDs.

      iii. Performing routine tasks during which there is exposure to airborne contaminants below permissible exposure limits, which the employee chooses to reduce further with the voluntary use of a respirator.

   e. WSEM Staff

      i. Functioning in an airborne isolation room with the presence of infectious disease agents.

      ii. Performing routine tasks in close proximity to residents with known or suspected ATDs.

      iii. Monitoring maintenance work that could result in exposure to infectious disease agents.

      iv. Monitoring the work of asbestos abatement contractors.

      v. Monitoring Class III asbestos spill cleanup or other work that may cause the disturbance of Asbestos Containing Material (ACM) or Potential Asbestos Containing Material (PACM).

      vi. Monitoring the removal of lead based paint or other procedures that may cause exposure of facility services employees to airborne contaminants.

      vii. Responding to spills or releases of known hazardous materials.

- During periods of ATD epidemics, such as Covid-19, all LHH staff (including all registry nurses) that potentially are in contact with our residents are to be included in the RPP, assigned an N-95 respirator, and may be required to wear it for any of the above functions.f.

2. Program Objectives

Laguna Honda is committed to providing a safe and healthy work environment for all employees and recognizes that respiratory protective equipment has limitations and that the success of such equipment is dependent on an effective respiratory protection program. The objectives of this RPP include:

a. Adherence to the requirements of both the Federal Respiratory Protection Standard 29CFR1910.134 and the Cal-OSHA Respiratory Protection Standard Title 8, Section 5144, Section 5199 Aerosol Transmissible Diseases, 1529 Asbestos, and Section 1532.1 Lead..

b. Designation of an appropriate RPP Administrator to oversee and implement this program.

c. Providing a detailed outline of procedures to:

   i. Select appropriate respiratory protective equipment,
   ii. Medically evaluate employees,
   ii.
   iii. Train and fit test employees,
   iv. Provide appropriate record keeping and program evaluation.

3. Program Administrator

The Laguna Honda Senior Industrial Hygienist or designee shall be the RPP Administrator and will be responsible for implementation and review of the program.

4. Respiratory Protective Equipment Selection

Table 1. Tasks Requiring Respirator Use and Selected Respirators

Employee Group	Task or Duty	Selected Respirator	Comments
Resident Care Providers and Support Staff	Performing routine patient care, cleaning, or maintenance tasks in AIIRs airborne infection isolation rooms or in the presence of residents with known or suspected ATD.	N95 Filtering Facepiece Respirator	Employees are required to wear at least an N95 respirator for protection from ATDs transmissible via the airborne route (AirIDs). LHH employees may choose to use an N95 respirator for protection against ATDs categorized as transmissible via droplets.
Resident Care Providers Facility Services Staff	Performing high hazard procedures as defined in the ATD Exposure Control Plan. Performing routine tasks resulting in exposure to nuisance dusts below permissible exposure levels limits	Powered Air Purifying Respirator (PAPR) with HEPA filters Filtering Facepiece Respirator	No one except the care providers performing the procedure should be present. This use is voluntary
Facility Services Staff Resident Care Providers	Performing work that could result in exposure to hazardous levels of airborne contaminants. Performing high hazard procedures	Half mask respirator or PAPR with the following cartridges: HEPA filters (P100) for Class III asbestos work;	Respirator use is required for Class III Asbestos work. Any employee doing Class III asbestos work who cannot be fit tested for a negative

	~~as defined in the ATD Exposure Control Plan.~~	Organic vapor cartridges for exposure to paint, solvents, oils, greases; Combination organic vapor/dust cartridge for spray painting.~~Powered Air Purifying Respirator (PAPR) with HEPA filters~~	pressure respirator must wear a PAPR. Other repair and maintenance work is not expected to result in exposures exceeding any Cal OSHA permissible exposure limits and the use of any respirator for these tasks is voluntary.~~No one except the care providers performing the procedure should be present.~~
EVS Floor Crew~~Facility Services Staff~~	Stripping and waxing floors.~~Performing work that could result in exposure to hazardous airborne contaminants.~~	Half mask respirator with organic vapor or combination organic vapor/acid gas cartridge.~~Half mask respirator or PAPR with the following cartridges: HEPA filters (P100) for Cclass III asbestos work; Organic vapor cartridges for exposure to paint, solvents, oils, greases; Combination organic vapor/dust cartridge for spray painting.~~	Respirator required if airborne contaminants are at hazardous levels, otherwise voluntary.~~Respirator use is required for Class III Asbestos work. Any employee doing Class III asbestos work who cannot be fit tested for a negative pressure respirator must wear a PAPR. Other repair and maintenance work is not expected to result in exposures exceeding any Cal OSHA permissible exposure limits and the use of respirators for these tasks is voluntary.~~
Industrial Hygienist, Senior Industrial Hygienist~~EVS Floor Crew~~	Monitoring LHH employee or contractor activities in areas where respirator use is required.~~Stripping and waxing floors~~	Use the same respirator as that required by the monitored LHH employee.~~Half mask respirator with organic vapor or combination organic vapor/acid gas cartridge~~	~~This use is voluntary~~
Facility Services Staff, Pharmacy Techs, and Senior Industrial Hygienist~~Industrial Hygienist, Senior Industrial Hygienist~~	Spill response~~Monitoring LHH employee or contractor activities in areas where respirator use is required~~	Half face respirator or PAPR with appropriate cartridge for spilled material.~~N95 filtering facepiece. Half face respirator with appropriate cartridges.~~	Certain designated LHH employees may respond to small chemical spills of known materials that are not expected to result in an oxygen deficiency or exposures greater than 10 times the PEL for any substance. No LHH employee will enter an IDLH atmosphere or attempt to

			~~respond to a spill or release of an unknown material.~~
~~Facility Services Staff, Pharmacy Techs, and Senior Industrial Hygienist~~	~~Spill response~~	~~Half face respirator or PAPR with appropriate cartridge for spilled material.~~	~~Certain designated LHH employees may respond to small chemical spills of known materials that are not expected to result in an oxygen deficiency or exposures greater than 10 times the PEL for any substance.~~ ~~No LHH employee will enter an IDLH atmosphere or attempt to respond to a spill or release of an unknown material.~~

- The use of powered air purifying respirators (PAPR) may be restricted during periods of ATD epidemics, such as Covid-19. In such cases, an N95 respirator shall be substituted for each PAPR.

The respiratory protection equipment selection process is based on:

a. A review of work procedures.

b. Potential airborne contaminants and concentrations.

c. Cal-OSHA substance-specific respirator requirements.

d. Only respirators certified by the National Institute for Occupational Safety and Health (NIOSH) will be used.

5. Medical Evaluations

Laguna Honda employees included in the RPP shall complete a medical evaluation prior to fit testing and equipment use to ensure they are able to perform work tasks while using a respirator. Medical evaluations shall be provided at no cost to the employee. An employee has the right to use his or her own personal physician in lieu of the designated Physician or other licensed health care provider (PLHCP)

a. Initial Medical Clearance Evaluations

Initial medical evaluation includes:

i. All new Laguna Honda employees shall be medically evaluated for clearance to use respiratory protection during their pre-employment exam at the

Zuckerberg San Francisco General Hospital (ZSFG) Occupational Health Service (OHS) using responses to questionnaires required by Cal OSHA.

- Employees in non-resident care classifications shall be evaluated using the RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE found in Appendix C.

- Resident care job classifications shall be evaluated using the ALTERNATE RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE: found in Appendix C.

ii. The PLHCP at the ZSFG OHS shall complete the Medical Clearance Certificate (Appendix D) and forward it to the Laguna Honda Senior Industrial Hygienist or designee.

iii. If an employee is not cleared for the use of a particular type of respirator, they must not be assigned to tasks that require the use of that respirator. However, if an employee is cleared to use a PAPR, but not a negative pressure respirator, they may perform tasks requiring a negative pressure respirator if provided with a PAPR (PAPR use may be restricted during periods of ATD epidemics, such as Covid-19).

b. Subsequent Medical Evaluations

Subsequent medical examinations shall be provided to an employee under the following circumstances:

i.   The PLHCP determines that an evaluation is needed.

i.ii. Employee reports medical signs/symptoms or a medical condition to a Supervisor that are related to his or her ability to use a respirator.

iii. Information from the RPP, including observations made during the fit testing or the program evaluation, which indicates the need for employee medical re-evaluation.

ii.

iv. The PLHCP determines that an evaluation is needed. It is DPH policy that this will include a re-evaluation every 5 years.

vi.iv. The employee requests re-evaluation due to a change in health status.

6. Training

Employees included in the RPP due to being in a departmentjob classification listed in Appendix A shall complete an initial training on respiratory protection before being

assigned to a task requiring the use of a respirator. The initial training ~~that~~ will consist of both c~~be completed during departmental orientation will be broken into two parts. Part I~~Conceptual training and hands-on training~~ ~~will be~~ delivered live, ~~or~~ on the e-Learning system, or ~~and the other~~practical training will be ~~delivered via hands-on training~~ during fit testing. These users shall also receive annual training, delivered via either of the same mediums.

a. ~~Part I~~ **Conceptual training** shall ~~include:~~

    i. The requirements of the RPP and information on where to find the written program.

    ii. Potential airborne hazards and health consequences resulting from exposures.

    iii. Why ~~and~~, when, and where respirator use is required

    ~~iii.~~iv. R ~~and the r~~isks and limitations of respirator use.

    ~~iv.~~v. Procedures for equipment cleaning, inspections, maintenance and storage.

    ~~v.~~vi. How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.

b. The **practical** **hands-on training shall** include:

    i. How to inspect the respirator.

    ii. How to don and doff the respirator.

    iii. How to perform positive and negative pressure seal checks.

7. **Fit Testing**

    a. Employees shall only be fit tested if they have been medically cleared for respirator use prior to the fit test. If they are not cleared for respirator use, they must not be assigned to tasks that require respirator use.

    b. Employees who are required to regularly wear a respirator shall be fit tested annually by WSEM or other staff trained by WSEM. New employees shall not be assigned to tasks requiring the use of a respirator until they have been fit tested.

    ~~b.~~c.   Loose fitting PAPR does not require a fit test but does require documented training regarding use.~~.~~

    ~~c.~~d.   In addition to annual fit testing, employees shall be re-fit tested if any of the following occurs:

     i.   Different respiratory protective equipment is introduced.

    ii.   The employee reports an improper fit.

   iii.   There is a significant change in the size or shape of an employee's face.

 iii.iv.   Per provider request.

d.e.   Employees who do not regularly wear respirators, but who may be required to wear one during an emergency or surge shall be fit tested as needed prior to wearing the respirator.

e.f. In accordance with Cal-OSHA, fit testing for a negative pressure respirator shall not be performed on any employee who has facial hair (including stubble, beard, mustache, sideburns) that interferes with the face to facepiece seal of the respirator. OSHA Compliance Directive CPL 2.120 defines the presence of facial hair to be "more than one day's growth".

f.g. Quantitative fit testing using a TSI PortaCount Pro or qualitative fit testing using Bitrex or Saccharin will be performed according to the protocols in Appendix A of Title 8 CCR Section 5144. If an employee objects to qualitative fit testing, or does not respond favorably to that protocol, then quantitative fit testing shall be offered using a TSI PortaCount instrument.

g.h.   Employees shall be given the opportunity to choose from several brands and sizes of respirators.

h.i.   Qualitative fFit test results shall be documented on the Fit Test Certificate found in Appendix E. Quantitative fit test results shall be documented on a similar form, generated from the TSI PortaCount instrument. Physical copies of these records shall be stored in the fit test clinic for one year. These records shall also be sent to the DPH OSH Respiratory Protection Database, where it is stored in accordance with the DPH Privacy Policy and Title 8 CCR Section 3204, for the duration of employment plus 30 years.

j.   The Industrial Hygienist or designee shall maintain a list of employees who have been fit tested within the last year showing the make and size of respirator for which they have passed the fit test. The list shall be updated at least quarterly and sent to Department Managers whose employees are required to use respirators.

8. Respiratory Protective Equipment Use

a. Requirements for Use

i. Employees must be medically cleared, trained and fit tested before using any required ~~respiratory protective equipment~~filtering facepiece (e.g. N95), any air purifying respirator (APR) (e.g. ½ face APR, full face APR, tight fitting PAPR) or any self-contained breathing apparatus (SCBA).

Employees must be medically cleared and trained before using any required loose-fitting PAPR.

ii. Employees are required to use the same make, model, style and size respirator for which they have passed during their ~~been~~ fit test~~ed~~.

iii. Employees are prohibited from using respiratory protective equipment if they have any condition that will prevent an effective seal (e.g. facial hair, extensive scarring, etc.).

b. Procedures Before and During Use

i. Employees must inspect equipment for integrity before use.

ii. Employees must perform user seal checks prior to use.

iii. Employees using tight-fitting PAPR units must perform an airflow test prior to each use.

iv. Corrective eyewear and other ~~personal protective equipment~~ necessary headwear (hair net, hard hat, etc.) must be worn in a manner that does not interfere with the respirator seal.

v. An employee must exit the work area to a designated safe zone if:

- Respiratory protective equipment malfunctions or becomes damaged.

- They experience an increase in breathing resistance.

- They detect chemical cartridge breakthrough.

9. Storage, Maintenance, And Disposal

a. Storage

i. N95 filtering facepiece respirators for use in patient care and cleaning of isolation rooms will be available from Central Supply and will be stored in the ante rooms or PPE carts ~~of~~ outside the isolation rooms when occupied by a resident with suspected or confirmed ATD. They may also be stored at the nurses' station or equipment room in each of the units.

ii. Facility Services, EVS, WSEM, and Pharmacy employees who ~~will be~~ are required to wear reusable air purifying respirators will be issued their own ~~half face~~ elastomeric respirator and related cartridges (filters), which they will store in accordance with manufacturer's instructions, and in a manner that protects from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals. ~~a plastic bag in their locker or work area.~~

iii. PAPRs may be stored in isolation room ante rooms (unless restricted during periods of ATD epidemics, such as Covid-19), the Facility Services Department, and the Industrial Hygienist's Office.

b. Maintenance, Cleaning and Disposal

i. Half-~~-~~face and full-face elastomeric respirators

- Elastomeric respirators will be inspected before and after each use to ensure all parts are working and have not been damaged. Damaged respirators will either be repaired or replaced by WSEM.

- Employees who have been issued their own elastomeric facepiece will be responsible for cleaning the respirator with a disinfectant wipe or mild soap and water after each use. Respirators will be air dried and returned to a ~~zip lock~~resealable plastic bag for storage.

- After use, cartridges will be placed in resealable plastic bag ~~zip-lock bags~~.

  - Chemical cartridges will be exchanged according to the manufacturer's change schedule. A cartridge may be replaced if it ~~replaced if they~~ becomes damaged, has passed its expiration date, or when the wearer perceives breakthrough of the contaminant.

  - Filter cartridges will be replaced when the wearer notices an increased resistance to breathing.

ii. N95 filtering facepieces

- N95s are designed for single use and will be discarded ~~<need to state where discarded?>~~ when used as source control and removed at the conclusion of a shift or after exposure to a confirmed or suspected case of ATD. ~~Re-use~~Extended use of respirators will only be permitted when used for source control.~~in the event of a shortage during a disease outbreak as per the ATD Exposure Control Plan~~ Please see COVID-19 Mitigation plan for additional guidance .

- N95s that are used voluntarily ~~or~~ for non-infectious dusts may be re-used for the duration of a single shift~~as long as they are not damaged~~.

iii. PAPRs (both loose and tight-fitting models)

- PAPRs will be maintained fully charged in their storage locations so that they are ready for use.

- Air flow will be checked before and after use of PAPRs.

- Filter cartridges on PAPRs will be changed when they are damaged or when air flow drops below 6 cubic feet per minute (CFM). Chemical cartridges will be exchanged according to the manufacturer's change schedule, or replaced if it becomes damaged, has passed its expiration date, or when the wearer perceives breakthrough of the contaminant.

- PAPR blowers will be cleaned by the user with disinfectant wipes after each use, according to manufacturer's instructions. PAPR hoods will be discarded after use in atmospheres contaminated with asbestos or an ATD.
- PAPR use may be restricted during periods of ATD epidemics, such as Covid-19.

10. Program Review

The Senior Industrial Hygienist or designee shall perform annual evaluations to ensure effectiveness of thisthe provisions of this program, in accordance with Title 8 CCR Section 5144 are being implemented. These evaluations will include:

a. Interviews of employees using respiratory protective equipment.

b. Observations of employees using equipment.

c. Investigation of environments in which equipment is used.

d. Review of stored fit test all records.

11. Record Keeping

a. Written Program

The Industrial Hygienist or designee shall maintain a hard copy of the written RPP and records of program evaluations. An electronic copy will be available on the LHH intranet web site.

b. Medical Clearance Records

i. Confidential records, including medical clearance questionnaires, will be kept in the employees' employee health medical files in accordance with the DPH

Privacy Policy and Title 8 CCR Section 3204 for the duration of employment plus 30 years.

iii.   Medical Clearance Certificates will be entered into the DPH OSH Respiratory Protection Database by WSEM or designee. Hard copies will be kept on file in the WSEM office

c. Training Records

Training records shall be maintained by the Department of Education and Training and Education on the eLearning system. WSEM or designee shall enter the training records into the DPH OSH Respiratory Protection Database, where it is maintained for the duration of employment plus 5 years.

d. Fit test Records

Fit test records shall be entered into the DPH OSH Respiratory Protection Database by WSEM or designee, where they are stored for the duration of employment plus 30 years. Hard copies shall be kept on file in the WSEM office, where they are stored for one yearuntil the next fit test.

ATTACHMENT:
Appendix A: Departments Job Classifications Included in the LHH RPP
Appendix B: Information for Employees Using Respirators When Not Required Under the Standard
Appendix C: Medical Questionnaires
Appendix D: Medical Clearance Certificate
Appendix E: Fit Test Certificate

REFERENCES:
United States Federal Respiratory Protection Standard 29CFR 1910.134
Cal-OSHA Aerosol Transmissible Disease Standard, 8 CCR Section 5199
Cal-OSHA Asbestos Standard, 8 CCR Section 1529
Cal-OSHA Lead Standard, 8 CCR Section 1532.1
Cal-OSHA Respiratory Protection, 8 CCR Section 5144
Cal-OSHA Respiratory Protection Standard, 8 CCR Section 5144

Revised: 23/04/2716/07/12 (Year/Month/Day)
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APPENDIX A

Departments~~Job Classifications~~ iIncluded in the LHH RPP

It is mandatory for all LHH staff that interact directly with residents to be included in the LHH RPP. This includes annual respirator fit testing and always wearing of an assigned respirator when interacting with residents. Departments in this category include:

Activity Therapy
Admissions & Eligibility
Beauticians
Clinical Informatics
Clinical Support Services
Contact Investigation Team
Contractors
Dietitians
Environmental Services
Food Nutrition Services
Facility Services
Health at Home
Infection Prevention & Control
Laguna Premier Club

Material Management
Medical Services
Nursing Administration
All Nursing Departments
Outpatient Clinical Services
Pharmacy
Psychiatry
Rehab Services
Social Services
Sheriff
Utilization Management
Worker Safety and Emergency
 Management

Departments not included in the LHH RPP

Accounting
Administrative Staff
Centralized Call Center
Information Systems
Information Technology Procurement

Office of Managed Care
Patient Financial Services
Payroll
Quality Management

Although it is not mandatory for all members in the above departments to be included in the LHH RPP, it is mandatory for those members whose roles require frequent interaction with residents (ie. Managers who conduct rounding exercises, select staff who deliver services and/or supplies on medical care floors, etc.).

2230	Physician Specialist	2922	Sr Medical Social Worker
2232	Senior Physician Specialist	2924	Medical Social Work Supv
2302	Nursing Assistant	2930	Psychiatric Social Worker
2303	Patient Care Assistant	3417	Gardener
2305	Psychiatric Technician	6138	Industrial Hygienist
2312	Licensed Vocational Nurse	6139	Senior Industrial Hygienist
2320	Registered Nurse	7120	Buildings/Grounds Maint Supv
2322	Nurse Manager	7203	Buildings/Grounds Maint Supv
2323	Clinical Nurse Specialist	7205	Chief Stationary Engineer
2324	Nursing Supervisor	7334	Stationary Engineer
2390	CPD Technician	7335	Sr Stationary Engineer
2406	Pharmacy Helper	7342	Locksmith
2409	Pharmacy Technician	7344	Carpenter
2424	X-Ray Laboratory Aide	7345	Electrician
2430	Medical Evaluations Assistant	7346	Painter
2450	Pharmacist	7347	Plumber
2454	Clinical Pharmacist	7524	Institution Utility Worker
2468	Diagnostic Imaging Tech II	P103	Special Nurse
2469	Diagnostic Imaging Tech III		
2536	Respiratory Care Practitioner		
2542	Speech Pathologist		
2548	Occupational Therapist		
2550	Sr Occupational Therapist		
2554	Therapy Aide		
2555	Physical Therapist Assistant		
2556	Physical Therapist		
2558	Senior Physical Therapist		
2574	Clinical Psychologist		
2576	Supv Clinical Psychologist		
2583	Home Health Aide		
2585	Health Worker I		
2587	Health Worker III		
2588	Health Worker IV		
2593	Health Program Coordinator III		
2622	Dietetic Technician		
2624	Dietitian		
2626	Chief Dietitian		
2736	Porter		
2738	Porter Assistant Supervisor		
2738	Porter Supervisor 1		
2785	Assistant General Svcs Mgr		
2903	Eligibility Worker		
2908	Hospital Eligibility Worker		
2909	Hospital Eligibility Supervisor		
2920	Medical Social Worker		

APPENDIX B:

Information for Employees Using Respirators When Not Required Under the Standard

4/20/2016   California Code of Regulations, Title 8, § 5144D to Section 5144: (Mandatory) Information for Employees Using Respirators When Not Required Under th...

This information is provided free of charge by the Department of Industrial Relations from its web site at www.dir.ca.gov. These regulations are for the convenience of the user and no representation or warranty is made that the information is current or accurate. See full disclaimer at http://www.dir.ca.gov/od_pub/disclaimer.html.

Subchapter 7. General Industry Safety Orders
Group 16. Control of Hazardous Substances
Article 107. Dusts, Fumes, Mists, Vapors and Gases
§5144. Respiratory Protection.

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Appendix D to Section 5144: (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Guide to Respiratory Protection at Work

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.

2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.

3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designated to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors or very small solid particles of fumes or smoke.

4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

https://www.dir.ca.gov/title8/5144d.html   1/2

APPENDIX C

MEDICAL QUESTIONNAIRES

Department of Public Health
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE: LHH
(As per Appendix C to § 5144; California Code of Regulations Title 8)

Can you read?   **Yes** ☐   **No** ☐

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. SECTION 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's Date _____

2. Your Name: _____ DSW: _____

3. Your age (to nearest year): _____ Date of Birth: _____

4. Sex (circle one)   **Male** / **Female**

5. Your height _____ft. _____in.

6. Your weight _____lbs.

7. Your job title: _____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire.

    (____) - _____ - _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire?   Yes ☐   No ☐

11. Check the type of respirator you will use (you can check more than one category):

a. __X___ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. __X___Other type (for example, half-or full-facepiece type, powered-air purifying, supplied air, self-contained breathing apparatus).

12. Have you worn a respirator?   Yes ☐   No ☐

13. If "yes", what type(s)? _____

PART A. SECTION 2. Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no" to answer each question).

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?
   Yes ☐   No ☐

2. Have you ever had any of the following conditions?

	YES	NO
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

3. Have you *ever* had any of the following pulmonary or lung problems?

	YES	NO
a. Asbestosis		
b. Asthma		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. Any other lung problems that you've been told about		

4. Do you *currently* have any of the following symptoms of pulmonary or lung illnesses?

	YES	NO
a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
Shortness of breath when walking with other people at an ordinary pace on level ground		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself		
f. Shortness of breath that interferes with your job		
g. Coughing that produces phlegm (thick sputum)		
h. Coughing that wakes you early in the morning		
i. Coughing that occurs mostly when you are lying down		
j. Coughing up blood in the last month		
k. Wheezing		
l. Wheezing that interferes with your job		
m. Chest pain when you breathe deeply		
n. Any other symptoms that you think may be related to lung problems		

5. Have you *ever* had any of the following cardiovascular or heart problems?

	YES	NO
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. Any other problems that you've been told about		

6. Have you *ever* had any of the following cardiovascular or heart symptoms?

	YES	NO
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. Any other symptoms that you think may be related to heart or circulation problems		

7. Do you *currently* take medication for any of the following problems?

	YES	NO
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		
e. Other medical condition(s) please describe: _____		

8. If you've <u>ever</u> used a respirator, have you *ever* had any of the following problems?

(If you've <u>never</u> used a respirator, check the following space… ☐… and go to question 9).

	YES	NO
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problems that interferes with your use of a respirator		

9. Would you like to talk to the health professional who will review this questionnaire?
    Yes ☐   No ☐

Department of Public Health
ALTERNATE RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE: LHH
(As per Appendix B to § 5199; California Code of Regulations Title 8)

To the PLHCP: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employees must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the employee: Can you read and understand this questionnaire (circle one):   Yes   No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: _____

Name: _____DSW: _____

Job Title: _____

Your age (to nearest year): _____

Sex (circle one):   Male   Female

Height: _____ ft. _____ in. **Weight**: _____ lbs.

Phone number where you can be reached (include the Area Code):   ( )_____

The best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one):   Yes   No

Check the type of respirator you will use (you can check more than one category):
 __X__ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 __X__ Other type (ex, half- or full-facepiece type, PAPR, supplied-air, SCBA**). (fill in type here)** _____**PAPR**_____

Have you worn a respirator (circle one):   Yes   No

If "yes," what type(s): _____

Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Have you ever had any of the following conditions?

	Yes	No
Allergic reactions that interfere with your breathing		
Claustrophobia – fear of closed in spaces		

2. Do you currently have any of the following symptoms of pulmonary or lung illness?

	Yes	No
Shortness of breath when walking fast on level or walking up a slight hill or incline		
Have to stop for breath when walking at your own pace on level ground		
Shortness of breath that interferes with your job		
Coughing up blood in the last month		
Wheezing that interferes with your job		
Chest pain when you breathe deeply		
Any other symptoms that you think may be related to lung problems		

3. Do you currently have any of the following cardiovascular or heart symptoms?

	Yes	No
Frequent pain or tightness in your chest		
Pain or tightness in your chest during physical activity		
Pain or tightness in your chest that interferes with your job		
Any other symptoms that you think might be related to heart or circulation problems		

4. Do you currently take medication for any of the following problems?

	Yes	No
Breathing or lung problems		
Heart trouble		
Nose, throat or sinuses		

Are your problems under control with these medications?   Yes   No

5. If you've used a respirator, have you ever had any of the following problems while respirator is being used?
   (If you've never used a respirator, check the following space and go to question 6) _____

	Yes	**No**
Skin allergies or rash		
Anxiety		
General weakness or fatigue		
Any other problem that interferes with your use of a respirator		

6. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?   Yes   No

_____   _____
Employee Signature   Date

_____   _____
PLHCP Signature   Date

APPENDIX D

MEDICAL CLEARANCE CERTIFICATE

DPH Medical Clearance Certificate

Human Resources, in conjunction with the supervisor/manager, completes Part 1 of this form. Basic information for all DPH employees who may need to wear respiratory protection for infectious agents in case of an emergency is included. If employees wear other types of respiratory protection, the supervisor/manager must add additional information to the form.

PART 1: To Be Completed By HR & Supervisor / Manager

Employee Name:	Last Name		First Name		DOB:	
Employee Address:					Social Security #	
Supervisor Name:	Last Name		First Name		Phone#:	
Supervisor Address:						

Use This Key to Specify Employee Respirator Type(s) & Working Conditions		
Respirator Types	Facepiece Filtering (N95/100) Respirator Half Mask Air Purifying Respirator Full Face Air Purifying Respirator	Powered Air Purifying Respirator (PAPR) Self Contained Breathing Apparatus (SCBA)
Duration	8 to 12 hours 4 to 8 hours	1 to 4 hours Less than 1 hour
Use Frequency	Regularly (daily) Frequently (few times / week) Occasionally (few times / month) Rarely (few times / year) No Regular Use – Special Circumstances Only for Protection Against Infectious Agents	
Work Effort Level	Light (ex: sitting / standing, performing light arm work) Moderate (ex: walking, moderate lifting) Heavy (ex: strenuous work, shoveling)	
Additional Personal Protective Equipment (PPE)	e.g. Gloves/Gowns/Face Shield	
Extremes in Temperature or Humidity	Is the employee working in environments with extreme temperature or humidity?	

Respirator Type(s)	Duration	Frequency of Use	Level of Work Effort	Additional PPE	Extremes in Temperature or Humidity
N95 or PAPR	8 Hrs	No Regular Use	Moderate	Gloves, Gowns, Faceshield	No

Part 2: To Be Completed By Health Care Provider

The named individual is:

☐ Medically qualified to wear the respirator(s) listed above
☐ Medically qualified to wear the respirator(s) listed above with the following restrictions:

_____

☐ Not medically qualified to wear the respirator(s) listed above
☐ Alternate respiratory protective equipment that could be used:

_____

Health Care Provider: NAME/TITLE: _____

Signature: _____

Date of Evaluation: _____   Date for Re-Evaluation: _____

APPENDIX E

FIT TEST CERTIFICATE

Employee Name: _____ Date: _____

DSW:_____ Medical Clearance Date: _____

Respirator Manufacturer _____

Respirator Type _____ Model Number _____ Size _____

Test Results

Activity	Qualitative Test Pass/Fail	Quantitative Test Fit Factor
Normal breathing		
Deep breathing		
Head side to side		
Head up and down		
Talking		
Grimace		
Bending		
Normal Breathing		
Overall Test Score		

Fit Tester: _____   _____
                            Print   Sign

I understand that I have been fitted for the respirator indicated on this form and that I should always wear this make and model of respirator. I have been trained on how to don and doff the respirator and how to perform a seal check each time I wear it.

Employee: _____   _____
                            Print   Sign

Laguna Honda Hospital and Rehabilitation Center

Security Management Plan ~~2020-2021~~2022-2023

I.   PROGRAM OBJECTIVES, INTENT and CORE VALUES

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to residents/patients, staff, and visitors.

It is the overall intent of this plan is to establish the framework, organization, and processes for the development, implementation, maintenance, and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology, and environmental controls.

The objectives of the Security Management program include:
- Continuous review, survey, and auditing of the physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess, and control security risks, and vulnerabilities
- Ensure timely and effective response to security emergencies
- Ensure effective responses to service requests
- Report and investigate security related incidents
- Promote security awareness and education
- Enforce various hospital rules and policies
- Establish and implement critical program elements that safeguard people, equipment, supplies, medications, and control traffic in and around the hospital campus.
- Establish policy and procedures for addressing illicit drugs on the hospital campus.

~~Laguna Honda Hospital and Rehabilitation Center (LHH) is a system of care within the San Francisco Department of Public Health (DPH) and the San Francisco Health Network (SFHN) that is committed to providing a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate. This commitment includes the provision of a physical environment that minimizes the risk of harm to patients/residents, served, staff, volunteers, contractors, and visitors.~~

~~It is the overall intent of this plan is to establish the framework, organization, and processes for the development, implementation, maintenance, and continuous improvement of a comprehensive Security Management Program. This program is designed to provide protection through appropriate staffing, security technology, and environmental controls.~~

~~The objectives of the Security Management program include:~~
- ~~Continuous review of physical conditions, processes, operations, and applicable statistical data to anticipate, discern, assess, and control security risks, and vulnerabilities~~

1 of 15
2020-2021 Security Management Plan
Approved by LHH Campus Safety and Security Committee –
Approved by Executive Committee –
To be Approved by Joint Conference Committee –

II. SCOPE and APPLICATION

The Security Management Plan comprises standards applicable to addressing and facilitating the protection, welfare, safety, and security of the environment. Included is a full range of protective services for persons, property, and assets at the hospital. The Security Management plan requires compliance with all policies and procedures. The management plan calls for best in class customer service for resident/patients, visitors, volunteers, contractors, and staff as well as the protection of property and assets.

The scope of the plan addresses all program elements required to provide a safe and secure environment. Key aspects include:

- Program planning, design, and implementation
- The measurement of outcomes and performance improvement
- Risk identification, analysis, and control
- Reporting and investigating of incidents, accidents, and failures
- Security Awareness, education, and training
- Emergency response
- Addressing legal and criminal matters
- Use and maintenance of equipment, locks, physical barriers, security surveillance systems, alarms, etc.
- Security of medications
- Traffic control
- Security of sensitive areas
- Visitors Screening and Property Searches

- Addressing legal and criminal matters
- Use and maintenance of equipment, locks, physical barriers, CCTV systems, alarms, etc.
- Security of medications;
- Traffic control
- Security of sensitive areas

III.   AUTHORITY

The SF Health Network provides the program's vision, leadership, and support. The Director of Health appoints a Director of Security who is responsible for the oversight of security program development, and implementation. The Director of Security reports directly to the Department of Public Health Chief Operating Officer and will collaborate with and maintain communication with the LHH Chief Executive Officer to ensure that the healthcare security program reflects an alignment with the LHH mission, vision and strategic objectives.

IV.   RISK ASSESSMENT

Security risks, vulnerabilities, and sensitive areas are identified and assessed through ongoing campus-wide processes that are coordinated by Facility Services, San Francisco Sheriff's Office, and the DPH Director of Security. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics, and physical systems. Considerations include:
Security risks, vulnerabilities, and sensitive areas are identified and assessed through ongoing facility-wide processes that are coordinated by the Director of Quality Management, Chief Operations Officer, the Director of Security, and the contract security provider. These processes are designed to proactively evaluate facility grounds, periphery, behaviors, statistics, and physical systems. Considerations include:

- Routine Environmental of Care Rounds
- Root Cause Analysis of significant events
- Failure Mode and Effects Analysis (FMEA)
- Sentinel Event Alerts
- Security Patrols
- Unusual Occurrence Reports- Review of pertinent data/information, incident reports, evaluations and risk assessments
- Community crime statistical data or CAPRISK Reports
- Facility crime, incident and property loss statistics, workplace violence, and crime statistics
- Customer and benchmarking surveys
- "At Risk" residents/patients (such as clinically indicated restraints, medical holds, and stand-by services)
- Hours of operation
- Hospital operations and processes
- Employee, resident and visitor identification
- Hospital and Rehabilitation Center operations and processes

The profile of potential risks results in an integrated approach to risk control and management. Identified "Sensitive Areas" include all areas with protected health information (PHI), Administrative Offices, Human Resources, Pharmacy, Nutritional Services, and Psychiatry, Information Technology, and Central Plant areas.

V. PROGRAM ORGANIZATION AND RESPONSIBILITIES

The Director of Security is responsible for the quality oversight of the security program. The Director of Security in partnership with the San Francisco Sheriff's Office is responsible for the overall management of the security program. This includes the program design, implementation, identification, control of risks, staff education, training, and consultation.

The Director of Security manages the work order with the San Francisco Sheriff's Office (SFSO) by participating in the development and approval of standard operating procedures, ensuring the appropriate resources are available to accomplish the objectives and goals of the Security Management Plan.

The SFSO Unit Commander manages the public safety and law enforcement services, including providing law enforcement personnel, management of SFSO operations, and compiling data from incident reports to form the Environment of Care Security Report.

The Unit Commander assures that SFSO assigned staff receive hospital related training, including racial humility and trauma informed care training; participate in safety and security, and threat management committees, and assures that all SFSO staff follow LHH security operating procedures.

The Director of Security and the SFSO Unit Commander will collaboratively establish and maintain communication and mutual ownership for outcomes by identifying and troubleshooting emergent safety and security concerns.

The Director of Security reports to the Environment of Care Committee about the implementation of new procedures and operations, as well as installation of new electronic security systems.

The Environment of Care Committee (EOC) comprised of clinical, administrative, operations support services, and labor representatives to ensure that the security management program is aligned with the core values and goals of the organization by providing direction, setting strategic goals, determining priority, and assessing the need for change.

The EOC is the central hub of the information collection and evaluation system and acts as a clearinghouse for action items, recommendations, and ensuring that risks are controlled in a timely fashion. The committee also ensures coordination, communication and integration of performance improvement, strategic planning, and injury prevention activities in committee activities.

In the context of security management, the Environment of Care Committee is designed to:
- Develop strategic goals and annual performance targets, relative to Security and the Environment of Care (EOC) programs.
- Carry out analysis and seek timely, effective, and sustainable resolution to security related issues
- Prioritize goals and resources.

The Director of Security is responsible for the quality oversight of the security program. The Director of Security in partnership with the contract security provider is responsible for the overall management of the security program. This includes the program design, implementation, identification, control of risks, staff education, and training, and consultation.

The Director of Security manages the work order with the San Francisco Sheriff's Office (SFSO) by participating in the development and approval of standard operating procedures, ensuring the appropriate resources are available to accomplish the objectives and goals of the Security Management Plan. The Director of Security reports to the LHH Campus Safety and Security Committee (CSS), and Executive Committee about the implementation of new procedures and operations, as well as installation of new electronic security systems.

The SFSO Unit Commander manages the public safety and law enforcement services, including providing law enforcement personnel, management of security and law enforcement operations, and compiling data from incident reports to form the Laguna Honda Campus Safety and Security and Executive Committee Security Reports. The Unit Commander assures that security and law enforcement staff receive hospital related training, participate in appropriate workplace violence prevention, safety and security, and threat management committees; and assures that all SFSO staff, follow LHH security operation procedures.

The Director of Security Services and the SFSO Unit Commander will collaboratively establish and maintain communication and mutual ownership for outcomes by identifying and troubleshooting emergent safety and security concerns.

The Laguna Honda Campus Safety and Security Committee (CSS) is comprised of clinical, administrative, operations support services, and labor representatives who ensure that the security management program is aligned with the core values and goals of the organization by providing direction, setting strategic goals, determining priority and assessing the need for change.

The LHH CSS Committee is the central hub of the Information Collection and Evaluation System and acts as a clearinghouse for action items, recommendations, and ensuring that risks are controlled in a timely fashion. The committee also ensures coordination, communication and integration of performance improvement, strategic planning and injury prevention activities in committee activities.

In the context of security management, the LHH CSS Committee is designed to:
- Develop strategic goals and annual performance targets, relative to Security and Safety Program.
- Carry out analysis and seek timely, effective, and sustainable resolution to security related issues
- Prioritize goals and resources

Department managers are responsible for the provision of a safe and secure work environment for staff through full implementation of established Environment of Care programs. This includes the identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting, and the protection of residents/patients and their belongings.
Department managers are responsible for the provision of a safe and secure work environment for staff through full implementation of established LHH CSS Committee programs. This includes the identification of security risks, staff education, developing and implementing department specific security policies and procedures, incident reporting, and the protection of patients and their belongings.

Employees are responsible for following security policies and practices about personal protection and reporting of security incidents, risks and threats. Employees include contract employees, volunteers, students, registry personnel and anyone working under the facility's auspices.

VI.   PROGRAM IMPLEMENTATION AND PROCESSES

Successful implementation of the Security Management Plan involves the incorporating the principles of the plan into the culture and operations of LHH. Implementation of the security program is the responsibility of the Director of Security and SFSO Unit Commander. The performance is monitored quarterly by the Environment of Care Committee, Campus Safety and Security Committee, and the Performance Improvement & Resident/Patient Safety Committee. They include:

1.   The designation of a person to be responsible for program development and oversight. The Director of Security as the person responsible for the quality oversight of the security program's development, implementation, and monitoring.

2.   The Security Services Department and the San Francisco Sheriff's Office conduct investigations and complete written reports about security incidents involving residents, staff, visitors, domestic related incidents that impact LHH, and property. Investigations are documented and reviewed by the SFSO Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with the SFSO Unit Commander ensures that incident reports are distributed to the appropriate departments (i.e., Quality, Risk Management, etc.) Significant events are reported to the Administrator-on-Duty, Nursing Ops, Executive Leaders, and the Environment of Care Committee.

3.   Security in collaboration with Facility Services will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, physicians, volunteers, and vendors.

4.   Access to the hospital's perimeter and buildings are maintained by appropriate security safeguards, including security surveillance cameras, routine checks on all perimeter doors, and the securing of individual departments after normal business hours. All employees are responsible for ensures that access to the facility is restricted to residents, employees, visitors by providing an appropriate greeting and wayfinding. Unauthorized individuals, suspicious persons and activity are reported to the SFSO/contract security supplier—**race, gender, and religious affiliation are NOT considered suspicious**.

5.   Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.

Successful implementation of the Security Management Plan involves the incorporation of the principles of the plan into the culture and operations of the organization. Implementation of the security program is the responsibility of the Director of Security, and SFSO Unit Commander. The performance is monitored quarterly by the Campus Safety and Security Committee and the Executive Committee. They include:

1.   The designation of a person to be responsible for program development and oversight. The Health Director has designated the Director of Security as the person responsible for the quality oversight of the security program's development, implementation and monitoring.

2.   The Security Services Department and the San Francisco Sheriff's Office conduct investigations and completes written reports about security incidents involving residents/patients, staff, visitors, volunteers, and property. Investigations are documented and

reviewed by the SFSO Unit Commander and the DPH Director of Security. Corrective actions are developed and implemented to mitigate risks. The Director of Security in collaboration with the SFSO Unit Commander ensures that incident reports are distributed to the appropriate departments (Quality, Risk Management, etc.) Significant events are reported to the Chief Executive Officer, LHH Chief Operating Officer and to the Director of Workplace Safety and Emergency Management.

3. Security will ensure that employees, vendors, and contractors wear personnel identification badges to facilitate the creation of a safe and secure environment. Badges are issued to all employees, consultant physicians, volunteers, and vendors.

4. Access to the hospital's perimeter and buildings is maintained by a lock down of unoccupied areas, routine checks on all perimeter doors, and the securing of individual departments after normal business hours. The contract security provider ensures that access to the facility is restricted by confirming unauthorized personnel and escorting them off the premises.

5. Security controls access to and egress from security sensitive areas by means of direct observation, locks and other physical barriers, signage, alarm systems and access control systems.

6. SFSO and the contract security provider conduct regular foot and vehicular patrols to identify potential security risks and assess the status of physical conditions within the buildings and on the hospital campus. Regular patrols, security checks of the campus interior and exterior, and parking areas, and maintaining fixed positions are conducted to deter theft, vandalism, and other criminal activity, including use or possession of contraband, and prohibited items.
7.
8. The Director of Security and the SFSO Unit Commander are actively involved in the Campus Safety and Security Committee and Threat Management Workplace Violence Prevention Committee, providing investigative and protective services for LHH Hospital Administration, Human Resources, and Resident.
9.
10. The Security Operations Center provides call-taking and dispatch services, monitors alarms and surveillance cameras to augment patrol staff and ensure an appropriate and timely response to security-related incidents and service request.
11.
12. The Security Services Department, and SFSO maintains records of all incident reports, service calls and crime statistics. Incident reports that involve safety, residents and environmental issues will be forwarded to the Executive Committee, Risk Manager, and Facilities Director.
13.
14. The collaborative efforts of Security Services and Facilities Services maintains and coordinates the badge access program. The Access Card Request Form is reviewed by the Facilities Department to determine the need for the requestor to have card access. Approved Card Request are processed by the Facilities Department. Records of all issued access cards are maintained with Human Resources and Facilities.
15.

16. The SFSO and the contract security provider will respond to hospital emergencies, including:

5. ~~The contract security provider conducts regular foot and vehicular patrols to identify potential security risks and assess the status of physical conditions within the buildings and on the hospital grounds. Regular patrols and security checks of stairwells, campus interior and exterior, and parking areas are conducted to deter theft, vandalism and other criminal activity. Security and Law Enforcement presence includes foot patrols, vehicle patrols and recording of security surveillance cameras in the Security Operations Center and maintaining fixed positions.~~

5. ~~The Director of Security is actively involved in a multidisciplinary, hospital wide Threat Management Team, and provides both investigative and protective services. The Director of Security in collaboration with the SFSO work closely with Administration, Human Resources, the Department of Public Health, and other law enforcement agencies on matters concerning criminal cases, threat management investigations, and other non-criminal cases.~~

5. ~~The Security Operations Center monitors all alarms, radio, and security telephone transmissions to ensure that the appropriate actions are initiated and communicated.~~

5. ~~The Security Services Department, and SFSO maintains records of all incident reports, service calls and crime statistics. Incident reports that involve safety, resident/patients, and environmental issues will be forwarded to the Safety Manager and the Risk Manager.~~

5. ~~The Security and Facilities Department maintains and coordinates the card access program. The requestor submits an Access Card Request form signed by the requestor's manager. The Access Card Request form is reviewed by the Facilities Department to determine the need for the requestor to have card access. Approved Card Requests are processed by Facilities. Records of all issued access cards are maintained with Human Resources and Facilities.~~

5. ~~The SFSO provides emergency response for the following:~~

- **Code Red** – Respond to the alarm point of origin to assist in implementing initial fire plan, aid local fire department and Facilities.
- **Internal / External disasters** - Control access, crowd management, and activate mutual-aid responses as required.
- **Code Green** - Deploy security personnel to designated locations to establish a perimeter and begin the search for missing residents.
- **Media and VIP Response** - Managing situations involving media or VIPs by aiding the Information Office and safeguarding info of any VIP on premises.
- **Lockdown Procedure** - Heightening existing security measures as needed during civil unrest, disturbances, demonstrations, or acts of terrorism.
- **Resident Assist** – SFSO will provide emergency assistance to address resident-initiated attacks on medical staff, including resident stand-by services. The contract security provider's assistance will be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a resident.
- **Resident Standby** – the contract security provider's assistance will be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a resident/patient, including following the resident/patient that is attempting to leave and radioing the exterior security units the elopement attempt.
- **Patient Abuse Reporting** – Investigation and document all incidents of resident/patient abuse as required by SOC-341.

- Code Blue – Upon notification, to providing crowd control as needed
- Code Red – Upon notification, respond to the alarm point of origin to assist in implementing initial fire plan, provide assistance to local fire department and Facilities.
- Internal / external disasters - providing staff to control access to the facility and provide assistance to/from local emergency response agencies
- Code Green - deploy security personnel to designated locations to establish a perimeter and begin the search for the missing resident/patient.
- Managing situations involving media or VIPs by providing assistance to the Information Office and/or Administration and safeguarding info of any VIP on premises.
- Lockdown Procedure - Heightening existing security measures as needed during civil unrest, disturbances, or acts of terrorism.
- Security also provides emergency assistance to medical/clinical staff, including but not limited to stand-by services, resident/patient restraints, searching for missing persons, crowd control, response to duress alarms, etc.

6.17.	All new employees, at the time of hire, will attend a New Employee Orientation Program. All employees will receive basic information related to the Security Department and its Security Management Plan. During the security portion of the orientation, employees will receive information about the following:

- Security Department Services
- Prudent security practices
- ID Policy
- Threat Management and Workplace Violence Prevention
- Reporting a security incidents or suspicious activity
- Security locations and phone numbers, etc.

18. Additional training will be provided to all Clinical and Ancillary Departments in Non-Violent Crisis Intervention (CPI), Management of Aggressive Behavior, and Threat Management and Workplace Violence Prevention, and Active Shooter.
19.
20. The SFSO Unit Commander and the contract security provider's Account Manager will verify that LHH assigned SFSO and contract security employees, complete all required trainings. Training records will be retained by the Department of Education and Training for Security Services and SFSO assigned staff.
21.
22. Security refresher in-services will be based on the assessment of the department's need, change in roles or regulatory requirements, and EOC findings.
7. Additional training will be administered as needed to assure competency in federal, state, local laws, and regulations: Crisis Prevention and Intervention, Management of Aggressive Behavior and Threat and Workplace Violence response.

8. The SFSO Unit Commander will verify that each SFSO employees assigned to Laguna Honda Hospital and Rehabilitation Center complete the required LHH New Employee Orientation,

~~LHH Security Standard Operating Procedures, Non-Violent Crisis Intervention (CPI) and LHH annual core competencies refresher training.~~

~~9. Documentation will be retained by the Department of Education and Training and/or the SFSO Training Representative. Security refresher in-services will be based on the assessment of the department's need, change in roles or regulatory requirements and/or findings of the Campus Safety and Security Committee.~~

VII.   PROGRAM EFFECTIVENESS

Through the Environment of Care Committee, the effectiveness of the security program is monitored and assessed on an ongoing basis. Identified risks are used to develop performance metrics to create a safe and secure environment for staff, residents, and visitors to the hospital. A quarterly report is submitted to the Environment of Care Committee. Recommendations are made, as needed, to facilitate improvements in performance. Action plans are developed and implemented to improve performance.
~~Through the LHH Safety and Security Committee, the effectiveness of the security program is monitored and assessed on an ongoing basis. Identified risks are used to develop performance measures to create a safe and secure environment for staff, patients and visitors to the hospital. Performance is reported to the LHH Safety and Security, and Executive Committee on a quarterly basis. Recommendations are made as needed to facilitate improvements in performance. Action plans are developed and implemented as needed to improve performance.~~

VIII.   PERFORMANCE

The hospital has developed and implemented a systematic, campus-wide approach for performance improvement. It is intended to assist the hospital in developing and maintaining improvement programs that are meaningful, realistic, and adjustable based upon relevant data and customer feedback. The standards and metrics by which the performance of this plan will be measured are based on hospital and department experiences, 2021-2022 Security Risk Assessment/Survey, 2021-2022 Annual Security Report, exercise evaluation results, observed work practices, customer expectations/satisfaction, and Environment of Care Committee recommendations.
~~The hospital has developed and implemented a systematic, department-wide approach for performance improvement. It is intended to assist the hospital in developing and maintaining improvement programs that are meaningful, realistic, and adjustable based upon relevant data and customer feedback. The standards and metrics by which the performance of this plan will be measured are based on hospital and department experiences, 2019-2020 Security Risk Assessment, exercise evaluation results, observed work practices, customer expectations/satisfaction, and/or LHH Safety and Security, and Executive Committee recommendations.~~

During 2022-2023, the measures that will be collected, tracked, and analyzed by the Environment of Care Committee on a quarterly basis include:

Performance Metric #1 – Code Green, SFSO Resident Elopement Response Incidents and Drills:
During actual Code Green incidents/drills, the effectiveness of the contract security provider will be measured to determine their response in the following areas:
- Initial Perimeter and Search
- Notification of SFPD, BART, and MUNI

- Documentation of Search Activity
- Locate/Not Located Procedure

1. The contract security provider will be measured on their ability to effectively respond i.e., initial perimeter search, and notification of SFPD, BART, and MUNI as applicable, and document the search activity:

Response-rate Threshold – 80%
Response-rate Target – 90%
Response-rate Stretch – 100%

2. The contract security provider, in collaboration with the hospital will be measured on its ability to make contact i.e., determine the location, and deem safe, an "At Risk" resident/patient, and when they are not located, follow the Not Located Procedure.

Locate/Return-rate Threshold –90%
Locate/Return-rate Target – 98%
Locate/Return-rate Stretch – 100

During 2020-21, the measures that will be collected, tracked and analyzed by the Safety, and Executive Committee on a quarterly basis include:

Performance Metric #1 – Code Green, "At Risk" SFSD Patient Alert Response Incidents and Drills:

During actual Code Green incidents/drills, the effectiveness of the contract security provider will be measured to determine their response in the following areas:

- Initial Perimeter and Search
- Notification of SFPD, BART, and MUNI
- Documentation of Search Activity
- Locate/Not Located Procedure

1. The contract security provider will be measured on their ability to effectively respond i.e. initial perimeter search, and notification of SFPD, BART, and MUNI as applicable, and document the search activity:

Response-rate Threshold – 80%
Response-rate Target – 90%
Response-rate Stretch – 100%

2. The contract security provider will be measured on its ability to locate an "At Risk" resident/patient, and when they are not located, follow the *Not Located Procedure*.

Locate/Return-rate Threshold –90%
Locate/Return-rate Target – 98%
Locate/Return-rate Stretch – 100

Performance Metric#2 – Employee Security Awareness:

During EOC rounds, hospital staff will be tested on 5 questions regarding their full knowledge of:

- Code Green Response

- Unauthorized Person

- Workplace Violence

- Disruptive Resident

- Contacting Security

Threshold - 80% Somewhat Satisfied

Target - 90% Satisfied

Stretch – 98% Very Satisfied

~~**Performance Metric#2 – Customer Satisfaction:**~~

~~In accordance with the scope of the security management plan, the management plan calls for best in class customer service for patients, visitors, volunteers, contracts and staff. On a quarterly basis, customers that consist of patients/residents, visitors, employees, and physicians that had a recent contact with Security Services, will be surveyed on their experience.~~

~~Customers will respond as either, Very Satisfied, Satisfied, Somewhat Satisfied, Dissatisfied, and Very Dissatisfied in the following areas:~~

- ~~Responsive~~
- ~~Treated with dignity and respect~~
- ~~Courteous~~
- ~~Effective~~
- ~~Overall Experience~~

~~**Threshold** - 80% Somewhat Satisfied~~
~~**Target** - 90% Satisfied~~
~~**Stretch** – 98% Very Satisfied~~

Performance Metric#3 – Electronic Security System Performance:

On a monthly basis the Security Operations Center will inspect the electronic security system for functionality. The Facilities Department will monitor all service call/work-orders to ensure timely response. The Security Director and SFSD Unit Commander will develop a plan to mitigate risk, resulting from system malfunctions. The action plan will be documented in Campus Safety and Security Report.

The monthly target is for 100% of the system to be inspected and will be 98% functional.

Performance Metric#4 – Contraband and Prohibited Item Reductions:

The security program will be measure on its performance to reduce contraband and prohibited items from the established baseline through:

- Patrol rounds at resident gathering places where illicit drug activity is suspected.
- Conducting property screening and searches at the Pavilion Lobby entrance.

Significant Reporting Performance – The security management plan will demonstrate effectiveness through significant performance results, including:

- DPH and SFSO, MOU Performance and Compliance

- Threats and Workplace Violence Incident Reductions

- Crimes Against Property and Person Reduction

- Use of Force Reduction

- Security/Law Enforcement Service Call Response Time

- Property Screening Audits   **Significant Reporting Performance –** The security management plan will demonstrate effectiveness through significant performance results, including:

- DPH and SFSO, MOU Performance and Compliance

- Workplace Violence Incident Reductions
- Crimes Against Property and Person Reduction
- Use of Force and Physical Intervention Reduction
- Verbal De-escalation Performance
- Threats Management Performance
- Security/Law Enforcement Service Call Response Time
- Employee Security Awareness

IX.   ANNUAL PROGRAM EVALUATION ANNUAL PROGRAM EVALUATION

On an annual basis, the security management program is evaluated relative to its objectives, scope, effectiveness, and performance. This evaluation process is coordinated through the Director of Security, in conjunction with the contract security provider, San Francisco Sheriff's Office, Environment of Care, and the Campus Safety and Security Committee.

The continued appropriateness and relevance of program objectives are assessed, as well as whether these objectives were met. The scope is evaluated to determine continued applicability. The year is reviewed retrospectively to determine the extent to which the program was effective in meeting the needs of the hospital, the residents, and staff. The performance results are assessed as an indicator of ongoing performance improvement. Results of this evaluation process will form the basis for strategic goal setting, planning, and verifying the continued applicability of program objectives.

On an annual basis, the security management program is evaluated relative to its objectives, scope, effectiveness and performance. This evaluation process is coordinated through the Director of Security, in conjunction with the contract security provider, LHH Safety and Security Committee, and the Executive Committee.   The continued appropriateness and relevance of program objectives are

assessed, as well as whether or not these objectives were met. The scope is evaluated to determine continued applicability. The year is reviewed retrospectively to determine the extent to which the program was effective in meeting the needs of the hospital, the residents and staff. The performance results are assessed as an indicator of ongoing performance improvement. Results of this evaluation process will form the basis for strategic goal setting, planning, and verifying the continued applicability of program objectives.

PUBLIC ACCESS AND NIGHT SECURITY

POLICY:

Access to the hospital grounds and buildings is controlled.

PURPOSE:

To assure a safe and secure environment for residents, staff, and visitors.

PROCEDURE:

1. General Procedure

a. The following persons have authorized access to certain ~~H~~hospital areas and must have identification or issued sticker visible at all times:

   i.   Residents who have been admitted.

   ii. Resident's visitors, who have signed in at the pavilion between the hours of 10:00 a.m. and 9:00 p.m., unless the Nursing Operations Manager authorizes special visitation after consultation with the neighborhood staff.

   iii. Employees who are:

   - Working during their regularly scheduled work hours,

   - called in to work (on-call, overtime, and emergency), or

   - on-site during their non-scheduled work hours

     - must (1) report to their respective department offices, (2) state the reason for being on campus and (3) receive permission from an authorized person (department head or designee) to be on-site. The department head is expected to know the purpose, place and duration of the employee's visit.

     - may visit the Human Resource Services or Payroll offices during business hours.

   iv. Administrative, management, and supervisory employees in the performance of their job responsibilities.

   v. Employees visiting a resident have visitor status and are expected to follow policies and procedures for visitors.

vi. Persons (e.g., vendor representatives, peer mentors, students, consultants) with an appointment to conduct official business.

vii. Volunteers duly enrolled in the hospitals' volunteer or clergy program.

b. Employees and residents who notice a suspicious package, event or person, shall contact the Sheriffs' substation at 4-2319 for immediate investigation. Give the following information:

 1. Identify yourself

 2. Location of incident

 3. Activity, what is the incident

 4. Number of persons involved

 5. Description of the persons involved

 6. ~~Danger, are there any weapons~~Are there any weapons involved.

c. The Administration building is closed between 5:00 p.m. and 6:00 a.m. and on weekends and holidays. Access to the Administration building during these times is only through employee badge access.

2. Night Procedure

a. Sheriff's Staff shall secure all perimeter Hospital doors from 5:00 p.m. – 6:00 a.m., and the Pavilion lobby entrance at 9:15pm.

b. Notices posted near all entrances will advise the public that visiting hours begins at 10 a.m. and concludes at 9:00 p.m. Ten minutes before 9:00 p.m., the Nursing Office Staff shall make an announcement via the public address system that visiting hours are ending.

c. The San Francisco Fire Department can gain emergency access to the buildings by accessing the emergency key located at boxes outside the main entrances to each building.

3. All employees shall use designated entrances and exits at night.

ATTACHMENT:
None

REFERENCE:
None

Revised: 96/07/15, 99/08/05, 12/09/25, 15/09/08 23/05/09(Year/Month/Day)
Original adoption: 94/08/15

DISORDERLY OR DISRUPTIVE VISITORS

POLICY:

Disorderly or disruptive visitors whose presence or activity threatens the health, safety or well-being of others at Laguna Honda Hospital and Rehabilitation Center (LHH) are to be escorted out of the hospital buildings and or grounds by either the contract security provider or the Deputies of the San Francisco Sheriff's Office.Department (SFSDO).

PURPOSE:

To provide safety and security for everyone on premises.

PROCEDURE:

1. Recommended visiting hours are daily, from 10:00 a.m. to 9:00 p.m., and between 9:00 p.m. and 10:00 a.m. if authorized by the Chief Medical Officer or designee, Chief Nursing Officer or designee, unit physician or nurse manager/charge nurse, who so notify the unit staff.

2. Residents' visitors are required to abide by LHH rules that are designed to provide for the safety and well-being of everyone on premises.

3. Visitors are to check in with SFSDO staff at the front lobby of the Pavilion Building. They shall legibly write their name, the resident they are visiting, the location, and the time they arrived. The SFSDO staff shall provide the visitor with a sticker with the date and the location they will be visiting. The visitor shall wear this sticker on their clothing where it is visible. Every adult visitor shall be issued a sticker to wear while visiting on the LHH Campus.

4. Whenever a visitor's demonstrated behavior that violates LHH safety policies, and verbal de-escalation attempts have failed, staff shall notify the SFSDO at 42319. The caller should:

    a. Identify yourself

    b. Location of the incident

    c. Activity, what is the incident

    d. Number, number of persons involved

    e. Description, give a brief description of person(s) involved

    f. Danger, are there any weapons involved.

g. REMAIN ON THE LINE.
If a weapon is brandished, or the situation poses potential risk of harm, call "Dr. Grey"

5. SFSDO staff shall conduct a preliminary investigation of the complaint(s) and determine if any crime has been committed. If no crime has been committed, the deputy may advise or admonish the visitor. If a crime has been committed, the deputy shall follow established procedures based on the nature, severity (infraction, misdemeanor, felony), and other factors in determining the appropriate action.

If the visitor has been asked, by LHH staff, to leave and if the visitor refuses, and all efforts to encourage that person to leave voluntarily fail, the Ddeputy may choose to charge the person with violating trespassing on hospital grounds.

6. The SFSDO Watch Commander may recommend that problematic persons be prohibited from entering the hospital. This information shall be submitted to the Executive Administrator, or designee.

7. Visitors with aggressive behaviors, may have restrictions placed upon their visits to the facility.

8. The Deputy City Attorney may be contacted for consideration of a stay away order or a restraining order.

ATTACHMENT:
None.

REFERENCE:
LHHPP 75-06 Dr. Grey Code
SFSD Response Template Calls for Service

Revised: 96/07/15, 10/06/08. 15/09/08, 16/11/08, 23/05/09 (Year/Month/Day)
Original adoption: 94/08/15

CALLS FOR SHERIFF'S ASSISTANCE

POLICY:

The San Francisco Sheriff's ~~Department~~ Office (SFS~~D~~O) will provide an emergency response to calls requested by Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) staff for their assistance.

PURPOSE:

To provide guidelines when calling for Sheriff's Office assistance.

PROCEDURE:

1. Call the Sheriff's Office at (4-2319) for assistance

2. State:

   a. Your name

   b. Incident location

   c. Nature of the incident.

   d. Number of people involved

   e. Description of the person/s involved

   f. Danger including weapons

   g. Remain on the line.

3. The cadet will dispatch deputies for immediate assistance.

4. Sheriff Deputies will respond immediately to the requested incident location.

5. The caller should stay on the line (if possible) to provide critical information to the cadet and responding deputies.

ATTACHMENT:
None.

REFERENCES:
SFS~~D~~O Response Template Calls for Service

Revised: 96/07/15, 98/11/16, 02/02/15, 10/06/08, 15/09/08, 23/05/09 (Year/Month/Day)
Original adoption: 93/05/10

DR. GREY CODE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide a system for employees who are confronted by a potentially violent or dangerous individual to request in an undetectable manner immediate assistance from the San Francisco Sheriff's ~~Department~~ Office (SFS~~D~~O).

PURPOSE:

To provide an appropriate level of safety and security by instituting a coded emergency response for situations involving weapons or other risk of violence or injury.

PROCEDURE:

1. In situations involving weapons or other risk of violence or injury, any employee can use the code phrase "Dr. Grey" to communicate to Sheriff's staff, or to any LHH staff person, in a manner that will not arouse suspicion of the aggressor of the need for immediate assistance from the Sheriff's Dept.

   a. If the employee is able to do so safely, the employee should immediately call the Sheriff's Office at 4-2319 and say "please ask Dr. Grey to come to (location)."

   b. Provide the information below:

      i. Identify yourself

      ii. Location of incident

      iii. Nature of the incident

      iv. Number of persons involved

      v. Description of the persons involved

      vi. Danger, are there any weapons.

   c. Provide the above information if doing so will not agitate the individual or escalate the situation. If you cannot give that information directly, say "I cannot talk right now."

   d. If you have indicated that you cannot give information directly, the Sheriff's staff will ask you some questions that can be answered with "yes" or "no."

      i. "Is there a weapon?" if yes,

- "Is there a gun?"

- "Is there a knife?"

ii.   "Is there more than one person involved?"

e.   If the individual becomes suspicious about the call, say that Dr. Grey was called to assist.

f.   If the situation prohibits calling the Sheriff Office, the employee should use the code phrase "Dr. Grey" in a sentence to any other employee who might safely go to another location to call the Sheriff Office.

g.   If an employee makes a statement to you using the code phrase "Dr. Grey," note carefully what was said, note anything unusual about the situation (including presence of strangers), go immediately to a secure area and call the Sheriff Office at 4-2319. Give your name, tell the location of the employee who gave you the Dr. Grey message, and repeat the message exactly as it was given to you.

2.   Deputies will be provided with all available information and immediately dispatched to the location, where they will address the situation in accordance with SFSO operation procedures. **The call for "Dr. Grey" will not be announced on the overhead public address system.**

3.   A code 33 will be announced on the radio. All persons using the LHH radio system will remain off the air until a Sheriff supervisor broadcasts a Code 4 (all clear message).

    All on-site Sheriff's sworn staff shall immediately respond to the location.

5.3.   Upon arrival, the Sheriff's staff will assess the situation and take appropriate action that may include but is not limited to:

a.   taking physical action to subdue the subject or maintaining safe perimeter control;

b.   calling for additional units as backup; and

c.   calling for staff assistance (e.g., department head, physician, psychologist, nurse manager, psychiatrist on duty (OD), etc.).

5.   When the situation has been stabilized, a Sheriff Supervisor will broadcast a Code 4 (all clear) to release the radio channel for normal use.

6.4.   Documentation:

a. The employees involved in the incident will complete an Unusual Occurrence report.

b. The Resident Care Team (RCT) will evaluate the incident and document it as needed in the medical record.

c. ~~The~~ SFS~~OD~~ will generate an Incident Report.

d. The Sheriff's office staff will log the time and nature of the call and the actions taken.

ATTACHMENT:
None.

REFERENCE:
SFS~~OD~~ Response Template Calls for Service

Revised: 00/01/08, 10/06/08, 15/09/08, 23/05/11 (Year/Month/Day)
Original adoption: 98/09/28

THEFT AND LOST PROPERTY

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide a means to help facilitate the return of personal belongings lost on the LHH campus.

2. ~~The~~ San Francisco Sheriff's ~~Department~~ Office (SFS~~D~~O) shall be notified ~~to report~~to report missing property due to theft. ~~when items are missing due to theft is reported.~~

3. LHH is not responsible for lost items of staff, volunteers, visitors, and/or contractors.

4. Personal belongings found that are unclaimed for 30 days shall be discarded or donated to the Volunteer Services department for processing.

PURPOSE:

To facilitate the return of property to the rightful owner and dispose unclaimed items. To promote property loss control, minimize theft through intervention, and provide a process to report resident loss of property.

PROCEDURE:

1. Lost and Found Items

    a. Any person who loses personal belongings or finds property shall:

        i. Place items in the receptacles labeled "lost and found" located in the hospital lobby and atrium or bring items to the Administration office.

        ii. The person(s) who located an item(s) shall provide as much information as possible to Administration staff.

    b. Administration staff shall record items brought to their attention or deposited in the bins on the Lost and Found log stored in the Administration Office.

    c. Items found will be stored for 30 days in the Administration Office.

    ~~d. Items determined by Administration staff to be of more than nominal value (i.e. wallets, cash, jewelry, phones) shall be turned over to the San Francisco Sheriff's Department (SFSD)~~SFSO ~~for processing.~~

    ~~e.~~d.   Administration staff shall contact the owner if sufficient identification is indicated on the item and check the lost items list to see if the item has been reported lost.

f.e. Lost items may be claimed from the Administration Office after a description of the lost item and identification of the person claiming the item is provided.

g.f. Persons who are unable to locate their lost items in the Administration Office may be referred to SFSD SFSO to file a report, if appropriate.

h.g.   Disposition of items found:

    i.   Soiled items will be discarded immediately.

    ii.   Property not claimed after 30 days from date of log in shall be donated to the LHH Volunteer Services department.

2. Theft of Property

a. LHH staff shall report theft of property to SFSDSFSO.

b. SFSD SFSO shall follow their internal processes in responding to the report of theft that may include preparing a Police Incident Report that is processed through the criminal justice system or providing a liaison with the San Francisco Police Department to assist with further investigation.

c. The SFSDSFSO shall maintain theft reports and statistical data.

d. The LHH Administration and SFSD SFSO shall meet twice a year to review statistical data to improve prevention of theft.

3. Claims and Liability

a. The resident may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. Social Worker or any member of Resident Care Team may assist resident in completing claims form.

b. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions, or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.
Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss for more detail.

ATTACHMENT:
None.

REFERENCE:
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss

Revised: 94/08/15, 12/09/25, 19/09/10 (Year/Month/Day)
Original adoption: 93/05/20

REPORTING VEHICULAR ACCIDENTS

POLICIES:

1. Employees/volunteers must maintain a valid driver's license appropriate for all classes of vehicles driven.

2. Employees/volunteers driving CCSF vehicles must report all vehicular accidents, using this procedure.

3. Employees/volunteers who possess a valid, appropriate driver's license (see above policy) and are driving a City vehicle on City business will be insured by CCSF if involved in an accident either on or off-premises.

PURPOSE:

To facilitate proper documentation of accidents, timely reporting to authorities and families, and expedition of repairs.

PROCEDURES:

1. The employee or Volunteer Shall:

   a. Do not discuss "fault" at the scene.

   b. Render aid and assistance, if able.

   c. Show, not give, to all parties as well as to any police officer present (and allow them to copy):

      i.   your name, address, and driver's license

      ii. your vehicle's license plate number

      iii. your vehicle's registration information

      iv. your insurer is: "City and County of San Francisco, c/o City Hall, Controller's Claim Desk, San Francisco, 94102. The City "self-insures" and will represent you as your insurer.

   d. Obtain from all other parties involved and write down:

      i.   driver's name, address and driver's license number

      ii. registered owner's name

    iii. legal owner's name

    iv. driver's insurance information

    v. driver's home and office telephone numbers

    vi. car's license plate number and expiration date

e. Immediately report any accident occurring on Laguna Honda grounds to SFS~~DO~~.

f. Immediately report any accident occurring off grounds to the local police jurisdiction and advise the dispatcher that the accident involves a City employee and a City vehicle (or the police won't respond) and request that the police respond to the scene to file a report on behalf of CCSF as your insurer.

   In the City, call SFPD non-emergency dispatcher at 553-0123 to request police response to the scene. Advise the dispatcher that the accident involves a City employee and a City vehicle and request that the police respond to the scene and file a report in behalf of the City as insurer.

g. Seek treatment for injury as follows:

    i. Emergency on Laguna Honda premises. Follow LHHPP 77-01 Medical Emergency: Employees, Volunteers & Visitors by calling:

- 911 for an ambulance

- And call or ask someone to call ~~the Hospital Operator's Emergency Line~~ 42999 for Laguna Honda physician assistance

~~Tell Hospital Operator 42999~~State:

- Exact location of the casualty.

- Casualty's condition and type of illness or acciden<u>t, and</u>~~t.~~

- Whether 911 has been called.

~~The Hospital Operator~~<u>Nursing office staff</u> will announce a "Code Blue" for on-site emergency.

    ii. Emergency off premises. In all jurisdictions, if 9-1-1 responds and the employee's injury requires emergency transport, the paramedic ambulance procedure will determine to which hospital the injured employee is delivered.

iii. Non-emergency on or off premises. On-duty employees or volunteers should read IIPP, Section 8 "Procedure for reporting occupational injury and illness." Subsection 8.3.1 states that non-emergency occupational injuries or illnesses are to be treated as follows:

At all time, Laguna Honda non-emergency on-the-job employee and volunteer injuries go to the ZSFGSFGH Emergency Department, a 24-hour facility located on 23rd Street at Potrero. (A parking garage is across the street.)

If the City-vehicle is not operable, the employee should obtain other means of transportation to reach medical services. Subsection 8.3.2 states that Laguna Honda shall assure transportation, if Worker's compensation later determines the injury to be work related; therefore, the employee should retain evidence of payment for transport and should file for reimbursement with the Laguna Honda Human Resources Department.

h. Write notes, as possible, about details (observed vehicle damage, special circumstances, and the other driver's remarks about injuries). Complete the Automotive Accident Report, a supply of which is kept in the glove compartment of each City owned vehicle. Forward one copy to SFSOD and keep a copy. Include at least the following:

   i.   Indication whether a major breakdown or an accident has occurred.
   ii. Names and addresses of all parties and their insurance providers (see section 4 above).
   iii. Description of each person's injuries.
   iv. Description of vehicle, damage, and estimation whether it exceeds $500.

i. Complete California Department of Motor Vehicles Accident report.

2. Procedure for Department Heads:

a. Department Heads who supervise fleet vehicles, which include all buses and all other types of vehicles, shall assure that each vehicle contains a copy of the current Hospital-wide P&P and at least one copy of Automotive Accident Report.
b. Immediately upon receiving information, Department Heads shall report vehicular accidents involving Departmental duty employees or duty volunteers to SFSOD.

c. Department Heads shall complete an IIPP-SIIR (Supervisor's Incident Investigation Report). In addition to the usual departmental routing of that report, the Department Head must forward one photocopy directly to Laguna Honda Box 9 for use in support of the Hospital's response to any investigation that may occur. Assistance regarding completion of the IIPP-SIIR can be obtained from the Industrial Hygienist.

d. Department Heads shall assure that all reports due under this policy have been submitted by close of the Department Head's next regular workday.

3. Procedure for SFSOD:

a. Upon notification of an on-premise accident, SFSDO shall respond according to departmental procedures.

b. Regarding both on- and off-premise accidents, SFSDO shall request a copy of the Automotive Accident Report or shall file a Police report, copies of which SFSDO will supply to:

    i. Chief Operating Officer;

    ii. Employee's immediate supervisor;

    iii. Hospital Administrative Assistant-Administration (City Attorney liaison); and

    iv. Facility Services Chief Engineer (i.e., Laguna Honda fleet manager and liaison to Central Shops).

4. Procedure in Case of Accident During Transport of Hazardous Materials:

a. If the employee is transporting hazardous materials (example is auto batteries) and there is spillage, release, or probability of same, the employee must make an immediate separate report to the supervisor; alternately, the employee may call that area's local 911 and request 911 inform the Hospital and local authorities of a potential or actual spill or release of hazardous substances.

ATTACHMENT:
Laguna Honda Hospital Automotive Accident Report

REFERENCE:
LHHPP 77-01 Medical Emergency: Employees, Volunteers & Visitors
LHHPP 80-04 Employee Regulations (section on work-related injury)
Laguna Honda Injury and Illness Prevention Program (IIPP) manual

Revised: 98/04/01,12/09/25 (Year/Month/Day)
Original adoption: 96/07/15

LAGUNA HONDA HOSPITAL
AUTOMOTIVE ACCIDENT REPORT

Complete this at the accident site. Do **not** give to other driver. Deliver to SFSD. Please ***print***.

OTHER DRIVER & OCCUPANTS

OTHER DRIVER

NAME_____

ADDRESS_____

TELEPHONE_____LICENSE #_____EXPIRES_____

BIRTH DATE_____LICENSE CLASS   1   2   3   A   B   C

OTHER VEHICLE LICENSE #_____ MAKE_____YEAR____ MODEL_____

LEGAL OWNER (IF NOT DRIVER) _____

ABOVE PERSON'S ADDRESS_____

ABOVE PERSON'S TELEPHONE _____

ANY VEHICLE ID #_____ DESCRIBE DAMAGE TO OTHER VEHICLE_____

_____

LOCATION WHERE OTHER CAR CAN BE EXAMINED BY CITY?_____

NAME, ADDRESS, TELEPHONE OF *REGISTERED OWNER*, IF DIFFERENT THAN ABOVE_____

_____

NAME, ADDRESS, TELEPHONE OF *LEGAL OWNER*, IF DIFFERENT THAN ABOVE_____

_____

OTHER VEHICLE OCCUPANTS AND THEIR INJURIES:

NAME_____ADDRESS/TEL_____

INJURIES_____ TAKEN TO_____

NAME_____ADDRESS/TEL   _____

INJURIES_____ TAKEN TO_____

WITNESS_____ADDRESS/TEL_____

CITY VEHICLE & OCCUPANTS

CITY VEHICLE ID#_____VEHICLE #_____PLATE_____YEAR_____

DESCRIBE DAMAGE AND LOCATION ON CITY VEHICLE_____

_____

CITY DRIVER NAME_____LAGUNA HONDA DEPT_____

WORK ADDRESS 375 Laguna Honda Blvd., S. F. 94116 BIRTH DATE _____

DRIVER'S LICENSE #_____EXPIRES_____LICENSE CLASS: 1   2   3   A   B   C

CITY VEHICLE OCCUPANTS & THEIR INJURIES:

NAME_____ADDRESS/TEL   _____

INJURIES_____ TAKEN TO

NAME_____ADDRESS/TEL_____

INJURIES_____ TAKEN TO

C I R C U M S T A N C E S

ACCIDENT DATE_____ACCIDENT TIME_____A.M. / P.M. CITY_____

ON WHAT STREET?_____AT WHAT CROSS STREET?   _____

DETAILS: HOW OCCURRED, SPEED OF EACH VEHICLE_____

_____

_____

_____

DESCRIBE THE OTHER DRIVER & OCCUPANTS: impairment of behavior; symptoms of alcohol or drugs;

polite/impolite/abusive; anyone talk about being injured but didn't look/act injured?; anyone appear injured?

_____

_____

_____

Any information you'd like the City Attorney representing you to know about this case?

_____

_____

_____

COMPLETE A DIAGRAM. SHOW ALL VEHICLES/OBSTACLES THAT AFFECTED THE ACCIDENT

Mark your north point ✝

SIGNATURE_____DATE_____

PRINT NAME_____CIVIL SERVICE CLASS_____

SECURITY SERVICES STANDARD OPERATING PROCEDURES
POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) takes reasonable preventive measures to provide a safe environment for everyone on LHH premises. LHH has zero tolerance toward violence, threats/intimidation that involve, or affect LHH or occur on LHH premises. As such, the possession of weapons on LHH premises is strictly prohibited. Anyone engaging in conduct that violates this policy is subject to remedial action.

PURPOSE:

The purpose of this policy is to: safeguard all covered persons, residents~~patients~~, and visitors, volunteers, and Department of Public Health (DPH) employees located at LHH, by addressing threats and aggressive behavior at the earliest stage; define inappropriate and unacceptable workplace behavior; and establish an effective process for responding to, managing, and reporting acts or threats of violence or aggressive behavior.

To provide guidelines for handing and responding to security related incidents. The Standard Operating Procedures (SOP) elaborate on existing hospital policies, and define the processes, and expectations of security services performed by ~~the~~SFSO and the contract suppliers, regarding ~~of~~ security, public safety, and law enforcement services. ~~, hereafter referred to as the contract security provider.~~

SCOPE:

This policy applies to all employees, contractors, students, and volunteers ("covered persons") who are employed by or provide services to Laguna Honda Hospital and Rehabilitation Center.

The SOPs found herein do not supersede existing hospital policies and procedures but are to be utilized as a reference in the carrying out of security services. SFSO and the ~~The~~ contract security provider will develop, and maintain their own operation procedures, which will align with LHH Security SOPs.

DEFINITION:

Acts/Threats of Violence – Any actions, statements or other intimidating conduct that gives reasonable cause to believe that the personal safety of an individual or group of individuals may be at risk.

LHH Premises – Any building or space, including parking lots, owned, leased, or operated by Laguna Honda Hospital and Rehabilitation Center, or a subsidiary.

Remedial Action – Includes, but is not limited to, corrective action/discipline up to and including termination of employment, criminal/civil prosecution if the conduct involves a violation of law.

Weapon – Includes any instrument, article, object, or substance which, under the circumstances, could reasonably be used to cause physical injury or death, such as firearms, knives, clubs, stun guns, or incendiary devices.

PROCEDURE:

1. Security Operations Center (refer to appendix Q for further details)

a. The Security Operations Center (SOC) will operate as the dispatch and security call center for ~~the~~ all security related incidents occurring at LHH campus and premises.

b. The SFSO ~~contract security provider~~ will ensure that the SOC is staffed with professionally trained dispatchers and telephone operators.

   i. The SOC is responsible for supporting the Incident Command Center during any activation of the emergency and disaster response plan.

   ii. The SOC operator must be able to initiate the plan of action for all information coming into the operations center via surveillance cameras, alarm panels, duress buttons, resident locator mobile view, emergency phones, and phone lines.

   iii. The dispatcher's goal is to provide timely service ~~security and law enforcement service~~ to Laguna Honda's customers. Assigned SFSO staff ~~security provider staff~~ will be trained~~,~~ and demonstrate a working knowledge of all SOC ~~and~~ Security Response Procedures.

   iv. The SOC is under the direct supervision of the SFSO Unit Commander~~contract security provider's leadership~~.

   v. The SOC is responsible for the following tasks:

   - Monitor, acknowledge, and respond to all alarms coming into the SOC.

   - ~~•~~ Monitor CCTV cameras of all high-risk areas, and dispatch SFSO accordingly. ~~contract security provider personnel to address all suspicious persons and activity.~~

   - Dispatch SFSO staff ~~security personnel~~ to all security related incidents and emergencies. ~~.~~

   - ~~• Coordinate security responses to all security emergencies.~~

- Perform additional security related task as directed by the SFSO Watch Commander. contract security provider's leadership.

- Document all service calls and response times. .

- Notify all necessary parties of emergency situations.

- Record all emergency and non-emergency service calls coming into the SOC i.e. names, locations, times, activities, and length of service time.

- Participate in monthly electronic system inspections.

- Monitoraintain SOC equipment and systems, and report system malfunctions, and track repair status.

- Report procedural discrepancies to appropriate parties.

- Participate in preliminary and continuing investigations, including providing security records in accordance with the Records Retention, and Disclosure Policy (refer to LHHPP 75-15 Security Records Retention and Disclosure Policy).

2. **Identification of employees, residents patients and visitors**

   a. All LHH employees, residents patients and visitors shall have identification when on LHH premises.

   b. All visitors authorized to enter the hospital will be issued a visitor's pass by the contract security provider.

3. **Reporting**

   a. Covered Persons are required to report any acts or threats of violence when they have observed or otherwise learned of such conduct by any person working for LHH, on LHH premises, using LHH services or that could reasonably be believed to affect the LHH workplace.

   b. Residents Patients or visitors to LHH premises are encouraged to make reports when they have observed or otherwise learned of conduct prohibited by this policy. LHH will encourage such reporting and will assist in the process.

   c. Incidents shall be reported to the Department Manager and Director of Security immediately. The contract security provider shall be called first for incidents that pose imminent danger of physical harm.

d. Retaliation against anyone who reports acts or threats of violence, or who participates in any procedures or investigations related to such complaints will not be tolerated.

e. All reports will be evaluated promptly, and remedial action will be taken when appropriate.

f. All employees who obtain a ~~protective or~~ restraining order which lists any LHH premises as protected areas shall provide a copy of the order to the SFSO~~contract security provider~~, Director of Security, and their Human Resources representative.

4. Prohibition of Weapons

a. The use or brandishing of any weapon to threaten or assault anyone on LHH premises is prohibited. Unless permitted by law and authorized in writing by the Director of Security in consultation with the Department of Public Health (DPH) director, hospital administrator or designee, employees may not have firearms in their vehicles if they park on LHH premises. The only exceptions to this prohibition are:

   i. Local, state, and federal law enforcement personnel who are required by their agencies to carry weapons may bring them into LHH facilities.

b. As required during any regulatory investigation or as requested by administrative staff, SFSO/~~the~~ contract security provider may be required to produce copies of their operation procedures, training documents, hospital training related to proficiency in core competencies, or participate in interviews pertaining to their services performed at LHH.

5. Searches

a. LHH reserves the right to have authorized personnel conduct searches (e.g., of workspace, company-owned vehicles, clothing, packages, purses, backpacks, etc.) of employees or ~~patients~~ residents that authorized personnel reasonably believe may be carrying a weapon into LHH premises in violation of this policy.

b. Any recommendations for change, additions, clarifications or deletions to these Standard Operating Procedures shall follow LHH's policy on procedures.

6. Threat Management Plan

a. The Director of Security is responsible for ensuring that all LHH premises are covered by a Threat Management Plan.

b. The Security Services Department in collaboration with Hospital Administration is responsible for developing a Threat Management Plan and designating a core

group of individuals responsible for Plan implementation in response to any reports or actions by covered persons, ~~patients~~ residents, or visitors who are or may be in violation of this policy.

c. The contract security provider shall follow the Department of Public Health's policies on privacy that includes the following:

    i.   Authorization for Use and Disclosure of Protected Health Information

    ii.   Data Security Policies

    iii.   DPH Privacy Policy

    iv.   Recording at DPH Facilities

7. DPH, City and County, and LHH Resources

a. The Director of Security in collaboration with the contract security provider provides specialized personnel protection services and specialized investigations.

b. City attorneys advise managers on legal issues and initiate and manage any legal services which may be required (e.g., restraining orders, injunctions).

c. Hospital Administration and the Communication's Department will develop and execute strategies, and publicize these through internal and external communications.

d. DPH Human Resources and Labor Relations assists with questions involving the application of human resources policies, and/or collective bargaining agreement interpretations.

e. Employee Assistance Program (EAP), and the Staff Incident Response Team (SIRT) serves as a resource to Threat Management Team to determine support services needed for covered persons, ~~patient~~ residents ~~s~~, or visitors affected by threats or acts of violence that have occurred on LHH premises or that could reasonably be believed to affect the LHH workplace. Support services may include, but are not limited to:

    i.   Clinical assessment of the individual deemed to be potentially violent.

    ii.   Assess the level of acuity related to the threat/act of violence.

    iii.   Coordination of critical incident management services.

    iv.   Referral to appropriate clinical behavioral services.

v.   Referral to appropriate community services.

f. DPH, City and County, and LHH resources may also include the coordination of outside consultants for threat assessment and case management support as appropriate.

8. Media Relations

a. The DPH Director of Communications will consult with the hospital's Executive Administrator/designee, Director of Security, and others as appropriate, prior to sharing information with reporters or other external audiences.

ATTACHMENT:
Appendix A: Threats and Violence in the Workplace: Prevention and Management Guidelines
Appendix B: Reporting Details for Threats or Acts of Violence
Appendix C: Threat Management Incident Flow Chart
Appendix D: Threat Management Grid
Appendix E: Threat Management Response Grid
Appendix F: Patrol Procedures
Appendix G: Security Incident Report Writing and Investigations
Appendix H: Visitors Screening Process
Appendix I: Arrest Procedure
Appendix J: Laguna Honda Hospital and Rehabilitation Center Security Training Program
Appendix K: Enforcement of the Smoking Policy
Appendix L: Response to Internal and External Emergency Disasters
Appendix M: Security Service Department Job Descriptions
Appendix N: Identification of Employee, Patients/Residents and Volunteers
Appendix O: Personal Safety and Cash Escorts
Appendix P: Security Operations Center
Appendix Q: Security Response Call Procedures
Appendix R: Significant Security Event Notification
Appendix S: Victims of Violent Crime Protection Plan

REFERENCE:
LHHPP 01-03 Hospital Organization Chart
LHHPP 24-07 Visiting Hours
LHPP 24-22 Code Green Protocol
LHPP 70-04 Code Silver
LHPP 70-05 Resident Evacuation Plan
LHPP 70-06 Fire Response Plan
LHPP 70-07 Spill Response Plan
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
LHHPP 76-02 Smoke and Tobacco Free Environment
DPH Organizational Chart – www.sfdph.org

California Penal Code
SFSD 520.217 San Francisco Sheriff's Department Form: Arrest by Private Person

Revised: 16/07/12,23/05/22 (Year/Month/Day)
Original adoption: 16/03/08

Appendix A: Threats and Violence in the Workplace: Prevention and Management Guidelines

These guidelines support the LHH *Workplace Violence Prevention Program*. The guidelines are a tool to assist the Threat Management Team and hospital staff responsible for threat management. The guidelines include:

- An overview of what to include in a threat management plan

- Suggested roles and responsibilities of the threat management team

- Guidelines for threat reporting, investigation, assessment and response

- Criteria for monitoring, evaluation and closure of incidents

- Threat documentation retention requirements

- Incident reporting format

- A threat management flow chart

- Risk assessment and response grids

1.0 Elements of a Threat Management Plan

1.1 Designation of a core group of individuals who are responsible for developing and implementing the Threat Management Plan.

1.2 Creation of protocols for appropriate follow-up/action plan to actual acts/threats of violence which shall include the following elements:

1.2.1 Designation of appropriate levels of authority for decision making.

1.2.2 Prompt, thorough, factual, and coordinated investigation of reports made.

1.2.3 Privacy and confidentiality issues shall be given utmost consideration. Information about the triggering incident and investigation shall be strictly limited to those persons who have a need to know, to include those individuals administering the Threat Management Plan, potential identifiable victims of the threat, city police, the contract security provider, and administrative staff. Distribution of investigation reports or information shall be appropriately limited.

1.2.4 Assessment of the risk utilizing risk assessment and investigation tools.

1.2.5 Coordination with DPH, City and County, and LHH resources, as appropriate.

1.2.6 Timely and appropriate response for varied situations (e.g., critical incident stress debriefing or debriefing of affected staff).

1.2.7 Appropriate provision of benefits and support services for victims and witnesses (may include confidential counseling, security, or other support services).

1.2.8 Security and safety assessment, if required by relevant state law and regulation, including an assessment of trends of aggressive and violent behavior and required training for staff, periodic re-evaluation of physical security applications (e.g., access control procedures, camera installation, alarms or distress buttons), and the establishment of a viable security management plan that ensures a sustained level of security preparedness in vulnerable areas such as Emergency Departments. (For California plans refer to California Occupational Health and Safety Act and California Health and Safety Code 1257.7 and 1257.8 (Hospital Security Act).

1.2.9 Worksite analysis to identify and correct hidden hazards or unsafe conditions (e.g., unlighted areas or areas where access shall be restricted because of the probability of violence).

1.2.10 Consistency with DPH and LHH policies on related issues, transfer laws regarding psychiatric patientsresidents, and employer protocol for appropriate disciplinary action, up to and including termination of employment.

1.3 Staff training and intervention procedures.

2.0 Composition and Responsibilities of Threat Management Team

2.1 The Threat Management Team shall embody a multi-disciplinary perspective, including representatives of front-line management, Risk Management, LHH Administration, DPH Security Services, Human Resources, Psychiatry Department, and Legal. In a situation involving a resident patient or visitor, the Team shall include clinical leadership/providers, and legal who will assist with residentpatient/visitor issues, determinations, and communications. The DPH Communication Officer will be contacted for any incidents that may attract media attention. The Team will not include anyone who is personally involved in the specific situation or who is a target of the act or threat of violence.

2.2 The Team will designate a clearly identified leader. The Team leader is responsible for:

2.2.1 Assembling the team members and ensuring appropriate representation discussed above.

2.2.2 Identifying and assigning tasks to implement a Threat Management Plan.

2.2.3 Adjourning the team meetings, developing the meeting agendas, and making certain meeting minutes are recorded and retained.

2.2.4 The Team is responsible for implementation of the elements required of a Threat Management plan (see Section 1.0).

2.2.5 The Team shall meet regularly and retain minutes of meetings, consistent with LHH records retention guidelines.

2.2.6 The Team shall regularly analyze trends/patterns to revise/update preventive measures.

3.0 Reporting

3.1 The ~~San Francisco Sheriff's Office~~ ~~contract security provider~~ will be called if there is immediate danger to any persons, i.e., perpetrator has a firearm drawn and poses an immediate threat.

3.2 The DPH Director of Security will be specifically identified as the person to whom incidents of violence shall be reported.

3.3 Reports of threats or violence shall be specific and detailed.

3.4 Unusual Occurrence Security Incident Reports can be used or adapted to document threats. Reports shall, at a minimum include the following:

3.4.1 A detailed description of the incident using specific language and quotes where possible

3.4.2 When and where it occurred

3.4.3 Identity and contact information of all involved parties (aggressor/target/witnesses)

3.4.4 Identity and contact information of manager/supervisor of both aggressor and target.

3.5 Managers shall engage with the Threat Management Team to determine who is responsible for Investigation and Risk Assessment.

4.0 Investigation and Risk Assessment

4.1 Investigations shall be prompt, thorough, and well documented. HR will be

included in any investigations involving employee threats. Represented employees are entitled to have union representation if they are involved in an investigation.

4.2 Risk is assessed based upon all relevant information available and after consultation with experts where appropriate. A risk level shall be assigned based on the following criteria:

4.2.1 Low Risk: This rating is consistent with a situation that requires management or security intervention, but where there is little reason to believe the individual's behavior will escalate to a higher level of aggression, where heightened emotion ·is successfully defused.

4.2.2 Moderate Risk: This rating is consistent with a situation that requires management and security intervention and where there is reason to believe the individual's behavior will escalate to a higher level of aggression or violence without specific remedial action.

4.2.3 High Risk: This rating is consistent with a situation that requires management and security (and possibly law enforcement) intervention and where there is evidence to support a high probability of imminent danger of injury or death to one or more individuals.

4.3 The Assessment Grid is a tool to assist in the assessment of risk but shall not be relied upon exclusively.

5.0 Response

5.1 The appropriateness and scope of the response to an act or threat of violence is determined on a case-by-case basis, based on the assessed risk level. The appropriate response for the Threat Management Team varies depending on the assessed risk level.

5.2 The identification and use of internal and external resources also varies based on the assessed risk level:

5.3.1 Low Risk: A manager may handle and resolve a low-risk incident of threat or act of violence without intervention of the Threat Management Team. The manager shall forward a copy of the initial report and a written summary of the assessed level of risk and action taken to the appropriate Threat Management Team member within 24 hours of resolution.

5.3.2 Moderate Risk: A moderate risk incident of threat or act of violence shall be referred to the Threat Management Team. The Threat Management Team may at its discretion, consult with DPH, City and County

resources, or LHH executive leadership for input regarding the appropriate response.

5.3.3 High Risk: A high risk incident of threat or act of violence shall be assessed and managed mutually by the Threat Management Team. This coordination will ensure specialized resources are appropriately factored into the resolution process.

5.4 The agreed upon response shall be documented in a detailed and specific action plan with next steps clearly identified and assigned to appropriate individuals.

6.0 Monitoring, Evaluation and Closure

6.1 For low-risk incidents of threats or acts of violence, Management is responsible for monitoring the success of the action plan and making adjustments when necessary.

6.2 For moderate and high-risk incidents of threats or acts of violence, a designated member of the Threat Management Team will monitor the success of the action plan and will convene the Team as needed if adjustments are necessary.

6.3 The Threat Management Team will periodically review inactive matters to identify trends and best practices.

7.0 Documentation/Retention

7.1 Documentation of incidents involving employee violence will be retained by the Human Resources Department. Incidents involving patients/residents will be maintained in the Resident/Patient Advocate Department. DPH Security investigations will be maintained with the DPH Director of Security. Incidents documented by the contract security provider will be handled in accordance with their operating procedures.

7.2 Threat Management Team meeting minutes and issue logs, tracking status/logs and resolution of reported issues will be retained by the Team.

Appendix B: Reporting Details for Threats or Acts of Violence

1.0   Reporting Responsibilities for Threats or Acts of Violence

Reports of threats or acts of violence may be reported by any employee, physician, resident, contractor, student, or volunteer who is the victim of, or witness to, a threat or act of violence. Residents, or visitors to LHH premises may also make reports when similar circumstances apply. Reports shall be submitted for such acts on LHH premises or when an act is reasonably considered to have an impact on the workplace.

2.0   Types of Threats or Acts of Violence Reported

Reports may include any acts or threats of violence including physical assaults and actions or statements, words, gestures, symbols, intimidation, or coercion that reasonably causes the affected individual or others, to believe their personal safety may be at risk. Examples include, but are not limited to:

Direct threats	Indirect or vague threats
Profanity or abusive language	Physical aggression or assaults
Yelling	Altercations
Stalking	Written or verbal threats
Harassment including repeated phone calls	Aggressive acts
Intimidation	

3.0   Report Details

Incident reports shall include all relevant objective facts and details of the threat or act of violence that occurred. Reports shall not include opinions or subjective perspectives of the incident. Reports shall include:

- What happened
- Where it happened
- Who was involved
- What was said
- Names of others who observed the incident
- Name of person threatened
- Name of person making threat

1.0   Report Submission

Incident reports shall be submitted as soon as possible, and not later than 24 hours after the incident. Reports shall be completed by the manager or supervisor of the victim of a threat or act of violence. If a manager or supervisor is not available, reports shall be taken by any other manager, supervisor, administrator, Human Resources representative, or security personnel.

2.0 Next Steps

The Threat Management Team shall consult with the manager or supervisor who submitted the incident report and assess the risk. If the risk is determined to be a low-level risk, the manager shall be directed to interview witnesses. The Threat Management shall designate an investigator for moderate and high-risk situations. The investigator will complete an incident report, and forward it to the Threat Management Team. The Threat Management Team will work with the manager to develop, implement, and monitor a plan of action to address, and resolve the problem.

Appendix C: Threat Management Incident Flow Chart

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              ┌─────────────────┐
              │ Manager receives│
              │  and documents  │
              │    complaint    │
              └────────┬────────┘
                       │
                       ▼
              ┌─────────────────┐
              │ Manager consults│
              │   with the DPH  │
              │Director of Security│
              └────────┬────────┘
         ┌─────────────┼─────────────┐
         ▼             ▼             ▼
    ┌─────────┐  ┌──────────────┐  ┌─────────┐
    │ Low Risk│  │Moderate to High Risk│ │High Risk│
    └────┬────┘  └──────┬───────┘  └────┬────┘
         ▼              ▼               ▼
  ┌────────────┐ ┌──────────────┐ ┌──────────┐
  │  Manager   │ │TMT Investigates*│ │ Call SFSO│
  │investigates*│ │and conducts   │ │          │
  │and conducts│ │  interviews   │ │          │
  │ interviews │ └──────┬────────┘ └──────────┘
  └─────┬──────┘   ┌────┴─────┐
        ▼          ▼          ▼
  ┌────────────┐ ┌─────────┐ ┌──────────────┐
  │  Manager   │ │   TMT   │ │  TMT and     │
  │documents all│ │consults │ │Manager develop│
  │findings and│ │with necessary│ │and implement a│
  │takes       │ │resources to│ │ process to   │
  │appropriate │ │ further  │ │  monitor and │
  │action to   │ │investigate*│ │resolve the issue│
  │resolve the │ └────┬────┘ └──────────────┘
  │issue       │      ▼
  └─────┬──────┘ ┌──────────────┐
        ▼        │TMT will turn over│
  ┌────────────┐ │investigation* to │
  │  Manager   │ │     SFSO      │
  │completes   │ │(As necessary) │
  │Security    │ └──────────────┘
  │Incident    │
  │Report and  │    * HR and Union
  │forwards to │    Representation
  │TMT         │    should be included.
  └────────────┘
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Appendix D: Threat Management Assessment Grid

The following Assessment Grid is to serve as guidelines to assist the Threat Management Team in developing an action plan to address a threat/workplace violence incident.

Assessment Grid			
	Low Risk	**Moderate Risk**	**High Risk**
Escalating Aggression	- One or two indirect threats or intimidating actions. - Intimidating style, at least occasionally - One or two angry outbursts/hostile style - One or two incidents of perceived harassment - Unacceptable physical actions short of body contact or property damage (e.g. door slamming, throwing small objects)	- Two or more threats with increasing specificity - Conscious intimidation or repeated bullying; impulsive - Repeated angry outbursts/overt angry style, inappropriate to context - Repeated pattern of harassment - Intentional bumping or restricting movement of another person	- Clear, direct, multiple threats; ultimatums-especially to authority; evidence of a violent plan - Intense undissipated anger - Repeated fear-inducing boundary crossing or seeking direct contact; stalking; violating physical security protocols with malicious intent - Grabbing, grappling, striking, hitting, slapping, or clearly using harmful force
Weapons Involvement	- Firearm in home - Long term, sanctioned use (e.g. hunting, target shooting, etc.)	- Firearm in vehicle - Increased training without known reason (e.g., not hunting season, competition approaching, etc.) - Emotionally stimulated by the use of a weapon for any purpose - Acquire new weapons or improve weapon(s) - Inappropriate display not directed toward others	- Carries firearm on person outside of home - Escalated practice or training in association with emotional release or issue preoccupation - Intense preoccupation with or repeated comments on violent use of weapons - Use or display of any weapon to intimidate harm
Negative Mental Status	- Tendencies toward depression, agitation or "hyper" behavior - Tendencies toward suspiciousness, blaming others, jealousy or defensiveness - Low/moderate substance use without links to violence related behaviors - Anger, some felt entitlement, or humiliation over any negative employment action or relationship setback	- Depressed, mood swings, "hyper", or agitated - Paranoid thinking, bizarre views, defensiveness, blaming others, hostile attitude; hostile jealousy - Substance abuse, especially amphetamine, cocaine, or alcohol - Unremorseful but compliant to avoid punishment (e.g. jail) - Mental preoccupation, persistent anger, entitlement, or humiliation over any negative employment action or relationship setback	- Depression unrelenting or with notable anger, high agitation or wide mood swings - High paranoia; homicidal/suicidal thought; psychotic violent thoughts - Substance abuse drives or exacerbates aggression/violence, or verified amphetamine or cocaine dependence - Obsession & strong feelings of anger, Injustice, or humiliation over any negative employment action or relationship setback; feels desperate, trapped
Negative Employment Status	- Possible discipline, negative performance review or termination non-violence related - Bypassed for raise, promotion, recognition or opportunity	- Recent/pending disciplinary action or negative review - Probable/pending termination or demotion, reinstatement unlikely - Unstable employment in last year	- Separation/termination inevitable - Terminated & all legal & other resources for reinstatement or compensation exhausted & ruled against subject

Assessment Grid

	Low Risk	Moderate Risk	High Risk
Personal Stressors	• Mild disruption in primary intimate relationship • Mild financial problems • Minor legal issues • Minor health problems • Inconsistent support system	• Primary relationship disruption (birth, separation, betrayal) • Significant financial pressures – to increase with job loss • Legal problems • Demoralizing health problems • No or marginal support system • Negative coping style	• Recent relationship loss (death, divorce, betrayal, abandonment) • Serious financial crisis • Serious legal problems • Serious health problems • No support system • Destructive coping style • Target of high provocation by associates or intimates
History of Violence and Conflict	• Early life problems at home/school • Pattern of mildly conflictual work relationships in past • Behavior related job turnovers	• Victim or witness to family violence as child or adolescent • History/pattern of litigiousness • Arrests/convictions, non-violence • History of serious work conflicts	• Has violated protective orders • Arrests/convictions for violence • Credible evidence of violent history • Failed parole/probation programs • Highly isolated; "loner" style
Buffers	• Evidence of respect or restraint shown • Responded favorably to limit setting, especially recently • Wants to avoid negative consequences for threatening behavior (e.g., jail, legal actions) • Genuine remorse for scaring people • Genuine understanding that violence or threats is not an acceptable course of action • Lack of inappropriate emotional associations or attachment to weapons • Appropriate seeking of legal help or other guidance with issue • Wants to genuinely negotiate or appropriately resolve differences • Job/relationship not essential to self-worth or survival strategy • Engages in planning for future • Adequate coping responses • Positive family/personal relationships; good support system • Religious beliefs prohibit violence, provide solace • No financial health or legal problems		
Organizational Influence & Impact	• Employee(s) fear of violence • Supervisory/management personal fear of violence • Highly vulnerable specific target(s) of serious harassment/stalking/predatory searching • Fear-induced employee(s) performance disruption, job avoidance/absenteeism • Heavy workload, high stress environment • Generally adversarial conflictual/mistrustful work environment • Counterproductive employee attempts to intervene/prevent violence • Co-worker or supervisor provocation of subject • Co-worker (or others) support of or encouragement of violent course of action • Management lack of knowledge of workplace violence dynamics or warning signs • Management denial or minimization of potential seriousness of situation • Management lack of crisis management experience/skills/tolerance level • Management active negative case management responses • Management resistance to accepting appropriate/specialized assistance • Management unavailability/remoteness from location of situation/key individuals		

Appendix F: Patrol Procedures

1.0 Security Positions and Post Orders:

Each security position will be assigned an area within the hospital campus, including the Hospital, Administrative Buildings, and the surrounding vicinity to conduct routine patrols, respond to security emergencies and non-emergency calls, document security related incidents, and deliver customer service that enhances the care experience for patients/residents, visitors, volunteers, and employees.

SFSO and the ~~The~~ contract security provider will develop position orders (post orders) for each position. The position orders will provide the assigned staff with the position title, day and hours of the position, special instructions pertaining to the position, emergency response information, scheduled locks and unlocks (if applicable), and areas of responsibility for special and routine patrols.

2.0 Interior Patrols/Building Checks:

Interior foot patrols/building checks of the hospital campus will be conducted on a regular basis as directed by the position orders. Building-checks will include ensuring that appropriate areas are secured, checking for security and safety hazards, suspicious persons/activity, and responding accordingly.

Assigned staff will contact hospital staff, introduce themselves and determine if there are any security related issues, they need to be made aware of.

All patrol/building check activity shall be documented, in detail, on the appropriate staff's daily activity report (DAR), or where applicable, the dispatch log.

2.1 During patrol/building checks, the assigned staff will promote a customer friendly environment by:

2.1.1 Watching as they approach all people, make eye contact, and provide proper greeting to persons within 10 feet.

2.1.2 Providing assistance, as necessary to persons showing outward signs of physical pain or illness, or agitation.

2.1.3 Without provoking a confrontation, stopping to investigate all suspicious persons and activity **—race, gender, and religious affiliation are NOT considered suspicious**.

2.1.4 Staff assigned or roving the resident neighborhoods shall check in with the nursing staff regarding security related incidents

3.0 Exterior and Vehicle Patrols:

3.1 Patrols of the campus, building exterior, grounds, parking lots and garages are to be patrolled on a regular basis as directed by the post orders. Patrols will include checking in and around vehicles, loitering activity, checking for evidence of vandalism, burglary, off property crimes, unsecured areas, smoke-free campus violations, parking violation, lighting, and other safety and security hazards.concerns.

3.2 SFSO and Tthe contract security provider's staff will make contact with any suspicious persons, and vehicles on hospital/facility property, according to their contract security provider's operation procedure.

4.0 Building Patrol/Security Checks Checklist:

4.1 The following are areas that shall be included in the interior and exterior building patrols/security checks.

4.1.1 Blocked doorways

4.1.2 Doors that are taped

4.1.3 Material stuffed into the doorjamb

4.1.4 Propped doors or doors fixed so as not to close

4.1.5 Unlocked or broken locks on storage areas

4.1.6 Unsecured electrical panels

4.1.7 Exterior lights not functioning

4.1.8 Landscaping that causes a safety hazard or opportunity for crime

4.1.9 Residents/Patients that appear to have gone AWOL, in accordance with the hospital's Code Green Policy.

4.2 As required, the Facilities Department shall be notified to address facility malfunctions that result in a security breach. SFSO/The contract security provider will provide appropriate provide security coverage protection until the breach has been addressed.

Appendix G: Security Incident Report Writing and Investigation

1.0 Security Incident Report Writing and Investigations

1.1 When responding to a security related incident, SFSO/the contract security provider/security representative will be responsible for investigating and documenting their findings on the appropriate security incident forms. Reports shall be thorough, accurate and informative.

1.2 A security incident report shall be completed for all incidents listed in section 4.0 of this procedure, and all reports shall be completed before going off shift. the contractor security provider's staff goes off shift.

1.3 It is expected that each of the SFSO/contract security provider's employees that respond, or receive information, complete the security incident report according to the following:

   1.3.1 Security Incident/Investigative Report – Completed by the security representative responsible for the initial report.

   1.3.2 Supplemental Report – Completed by each security representative that has additional information to the existing incident report.

   1.3.3 Witness Statements – Completed for all persons interviewed regarding the incident. The statements shall be signed and dated by the witness.

1.4 Interviewing witnesses shall be conducted in accordance with the SFSO/contract security provider's operations policy.

1.5 A DPH specific security incident report number will be assigned to each DPH Security Investigative report. The report number will consist of the facility, year, month, and the next number listed in the incident log, for example: *LHH-16-01-012.*

1.6 The report's narrative shall fully reconstruct the circumstances based on the responding security representative's observations, witness interviews, and forensic evidence

2.0 Submitting and Processing the Security Incident Report:

2.1 Before the end of shift or before leaving from duty, security incident reports shall be completed and submitted to the contract security provider's Watch Commander/sShift sSupervisor

2.2 The Watch Commander/Shift Supervisor contract security provider's shift supervisor will ensure that the incident report is escalated for reviewed in

accordance with their ~~contract security provider's~~ operations procedures.

2.3 All security incident reports will be entered into ~~the~~a reporting database.

2.4 The Director of Security's office will send, electronically, all DPH security incident reports to the appropriate hospital staff and committees in accordance with the Records Retention and Disclosure Policy.

2.5 Request for criminal reports will be made to the appropriate law enforcement agency/Office of the Sheriff.

3.0 Daily Activity Reports (DAR):

3.1 In accordance with the SFSO/contract security provider's operations procedures, a completed DAR will be submitted at the end of the shift to the ~~contract security provider's shift superviso~~r. The DAR serves as a verification record of the date and time the employee worked, the employee's whereabouts during the shift, response activity, time spent during service calls, and people the employee came in contact with during their shift.

3.2 The DAR is a timekeeping document used to verify the employee's actual work hours for the shift.

3.3 The DAR shall be kept current at all times and shall never be more than one hour behind time.

3.4 Entries shall be short and simple.

3.5 Every position change, building patrolled/checked each floor in the building patrolled/checked, and security and safety hazards shall be documented on the DAR.

3.6 DAR CODES:

To measure the productivity of the contract security provider's employee, the following services will be documented on the DAR:

DAR Services:

Alarms	Burglar	Actual
		Human Error
		Malfunction
	Environmental	Actual
		Human Error
		Malfunction
	Fire	Actual
		Human Error
		Malfunction
	Help/Panic Button	Actual
		Human Error
		Malfunction
	Infant Abduction	Actual
		Human Error
		Malfunction
	Other	Actual
		Human Error
		Malfunction
Employee Assist		
Local Law Enforcement On-site		
Medical Assist	Emergency 911 Called	
	Non-emergency 911 Called	
	Non-emergency 911 Not Called	
Motor Vehicle	Citation Issued	Parking Violation
		Speeding
		Reckless Driving
		Other
	Motorist Assist	Locate Lost Vehicle
		Lights On

		Valet Parking
	Notice Issued	
	Towed	
Personal Assist/Behavior Control	Employee	Standby
		Restraint
		Escort
		Transport
		Confidential/No Information ~~Patient~~Resident
		CPR
		Hold
		Watch
		Suicide
	~~Patient~~Resident	Standby
		Restraint
		Escort
		Transport
		Confidential/No Information ~~Patient~~Resident
		CPR
		Hold
		Watch
		Suicide
	Visitor	Standby
		Restraint
		Escort
		Transport
		Confidential/No Information ~~Patient~~Resident
		CPR
		Hold

		Watch
		Suicide
Safety	Biohazard	No Injury
		With Injury
	Burn	No Injury
		With Injury
	Drills/Exercises	Fire Drill
		Bomb Threat
		Weapons of Mass Destruction
		BioTerrorism
		Other
	Fall	No Injury
		With Injury
	Other	No Injury
		With Injury
Visitor Assist		

4.0 Security Incident Categories:

Criminal:		
Assault	On Facility Employee	No Injury
		With Injury
	On In- ~~Patient~~Resident	No Injury
		With Injury
	On Out- ~~Patient~~Resident	No Injury
		With Injury
	On Physician	No Injury
		With Injury
	On Security Staff	No Injury
		With Injury
	On Vendor	No Injury
		With Injury
	On Visitor	No Injury
		With Injury
Battery	On Facility Employee	No Injury
		With Injury
	On In- ~~Patient~~Resident	No Injury
		With Injury
	On Out- ~~Patient~~Resident	No Injury
		With Injury
	On Physician	No Injury
		With Injury
	On Security Staff	No Injury
		With Injury
	On Vendor	No Injury
		With Injury
	On Visitor	No Injury
		With Injury

Bomb Threat	Device Found	No Injury
		With Injury
	No Device Found	No Injury
		With Injury
	With Explosion	No Injury
		With Injury
Burglary	Facility	Forced
		Unforced
	Vehicle	Forced
		Unforced
	Vending Machine	Forced
		Unforced
Counterfeit Currency - Forgery	Bank Notes	
	Checks	
	Money Orders	
	Other	
Death	Homicide	
	Suicide	Attempted/Threatened
		Actual
Disturbing the Peace	Disorderly Conduct	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
	Labor Disturbance	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor

		By Other
	Noise Complaint	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
	Other	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
Drug/Alcohol	Fraud	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
	Other	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
	Possession	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor

		By Other
	Sale	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
	Sought	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
	Use	By Facility Employee
		By ~~Patient~~Resident
		By Visitor
		By Physician
		By Vendor
		By Other
Harassment	Electronic	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor
		Against Other
	Other	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor

		Against Other
	Verbal	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor
		Against Other
	Written	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor
		Against Other
Kidnapping	Custodial Interference	Infant/Child Abduction
		Other
	Other	
Off Property	Assault	No Injury
		With Injury
	Battery	No Injury
		With Injury
	Burglary	Vehicle
		Building
		Other
	Harassment	Written
		Telephone
		Verbal
		Other
	Other	
	Robbery	
	Sex Crimes	

	Theft	Pick Pocket
		Of Auto
		From Auto
		From Person
	Vandalism	▨▨▨▨▨▨▨
Rape	Actual	Of Facility Employee
		Of ~~Patient~~Resident
		Of Visitor
		Of Physician
		Of Vendor
		Of Other
	Attempted	Of Facility Employee
		Of ~~Patient~~Resident
		Of Visitor
		Of Physician
		Of Vendor
		Of Other
Robbery	Actual	Facility Employee
		~~Patient~~Resident
		Visitor
		Physician
		Vendor
		Other
	Attempted	Facility Employee
		~~Patient~~Resident
		Visitor
		Physician
		Vendor
		Other
Sexual Misconduct	Lewd or Lascivious Acts	Facility Employee

		~~Patient~~Resident
		Visitor
		Physician
		Vendor
		Other
	Other	Facility Employee
		~~Patient~~Resident
		Visitor
		Physician
		Vendor
		Other
	Sexual Harassment	Facility Employee
		~~Patient~~Resident
		Visitor
		Physician
		Vendor
		Other
Solicitation		
Theft - Facility	From Auto	Lost/Missing
		Recovered/Found
	Of Access Card	Lost/Missing
		Recovered/Found
	Of Auto	Lost/Missing
		Recovered/Found
	Of Bicycle	Lost/Missing
		Recovered/Found
	Of Cash	Lost/Missing
		Recovered/Found
	Of Computer Equipment	Lost/Missing
		Recovered/Found

	Of Medical Equipment	Lost/Missing
		Recovered/Found
	Of Narcotic Keys	Lost/Missing
		Recovered/Found
	Of Narcotics	Lost/Missing
		Recovered/Found
	Of Prescription Blank/Book	Lost/Missing
		Recovered/Found
	Other	Lost/Missing
		Recovered/Found
Theft - Personal	From Auto	Lost/Missing
		Recovered/Found
	Of Auto	Lost/Missing
		Recovered/Found
	Of Bicycle	Lost/Missing
		Recovered/Found
	Of Cash	Lost/Missing
		Recovered/Found
	Other	Lost/Missing
		Recovered/Found
Threat	Electronic	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor
		Against Other
	Other	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician

		Against Vendor
		Against Other
	Verbal	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor
		Against Other
	Written	Against Facility Employee
		Against ~~Patient~~Resident
		Against Visitor
		Against Physician
		Against Vendor
		Against Other
Trespass/Loitering	Grounds	
	Inside Buildings	
	Parking Areas	
Vandalism	Facility Property	
	Personal Property	
Weapon	Confiscated	
	Held for Safekeeping	
Non-Criminal:		
Accident - Vehicular	Bicycle	No Injury
		With Injury
	Facility Motor Vehicle	No Injury
		With Injury
	Non-Facility Motor Vehicle	No Injury
		With Injury
Animal Control		
Fire	Actual	No Injury

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		With Injury
	Arson	No Injury
		With Injury
	Cause Unknown	No Injury
		With Injury
	Other	No Injury
		With Injury
Missing Person/~~Patient~~Resident	Adult	
	Child	
Property - Facility	Confiscated	
	Damaged	
	Lost/Missing	Access Card
		Narcotics Keys
		Facility Keys
	Other	
	Recovered/Found	
	Serviced	Doors
		Cash Escort
		Chart Run
		Area Check
		Flags
		Mail Pickup/Drop Off
		Power Outage
		Water Leak
Property - Personal	Confiscated	
	Damaged	
	Lost/Missing	
	Other	
	Recovered/Found	

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Suspicious Activity	Contacted by Security Services	Person
		Misuse of Access Card
		Misuse of Member Card
		Vehicle
		Package or Object
		Other
	No Contact	Person
		Misuse of Access Card
		Misuse of Member Card
		Vehicle
		Package or Object
		Other

Appendix H: Visitors Screening Process

1.0 Scope:

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

2.0 Procedure:

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

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

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

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

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

3.0 Limitations on Visitors

3.1 Refer to the LHHPP 24-07 Visiting policy.

3.2 Two visitors at one time are preferred.

3.3 Space constraints may limit the number of visitors.

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

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

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

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

4.0 Visiting Hours

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

5.0 Visitor Screening and Authorization

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

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

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

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

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

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

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

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

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

5.4   Actions when illegal weapons or drugs are found:

5.4.1   Illegal weapons/metal objects

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

5.4.2   Drugs and drug paraphernalia

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

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

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

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

6.0 Visitor Authorization

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

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

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

7.0 Visitor Pass Log

Laguna Honda Hospital and Rehabilitation Center
VISITOR PASS LOG

DATE:	SECURITY REPRESENTATIVE:	POSITION:		

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

Appendix I: Arrest Procedure

1.0 Arrest by a Private Citizen: It is expected that the security provider, when responding to an incident involving an arrest explain the following to the private citizen:

1.1 **Authority (P.C. 834, 837)**

    1.1.1 Any private citizen has the authority to make an arrest when the following incident occurs:

        1.1.1.1 For a public offense committed or attempted in their presence.

        1.1.1.2 When the person arrested has committed a felony, although not in his/her presence.

        1.1.1.3 When a felony has been in fact committed, and the private citizen has reasonable cause for believing that the person to be arrested committed the act.

    1.1.2 Whenever any person is summoned to the aid of any uniformed peace officer, such a person shall be vested with such powers of a police officer as have expressly delegated him/her by the summoning officer or as are otherwise reasonably necessary to properly assist such officer. **(P.C. 839)**

    1.1.3 Any person making an arrest may orally summon as many persons as they deem necessary to aid them in the arrest.

    1.1.4 A private citizen can use a reasonable amount of force in affecting a citizen's arrest when there is reason to believe the person being arrested is resisting arrest.

    1.1.5 Reasonable force is defined as only that force necessary to affect the arrest or protect oneself from a violent attack.

    1.1.6 Excessive force is more than the force necessary to affect the arrest or protect oneself from a violent attack.

    1.1.7 Any person making an arrest may take from the person arrested all offensive weapons which they have on their person and shall deliver them to a law enforcement officer (typically on site).

    1.1.8 An arrest is made by the actual restraint of the person, or by submission to the custody of the person making the arrest. The person arrested may be subjected to such restraint as is reasonable for their arrest and detention.

1.1.8.1   The person making the arrest shall inform the person to be arrested of the intention to arrest them, the cause of the arrest, and the authority to make it, except:

1.1.8.1.1   When the person making the arrest has reasonable cause to believe that the person to be arrested is actually engaged in the commission, or an attempt to commit a felony offense or when a misdemeanor offense has been committed in their presence

1.1.8.1.2   The person to be arrested is pursued immediately after its commission, or after an escape.

1.1.8.1.3 The person making the arrest, shall on request of the person he/she is arresting, informs the latter of the offense for which he is being arrested.

1.1.9 A private citizen who has arrested another for the commission of a public offense shall, without unnecessary delay, deliver the person to a Peace Officer.

1.1.10 The private citizen shall complete an Arrest by Private Person form (SFS~~DO~~ Form 520.517).

1.1.11 The person making the arrest shall prove to the satisfaction of the court of law that the arrest was made in good faith, only after the arresting individual personally knew that the acts were committed in violation of a specific criminal law, State or Federal, the person apprehended committed the offense.

1.1.12 The person making the arrest is personally responsible, both criminally and civilly, for any false arrest. Thus, such persons are subject to defend a legal action in a claim of damages growing out of a false arrest.

2.0 Arrest by a Peace Officer: The security supplier's staff with peace officer authority shall conduct the arrest in accordance with the law as listed below:

2.1 **Authority (P.C. 834, 836)**

2.1.1 A peace officer *"may"* make an arrest under the following circumstances:

2.1.1.1   Pursuant to an arrest warrant.

2.1.1.2 Whenever the officer has reasonable *(*or probable*)* cause to believe the suspect has committed a crime.

2.1.1.3 Whenever the officer has reasonable (or probable) cause to believe a crime has in fact been committed.

2.1.2 Note that only "*reasonable*" or "*probable*" cause is needed: The fact that the officer may be mistaken as to defendant's guilt, of that a crime even occurred, is irrelevant so long as the arrest is made with probable cause to believe one is guilty and that a crime occurred. The arrest would still be lawful.

2.1.3 The use of the word "*may*" in the statute indicates that the officer is under no obligation to make an arrest. It is a matter of discretion whether or not, despite the existence of "probable cause," an arrest will be made. An officer is not generally required to arrest an individual despite the officer's determination that an arrest could legally be made.

2.1.4 "*Posse Comitatus*:" Further, a uniformed peace officer, or any peace officer has statutory authority to command any "*able-bodied*" individual over the age of 18 to assist in an arrest. (**P.C. 150**)

2.1.5 In a domestic violence situation, a peace officer:

2.1.5.1 Shall make a good faith effort to explain to the victim/witness of his or her right to make a private person's arrest; or

2.1.5.2 When responding to a situation involving the violation of a domestic violence restraining or protective order.

2.2 Reasonable Force (P.C. 835a):

2.2.1 Any peace officer who has reasonable cause to believe that the person to be arrested has committed a public offense may use reasonable force to effect the arrest, to prevent escape or to overcome resistance.

2.2.2 A peace officer who makes or attempts to make an arrest need not retreat or desist from his efforts by reason of the resistance or threatened resistance of the person being arrested; nor shall such officer be deemed an aggressor or lose his right to self-defense by the use of reasonable force to effect the arrest or to prevent escape or to overcome resistance.

2.3 Deadly Force (Section 13-410):

2.3.1 The use of deadly force by a peace officer against another is justified pursuant to section 13-409 only when the peace officer reasonably believes that it is necessary:

2.3.1.1   To defend himself or a third person from what the peace officer reasonably believes to be the use or imminent use of deadly physical force.

2.3.1.2   To effect an arrest or prevent the escape from custody of a person whom the peace officer reasonably believes:

2.3.1.2.1   Has committed, attempted to commit, is committing or is attempting to commit a felony involving the use or a threatened use of a deadly weapon.

2.3.1.2.2   Is attempting to escape by use of a deadly weapon.

2.3.1.2.3   Through past or present conduct of the person which is known by the peace officer that the person is likely to endanger human life or inflict serious bodily injury to another unless apprehended without delay.

2.3.1.2.4   Is necessary to lawfully suppress a riot if the person or another person participating in the riot is armed with a deadly weapon.

2.3.1.3   Notwithstanding any other provisions of this chapter, a peace officer is justified in threatening to use deadly physical force when and to the extent a reasonable officer believes it necessary to protect himself against another's potential use of physical force or deadly physical force.

2.4   **Excessive Force Definition:**

2.4.1   Excessive force refers to force in excess of what a peace officer reasonably believes is necessary. A peace officer may be held liable for using excessive force in an arrest, an investigatory stop, or other seizures. A peace officer may also be liable for not preventing another peace officer from using excessive force.

2.4.2   Whether the peace officer has used force in excess of what he reasonably believed necessary at the time of action is a factual issue to be determined by the jury.

3.0 Security Provider Reporting Responsibilities:

3.1   It is expected that the SFSO/contract security provider, upon conclusion of an incident resulting in an arrest or use of force take the following actions:

3.1.1 Notify hospital administration, including Administrator on Duty (AOD), Chief Operations Officer, and the DPH Director of Security

3.1.2 By the end of shift, complete an incident report, including supplemental reports of all responding staff, written statements from all reporting witnesses, and forensic evidence.

3.1.3 By the end of shift, the arrest report (or preliminary report) will be submitted to the security provider's Unit Commander/Account Manager. The Unit Commander/Account Manager will report the incident to the DPH Director of Security.

4.0 Jurisdiction

4.1 The security provider is authorized to pursue/investigate incidents outside of LHH property when the following exist:

1.1.1 Pursuit shall take place without unreasonable delay after a felony offense on LHH property has been committed.

4.1.2 Within the geographical limits of LHH property in accordance to the security supplier's written protocol.

4.1.3 When appropriate, in pursuit of an "AT RISK" ~~patient~~resident.

Appendix J: Laguna Honda Hospital and Rehabilitation Center Security Training Program

1.0 Each of the SFSO/contract security provider's employees shall complete hospital orientation, and participate in an ongoing hospital security training program, which will include the following:

   1.1 A six-week, SFSO sworn staff ~~contract security provider developed, and delivered~~ field training officer program (FTO), including the below subjects. ~~following subjects:~~

   ~~1.1~~1.2   The contract security provider will receive the below training from their Account Manager.

      ~~1.1.1~~1.2.1   New Employee Orientation

      ~~1.1.2~~1.2.2   Emergency Preparedness

      ~~1.1.3~~1.2.3   Care Experience Training

      ~~1.1.4~~1.2.4   Security Operation Procedures

      ~~1.1.5~~1.2.5   Tour of the Hospital Campus

      ~~1.1.6~~1.2.6   Hospital Organizational Structure

      ~~1.1.7~~1.2.7   Use of Standard Precautions

      ~~1.1.8~~1.2.8   Smoke Free Campus

2.0 Each of the SFSO/contract security provider's supervisors, including commanding officer shall complete the following:

   ~~2.1 International Association for Healthcare Safety and Security's Basic and Supervisor Training Course,~~

   ~~2.2~~2.1   Annual Emergency Preparedness Training.

   ~~2.3~~2.2   Annual Core Competency Refresher Training as determined by the contract security provider's commanding officer.

3.0 Documentation of the training will be maintained onsite, and produced during regular compliance audits/regulatory investigations

4.0 The Department of Education and Training ~~Supervisors, Managers, Directors, and Administrators~~ will audit ~~for~~ensure ~~complaince~~compliance ~~that~~ the above list of training topics and applicable policies that require employee signature of

acknowledgement/attestation. ~~are enforced among employees within their departments and with contractors.~~

Appendix K: Enforcement of the Smoking Policy

1.0 Enforcement of the Smoking Policy:

All employees, physicians, volunteers, and contractors share the responsibility to respect and assist in the compliance of ~~enforcing~~ this policy. Any individual found violating this policy shall be politely informed of the facility's No Smoking Policy and asked to extinguish the item or move to a location off campus.

1.1 If the smoker refuses to extinguish their item, ~~the~~ attempt to redirect their focus and attention to the desired outcome by providing clear direction or instruction that includes reasonable choices.~~contract security provider's staff shall be notified of the location of the smoker, and shall respond to enforce the policy.~~

1.2 The contract security provider shall perform patrols throughout the campus on an ongoing basis to ensure adherence to this policy. If the security representative identifies any person in violation of this policy, they will attempt to gain compliance ~~enforce the policy~~ as described in the hospital's Smoking Free Campus Procedure.

1.3 Supervisors, Managers, Directors, and Administrators will ensure that this policy is enforced among employees within their departments and with contractors.

Appendix L: Response to Internal and External Emergency Disasters

1.0 Response To Internal and External Emergency Disasters

   1.1   The purpose of the Laguna Honda Hospital and Rehabilitation Center Plan is to identify routine security operation procedures and describe procedures for the escalation of security protection during emergency and disaster incidents and permit the continuance of current operational functions with minimal interruptions to our employees, patients/residents and volunteers. The emergency operation plan identifies the organization's capabilities and establishes response efforts when the organization cannot be supported by the City and County of San Francisco community services for at least 96 hours.

2.0 Threat Assessment Process

   2.1   The focal point for routine or special intelligence gathering and dissemination will be conducted by the Department of Public Health and the San Francisco Sheriff's Office (SFSO). contractual security provider. Information will be gathered, evaluated, and presented to the Director of Security and Executive Administrator, Administrator-On-Duty, the contract security provider, and the Excutive Commiteeother hospital administration, as appropriate.

      2.1.1   Laguna Honda Hospital and Rehabilitation Center (LHH) will rely on Federal, State and local authorities, including SFSOthe contract security provider for receipt of credible threat warnings. LHH will immediately share information with the appropriate governmental agencies to validate the credibility of a threat or warnings gathered through official and open sources. Credible intelligence will be discussed by the Director of Security and the SFSO Unit Commander with the LHH Executive Administrator, or their designee before recommending a protection level change for the program or for a selected facility (ies) within the program.

      2.1.2   Under exigent circumstances, where there is an imminent threat or an internal/external disaster occurs, local hospital, and Department of Public Health (DPH) communications will be initiated. The local hospital and vise-versa shall communicate per standard operating procedures. The campus-wide execution of the LHH Security Enhancement Plan, will be executed under the direction of the Department of Public Health's Director of Security or designated representative, and in conjunction with SFSO the contract security provider's commanding officer, and after coordination with the appropriate San Francisco City and County Leadership.

      2.1.3   Implementation of an enhanced PROTECTION level will be based on real-time credible intelligence gathered through the news media, the contract security provider, Federal, State, and City law enforcement agencies, the DPH Director of Security, hospital administration, and the Department of

Public Health leadership.

2.1.4 Threats that fall under the Violence in the Workplace Policy require that all employees, physicians, and management staff report any incident where they:

2.1.4.1 Believe they have been the subject of actual or threatened violence, or

2.1.4.2 Have observed or otherwise learned of such conduct by any person employed by LHH, using LHH services, or on LHH premises.

2.1.5 These incidents shall be reported to the Administrator-On-Duty, Executive Administrator, or designed~~Chief Operations Officer~~, and DPH Director of Security.

2.1.5.1 Incidents to be reported include acts or threat of violence which manifest themselves in the workplace; acts or threats of violence stemming from work-related issues which manifest themselves either within or outside the workplace environment; and acts or threats of violence which may be unrelated to the workplace, but which manifest themselves within the workplace.

2.1.5.2 Laguna Honda Hospital and Rehabilitation Center is responsible for developing a Violence Prevention Plan and designating a core group of individuals known as the Campus Security and Safety Committee who will be responsible for plan implementation in response to any reports or actions by employees, ~~patients~~residents, or other persons which are or may be in violation of this policy. Such plans shall meet the requirements of state and federal law and regulations including, but not limited to, the California Occupation Health and Safety Act and California Health and Safety Code 1257.7 &1257.8 (Hospital Security Act).

2.1.6 A protocol for an immediate follow-up plan to actual acts and/or threats of violence shall include the following elements:

2.1.6.1 Designation of appropriated levels of authority for decision making.

2.1.6.2 Prompt, thorough, factual and coordinated investigation of all reports.

2.1.6.3 Consideration of privacy and confidentiality issues. Notification shall be strictly limited to those persons who have a need to know,

to include those individuals administering the Threat Management Plan, potential identifiable victims of the threat, local police authorities and administrative staff.

2.1.6.4 Conscientious designation of persons who shall receive confidential reports related to the incident.

2.1.6.5 Early and continuing assessment of the seriousness of the situation. This assessment shall include an evaluation of the type of risk, the natures and severity of the potential harm, the likelihood that the potential harm will occur and the imminence of the potential harm.

2.1.6.6 Coordination with DPH leadership and resources as appropriate.

2.1.6.7 Utilization of fitness for duty, other psychological examination, or collateral interviews with witnesses or victims for fact finding and/or risk assessments.

2.1.6.8 Confidential counseling and other support services for victims and witnesses separated from any fact finding and/or risk assessment functions.

2.1.6.9 Timely and reasonable response to the situation following an assessment of all facts identified during the investigation.

2.1.6.10 Appropriate case response for varied situations (e.g., critical incident stress debriefing or threat response).

2.1.7 Security and safety assessment as required by California Health & Safety Code Section 1257.7 & 1257.8 for Hospitals and Emergency Departments, including an assessment of trends of aggressive and violent behavior and required training for staff, periodic re-evaluation of physical security applications (e.g., access control procedures, camera installation alarms or duress distress buttons), and the establishment of a viable security management plan that will ensure a sustained level of security preparedness in vulnerable areas.

3.0 Report And Alert Procedures

3.1 Once credible intelligence is received, the Director of Security and the SFSO the contract security provider's commanding officer will be notified. The Director of Security will brief key executives. Protection Level is then implemented as well as the Internal Crisis Communications Plan.

3.1.1 In a serious incident, the Security Operations Center (SOC) shall notify

the SFSO contract security provider's chain of command in accordance with their operations procedure. The Director of Security shall be notified according to the Serious Event Notification Procedure.

3.1.2   For incidents that occur after hours the SOC in coordination with the SFSO Watch Commander contract security provider's shift supervisor will gather all information known at that time, and contact the Administrator-On-Duty, including providing updates as they occur.

3.1.2.1   Operator Services shall be contacted and informed of the incident as required.

3.1.2.23.1.2.1   All security specific messages will be classified "Confidential," and will direct the information to be disclosed only to those authorized personnel with a "need to know"

4.0 Emergency Security Operations

4.1 The SFSO contract security provider's commanding officer shall be notified to request additional staffing as appropriate. contract security staff

4.14.2   The contract security Account Manager shall be notified to request additional staff as appropriate.

4.24.3   LHH representatives who are authorized to make this request are

4.2.14.3.1   DPH Director of Security

4.2.24.3.2   Executive Administrator

4.2.2 Chief Operations Officer

4.2.34.3.3   Administrator-On-Duty

4.34.4   Incident Command Center (ICC), Security Operations Procedures

4.3.14.4.1   Depending on the scale of the impact at LHH, the ICC would be activated to support other DPH facilities and serve as a guiding resource.

4.3.24.4.2   Initially the role of the ICC will be to facilitate data collection, verification and evaluation of situation status, and communication. The ICC will then present data and decisions back to the appropriate leaders, and departments as well as communication externally on behalf of LHH. ICC will coordinate mutual aid requests between operational areas within DPH. (This includes the coordination of all mutual aid requests other than that provided through established discipline-specific systems such as the Disaster Medical/Health, City Law Enforcement and Fire and Rescue Mutual Aid Systems). Receive

and disseminate emergency alerts and warnings.

5.0 Field Operations Procedures

5.1 Primary Responsibilities of the SFSO~~contract security provider~~:

5.1.1 Monitor and have authority over the safety and rescue operations and hazardous conditions.

5.1.2 Organize and enforce scene/facility protection and traffic safety.

5.1.3 Provide appropriate presence in the area of traffic and pedestrian control, crowd management and access control, secure food, water, medical and blood resources, and establish routine briefings with hospital administration and the ICC.

5.2 Primary Responsibilities of the Security Director and SFSO ~~Contract Security Provider's~~ Commanding Officer:

5.2.1 The Director of Security and Commanding Officer are~~is~~ expected to implement emergency procedures to ensure the safety of all staff, ~~patients~~ residents and visitors. These responsibilities are not limited to the individual departments but extend throughout the entire medical center as outlined in the hospital's Emergency Preparedness Plan. ~~Security Officer's Checklist.~~

5.3 Based upon the protection level assigned:

5.3.1 Protection Level 1- At this stage, the disaster causalities will be geographically contained, as determined by the ICC. Additional demands would be for staff and supplies only (Defined as a disaster of unknown magnitude). However, available information indicates that normal hospital resources are adequate to handle the incident: SFSO ~~The contract security provider~~ will assign staff to address traffic control, divert visitors, and personnel, and divert unauthorized personnel.

5.3.2 Protection Level 2- A Level II internal disaster is different from the Level I disaster in that the Incident Command Center (ICC) is partially activated, and treatment areas are established. A Level II external disaster is defined as an incident involving more than one DPH facility, or a disaster in the community that has the potential of exceeding the normal resources of departments within the hospital.

5.3.2.1 The ICC is partially activated. The entire ICC team is not activated initially. All departments are notified accordingly. Additional staff ~~is~~are called, as needed. The SOC will notify the Commanding

Officer, Administrator-On-Duty, Director of Security, and the SFSO Watch Commander. Contract Security Provider's, Shift Supervisor, and staff.

5.3.2.2 All staff and employees remain on-site and continue routine work. Initially SFSO staff the contract security provider's staff will report in to the SOC/Shift Supervisor for instructions. Visitors and outpatients outresidents may remain in the building.

5.3.3 Protection Level 3-5 – SFSO/All contract security provider personnel will receive assignments by their chain-of-command.

5.3.3.1 A Level III disaster is different from a Level I or II in that the ICC is fully activated. A Level III means a large disaster, some 50 to 150-plus casualties. SFSO and the The contract security provider will provide protection to the perimeters of all buildings, secure the hospital and all other buildings, provide crowd management control, access control, and establish a presence.

5.3.3.2 Depending on the circumstances of the event, SFSO contract security law enforcement services in conjunction with SFPDCity law enforcement will establish a security zone around the hospital perimeter, crowd management control, traffic control on public streets, establishing security check points to control access to the hospital campus.

5.3.3.3 Shall the responding SFPOD City law enforcement agency initiate its Incident Command structure, then Hospital Incident Command, the SFSO Contract Security Provider's incident command, and SFPD City Law Enforcement Incident Command would create a Unified Command structure. The Unified Command enables coordination of tasks and resources between the various entities.

6.0 Special Purpose Areas For Security Staffing Considerations

6.1 Triage Area

6.2 Treatment Areas

6.3 Morgue Area

6.4 Media Center

6.5 Labor Pool

6.6 Command Center

6.7 Parking Areas

6.8 Facility Areas i.e., Central Plant, Food and Water Supply areas

7.0   Special Duties – Security Services

7.1 Establish two-way radio communication in the ICC

7.2 Secure the perimeter of impacted area(s)

7.3 Stand by the media center (if designated)

7.4 Media shall not be allowed to enter the building without the specific authorization of the Public Information Officer or designee.

Appendix M: Security Service Department Job Descriptions

1.0 SFSO and Contract Security Provider Job Descriptions:

    1.1 SFSO Commanding Officer/Security Provider Account Manager

        1.1.1 The SFSO Commanding Officer and Contract Security Provider Account Manager manages the security and law enforcement services, at LHHto all DPH facilities, including clinical support services, ent service,; problem solving and resolution,; and operational effectiveness,; preparation of post orders,; staffing,; scheduling,; supervision, and training.

        1.1.2 Implements and oversees the security operation. , including the supervision of all assigned staff and supervisors.

        1.1.31.1.2 Implements and oversees the process for incident reporting and investigations.

        1.1.41.1.3 Assists with the functions of physical and personal security and safety measures of residents, patients, staff, and visitors.

        1.1.51.1.4 Protects staff and facility property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

        1.1.61.1.5 Makes regular hospital and clinic service service rounds to solicit feedback regarding the customer satisfaction contract security provider's service to residents, staff and visitors.internal and external customers. Service rounding shouldwill be documented, and submitted to the Director of Security.

        1.1.71.1.6 Preserves order and may enforce regulations pertaining to staffpersonnel, residentspatients, and visitors on Laguna Honda Hospital and Rehabilitation Center premises.

2.0 SFSO Watch Commander and Contract Security Provider's Shift Supervisor:

    2.1 The SFSO Watch Commander and Contract Security Provider Shift Supervisor contract security provider's shift supervisor is responsible for implementing and overseeing their respective security operations during their scheduled shift by:

        2.1.1 Directing and supervising all assigned staff's activity.

        2.1.2 Reviewing all daily activity and incident reports.

        2.1.3 Interfacing with hospital administrators, managers, and supervisors as

required.

2.1.4 Responding to all security related incidents and emergencies, ~~and~~ coordinating ~~c~~ communications with hospital administration, and their commanding officer/manager~~.~~

2.1.5 Assisting with the functions of physical and personal security and safety measures of resident~~patients~~, staff, and visitors.

2.1.6 Protecting staff and property from theft or damage, persons from hazards or interference, including the potential for violence in the workplace.

2.1.7 Making periodic tours to check for irregularities~~,~~ and inspecting protection devices.

2.1.8 Preserving order and enforcing regulations pertaining to staff~~personnel~~, visitors, and premises as warranted.

3.0 SFSO and Contract Security Provider's Leadership Staff

3.1 The SFSO Leadership Staff and Contract Security Provider's ~~contract~~ ~~security provider's~~ leadership staff are ~~is~~ responsible for assisting with the functions of physical and the personal security and safety measures of residents~~patients~~, staff, and visitors by:

3.1.1 Protecting staff and facility property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

3.1.2 Primary functions include being a first responder to emergency situations. ~~at the assigned healthcare facility.~~

3.1.3 Making periodic tours to check for irregularities and inspecting protection devices.

3.1.4 Preserving order and gaining compliance on hospital policies~~enforcing regulations~~ pertaining to staff ~~personnel~~, visitors, and premises as warranted.

~~3.1.5 In the absence of the contract security provider's shift supervisor, assuming their responsibilities.~~

~~3.0 Contract Security Provider's Training Coordinator~~

~~3.1 The contract security provider's training coordinator is responsible for planning, coordinating, and delivering training to all assigned staff by:~~

3.1.11   Conducting monthly proficiency drills related to the security response of all assigned staff.

3.1.13   Conducting annual competency assessments for all assigned staff.

3.1.15   Supervising and assessing assigned staff's response to security related incidents.

3.1.17   Adapting training programs for specific sites and client's needs.

3.1.19   Implementing conducting and overseeing Emergency Preparedness Training Programs.

3.1.213.1.5 Coordinating training that focuses on defusing aggressive behavior for assigned staff, and client personnel as needed or as directed.

4.0 SFSO Contract Security Provider's Radio Dispatch Operator

The SFSO contract security provider's dispatch operators are directly responsible for answering telephones, acknowledging alarm signals, monitoring surveillance cameras and video recording devices. as assigned throughout the assigned department by:

4.1.1 Providing information to the DPH Security Maintenance Planner regarding system malfunctions. Security Systems Administrator, supervisor and assigned staff as required.

4.1.2 Documenting security related incidents, and responding to security emergencies.

4.1.3 Responding to service calls by dispatching appropriate staffing.

4.1.4 Assisting with security device inspections.

4.1.5 Assisting with producing forensic evidence as directed by the Commanding Officer, or Director of Security.

4.1.6 Assisting with the functions of physical and personal security and safety measures of staff, residentspatients, and visitors.

4.1.7 Assisting with the protection of staff and facility property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

4.0 Contract Security Provider's Telephone Operator

4.1 The contract security provider's dispatch operators are directly responsible for

answering telephones, acknowledging alarm signals, monitoring video recording devices as assigned throughout the assigned department by:

– Providing information to the Security Systems Administrator, supervisor and assigned staff as required.

4.1.8 Documenting security related incidents, and responding to security emergencies.

4.1.8 Responding to service calls by dispatching appropriate staffing.

4.1.8 Assisting with security device inspections.

4.1.8 Assisting with producing forensic evidence as directed by the Commanding Officer, or Director of Security.

4.1.8 Assisting with the functions of physical and personal security and safety measures of staff, patients, and visitors.

4.1.8 Assisting with the protection of staff and property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

5.0 SFSO and Contract Security Provider's Uniformed Patrol and Security Service Staff:

5.1 SFSO Deputies and Cadets and The contract security office provider's patrol, and security services staff are responsible for being a first responder to emergency situations at the healthcare facility by:

5.1.1 Documenting all security related incidents.

5.1.2 Responding to security emergencies.

5.1.3 Making periodic tours to secure areas, providing customer service; , mitigating disruptive behavior; , deterring crimes, and providing verbal de-escalation or non-violent crisis intervention, unless such a mental state incident requires the use of force, which will be concluded in accordance with SFSO the contract security provider's operation procedures and the contract security's training in Non-Violent Crisis Intervention.

5.1.4 Inspecting protection devices as required and checking for irregularities.

5.1.5 Preserving order and gain compliance on hospital policies enforcing regulations pertaining to staff personnel, residents, and visitors, on the and premises, as warranted.

5.1.6 Assisting with the functions of physical and personal security and safety measures of residents patients, staff, and visitors.

5.1.7 Protecting staff and <u>facility</u> property from theft or damage, or persons from hazards or interference, including the potential for violence in the workplace.

5.0 Security Administrative Specialist (DPH Position)

~~5.1 The Security Administrative Specialist is responsible for administrative functions including:~~

~~5.1.7 Incident Report processing, record keeping, and filing, reception, compilation of data for reports, and tracking statistics.~~

~~5.1.7 Monitoring LHH security personnel compliance.~~

~~5.1.7 Data entry.~~

~~5.1.7 Other miscellaneous and/or ancillary tasks as assigned by the Director of Security.~~

5.0 <u>DPH Security Maintenance Planner</u>~~Security Systems Administrator~~ (DPH Position)

5.2 The Security <u>Maintenance Planner</u> ~~Systems Administrator~~ oversees the implementation of hospital's security systems and technology integration by:

5.2.1 Consulting.

5.2.2 Assisting and tracking master system architecture for <u>L</u>~~DPH facilities in order~~ to achieve logical collective implementation.

5.2.3 Providing Contractor/Local support for programming or bringing systems into operations.

5.2.4 Maintaining Security System Server Software Licensing.

5.2.5 Providing liaison for ~~Local~~ Security and Systems designers and manufacturers.

5.2.6 Ensuring design/construction projects are consistent with industry best practices as well as industry design standards, scope, schedule and budgets.

5.2.7 Reinforcing the direction of hospital facility systems, and developing relationships with IT, Facilities, <u>SFSO, and</u> the Contract Security Provider, ~~and Contractors in order~~ to maintain system efficiencies.

5.2.8 Conducting monthly inspections of the hospital security system to ensure functionality.

5.2.9 Implementing the Sheriff's Operations Center, SOCsecurity operation center's program which includes the following:

5.2.9.1 Overseeing the SOC security operation center functions.

5.2.9.2 Producing audit reports, and forensic evidence during investigations.

5.2.9.3 Assisting with the functions of physical and personal security and safety measures of residentspatients, staff, and visitors.

5.2.9.4 Making periodic tours to check for irregularities and inspecting protection devices.

Appendix N: Identification of Employee, Patients/Residents and Volunteers

1.0 Identification of Employees, ~~Patients~~ Residents and Visitors

The following establishes a photo identification badge process that allows immediate identification of employees and physicians by residents/patients, staff, physicians, volunteers, and visitors during work, and complies with Title 22, Senate Bill 956, and Assembly Bill 1439.

1.1 **Scope:** This policy applies to all LHH employees, consultant physicians/providers, contractors and volunteers.

1.2 **Procedure: Requesting an Employee Photo Identification Badge:**

1.2.1 Obtain a Badge/Access Card Request Form from Human Resources.

1.2.2 Fill out the form completely, including the appropriate employee and manager signatures.

1.2.3 Turn in the completed Badge/Access Card Request form to Facility Services.

2.0 Human Resource and Facilities Processing and Distribution of Employee Badges

2.1 Process Badge/Access Card Request Forms

2.2 Badges will include the following information: first name, or initial of the first name, last name, license, or certified title of all physicians, licensed health care professionals, and other certified health care professionals working at LHH. Professional title and department will be displayed, as appropriate. All badge lettering will be in 18-point type.

2.3 Employees are issued an initial badge at no charge. The cost to the employee for the replacement of lost badges is $20.00. **Stolen badges are replaced at no charge with proof of an incident report filed with a law enforcement agency.**

2.4 The replacement of a badge for a change in name or title, or damaged badges will be done for no charge.

2.5 Issue ID Badge to the Employee.

3.0 Badge Programming Process

3.1 The Facilities Department in collaboration with Security Services is

responsible for programming badge access.   The framework for programing badges included creating access levels and creating templates, which detail the locations for each access level. Generally, access levels are based on the following criteria:

3.1.1   **Administrative Access** – Access to all card readers (excluding Pharmacy) is provided to hospital staff functioning in an executive/senior leadership, utility, and fire-life safety role.

3.1.2   **Security Sensitive Area Access** – The Director/Manager of security sensitive areas will serve as the department's gatekeeper. Working with the Facilities Department, the manager/director will provide a list of hospital staff authorized to access their area, or by signing the Badge/Access Card Request Form will approve access for an employee.

3.1.2.1   Access to secured areas is provided to employees that do not have administrative access level badges.

3.1.3   Security Sensitive Areas Defined:

(a.) Administration

(b.) Cash Counting & Accounting Areas

(c.) Central Plant

(d.) Facilities and Engineering Areas

(e.) Human Resource (HR) Areas

(f.) Information Technology (IT) Areas

(g.) Materials Management

(h.) Nutritional Services (Food Storage/Prep Areas)

(i.) Personal Health Information (PHI) Areas

(j.) Pharmacy and Medication Storage Areas

(k.) Radiology

(l.) Security/Law Enforcement Areas

3.1.4 **Clinical Access** – Access to clinical/~~patientcare~~resident-care, and physician areas, including sleep rooms is provided to hospital physicians, residents, medical students, and staff functioning in a direct ~~patient~~resident-care role.

    3.1.4.1   Non-physician care providers must be approved for Security Sensitive Areas.

3.1.5 **Pharmacy Access** – The Pharmacy Director/designee is responsible for the programming of badges that grant access to pharmacy area, medication storage areas, or other controlled substances.

3.1.6 **General Access** – All employee/physician badges will be programmed to access non-security sensitive areas i.e., building exterior, stairwells, and employee common areas.

3.1.7 **Multiple Access Levels** – In cases where an employee's position has responsibility that requires more than one access level, the badge will be program for each level. For Example, a physician that is an executive/senior leader badge would be program for Administrative and Clinical Access, or a volunteer that has been approved to serve on the NM secure unit.

3.1.8 **Temporary Access** – In cases where an employee's position requires that a security sensitive area, excluding Pharmacy, the employee's supervisor will submit an email request to the department's gatekeeper and Facilities Department. The request will include the location, shift hours, and starting and ending dates of the employee's assignment. Once the request is approved, Facilities will program temporary access as requested.

4.0 Wearing the Employee Photo Identification Badge

4.1 The photo identification badge is to be always worn while on hospital property or in the process of providing services on behalf of the LHH, which includes traveling to and from parking structures and their workplace. The photo identification badge shall be worn on the upper half of the body with the name and photograph clearly visible.

4.2 Managers are to inform staff about this policy and the expectation that the photo identification badge is worn while on LHH ~~premesis~~premises~~work~~.

4.3 Managers will ensure that employees wear their photo identification badge on the upper half of the body with the name and photo identification clearly visible.

5.0 All LHH campus employees are expected to question suspicious individuals and immediately report to the contract security provider and the department manager or supervisor**; race, gender, and religious affiliation are NOT considered suspicious**. 1.0

4.45.1 .

4.55.2 To safeguard the badge, to prevent loss and ensure effective security, badges shall not be worn off premises, left on unattended clothing, or otherwise unsecured.

5.06.0 Requesting a Temporary Employee Identification Badge

5.16.1 Employees who fail to bring their badges to work shall inform their immediate supervisor upon entry into the workplace.

5.26.2 The employee's supervisor or designee will inform contract security provider that the employee needs a temporary badge. The supervisor or designee will verify that the person is employed with LHH and is scheduled to work.

5.36.3 The employee shall show California identification and submit the California ID in exchange for the temporary identification badge, and sign the temporary ID log prior to receiving the temporary ID.

5.46.4 The Security Department staff will log-in the employee and the supervisor's name on the temporary identification badge log then take possession of the employee's California Identification.

5.56.5 The employee will wear the temporary badge in a visible location on the upper half of the body until the end of the shift.

5.66.6 At the end of the shift the employee will return to the Security Department to return the temporary badge, receive their California ID, and sign the temporary badge log verifying receipt of their California identification.

5.76.7 The security staff will receive the temporary identification badge at the end of the shift and return the employee's California identification upon receipt of the signature from the employee.

5.86.8 Because the temporary badge does not have a photo or the name of the employee, concerned parties will be able to confirm the employee's name and title by calling the Sheriff's Operations Center ecurity Department at (415) 759-2319, (The phone number will be noted on the temporary badge) and provide the temporary badge number and the date that the employee is working.

5.96.9   If the employee later determines that their badge has been lost the employee shall immediately notify Facility Services to arrange to receive a replacement badge.

    5.9.16.9.1   The lost badge will be deactivated by the Facilities Department.

5.106.10   The employee and manager will complete a request for photo identification badge replacement form at Human Resources.

6.07.0 Recovery of Employee Photo Identification and Access Cards upon Transfer or Termination:

6.17.1   The identification badge is the property of LHH and shall be returned to the department manager or supervisor upon termination, resignation, or transfer from the facility.

6.27.2   Managers will inform staff about the policy and the expectation to return photo identification cards and access cards prior to termination, transfer, or retirement.

6.37.3   Managers will obtain photo identification badges and access cards from staff prior to leaving the premises on the last day of work. Badges and access cards shall be returned to the Facility Services Department.

6.47.4   If the employee leaves without notice or fails to turn in their his/her badge, the manager will call the Human Resources and the Facility Services Department immediately.

6.57.5   Immediately upon being notified that an employee failed to turn in their badge, Facility Services Department will deactivate the badge/access card.

6.67.6   A monthly report listing all employee, physician, transfers, and terminations will be submitted to the Facility Department by Human Resources for reprogramming/deactivation of badges.

7.08.0 Resident/Patient Identification

To ensure proper identification of residents/patients receiving care, treatment, or services at LHH, all residents/patients are identified at the point of initial contact upon registration or admission using at least two resident/patient identifiers (neither to be the resident's/patient's room number or physical location).

Two resident/patient identifiers will be used whenever administering medications or blood products, collecting blood samples and other specimens for clinical testing, or providing other treatments or procedures. A defined process and procedure will be

followed in the management of resident/patient identification. Containers used for blood and other specimens are to be labeled in the presence of the resident/patient.

7.18.1   Resident/Patient Identification Process (Initial Identification)

All in- and outpatients receiving care at LHH are asked to provide identification upon presentation to the hospital. A combination of two identifiers from those listed is used to confirm the resident/patient's identity. The following approved identifiers and sources may be used for positive identification:

7.1.18.1.1   resident /patient name

7.1.28.1.2   date of birth

7.1.38.1.3   medical record number

7.1.48.1.4   medical record card

7.1.58.1.5   government issued photo identification

7.1.68.1.6   last four digits of the social security number

7.1.78.1.7   Sources of resident/patient identifiers may include: the resident/patient, relative, guardian, domestic partner, or a health care provider who has previously identified the /patient.

7.28.2   An identification band will be placed on all inpatients/residents as part of the admission process on the care unit/neighborhood.

7.38.3   The preferred placement of the resident/patient ID band is the upper extremity (right arm preferred) unless physical condition or procedure precludes this (in which case another extremity is used).

7.48.4   Resident/Patient Identification Reconfirmation

Two unique identifiers will be used at LHH to reconfirm resident/patient identification prior to every instance of administering medications or blood products, taking blood samples and other specimens for clinical testing, or performing other treatments or procedures:

7.4.18.4.1   The resident/patient's full name and date of birth on the identification band will be checked against the identifiers on the requisition, medication or specimen collection container label.

7.58.5   Resident/Patient Identification Procedure

The initial identification process will be performed by hospital personnel, who will then apply a resident/patient identification band.

7.5.18.5.1   The Admitting Office staff shall place the plastic identification band on each resident/patient. Residents/Patients admitted directly to an inpatient unit shall have the identification band placed by *nursing personnel* immediately upon receiving the ID band. Nursing personnel shall perform the initial identification process before placing the ID band.

7.68.6 ....Resident/Patient Identification Band

The resident/patient identification band shall remain on the resident/patient until discharge. If an ID band shall be removed for procedural access or other clinical circumstance, another ID band is obtained prior to removing the original, the information is verified by comparing the resident/patient identifiers on the new band with that of the band to be removed, and ID band is replaced at an alternate site.

If at any time, the resident/patient is found to not have an ID band, the initial identification process shall be performed and a replacement ID band applied.

8.09.0 Visitor Passes

8.19.1   All visitors authorized to enter the hospital will be issued a visitor's pass by the contract security provider.

Appendix O: Personal Safety and Cash Escorts

1.0 Personal Safety Escorts

SFSO/The contract security provider isare expected to provide, upon request, to all employees, a personal safety escort, andor cash escort, if applicable, s to employees transporting cash on behalf of the organization. Personal Safety and Cash Escorts shall be considered a priority call and shall be responded to in a timely manner. Personal Safety Escorts include providing vehicle escorts.

Visual escorts involve SFSO/the contract security provider to either maintaining a fixed position, or conducting frequent vehicle patrols to monitor foot traffic.

Employees are encouraged to give 15-minute lead time for escort appointments.

2.0 Procedure – Personal Safety Escorts:

2.1 Upon notification of a request for escort, the Sheriff's ecurity Operations Center (SOC) will respond to the location of the requested escort.in accordance with the contract security provider's operation procedures.

2.22.1 The responding staff person will accomplish the following:

2.2.12.1.1 Greet the staff person to be escorted.

2.2.22.1.2 Confirm the destination of the escort.

2.2.32.1.3 Be aware of their surroundings and remain with the staff person until they are safe inside their vehicle or at the destination of the escort.

2.2.42.1.4 Conduct a visual check around the vehicle and remain with the person until they have started their vehicle.

3.0 Procedure – Cash Deposit Escorts:

3.1 When hospital staff requests an escort to transport cash, the SOC will dispatch the appropriate staff. The responding staff person will accomplish the following:

3.1.1 Make contact with the requestor at the designated location.

3.1.2 If the employee requests to be escorted from their department to transport cash to the Cashier's Office or other destination, the responding staff person will meet the employee at the department and provide the escort.

3.1.3 If the security representative arrives at the designated meeting area before the employee, the security representative will stand by until the employee's

arrival.

3.1.4 When the employee arrives, the responding staff person will provide the escort.

3.1.5 If necessary, advise the employee to keep the deposit in an inconspicuous place.

3.1.6 The responding staff person shall also determine if the employee will need an escort back to the original location~~,~~ or to their vehicle.

3.1.7 In the event of a robbery or attempted robbery, <u>SFSO/</u>~~the contract security provider~~ will follow their operating procedure.

3.1.8 If the hospital staff has routine cash transport duties, it is recommended that the department ~~shall~~ <u>reserve</u> ~~schedule~~ a <u>standing</u> ~~regular fixed~~ appointment with the SOC<u>.</u> ~~for the routine escorts on a daily or weekly basis.~~

Appendix P: Security Operations Center

1.0 Operation Center Training Checklist:

1.1 Understand the purpose and role of the system operator

1.2 Demonstrate the ability to log into the P2000 system

1.3 Demonstrate the ability to open the System Tree Functions

1.4 Demonstrate the ability to review camera footage

1.5 Demonstrate the ability to unlock/lock doors via computer

1.6 Demonstrate the ability to export camera footage files

1.7 Demonstrate familiarity with reader modes

1.8 Demonstrate the ability to search for video files

1.9 Identify main alarm monitoring components and options

1.10 Identify critical and non-critical alarms, and the demonstrate the appropriate response to each

1.11 Demonstrate the ability to respond to Aeroscout Alarms and Code Green Protocol

1.12 Demonstrate alarm acknowledgement features: Single and Group

1.13 Demonstrate the ability to use the Maps Program

1.14 Demonstrate use of trace menu: Zone/Device/Badge/Historical/Live

1.15 Demonstrate the ability to produce and program and photo ID Badge

1.16 Demonstrate the ability to reactivate an inactive access card

1.17 Demonstrate the ability to deactivate an access card

1.18 Familiarize with the badge replacement policy

1.19 Demonstrate the ability to arm/disarm alarm panels

2.0 Operations Center Core Competencies:

2.1 Building Addresses/Number Identifiers

2.2 Alarm Acknowledgement

2.3 Policy on when to dispatch for alarms

2.4 How to check alarm status

2.5 Logging on and off the P2000 security computer system

2.6 Providing access via P2000 security computer system

2.7 Policy for allowing access via P2000 security computer system

2.8 Turning off Emergency Strobe Lights

2.9 Disconnecting an Emergency Phone

2.10 Aware of all radio codes and positions

2.11 ~~Knowledge of the Federal Communications Commission (FCC) call sign~~

2.12 Officer deployment and responsibilities

2.13 Completing Work Order Form

2.14 Opening and closing the P2000 security program

2.15 Locating a camera on the P2000 security system

2.16 Placing a camera on the monitor

2.17 Significant Event Notification Procedures

2.18 SOC Malfunction Procedures

2.19 Procedures for Code Red

2.20 Procedures for Internal and External Disaster Involvement

2.21 Procedures for Code Silver

2.22 Procedures for Code Green

2.23 Procedures for Duress-button response

2.24 Procedures for Emergency Response

2.25 Customer Service

2.26 System Rebooting

3.0 SOC Workflow:
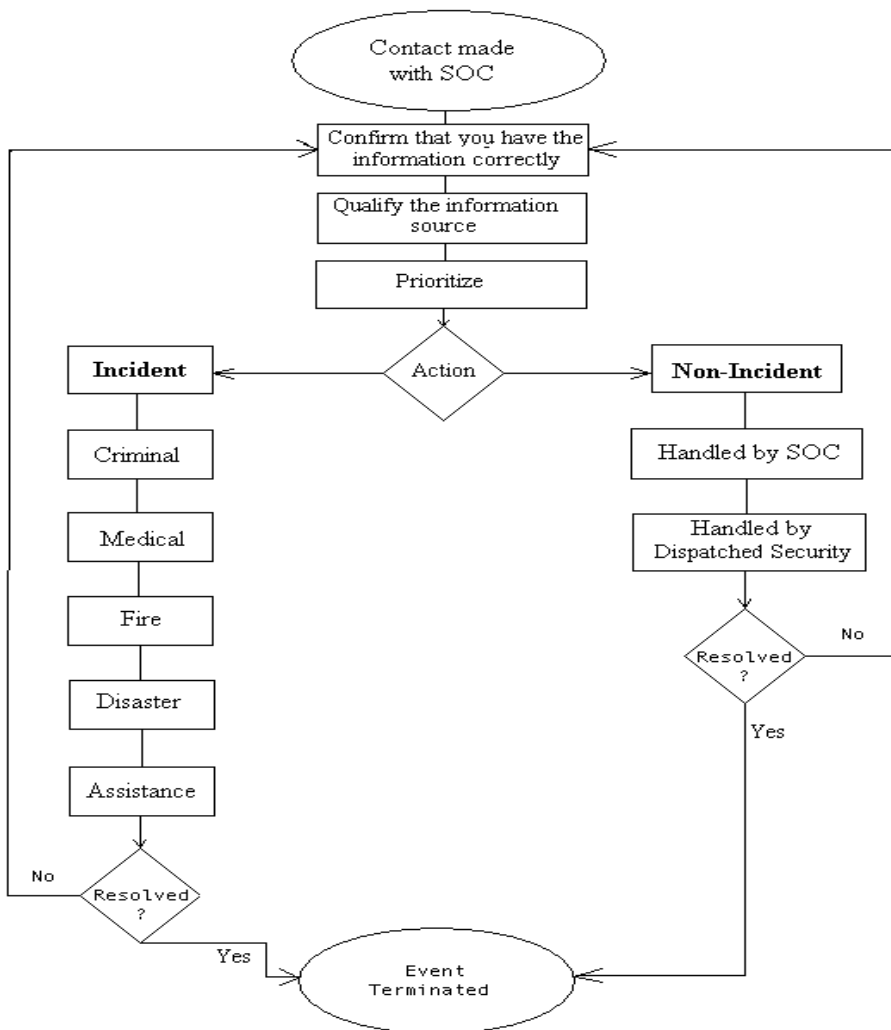
3.1 All cameras should be "called up" and tested for proper view of intended area as well as quality of picture. Inadequate images should be identified, and troubleshooting should be conducted. Any dysfunctional cameras should be replaced immediately.

All door contact alarms should be equipped with cameras that monitor the doors with automatic camera call-up and map location of the local sounder is activated.

3.2 All emergency phones, and AeroScout alarm activations should be equipped with

~~cameras which monitor all exciter locations, and upon activation, call-up camera and map of the local exciter is activated.~~

4.0 SOC System Malfunction Escalation Process:

During a system malfunction, the SOC Operator will be responsible for the following:

4.1 Documenting all system failures, including video and alarm systems.

4.2 Document on the Problem Description Log the following information:

   4.2.1 Date of occurrence

   4.2.2 Entered by

   4.2.3 System Affected

   4.2.4 Description of Problem

   4.2.5 Steps taken to resolve the problem

   4.2.6 Notifications as necessary

   4.2.7 Upon inspection by the contract service provider/facilities engineer, require that they enter the date, initials, and comments regarding the system's status

4.3 Notify the shift supervisor/Watch Commander, and provide the following information:

   4.3.1 Description of problem

   4.3.2 Steps taken to resolve problem

   4.3.3 Update the shift supervisor/Watch Commander of any system status changes.

4.4 The shift supervisor/Watch Commander will contact the contracted service provider and the Facilities Services Department to report the system malfunction.

4.5 Problem Description Log diagram:

SURVELLANCE CAMERAS/VIDEO SYSTEMS/ALARMS/RADIO CONSOLETTE PROBLEM DESCRIPTION LOG							
Date	Entered By	System Affected	Description of Problem	Steps Taken to Resolve Problem	Date	Technician	Comment
Enter date of occurrence	Name and Star #	Which video system or systems were affected	Describe the problem in detail	List all steps taken to resolve the problem(s) and all notifications made	Date Siemens responded	Technician's Name	Additional information provided by Siemens Technician

5.0 SOC Response to a Non-Emergency Service Call:

When the SFScontract security provider is required to respond to a non-emergency service call:

5.1 The dispatcher/phone operator will give an appropriate greeting, and determine the service needed.

5.2 Non-emergency service calls are dispatched in the order of priority according to the contract security provider's operation procedure.

5.3 The response time to respond to a non-emergency service call is 5 minutes from the time the SOC receives the service request from the caller.

5.4 The dispatcher/phone operator should get the requester's contact information to periodically update them on the status of the security response or any delays to provide service

6.0 Security Response to Emergency Call:

When the SFSO contract security provider is required to respond to an emergency service call:

6.1 The dispatchers/phone operator will give an appropriate greeting and determine the security emergency.

6.2 To maintain discretion, while getting pertinent information, the security dispatcher/operator will ask appropriate Yes/No questions. For example:

6.2.1 Is the person in front of you currently?

6.2.2 Has the person displayed a weapon?

6.2.3 Has anyone been injured?

6.3 The dispatcher will dispatch a deputy contract staff to respond. in accordance with the contract security provider's operation procedures.

6.3 Based on the information learned from the caller, the dispatcher/phone operator will communicate the information to the responding deputycontract staff persons.

6.46.3 When possible, the SOC should notify callers waiting for non-emergency service of the delayed response due to an emergency incident.

6.56.4 The response time to respond to an emergency incident is 3.5 minutes from the time the SOC receives the emergency call. The dispatcher/phone operator should get the requesters contact information to periodically update them on the status of the security response.

7.0 Security Response to Duress-Panic Button Activation:

7.0 When the SOC receives a staff duress-button activation, the security dispatcher should immediately dispatch a deputy contract staff to respond. in accordance with the contract security provider's operation procedures.

7.1 When a duress-button is activated, location associated with the duress-button will appear on the dispatcher's monitor, including the location of the panic-button activation.

7.2 The dispatcher/phone operator will acknowledge the alarm via computer and call the phone number for the activated duress-button.

7.3 To maintain discretion, while getting pertinent information, the security dispatcher/phone operator will ask appropriate Yes/No questions. For example:

7.3.1 Is the person in front of you currently?

7.3.2 Has the person displayed a weapon?

7.3.3 Has anyone been injured?

7.3 Based on the information learned from the caller, the dispatcher/phone operator will communicate the information to the responding deputycontract staff persons.

7.4 The response time to respond to a duress-button activation is 3.5 minutes from the time the SOC receives the alarm.

8.0 SOC Response to Civil Disturbance:

8.1 SOC will immediately radio the ~~Watch Commander~~contract provider's shift supervisor, and report the details of the event.~~, including location.~~

8.2 The SOC ~~Dispatch contract staff to respond in accordance with the contract security provider's operation procedures, including~~ accomplishing the following:

   8.2.1 Upon hospital leadership approval, remotely lockdown the facility as directed.

   8.2.2 Notify ~~Ensure~~ Nursing Operations ~~Operator Service's~~ to communicat~~eeion~~ the ~~to activate the~~ appropriate overhead ~~facility~~ response.

   8.2.3 Activate the Significant Incident Notification Procedure.

   8.2.4 Monitor surveillance cameras ~~CCTV cameras~~ of the impacted ~~affected~~ areas and report all suspicious incidents to the Watch Commander. ~~contract provider's shift supervisor.~~ Complete a supplemental report, describing all suspicious incidents.

8.3 When possible, the SOC should notify callers waiting for non-emergency service of the delayed response due to an emergency incident.

9.0 SOC Response to a Bomb Threat:

9.1 SOC will immediately radio the Watch Commander ~~contract provider's shift supervisor~~, and report the details of the event.

9.2 The ~~Dd~~ispatch will follow ~~contract staff to respond in accordance with~~ the hospital's Bomb Threat Procedure.

9.3 SOC will activate the Significant Incident Notification Procedure.

9.4 The SOC will be the clearinghouse for all information associated with the bomb threat and will keep administrative staff, including the Administrator-On-Duty informed of the status of the bomb threat.

9.5 Monitor surveillance cameras ~~CCTV cameras,~~ and report all suspicious incidents to the Watch Commander. ~~contract provider's shift supervisor~~. Complete a supplemental report, describing all suspicious incidents.

9.6 As directed, contact the Nursing Operations to communicate the appropriate overhead message. ~~ensure Operator Service's communication to activate the appropriate facility response~~.

10.0 SOC Response when there is no water supply:

10.1 Gather all detailed information regarding the incident and activate the Significant Event Notification Procedure.

~~10.1~~ As information is received, dispatch the Watch Commander~~contract staff to respond in accordance with the contract security provider's operation procedures.~~

~~10.1~~ Contact the Nursing Operations to communicate the appropriate overhead message. ~~Ensure Operator Services communication to activate the appropriate facility response.~~

10.2 Contact the Engineering Department, Environmental Services, and the Hospital Command Center as required.

11.0 SOC Response to hazards/spills:

11.1 If the SOC is called to support a hazardous spill, they will dispatch the Watch Commander ~~contract security provider's shift supervisor~~ to assess the situation, and determine the appropriate public safety ~~security~~ response, including accomplishing the following:

   11.1.1 Prevent anyone from entering the area

   11.1.2 Assist with evacuation as directed

11.2 Activate the Significant Incident Notification Procedure.

11.3 Contact the Nursing Operations to communicate the appropriate overhead message ~~Ensure Operator Service's communication to activate the appropriate facility response.~~

~~11.3 Notify the Department of Workplace Safety and Emergency Management at 4-3321.~~

11.4 Notify the Watch Engineer.

~~11.4 Upon hospital leadership approval, remotely lockdown the facility as directed.~~

12.0 SOC Response to a power outage

12.1 If the SOC is called to support a campus power outage, they will dispatch the Watch Commander ~~contract security provider's shift supervisor~~ to assess, and determine the appropriate response, including accomplishing the following:

   12.1.1 Notify the Engineer Department~~, if applicable~~

12.1.2 Receive direction from the Engineering Department and Hospital Command Center if applicable

12.1.3 Deputies and contract security staff may be required to Pprevent anyone from entering the area. as directed

12.1.4 Assist with evacuation/escorts as directed

12.1.5 Activate the Significant Event Notification Procedure.

12.1.5 Upon hospital leadership approval, remotely lockdown the facility as directed

12.1.6 Ensure that the offices are secured in impacted buildings.

12.1.7 Limit visitation as directed

12.1.8 Maintain communications with appropriate leaders as directed/appropriate

13.0 SOC Response to a person trapped in an elevator

13.1 If the SOC is called to support a report of a person(s) being trapped in an elevator, determine the elevator location, and building address, and dispatch the Watch Commander and the Engineering Department contract security provider's shift supervisor to assess, and determine the appropriate response, including accomplishing the following:

13.2 Receive direction from the Engineering Department if applicable

13.3 Provide appropriate information to the responding deputy. contract security staff.

13.4 As required ensure that communication is maintained with the person(s) in the elevator determining the following:

13.4.1 If anyone is injured

13.4.2 If anyone is experiencing any physical illness

13.4.3 How many people are in the elevator?

13.4.4 How long has the elevator been inoperable?

13.5 As required, ensure that the fire department and the elevator service company have been notified.

13.6 Maintain communication with appropriate leaders as directed/appropriate

13.7 The response time to respond to an elevator assist is 3 minutes from the time the SOC receives the alarm.

13.8 If the responding deputy ~~contract security provider staff~~ is required to maintain communication with the trapped person(s), encourage them to remain calm, and periodically assess their physical and mental wellbeing until they are freed from the elevator.

13.9 Document the incident including the names of the victims, their witness statements, and contact information of all respondents.

14.0 Missing Resident Response:

If the SOC is called to respond to a missing resident, obtain "Emergency Notification of Missing Resident" form from Nursing Operations or Nurse Manager (refer to LHHPP 24-22 Code Green Protocol). The form shall include a full description, including name, age, ethnicity, sex, hair color, height, weight, eye color, description of clothing, mental status, and any other pertinent information.

14.1 Dispatch the Watch Commander~~contract security provider's shift supervisor~~ to assess, and determine the appropriate response, including accomplishing the following:

14.1.1 Activate the Significant Event Notification Procedure.

14.1.2 Maintain communications with appropriate leaders as directed/appropriate.

15.0 Active Shooter Response:

If the SOC is called to respond to an incident involving an active shooter, refer to LHHPP 70-04 Code Silver for notification and Incident Command procedure.

15.1 Dispatch the Watch Commander ~~contract security provider's shift supervisor~~ to assess and determine the appropriate response.

15.2 As directed, communicate with the SFSO ~~contract security provider's~~ chain-of-command for immediate support.

15.3 Activate the Significant Incident Notification Procedure.

15.4 Maintain communications with appropriate leaders as directed/appropriate.

16.0 Operations Center Systems and Processes:

16.1 P2000 Security System

P2000 is a company which manufactures both hardware and software for the purpose of electronic security. The hardware ranges from the alarm contacts, to switches, to alarm panels which control the signals and communication process. Some panels function independently should something happen to the server or host computer. Other devices must be in constant contact with the host or server in order to function. Alarm signals going directly into P2000 will allow the Operator/Dispatcher to <u>receive and</u> acknowledge alarm activity.

The system can accumulate data from the field, storing it in a retrievable fashion, and also is capable of combining the badging process with access card control activity.

16.2 Alarms – Structuring, Priorities

Alarm signals should appear in a "coded" format that allows the dispatcher/phone operator, at a glance to make sense of the alarm, in order to take action. The code will indicate the facility, building, and location, and type of alarm i.e. duress alarm, motion detector, intrusion alarm, and AeroScout alarm.

P2000 allows for prioritizing incoming alarms, so that a high priority alarm is not knocked off the viewing screen by a low priority alarm. P2000 makes the lowest priority a lower number and the higher the priority the higher the numbering sequence. Duress alarms, Safe Door alarms, Narcotics Cabinets, etc, are highest levels, while an alarm on an interior door for a storage area would be a (much) lower priority.

P2000 is also an alarm monitoring software, which allows for incorporating camera control into the same "window". "Wav" files can be attached to categories of alarms, in order to attract the attention of the dispatcher/operator to specific "higher" categories of alarms and conditions.

17.0 Releasing Information outside the SOC

The Records Retention and Disclosure Policy address the process for obtaining LHH security records, reports, and video surveillance footage. Except for criminal law enforcement reports, all written and forensic records occurring on LHH premises are the property of Laguna Honda Hospital and Rehabilitation Center.

All requests for information should be forwarded to the Department Information Office, Deputy City Attorney, or DPH Director of Security.

Requests for criminal reports should be addressed to the appropriate law enforcement agency.

18.0 Notifications of Events & Incidents

The following is a list of significant events, which if occuring(ed) on the Laguna Honda Hospital, and Trauma Center will require an electronic/phone communication from the contract security provider to the DPH Director of Security:

18.1 Arrest activity involving the use of force

18.2 Robber

18.3 Facility Property Theft (in excess of $950)

18.4 Sex Offense

18.5 Homicide

18.6 Suicide

18.7 Internal and External Disasters

    18.7.1 Bomb Threats

    18.7.2 Fire

    18.7.3 Natural Disasters

18.8 Significant Law Enforcement activity at the facility that involves use of force

18.9 Significant Media activity at the facility

In addition to the DPH Director of Security, at a minimum, the following should be notified of any significant events:

18.10 Administrator-On-Duty

18.11 Security Provider's Chain of Command

Appendix Q: Security Response Call Procedures

1.0 Purpose

To clearly define the process and expectations of SFSO/~~the~~ contract security provider when responding to request for security/law enforcement services.

2.0 Non-Emergency Service Calls:

2.1 When the Sheriff's ~~ecurity~~ Operations Center (SOC) receives a non-emergency service call, the SOC Operator will answer the phone with an appropriate greeting. "Sheriff's Operations Center, how may I assist you?~~.~~"

~~2.2~~ Non-emergency calls-for-service ~~calls~~ will be dispatched in order that they were received, upon a deputy's available to take the service ~~accordance with the contract security provider's operation procedures.~~

~~2.3~~2.2   The expected response time to respond to a non-emergency call-for-service ~~call~~ shall not exceed 10-minutes from the time the SOC receives the service request from the caller. The SOC operator will record the requesters contact information, including name and phone number. In the event of a delay in response, periodic updates will be made to the caller.

3.0 Emergency Service Response Calls:

3.1 The SOC operator will answer the phone with an appropriate greeting.

3.1.1 To maintain the caller's discretion, the SOC operator will advise the caller not to hang-up and begin gathering pertinent information.

3.2 Based on the information learned from the caller, the SOC operator will dispatch deputy ~~staff~~ to respond to the emergency, providing information regarding the incident.

3.3 SFSO ~~The contract security provider's staff~~ will respond to emergencies in accordance with their ~~contract security provider's~~ operation procedures.

3.3.1 It shall be the responsibility of the SFSO Watch Commander ~~contract security provider's leadership~~ to provide oversight of the incident, and communicate with hospital leadership, including the Chief Executive Officer, ~~Administrator,~~ Administrator-On-Duty, and the DPH Director of Security.

3.4 Security emergencies are expected to be responded to in a timely manner. All non-emergency tasks shall be disrupted, and the responding staff person will explain the need to respond an emergency.

3.5   When possible, the SOC shall notify callers waiting for non-emergency service of the delayed response due to an emergency incident.

3.6   The expected response time to an emergency incident shall not exceed 3.5 minutes. minutes.

3.7   Response time begins at the point that the SOC receives the emergency call. The SOC shall get the requesters contact information to periodically update them on the status of the response.

3.8   The responding personnel is expected to maintain safety when responding to an security emergency call-for-service. emergencies. Where necessary, responding staff shall call the elevators to their location, and announce to passengers, the need to respond to a security emergency.

4.0 Response to Duress Button Activations:

4.1   When the SOC receives a duress-button activation, will dispatch a deputy to respond. the operator will respond in accordance with the contract security provider's operation procedures.

4.2   The SOC operator will contact the department to confirm receipt of the alarm and gather additional information to provide to the responding deputy.staff.

4.3 In addition to radioing staff, the SOC operator will acknowledge the alarm via computer, and document the alarm in the appropriate log., in accordance with the contract security provider's dispatch procedures.

4.44.3   The respondng deputy(s) will treat an activated duress-button as a priority call-for-service. assigned staff that are dispatched to a duress alarm activation are expected to respond immediately. All non-emergency tasks shall be disrupted, and responding staff person will explain to the caller the need to respond to an emergency.

4.54.4   The expected response time to a duress-button activation shall not exceed 3.5 minutes.

4.64.5   The responding deputies personnel are expected to maintain safety in responding to a duress-button activation. When necessary, responding staff shall call the elevators to their location, and announce to the passengers the need to respond to a security emergency.

4.74.6   Immediately upon conclusion of the duress-button incident, if applicable, the responding deputy staff will reset the alarm, and ensure that the SOC has a reset reading before leaving the scene.

5.0 Bomb Threat Response:

5.1   Hospital staff are trained to respond to a bomb threat as follows:

   5.1.1 Remain calm and listen carefully to language, background noises and other details.

   5.1.2 Obtain as much information as possible and write out the exact words used by the caller.

   5.1.3 Listen very carefully to the caller, obtain as much information as possible, and record the information.

   5.1.4 Interrupt only to ask:

      5.1.4.1 When is the bomb going to explode?

      5.1.4.2 Where is the bomb right now?

      5.1.4.3 What kind of bomb is it?

      5.1.4.4 What does it look like?

      5.1.4.5 Why did you place it?

5.2   Notification Process:

   Any person receiving a bomb threat will notify the SOC from either the external emergency phone number or the internal emergency extension number.

   5.2.1 The SOC will respond in accordance with SFSO's the contract security provider's operation procedures, including activating the Significant Event Notification Procedure.

   5.2.2 The SOC will be the clearinghouse for all information associated with the bomb threat and will keep administrative staff, including the AOD, informed of the status of the bomb threat.

      5.2.2.1 Knowledge of the existence of a bomb is to be restricted to those individuals who have a need to know in order to prevent general overreaction and panic.

5.3   Bomb Search Evacuation Process:

   SFSO The contract security provider will follow the bomb threat process and evacuate, according to LHH Bomb Threat Procedure.

6.0 Fire Response (Code Red):

During a Code Red, SFSO ~~the contract security provider~~ will respond according to LHH Code Red (Fire) Procedure.

6.1 Key Points during a Code Red:

6.1.1 A decision to evacuate shall come from the Hospital Incident Command System of SFFD.

6.1.2 SFSO ~~The contract security provider will~~ will receive all direction from the Facilities Department.

6.1.3 In hospital neighborhoods/care units, residents ~~patients~~ may be evacuated horizontally (from a danger area to a safe area on the same floor).

6.1.4 People are allowed to re-enter the evacuated area when SFFD informs the hospital (or Facilities Department) "all clear".

~~**6.0 Cardiac and Respiratory Arrest Response (Code Blue):**~~

~~When called to address a security related issue surrounding a Code Blue (Cardiac/Respiratory Arrest), the role of the contract security supplier's staff will be to provide the following:~~

~~6.1 Respond to the scene of the Code Blue and assume crowd control duties, including any person(s) interfering with the code response team, while providing treatment to the patient.~~

~~6.1 While using tact and showing compassion, direct visitors and family members away from the scene.~~

~~6.1 The contract security provider will maintain their position until cleared by the Code Blue Team Leader~~

~~6.1 Document the response on a Daily Activity Report, and Security Incident Report~~

7.0 Civil Disturbance Response:

The likelihood of a civil disturbance may be precipitated by social, political and weapons victim related tensions. Civil disturbances range from relatively small incidents that affect only one area to large scale riots that affect the entire city, state or nation. The impact on Laguna Honda Hospital and Rehabilitation Center will be the treatment of casualties and the implementation of security measures, including increasing security presence to address crowd control, and locking down the facility to mitigate risk to staff, visitors and ~~patients~~ residents from civil disturbance activity.

In accordance with the LHH Shelter in Place Policy for security emergencies, the purpose of this policy is to protect the health and welfare of all occupants within the hospital and surrounding offices during a civil disturbance incident.

7.1 During a Civil Disturbance the SOC will be expected to respond in accordance with SFSO ~~the contract security provider's~~ operation procedure, including accomplishing the following:

   7.1.1 Utilize video surveillance, monitoring all exterior entrances and exits.

   7.1.2 Ensure that the Executive Administrator has been notified.

   7.1.3 Ensure that the Administrator-On-Duty (AOD) has been notified.

   7.1.4 Activate the Significant Event Notification Procedure.

7.2 SFSO ~~The contract security provider's staff~~ will respond to the civil disturbance according to ~~the~~ their operation procedure, including providing protection to sensitive utilities/~~areas~~areas, as ~~to~~required, to prevent tampering or damage to these services:

   7.2.1 Central Plant

   7.2.2 Main Gas Feed

   7.2.3 Sprinkler System Pumps and Valves

   7.2.4 Liquid Oxygen Tanks

   7.2.5 Hazardous Waste Storage Areas

   7.2.6 IT Server Rooms

~~7.2~~ If the situation~~s~~ warrants, SFSO ~~the contract security provider~~ will provide protection to Facility Services ~~facility~~ employees that ~~are required to~~ secure glass entrances with plywood to deter vandalism~~., protect property and secure the entrances.~~

8.0 Hazardous Material Incident Response:

In the event SFSO ~~the contract security provider~~ is contacted to respond to an incident involving hazardous material, refer to the Hospital Policy Spill Response Plan.

9.0 Missing At Risk Patient/Resident Response:

In the event SFSO ~~the contract security provide~~r is contacted to respond to an incident involving an At-Risk ~~Patient/~~Resident, the following shall be accomplished in accordance with LHH Code Green Procedure:

9.1   Upon obtaining a full description of the ~~patient~~resident, the Watch Commander ~~contract security provider's shift supervisor~~ will deploy deputies~~contract security provider staff~~ to designated locations to establish a perimeter and begin the search for the missing resident~~patient,~~ according to their operation procedure.

~~9.1~~   If the ~~patient~~ resident is found, and based on the protective hold, SFSO will persuade the resident to return and notify Nursing Operations to assist.   ~~by the contract security provider, the contract security staff will return the patient to the unit for an evaluation by the primary care team.~~

9.2   If necessary, SFSO will notify ~~via telephone or radio to~~ the following:

9.2.1   San Francisco Police Department

9.2.2   MUNI

9.2.3   BART

10.0 Active Shooter Response:

In the event SFSO~~the contract security provider~~ is notified ~~contacted~~ to respond to an incident involving an active shooter, the following shall be accomplished in accordance with LHH Code Silver Procedure.

Upon receiving pertinent information, in accordance with the SFSO ~~contract security provider's~~ operation procedure, they ~~contract security provide~~r will accomplish the following:

10.1 Communicate with the SFSO ~~contract security provider's~~ chain-of-command for immediate support.

10.2 Respond immediately.

10.3 Initiate the Internal and External Disaster Response Procedure, including accomplishing the following:

10.3.1 Depending on the circumstances of the event, law enforcement services in conjunction with local law enforcement will establish a security zone around the hospital perimeter, perform crowd control, and traffic control on public streets, and establish security check points to control access to the hospital campus.

10.3.2 Shall the responding City law enforcement agency initiate its Incident Command structure, then the contract provider staff and law enforcement staff shall be part of ~~the~~ a Unified Command structure. The Unified Command enables coordination of tasks and resources among the various entities.

Appendix R: Significant Security Event Notification

1.0 Purpose Statement:

The purpose of the Security Significant Event Notification Procedure is to define significant security ~~events and~~ describe procedures for escalation and reporting of the event(s).

2.0 Significant Security Events:

2.1 The following is a list of significant security events, which if occuring(ed) on the Laguna Honda Hospital and Rehabilitation Center Campus will require an electronic/phone communication from SFSO ~~the contract security provider~~ to the DPH Director of Security:

2.1.1 Arrest activity involving the use of force

2.1.2 Robbery

2.1.2 Facility Property Theft (in excess of $950~~1,000~~)

2.1.3 Sex Offense

2.1.4 Homicide

2.1.5 Suicide

2.1.6 Internal and External Disasters

2.1.7.1 Bomb Threats

2.1.7.2 Fire

2.1.7.3 Natural Disasters

2.1.7 Significant law enforcement activity at the facility that involves use of force

2.1.8 Significant media activity at the facility

3.0 Significant Security Event Notification:

3.1 Upon experiencing a significant security event, SFSO ~~the contract security provider~~ will be responsible for notifiying at a minimum, the following:

2.1.1 Administrator-On-Duty

3.1.2 S~~FSO~~~~ecurity Provider's~~ Chain of Command

3.1.3 Executive Administrator

3.1.4 DPH Director of Security

3.2 As additional information regarding the event becomes available, follow-up notifications will be made available to those listed in section 3.1.1-4.

3.3 The DPH Director of Security in conjunction with the following will coordinate the appropriate response plan:

3.3.1 Executive Adminstrator

3.3.3 Chief Operating Officer

3.3.4 Administrator-On-Duty

4.0 Significant Security Event Notification Workflow:

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┌─────────────────┐     ┌──────────────────────┐     ┌────────────────────────────────────────┐
│ Significant     │────▶│ Contract Security    │────▶│ Contract Security Provider Initiates   │
│ Security Event  │     │ Provider Response    │     │ Notification                           │
│ Occurrence      │     │                      │     │                                        │
└─────────────────┘     └──────────────────────┘     └────────────────────────────────────────┘
                                                                         │
                                                                         ▼
┌───────────────────────────────────────────────────────────────────────────────────────────┐
│  Executive Administrator     DPH Director of Security     Security Provider's Chain of Command │
└───────────────────────────────────────────────────────────────────────────────────────────┘
                                        │
                                        ▼
                        ┌──────────────────────────────────┐
                        │ Director of DPH                  │
                        │ Executive Administrator          │
                        │ Administrator-On-Duty (AOD)      │
                        └──────────────────────────────────┘
                                        │
                                        ▼
                        ┌──────────────────────────────────┐
                        │ Significant Security Event        │
                        │ Administrator-On-Duty Notified    │
                        └──────────────────────────────────┘
                                        │
                                        ▼
                        ┌──────────────────────────────────┐
                        │ Executive Administrator/Designee  │
                        └──────────────────────────────────┘
                                        │
                                        ▼
                        ┌──────────────────────────────────┐
                        │ Chief Medical Officer and Chief   │
                        │ Nursing Officer                   │
                        └──────────────────────────────────┘
                                        │
                                        ▼
                        ┌──────────────────────────────────┐
                        │ Executive Staff, beginning with   │
                        │ DPH Public Information Officer     │
                        │ (PIO)                             │
                        └──────────────────────────────────┘
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Appendix S: Victims of Violent Crime Protection Plan

1.0 Purpose

The scope is to establish guidelines for a ~~patient~~/resident that requires special arrangements for protection due to threatening circumstances.

2.0 Procedure

To aid in managing the protection of a ~~patient~~/resident who requires security protection. Visitors will be screened against the authorized visitors list, as provided by the ~~patient/r~~resident.

2.1 The SFSO Watch Commander ~~contract security provider's shift supervisor~~ will receive information regarding any ~~patient~~/resident that requires security protection.

2.2 It is acknowledged that during off hours, or as the situation demands, the AOD speaks with the authority of the Executive Administrator in their absence. When operational and security demands warrant, the AOD has the power to authorize additional deployment of SFSO/contract security provider personnel. The AOD will convey such need to the SFSO Watch Commander or contract security provider's shift supervisor.

2.3 The appropriate medical/nursing staff, and the SFSO/contract security provider will gather from SFPD ~~city law enforcement~~, information regarding the level of the threat, and the potential impact on the hospital regarding any attempt of violence against the ~~patient~~/resident.

2.4 SFPD and SFSO ~~City law enforcement~~ measures may include assigning a law enforcement ~~police~~ officer outside the ~~patient's~~/resident's room.

2.5 The SFSO/contract security provider's staff will conduct frequent patrols on the unit, including addressing any disruptions to resident-care and employee safety. ~~large crowds forming on the unit.~~

3.0 ~~Patient/~~Resident Protection Visiting Process

Authorized visitors will be limited to immediate family members or surrogate decision maker, and those visitors approved by the ~~patient~~/resident. All other visitors will be denied access in accordance with the LHH Visiting Policy.

3.1 Information regarding the resident ~~patient~~ will be provided by the appropriate nursing/medical staff ~~only~~ to the next of kin that has been approved by the ~~patient~~/resident.

3.1.1 Media inquiries regarding the resident ~~patient~~ will be addressed by the Public Information Officer.

3.1.2 All other inquiries regarding the ~~patient/~~resident will be addressed by the neighborhood's nurse manager or designee.

PUBLIC ACCESS AND DEFINED RESTRICTED AREAS

POLICY:

Public access is available, except in defined restricted areas, at the Laguna Honda Hospital and Rehabilitation Center (LHH) campus.

PURPOSE:

To protect residents, volunteers, visitors and employees, as well as physical structure, supplies and equipment within the hospital and campus setting.

PROCEDURE:

1. The following persons have public access to the hospital:

    a. Staff performing work on regularly scheduled shifts.

    b. If greater than one hour before or after assigned work hours, employee shall first report to the shift supervisor and declare the purpose, place and duration of the visit.

    c. No specific permission is required to visit the Human Resources or Payroll offices during normal business hours.

2. The following persons have restricted public access to the hospital:

    a. Current admitted residents with assigned neighborhoods and their approved visitors.

    b. Refer to LHHPP 24-07 Visiting Hours for approved access to LHH.

    ~~c.~~ Drop-in visitors shall be provided with public access information by <u>SFSO/</u>the security contract provider. ~~During business hours of 8:00 a.m. and 5:00 p.m. drop-in visitors shall be directed to the Administration office for further assistance.~~

    ~~d.~~<u>c.</u>   Volunteers making contributions to specific department or have program assignments.

    ~~e.~~<u>d.</u>   Vendors and/or other LHH partners with an appointment for official business with a supervisor.

3. Defined restricted areas without public access include floors:

    a. Second floor service area corridor connecting new building and Administration building.

b. Floors six, seven and eight in the Administration building.

4. All staff can contribute to a safe and secure environment by greeting, assisting, and redirecting any person not wearing proper identification, preventing tailgating by closing all doors behind them when entering or leaving, and ~~Staff shall not interfere with anyone's presence, but~~ immediately report~~ing~~ the presence of anyone who seems not to fit into the above categories to SFSO/the security contract provider. Include location, direction headed, and description **—race, gender, and religious affiliation are NOT considered suspicious.**

~~4.~~5.   ~~.~~

~~5.~~6.   Staff shall not authorize a vendor in the hospital without a prearranged appointment with a department head. No one may sell items to residents or staff without the explicit written authorization of the Executive Administrator or designee. Staff shall report the presence of sighted vendors to SFSO/the security contract provider who shall determine whether the vendor is authorized.

~~6.~~7.   SFSO/~~Tt~~he security contract provider shall record the name and address of any offender and provide escort from the premises. ~~or to the San Francisco Police Department.~~ This procedure applies to employee offenders as well as others; each incident shall be reported to the respective department head.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-07 Visiting Hours
LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12 (Year/Month/Day)
Revised 23/05/23

San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Laguna Honda Hospital and Rehabilitation Center
Security Services Standard Operating Procedures

Title:	Firearms, Dangerous Weapons and Contraband Policy		
Category:	Security Services Department – Standard Operating Procedure		
Executive Sponsor:	Executive Administrator – Laguna Honda Hospital and Rehabilitation Center		
Policy Owner:	Director of Security, Department of Public Health		
Policy Custodian:	Director of Security, Department of Public Health		
Scope/Applicable Areas:	LHH Campus		
Review Period:	Bi-annual		
Original Date:	5/2016	**Review/Revised Date(s):**	9/2020, 23/05/23
Department Approvals: **Committee Approvals:**	San Francisco Sheriff's Department		LHH Campus Safety and Security Committee
Effective Date:	7/2016		

1.0 Policy Statement

It is the policy of the Laguna Honda Hospital and Rehabilitation Center (LHH) to provide a safe, secure, accessible, and effective environment of care, consistent with its mission, scope of services and applicable governmental mandate.

2.0 Purpose

To minimize the risk of harm to ~~rsidents~~residents~~patients~~, visitors, staff, physicians, and volunteers by establishing a policy relative to the possession of firearms, dangerous weapons, and contraband on Laguna Honda Hospital and Rehabilitation Center premises.

3.0 Scope/Coverage

This policy applies to all employees and physicians, and all persons entering Laguna Honda Hospital and Rehabilitation Center premises.

4.0 Definitions

4.1   Possess –   To have physical possession or control of, either on the person, in a desk, locker, cabinet, briefcase or other container, or in a vehicle.

4.2   Firearm - An instrument from which a projectile, powered by an explosive charge, may be fired which can readily create the risk of death of other serious physical injury.

4.3   Dangerous Weapon —Any- Any explosive device; electric or electronically powered weapon; a baton, blackjack, sap, billy, sap glove, nightstick, metal knuckles or chukka sticks; any sharp-edged instrument which by its design and purpose is intended for use as a weapon; any instrument which fires a projectile by other than an explosive charge and can readily cause physical injury.

> 4.3.1 Weapons also include any instrument, article or substance which, under the circumstances in which it is used or threatened to be used, is capable of causing physical injury or death.

4.4   Serious Physical Injury - A physical injury, which directly creates a substantial risk of death or which causes death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of anybody organ.

4.5   Contraband - Goods which under normal circumstances are illegal to possess e.g., marijuana, cocaine, any unidentifiable substances, syringes, pipes, etc.

4.6   Rendered Safe - Completely unloading, closing or deactivating the weapon

5.0   **Firearm/Dangerous Weapon Procedure**

5.1   **Notification Process**

    5.1.1   Any employee who has knowledge that a firearm or dangerous weapon is present on LHHDPH premises shall notify SFSO/the contract security provider/law enforcement, and the DPH Director of Security immediately

    5.1.2   Provide as much information as possible including, the reporting person's name, department, location, and description of the subject believed to be in possession of the weapon

    5.1.3   DO NOT HANDLE FIREARMS. Leave the firearm where it is, isolate the area to the best of your ability, and notify Local Law Enforcement.

5.2   **Response Procedure**

5.2.1   SFSO ~~The contract security provider staff~~ will investigate.

5.2.2   If necessary, SFSO~~the contract security provider~~ will activate the Significant Event Notification Procedure.

5.2.3   All persons entering LHH premises who have in their possession a weapon of any kind, shall surrender the weapon to –if applicable—SFSO ~~the contract security provider,~~ or take the weapon out of the building.

5.2.4   Weapons turned over to SFSO ~~the contract security provider~~ will be secured in accordance with their ~~contract security provider's~~ operation procedure.

5.2.5   Should the person in possession of a weapon, with no valid reason to retain the weapon, refuse to surrender it, upon notifying SFSO ~~the contract security provider,~~ their staff will respond in accordance to their operation procedure.

5.2.6   Should a person's physical condition preclude a voluntary relinquishment, i.e., unconscious, heavily sedated, etc. and they are found to be in possession of a weapon; SFSO ~~the contract security provider~~ will be called to confiscate the weapon and follow their process for rendering the weapon safe and securing in the weapon. The owner will be advised of these actions as soon as their condition allows.

5.2.7   All persons not authorized to carry a concealed firearm are in violation of the California Penal Code, which SFSO ~~the contract security provider's staff~~ will respond according to their operation procedure.

5.2.8   When the person carrying a weapon is an employee, in addition to SFSO ~~the contract security provider,~~ the Department Manager, the DPH Director of Security, Executive Administrator, and Human Resources, should be notified immediately.

5.2.8.1   Call 911 anytime a weapon is being presented in a life threating manner.

5.3   Investigation and Documentation

5.3.1 SFSO ~~The contract security provider~~ will investigate, and document all reports of firearms, dangerous weapons, and contraband. The report will include the following:

    5.3.1.1 Description of weapon/contraband

    5.3.1.2 Any events occurring before, during, or after the process of weapons or contraband.

    5.3.1.3 Disposition of weapon/contraband.

    5.3.1.4 Name, addresses, contact information, and description of all parties involved

    5.3.1.5 Witness Statements

    5.3.1.6 Supplemental reports

    5.3.1.7 Required camera footage and photographs

5.3.2 Request for criminal reports will be made to the appropriate law enforcement agency.

5.4 Persons Allowed to Carry Weapons on Laguna Honda Hospital and Rehabilitation Premises:

5.4.1 Duly sworn federal, state and city and county law enforcement

5.4.2 On Duty Corrections personnel

5.4.3 California Concealed Weapons Permitted Personnel

5.4.4 Contracted Security providing executive protection

5.4.5 On Duty armored car and ATM guards functioning within the scope of their duties

5.5 Law Enforcement Weapons

5.5.1 Law enforcement officers on active duty are not required to surrender their weapons.

5.5.2   When off-duty, law enforcement officers visiting a resident~~patient~~ or receiving treatment, they are allowed to keep their weapon in public access areas only; weapons will not be allowed in treatment areas and shall be kept under the control of the San Francisco Sheriff's Office for safekeeping.

5.5.3   Law enforcement personnel may surrender their weapons and other issued items such as handcuffs, batons and ammunition to their watch-commander or supervising sergeant, or to any other designated person.

5.5.4   If the law enforcement officer's watch-commander or sergeant ~~is~~are not available, the weapon should be secured by the San Francisco Sheriff's Office.

6.0   Contraband Procedure

6.1   Notification Process

6.1.1   Any employee who discovers contraband (or suspected contraband), left unattended, on LHH~~DPH~~ premises shall notify their supervisor immediately.

6.1.2   If the supervisor determines that SFSO ~~the contract security provider/law enforcement~~ should be notified, provide as much information as possible including, the reporting person's name, department, location, and description of the contraband.

6.1.3   If found on a person, DO NOT ATTEMPT TO SEIZE THE ITEM.

~~6.2.0~~   The employee should complete the appropriate report to document the incident. ~~Unusual Occurrence Form (UO) as required~~

~~6.3~~6.2   Processing Contraband

~~6.3.1~~6.2.1   The employee that comes into possession of contraband will treat the contraband as follows:

~~6.3.1.1~~6.2.1.1 The contraband will be placed in an appropriate envelope and sealed in the presence of another employee with both placing their initials across the seal.

~~6.3.1.2~~6.2.1.2 The contraband will be secured inside a locked cabinet.

~~6.3.1.3~~6.2.1.3~~Local law enforcement and the~~ San Francisco Sheriff's Office will be contacted to take possession of the contraband~~and asked for assistance~~.

~~6.3.1.4~~6.2.1.4   The contraband will be turned over to SFSO and process for destruction, in accordance with their operational procedures. ~~local law enforcement or disposed of in accordance with law enforcements instructions.~~

SAFETY SUPPORT FOR LHH PATIENT/RESIDENT

POLICY:

When it is determined by an appointed medical professional, or when staff have reasonable cause to believe that a patient/resident presents a danger to themselves and others, SFSO/the contract security provider shall be called to provide safety support.

PURPOSE:

1. It is expected that SFSO/the contract security provider's staff shall take an active role to support the nursing/medical staff and assist in controlling any patient/resident that attempts to harm themselves or others. Such support includes:

   a. Stand-by – assistance is limited to a security presence as a deterrent, or backup to the medical/nursing staff's actions.

   b. Assist – assistance shall be provided at the direction of a physician, affiliated professional, or nurse, to assess, control, moderate, or prevent the inappropriate behavior of a patient. The contract security provider's actions may include taking control of a potentially escalating situation by giving directives/setting limits.

   c. Physical Intervention – assistance involves the act of physically containing a patient/resident or assisting the nursing/medical staff with patient/resident restraint. When assisting the nursing/medical staff with restraining the patient/resident, the SFSO/contract security's provider's role is limited to physically holding the resident/patient, while the nursing/medical staff apply restraints.

PROCEDURE:

1. When SFSO/the contract security provider has been dispatched to perform any type of patient/resident assist, the officer shall report to the nurse's station and/or location of the event to receive information, and instruction regarding the patient/resident assist.

2. Upon receiving information from the nursing/medical staff, SFSO/the contract security provider shall use appropriate intervention techniques that align with Non-Violent Crisis Intervention, CPI, to restore a safe and secure environment, considering the following:

   a. The patient/resident is an imminent threat to other patients/residents, visitors and staff

   b. According to the Code Green policy, the patient is considered "At Risk" for elopement

    c. The patient/resident is on a psychiatric hold (LPS conservatorship for psychiatric evaluation or treatment)

    d. The patient/resident is awaiting medical treatment

3. Excluding an imminently threatening situation, when conducting any type of safety support, SFSO/the contract security provider's staff shall enter the patients/resident's room accompanied by nursing/medical staff.

    a. SFSO/Tthe contract security provider's conversation with the patient/resident shall be limited to setting limits in order to control the patient/resident, to support the nursing/medical staff.

4. If during the safety support process, the patient/resident begins to display risk behavior i.e., raising of voice, using profanity, refusal to comply with the nursing/medical staff's direction, or attempt to intimidate—using threatening physical gestures, or communicating threats, SFSO/the contract security provider shall give verbal directives, to include communicating the consequences of the patient/resident's behavior. , in order to control the patient/resident.

    a. At any point during a standby if the person becomes combative, SFSO/the contract security provider shall take an active role in controlling the patient through physical interventions that align with Non-Violent Crisis Intervention, CPI, n, according to the contract security provider's operation procedures.

    b. A patient/resident who is taken into custody by SFSPthe contract security provider shall be first medically cleared by the hospital medical staff prior to being transported. SFSO The contract security provider's staff shall conduct a standby until the patient/resident is medically cleared.

    c. When SFSO/the contract security provider is conducting a standby for a patient/resident who is NOT on a psychiatric hold, but the nursing/medical staff's instructions is for the patient/resident are to be monitored, the patient/resident due to being "At Risk," the name(s) of the nursing/medical staff shall be included in the contract security provider's incident report.

ATTACHMENT:
None.

REFERENCE:
LHHPP 75-10 Security Services Standard Operating Procedures

Original adoption: 16/07/12, 19/07/09, 23/05/23 (Year, Month, Day)

Deleted Hospital-wide Policies and Procedures

Laguna Honda Hospital and Rehabilitation Center
Security Services Standard Operating Procedures

Title:	Inpatient Patients in Custody
Category:	Security Services Department – Standard Operating Procedure
Executive Sponsor:	Executive Administrator – Laguna Honda Hospital and Rehabilitation Center
Policy Owner:	Director of Security, Department of Public Health
Policy Custodian:	Director of Security, Department of Public Health
Scope/Applicable Areas:	LHH Campus
Review Period:	Bi-annual

Original Date:	6/2016	**Review/Revised Date(s):**	9/2020
Department Approvals: **Committee Approvals:**	San Francisco Sheriff's Department		LHH Campus Safety and Security Committee
Effective Date:	7/2016		

1.0 Procedure for Managing Patients/Residents in Custody

1.1 Upon notification by the hospital staff of a patient/resident in police custody, the contract security provider will be dispatched to the area. The contract security provider will advise the correctional custodial officer of the hospital's organizational structure including the Resident Care Team members and provide the correctional custodial officer with the following information:

1.2 Upon notification by the hospital unit of an inpatient in police, correctional officer, or bail bondsman custody, the contract security provider's Watch Commander will be dispatched to the unit.

    1.2.1 Regular patrols will be conducted, throughout each shift, by the contract security provider to determine if there are any police or correctional custodial officers assigned to inpatients.

1.3 The Nursing/Medical staff and Watch Commander will huddle with the custodial officer regarding any concerns that a restraint (handcuffs, shackles, etc.) may hinder treating the patient, or have the potential to cause nerve, muscle or circulatory impairment. In addition, the hospital staff will follow standard patient protocol per hospital policy.

1.4   In situations involving arrest and transport where a patient requires medical attention, the Watch Commander will support medical/nursing staff, ensuring that the patient has immediate medical attention, and that all health concerns are cleared before they are eligible for booking on a felony charge and/or warrant at the county jail.

    1.4.1   In many cases this requires that a guard be placed on the patient until they are discharged from the hospital.

1.5   In cases where a serious medical condition exists, the Watch Commander will reach out to other criminal justice partners such as the District Attorney's. Office, Public Defender's Office, the SF Superior Courts and the Adult Probation Department to develop an appropriate action plan that serves the courts and the patient receiving the appropriate medical attention.

1.6   Patients in custody will always be guarded, including during transport within the facility, by the agency/institutions responsible for the patient. In the event the custodial officer is unable to remain with the patient, it will be the responsibility of the hospital's Custody Division to guard the patient.

1.7   The contract security provider will advise the correctional custodial officer of the appropriate medical/nursing staff, and will provide the correctional custodial officer with the following hospital information:

    1.7.1   Emergency Response Procedures
    1.7.2   Fire Safety, including the location of emergency exits, fire pull stations, and fire extinguishers
    1.7.3   Universal Precautions
    1.7.4   Contract Security Provider's Contact Information
    1.7.5   Shelter In Place
    1.7.6   Sign the Forensic Patient Log

1.8   No visitors will be allowed except for those authorized by the law enforcement agency /correction agency institution.

1.9   In the Critical Care units, the correctional custodial officer will be stationed near the bedside, at a location that assures adequate visual contact and supervision.

1.10   In the hospital's Forensic Unit, when a patient in custody is admitted to surgery, the

correctional custodial officer/law enforcement officer will remain in the operating room until the patient is anesthetized before leaving the operating room. Upon the patient awakening, the correctional custodial officer /law enforcement officer will accompany and remain with the patient for the duration of the patient's stay.

1.11   Nursing/Medical staff, under the advisement of the custodial officer will take precautions to assure that any potentially dangerous instruments or equipment remains inaccessible to the patient in custody.

2.0 Transportation and Movement (Pregnant Patients in Custody)

2.1   The movement of prisoners throughout the hospital campus will always be accomplished in a safe and secure manner in accordance with the contract security provider's Transportation and Movement Policy, which includes the following direction for pregnant patients in custody:

2.2 An inmate known to be pregnant or in recovery shall not be:
   2.2.1   Handcuffed with her hands behind her back
   2.2.2   Restrained with belly or waist chains,
   2.2.3   Restrained with leg irons or secured to another inmate

2.3   An inmate known to be pregnant or in recovery may only be handcuffed in front of her body.

2.4   Unless deemed necessary for the safety and security of the inmate, the staff, and public, a pregnant inmate will not be restrained by the wrists, ankles or both during:
   2.4.1   Active labor, during delivery, or as determined by the attending physician,
   2.4.2   Transport to the hospital for delivery, or
   2.4.3   Immediate recovery after giving birth.

2.5   Restraints shall be removed when a professional who is currently responsible for the medical care of a pregnant inmate during a medical emergency, labor, delivery or recovery when that professional determines that the removal of restraints is medically necessary.

Deleted Outpatient Clinic Services Policies and Procedures

CLEANING OF MEDICAL INSTRUMENTS PRIOR TO DISINFECTION OR STERILIZATION

POLICY:

Reusable medical instruments are cleaned prior to disinfection or sterilization consistent with LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments".

PURPOSE:

Reusable instruments may serve as a vehicle in the transmission of infections if they are not properly processed. To ensure the final anti-microbial process (i.e. sterilization, high level disinfection, etc.) is effective, prior disassembly and cleaning is required.

PROCEDURE:

1.   **Use of Personal Protective Equipment and Attire**

      A. Gloves:

      Vinyl or latex gloves are worn when hand-washing delicate microsurgical instruments.

      Thicker, more durable gloves are worn for handling full trays of instruments, other heavy items or sharps.

      The cuff of the gloves shall be long enough to prevent water from coming over the wrist and into the glove.

      B. Gowns:

      Long sleeved, fluid-resistant cover gowns are worn. Gloves are pulled up over the gown cuff.

      C. Masks and Eye Protection:

      To prevent mucous membranes from potential splashes, sprays, or aerosols created during the processing, a fluid resistant mask and eye protection must be worn.

      D. Feet and Leg Protection:

      Rubber or plastic boots or disposable shoe cover/legging combinations are worn when processing items where large amounts of fluid will be involved.

      E. Hair

      Hair must be covered with a cap.

2.   Soaking (Pre-Cleaning)

Immediately after use, medical instruments are immersed in enzymatic detergent and soaked until cleaning. Soaking of instruments is required to prevent drying of blood, body fluids or other organic materials on instruments.

Soaking is done using the facility approved enzymatic detergent prepared according to the manufacturer's recommendations. Tepid water is used to prevent coagulation of protein materials.

When soaked items are transferred from one location to another, all liquid is removed prior to transfer. Containers must be either a plastic or rubber bin with a lid or a solid bottomed rigid sterilization container system with the lid in place.

3.   Cleaning

Cleaning is the single most important step in making a medical instrument ready for reuse. Without adequate cleaning, disinfection and sterilization processes are ineffective.

Cleaning can be done **manually or mechanically** (by machines). Whenever possible, cleaning is done mechanically.

Instruments that require disassembly must be disassembled prior to cleaning to ensure exposure of all surfaces to the cleaning process.

Cleaning is done using the facility approved enzymatic detergent prepared according to the manufacturer's recommendations.

A. Manual Cleaning:

The sink used for cleaning instruments is separate from those used for hand-washing or surgical scrub.

Instruments are not cleaned under *running* water, as this will create aerosols. Immersible instruments are cleaned under water. Items that cannot be immersed are cleaned in a manner that does not produce aerosols.

Brushes and other cleaning implements are used to facilitate in the cleaning process. Brushes and other cleaning implements are disinfected or sterilized daily.

B. Mechanical Cleaning:

In the Outpatient Clinics an ultrasonic cleaner is used for mechanical cleaning. Refer to Appednix A: Operation of the Mettler Electronics Cavitator Ultrasonic Cleaner Model ME 5.5

C. Rinsing and Drying:

After cleaning, instruments are thoroughly rinsed with potable water and manually dried with a cloth or allowed to air dry.

Appendix A: Operation of the Mettler Electronics Cavitator Ultrasonic Cleaner Model ME 5.5

1. Fill the tank with enough water and appropriately diluted detergent to cover the platform and the instruments to be cleaned. A facility approved high sudsing, neutral pH detergent is used.

2. Plug the unit into a grounded AC outlet.

3. Turn the timer/switch to 15 minutes. Cleaning will start immediately as evidence by a "hissing" sound from the tank. The "hissing" sound indicated vapor-phase cavitation, the most efficient type of cavitation.

4. After the designated time has elapsed, the unit will automatically turn off.

5. Remove the instruments for rinsing and drying.

6. Drain the tank.

7. Unplug the unit.

Reference:
LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments".

Most recent review: 10/10. 13/08/02
Revised: 13/11/21

HIGH-LEVEL CHEMICAL DISINFECTION

POLICY:

High-level chemical disinfection is performed by trained and qualified Clinic Staff according to accepted standards of practice and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

PURPOSE:

High-level chemical disinfection is a process used for the disinfection of semi-critical resident care devices (devices that touch mucous membranes or non-intact skin). This level of disinfection is effective in destroying most types of harmful microorganisms, but not necessarily bacterial spores

PROCEDURE:

1. Prior to the disinfection process, all devices are cleaned according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments" and to LHH Outpatient Clinic Policy C3 "Cleaning of Medical Instruments Prior to Disinfection and Sterilization".

2. Fluid resistant gowns, gloves, face masks, and eye protection are worn during the cleaning and disinfection procedures.

3. Hospital approved high-level disinfectants must be used.

    Chemicals are mixed, stored and used in accordance with manufacturer's recommendations and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

4. Refer to Appendix A for Specific instructions on the use of Cidexplus® OPA Solution (*ortho*-Phthalaldehyde 0.55%) for high-level disinfection.

5. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and *Legionella*.

Reference:
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
CDC Guideline for Disinfection and Sterilzation in Healthcare Facilities, 2008

Revised: 12/05/15

Appenidix A: Use of Cidexplus® OPA Solution (*ortho*-Phthalaldehyde 0.55%) for High-Level Chemical Disinfection

For Complete information on use refer to Cidexplus®OPA Product information

1. **Material Compatibility**

   For compatibility of device materials with Cidexplus® OPA refer to device manufacturer's recommendations and Cidexplus® OPA Product information.

2. **Cleaning Agent Compatibility**

   Detergents that are either highly acidic or alkaline are contraindicated as cleaning agents since improper rinsing could affect the efficacy of the Cidexplus® OPA Solution by altering its pH. Rinse devices completely prior to immersion in Cidexplus® OPA Solution.

3. **Safety**

   Caution: Contains *Ortho*-Phthalaldehyde
   - Harmful by inhalation and if swallowed
   - Irritating to respiratory system and skin
   - Risk of serious damage to eyes
   - May cause sensitization by inhalation and skin contact

   Precautions
   - Wear suitable protective clothing, gloves and eye/face protection
   - Use only in well-ventilated areas
   - Avoid contamination of food
   - Avoid release to the environment

   First-Aid Measures
   - Refer to Cidexplus® OPA Product Information

4. **Directions for Use**

   Activation
   a. Does not require activation before use.
   b. **Test the activated solution with compatible test strips prior to each use. The minimum effective concentration (MEC) of *ortho*-Phthalaldehyde is 0.3%.**

5. **Cleaning**

   Feces, mucous, tissues, blood and other body fluids must be thoroughly cleansed from surfaces and lumens of devices before processing in Cidexplus® OPA Solution.

   Thoroughly clean, rinse and rough dry devices before immersing in Cidexplus® OPA Solution.

   Clean and rinse lumens of hollow instruments before filling with Cidexplus® OPA Solution.

6. **Usage**
   a. **Test the solution with Solution Test Strips prior to each use.**
   b. Immerse cleaned and rough dried medical devices completely in the Cidexplus® OPA Solution, filling all lumens.
   c. Leave medical devices completely **immersed for at least 12 minutes at room temperature** for High-Level Disinfection.
   d. Rinse with sterile water
   e. Used *ortho*-Phthalaldehyde solution is neutralized as per Product Information and is placed in a sealed container provided by Industrial Hygienist and will be picked up by Facility Services for disposal

Revised: 12/05/15

FLEXIBLE NASOPHARYNGEAL LARYNGOSCOPE

POLICY:
Flexible nasopharyngeal laryngoscopes are cleaned and disinfected consistent with LHH Infection Control Policies G4 "Cleaning of Reusable Medical Instruments", G7 "High-Level Chemical Disinfection" and F9 "Chemical Sterilization Standards".

PURPOSE:
To destroy microorganisms both cleaning and high-level disinfection are necessary to prevent disease transmission.

PROCEDURE:

1. Classification and processing requirements

A flexible nasopharyngeal laryngoscope is classified as a semi-critical medical device because during use the device makes contact with mucous membranes but does not usually penetrate normally sterile areas of the body. Refer to Infection Control Policy G2, "Classification of Reusable Medical Devices and Processing Requirements."

High-Level Disinfection is acceptable for processing semi-critical medical devices.

2. High-level disinfection on the day of use

   a. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

   b. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."

   c. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

   d. Prepare the proper container for the high-level disinfectant and pour the solution into it.

   e. Immerse the scope for the scope and disinfectant manufacturers' recommended time and temperature conditions for high-level disinfection.

   f. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

      NOTE: These conditions should be strictly followed since over immersion may damage the scope.

   g. Using sterile gloves:

      - Remove the scope from chemical solution.

      - Rinse the scope thoroughly using sterile water.

      - Dry the scope thoroughly using sterile gauze.

3. Cleaning after procedure and use of the laryngoscope

   Immediately after removing the laryngoscope from the patient:

   A. Gently wipe all debris off insertion tube with gauze soaked in freshly prepared enzymatic detergent solution.

   B. Ensure all debris has been removed from the insertion tube, deflection section, and illumination/observation windows.

   C. Transfer the laryngoscope from the procedure room to the reprocessing room in a leak proof enclosed container. .

   D. In the reprocessing room thoroughly but gently wash the entire outer surface of the scope with a mild pH enzymatic detergent following the manufacturer's instructions.

   E. Thoroughly rinse the scope with potable water and gently dry or allow to air dry.

4. High-level disinfection after initial cleaning procedure

   A. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

   B. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."

   C. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

   D. Prepare the proper container for the high-level disinfectant and pour the solution into it.

   E. Immerse the scope for the scope and disinfectant manufacturers' recommended time and temperature conditions for high-level disinfection.

   F. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

      NOTE: These conditions should be strictly followed since over immersion may damage the scope.

   G. Using sterile gloves:

      - Remove the scope from chemical solution.

      - Rinse the scope thoroughly using sterile water.

      - Dry the scope thoroughly using sterile gauze.

5. Storage

Store the laryngoscope in a clean, dry, dust-free locked storage cart. The storage area will be cleaned with a hospital approved disinfectant each time the laryngoscope is used. The laryngoscope will be placed in a cleaned tray lined with a new chuck and locked until the next time it is used.

6. DISPOSAL OF *Ortho*-PHTHALALDEHYDE SOLUTION

Used *ortho*-Phthalaldehyde solution is neutralized as per Product Information and placed in a sealed container provided by the Industrial Hygienist and will be picked up by Facility Services for disposal.

References:
LHH Infection Control Policy G2, "Classification of Reusable Medical Devices and Processing"
LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments"
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
LHH Infection Control Policy F9, "Chemical Sterilization Standards"

Revised: 12/05/15

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

STATE OF CALIFORNIA

dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
BOARD OF REGISTERED NURSING
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CALIFORNIA NURSING PRACTICE ACT

Website: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2725-2742

Scope of Regulation
Excerpt from Business and Professions Code
Division 2, Chapter 6. Article 2

Section 2725. Legislative intent: Practice of Nursing Defined

2725. (a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

  (b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

  (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

  (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

  (3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

  (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

  (c) "Standardized procedures," as used in this section, means either of the following:

  (1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

(d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing.

(e) No state agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute. "State agency" includes every state office, officer, department, division, bureau, board, authority, and commission.

2725.1. (a) Notwithstanding any other provision of law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon or an order by a certified nurse-midwife, nurse practitioner, or physician assistant issued pursuant to Section 2746.51, 2836.1, or 3502.1, respectively, if the registered nurse is functioning within a licensed primary care clinic as defined in subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b), (c), (h), or (j) of Section 1206 of, the Health and Safety Code.

(b) No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(c) Nothing in this section shall be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section 2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

(d) Nothing in this section shall be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

2725.2. (a) Notwithstanding any other provision of law, a registered nurse may dispense self-administered hormonal contraceptives approved by the federal Food and Drug Administration (FDA) and may administer injections of hormonal contraceptives approved by the FDA in strict adherence to standardized procedures developed in compliance with subdivision (c) of Section 2725.

(b) The standardized procedure described in subdivision (a) shall include all of the following:

(1) Which nurse, based on successful completion of training and competency assessment, may dispense or administer the hormonal contraceptives.

(2) Minimum training requirements regarding educating patients on medical standards for ongoing women's preventive health, contraception options education and counseling, properly eliciting, documenting, and assessing patient and family health history, and utilization of the United States Medical Eligibility Criteria for Contraceptive Use.

(3) Demonstration of competency in providing the appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient.

(4) Which hormonal contraceptives may be dispensed or administered under specified circumstances, utilizing the most recent version of the United States Medical Eligibility Criteria for Contraceptive Use.

(5) Criteria and procedure for identification, documentation, and referral of patients with contraindications for hormonal contraceptives and patients in need of a follow-up visit to a physician and surgeon, nurse practitioner, certified nurse-midwife, or physician assistant.

(6) The extent of physician and surgeon supervision required.

(7) The method of periodic review of the nurse's competence.

(8) The method of periodic review of the standardized procedure, including, but not limited to, the required frequency of review and the person conducting that review.

(9) Adherence to subdivision (a) of Section 2242 in a manner developed through collaboration with health care providers, including physicians and surgeons, certified nurse-midwives, nurse practitioners, physician assistants, and registered nurses. The appropriate prior examination shall be consistent with the evidence-based practice guidelines adopted by the federal Centers for Disease Control and Prevention in conjunction with the United States Medical Eligibility Criteria for Contraceptive Use.

(10) If a patient has been seen exclusively by a registered nurse for three consecutive years, the patient shall be evaluated by a physician and surgeon, nurse practitioner, certified nurse-midwife, or physician assistant prior to continuing the dispensation or administration of hormonal contraceptives.

(c) Nothing in this section shall be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

2725.3. (a) A health facility licensed pursuant to subdivision (a), (b), or (f), of Section 1250 of the Health and Safety Code shall not assign unlicensed personnel to perform nursing functions in lieu of a registered nurse and may not allow unlicensed personnel to perform functions under the direct clinical supervision of a registered nurse that require a substantial amount of scientific knowledge and technical skills, including, but not limited to, any of the following:

(1) Administration of medication.

(2) Venipuncture or intravenous therapy.

(3) Parenteral or tube feedings.

(4) Invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning.

(5) Assessment of patient condition.

(6) Educating patients and their families concerning the patient's health care problems, including post-discharge care.

(7) Moderate complexity laboratory tests.

(b) This section shall not preclude any person from performing any act or function that he or she is authorized to perform pursuant to Division 2 (commencing with Section 500) or pursuant to existing statute or regulation as of July 1, 1999.

2725.4 Abortion by aspiration techniques; Requirements

Notwithstanding any other provision of this chapter, the following shall apply:

(a) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall complete training recognized by the Board of registered Nursing. Beginning January 1, 2014, and until January 1, 2016, the competency-based training protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used.

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall adhere to standardized procedures developed in compliance with subdivision (c) of Section 2725 that specify all of the following:

1. **The extent of supervision by a physician and surgeon with relevant training and expertise.**
2. **Procedures for transferring patients to the care of the physician and surgeon or a hospital**
3. **Procedures for obtaining assistance and consultation from a physician and surgeon.**
4. **Procedures for providing emergency care until physician assistance and consultation are available.**
5. **The method of periodic review of the provisions of the standardized procedures**

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

2725.5. "Advanced practice registered nurse" means those licensed registered nurses who have met the requirements of Article 2.5 (commencing with Section 2746), Article 7 (commencing with Section 2825), Article 8 (commencing with Section 2834), or Article 9 (commencing with Section 2838).

2726. Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery.

2727. This chapter does not prohibit:

(a) Gratuitous nursing of the sick by friends or members of the family.

(b) Incidental care of the sick by domestic servants or by persons primarily employed as housekeepers as long as they do not practice nursing within the meaning of this chapter.

(c) Domestic administration of family remedies by any person.

(d) Nursing services in case of an emergency. "Emergency," as used in this subdivision includes an epidemic or public disaster.

(e) The performance by any person of such duties as required in the physical care of a patient and/or carrying out medical orders prescribed by a licensed physician; provided, such person shall not in any way assume to practice as a professional, registered, graduate or trained nurse.

2727.5. A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care.

This section shall not grant immunity from civil damages when the person is grossly negligent.

2728. If adequate medical and nursing supervision by a professional nurse or nurses is provided, nursing service may be given by attendants, psychiatric technicians, or psychiatric technician interim permittees in institutions under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or subject to visitation by the State Department of Public Health or the Department of Corrections and Rehabilitation. Services so given by a psychiatric technician shall be limited to services which he or she is authorized to perform by his or her license as a psychiatric technician. Services so given by a psychiatric technician interim permittee shall be limited to skills included in his or her basic course of study and performed under the supervision of a licensed psychiatric technician or registered nurse.

The Director of State Hospitals, the Director of Developmental Services, and the State Public Health Officer shall determine what shall constitute adequate medical and nursing supervision in any institution under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or subject to visitation by the State Department of Public Health.

Notwithstanding any other provision of law, institutions under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services may utilize graduates of accredited psychiatric technician training programs who are not licensed psychiatric technicians or psychiatric technician interim permittees to perform skills included in their basic course of study when supervised by a licensed psychiatric technician or registered nurse, for a period not to exceed nine months.

2728.5. Except for those provisions of law relating to directors of nursing services, nothing in this chapter or any other provision of law shall prevent the utilization of a licensed psychiatric technician or psychiatric technician interim permittee in performing services used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or developmentally disabled persons within the scope of practice for which he or she is licensed or authorized in facilities under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or licensed by the State Department of Public Health, that he or she is licensed to perform as a psychiatric technician, or authorized to perform as a psychiatric technician interim permittee including any nursing services under Section 2728, in facilities under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or subject to visitation by the State Department of Public Health.

2729. Nursing services may be rendered by a student when these services are incidental to the course of study of one of the following:

   (a) A student enrolled in a board-approved prelicensure program or school of nursing.

   (b) A nurse licensed in another state or country taking a board-approved continuing education course or a postlicensure course.

2730. If he does not represent or hold himself out as a professional nurse licensed to practice in this State and if he has an engagement, made in another State or country, requiring him to accompany and care for a patient temporarily residing in this State during the period of such engagement, a nurse legally qualified by another State or country may give nursing care to such patient in this State.

2731. This chapter does not prohibit nursing or the care of the sick, with or without compensation or personal profit, when done by the adherents of and in connection with the practice of the religious tenets of any well recognized church or denomination, so long as they do not otherwise engage in the practice of nursing.

2732. No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act.

   Every licensee may be known as a registered nurse and may place the letter "R. N." after his name.

2732.05. (a) Every employer of a registered nurse, every employer of a registered nurse required to hold any board-issued certification, and every person acting as an agent for such a nurse in obtaining employment, shall ascertain that the nurse is currently authorized to practice as a registered nurse or as a registered nurse pursuant to a board-issued certification within the provisions of this chapter. As used in this section, "board-issued certification" includes, but is not limited to, certification as a nurse practitioner, nurse practitioner with a furnishing number, nurse anesthetist, nurse midwife, nurse midwife with a furnishing number, public health nurse, clinical nurse specialist, or board listed psychiatric mental health nurse.

   (b) Every employer of a temporary licensee or interim permittee and every person acting as an agent for a temporary licensee or interim permittee in obtaining employment shall ascertain that the person is currently authorized to practice as a temporary licensee or interim permittee.

   (c) As used in this section, the term "agent" includes, but is not limited to, a nurses' registry and a traveling nurse agency.

   Examination by an employer or agent of evidence satisfactory to the board showing the nurse's, licensee's, or permittee's current authority to practice under this chapter, prior to employment, shall constitute a determination of authority to so practice.

   Nothing in this section shall apply to a patient, or other person acting for a specific patient, who engages the services of a registered nurse or temporary licensee to provide nursing care to a single patient.

2732.1. (a) An applicant for license by examination shall submit a written application in the form prescribed by the board.

Upon approval of the application, the board may issue an interim permit authorizing the applicant to practice nursing pending the results of the first licensing examination following completion of his or her nursing course or for a maximum period of six months, whichever occurs first.

If the applicant passes the examination, the interim permit shall remain in effect until a regular renewable license is issued by the board. If the applicant fails the examination, the interim permit shall terminate upon notice thereof by first-class mail.

(b) The board upon written application may issue a license without examination to any applicant who is licensed or registered as a nurse in a state, district or territory of the United States or Canada having, in the opinion of the board, requirements for licensing or registration equal to or higher than those in California at the time the application is filed with the Board of Registered Nursing, if he or she has passed an examination for the license or registration that is, in the board's opinion, comparable to the board's examination, and if he or she meets all the other requirements set forth in Section 2736.

(c) Each application shall be accompanied by the fee prescribed by this chapter for the filing of an application for a regular renewable license.

The interim permit shall terminate upon notice thereof by first-class mail, if it is issued by mistake or if the application for permanent licensure is denied.

2733. (a) Upon approval of an application filed pursuant to subdivision (b) of Section 2732.1, and upon the payment of the fee prescribed by subdivision (k) of Section 2815, the board may issue a temporary license to practice professional nursing, and a temporary certificate to practice as a certified nurse midwife, certified nurse practitioner, certified public health nurse, certified clinical nurse specialist, or certified nurse anesthetist for a period of six months from the date of issuance.

A temporary license or temporary certificate shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(b) Upon written application, the board may reissue a temporary license or temporary certificate to any person who has applied for a regular renewable license pursuant to subdivision (b) of Section 2732.1 and who, in the judgment of the board has been excusably delayed in completing his or her application for or the minimum requirements for a regular renewable license, but the board may not reissue a temporary license or temporary certificate more than twice to any one person.

2734. Upon application in writing to the board and payment of the biennial renewal fee, a licensee may have his license placed in an inactive status for an indefinite period of time. A licensee whose license is in an inactive status may not practice nursing. However, such a licensee does not have to comply with the continuing education standards of Section 2811.5.

2736. (a) An applicant for licensure as a registered nurse shall comply with each of the following:

(1) Have completed such general preliminary education requirements as shall be determined by the board.

(2) Have successfully completed the courses of instruction prescribed by the board for licensure, in a program in this state accredited by the board for training registered nurses, or have

successfully completed courses of instruction in a school of nursing outside of this state which, in the opinion of the board at the time the application is filed with the Board of Registered Nursing, are equivalent to the minimum requirements of the board for licensure established for an accredited program in this state.

(3) Not be subject to denial of licensure under Section 480.

(b) An applicant who has received his or her training from a school of nursing in a country outside the United States and who has complied with the provisions of subdivision (a), or has completed training equivalent to that required by subdivision (a), shall qualify for licensure by successfully passing the examination prescribed by the board.

2736.1. (a) The course of instruction for an applicant who matriculates on or after September 1, 1985, shall include training in the detection and treatment of alcohol and chemical substance dependency.

(b) The course of instruction for an applicant who matriculates on or after January 1, 1995, shall include training in the detection and treatment of client abuse, including, but not limited to, spousal or partner abuse. The requirement for coursework in spousal or partner abuse detection and treatment shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.

2736.5. (a) Any person who has served on active duty in the medical corps of any of the Armed Forces of the United States and who has successfully completed the course of instruction required to qualify him or her for rating as a medical service technician—independent duty, or other equivalent rating in his particular branch of the Armed Forces, and whose service in the Armed Forces has been under honorable conditions, may submit the record of such training to the board for evaluation.

(b) If such person meets the qualifications of paragraphs (1) and (3) of subdivision (a) of Section 2736, and if the board determines that his or her education would give reasonable assurance of competence to practice as a registered nurse in this state, he or she shall be granted a license upon passing the standard examination for such licensure.

(c) The board shall, by regulation, establish criteria for evaluating the education of applicants under this section.

(d) The board shall maintain records of the following categories of applicants under this section:

(1) Applicants who are rejected for examination, and the areas of such applicants' preparation which are the causes of rejection.

(2) Applicants who are qualified by their military education alone to take the examination, and the results of their examinations.

(3) Applicants who are qualified to take the examination by their military education plus supplementary education, and the results of their examinations.

(e) The board shall attempt to contact by mail or other means individuals meeting the requirements of subdivision (a) who have been or will be discharged or separated from the Armed Forces of the United States, in order to inform them of the application procedure provided by this section. The board may enter into an agreement with the federal government in order to secure the names and addresses of such individuals.

2736.6. The board shall determine by regulation the additional preparation in nursing, in a school approved by the board, which is required for a vocational nurse, licensed under Chapter 6.5 (commencing with Section 2840) of this division, to be eligible to take the examination for licensure under this chapter as a registered nurse. The board shall not require more than 30 units in nursing and related science subjects to satisfy such preparation.

2737. An applicant for a license authorizing him to practice nursing in this State under this chapter, upon the filing of his application shall pay the fee required by this chapter.

2738. The board shall hold not less than two examinations each year at such times and places as the board may determine.

2740. Examinations shall be written, but in the discretion of the board may be supplemented by an oral or practical examination in such subjects as the board determines. All examinations shall be conducted by such persons and in such manner and under such rules and regulations as the board may prescribe.
   The board shall finally pass or reject all applicants. Its actions shall be final and conclusive and not subject to review by any court or other authority.

2741. An application for reexamination shall be accompanied by the fees prescribed by this chapter.

2742. The board shall issue a license to each applicant who passes the examination and meets all other licensing requirements. The form of the license shall be determined in accordance with Section 164.

Portable Tub/Shower Trolley Competency for Nursing Staff

EMPLOYEE NAME:_____ **CLASS** (circle)**: RN LVN CNA PCA**

Last   First

SHIFT (circle): **AM   DAY   PM**   **DATE**:_____

Direction: Write **S** (able to state or demonstrate) to indicate satisfactory or **U** (unable to state or demonstrate) to indicate unsatisfactory performance.

Procedure Steps	S or U	Comments
1. Reads the care plan to check if the shower trolley is appropriate for the resident and what are the resident's bathing preferences and needs. Transporting the resident requires two staff members.		
2. Washes hands and gathers equipment (e.g., gown, towels, clothes, etc.).		
3. Greets the resident and explains the shower tub procedure.		
4. Moves the portable tub next to the bed and locks all four brakes by depressing the brake tabs above the wheels.		
5. Lowers the two-handed grip side rail by pressing the two catches together. Using the foot pedal, lowers/raises the portable tub to the bed height. Pumps the pedal to raise the portable tub. Depresses and holds the pedal to lower the portable tub.		
6. Uses the mattress as a stretcher platform to overlap the portable tub on the bed.		
7. The resident can be transferred to the portable tub with the EZ lift, ceiling lift, sliding board, side transfer from a wheelchair, or lateral transfer from a bed. If performing a lateral transfer from the bed, gently moves the resident onto the portable tub mattress (see lateral transfer competency). Ensures that the resident is in the center of the portable tub to prevent it from tipping over.		
8. Raises the side rail to the locked upright position.		
9. Raises/lowers the trolley to a comfortable height for transport using the manual foot pedals. Pumps the pedal to raise the portable tub. Depresses and holds the pedal to lower the portable tub.		
10. To transport the resident, releases the breaks and ensures that the gray tabs above two of the wheel are in the up/steer position. Transports the resident in the tub to the shower room. Ensures the resident is properly covered for privacy/dignity.		
11. Closes the shower room door to provide privacy.		
12. When in the shower room, presses the wheel lock tabs to brake/lock all four wheels.		
13. Adjusts the trolley to a comfortable working height.		
14. Positions the flexible drain hose next to the floor drain to facilitate water drainage.		
15. When showering/bathing the resident, adjusts the water temperature to the resident's preferences. The head pillow is useful when washing the resident's hair. a. If bathing the resident, leaves the tub in a horizontal position and proceeds with the bath. After the bath, removes the stopper. Using the horizontal adjustment lever, gently slopes the portable tub to allow the water to drain from the tub.		

b. If showering the resident, removes the drain stopper. Using the horizontal adjustment lever, gently slopes the portable tub to allow the water to drain from the tub. Proceeds with the shower.		
16. When done bathing/showering, dries the resident in the tub with towels and wraps the resident with a robe or towels to ensure the resident is covered and warm.		
17. Uses the horizontal adjustment lever underneath the portable tub to gently return the portable tub to the locked horizontal position. Returns the end of the flexible drain hose to its holder.		
18. Unlocks the wheels and transports the resident back to their room. When transferring the resident back to bed/chair, lock the tub wheels and bed/chair.		
19. Return the tub to the shower room for disinfection.		

20. Infection Control After Each Use:
   i. Hand hygiene and dons clean pair of gloves.
   ii. In the shower room, presses down on all four wheels locks
   iii. Cleans the top of the mattress and the head support with facility approved disinfectant.
   iv. Ensures the surface is wet (avoid excessive solution) for the minimum contact time as recommended by the disinfectant manufacturer.
   v. Lowers the side rail on one side by pressing the two release catches together. Peels the side strip off the stretcher to detach the mattress. Leaves the other side of the mattress attached.
   vi. Cleans the underside of the mattress and the top of the stretcher with the facility approved disinfectant.
   vii. Reaches under the stretcher and locates the two-handed securing device. Presses the button and moves the catch to one side. This tilts the stretcher and allows access to the underside of the stretcher for cleaning.
   viii. After cleaning, leaves the stretcher in the tilted position to dry.
   ix. When the mattress and stretcher are dry, returns the stretcher to the storage room.
   x. Wash hands		

DESCRIBE ALL INDICATORS WHEN UNSATISFACTORY IS CHECKED:

Meets LHH standards for Portable Tub/Shower Trolley Competency for Nursing Staff ___
_____

Does not meet LHH standards for Portable Tub Shower Trolley Competency for Nursing Staff __
_____

NAME/TITLE OF OBSERVER_____   DATE _____

REFERRAL FOR EMPLOYEE WHO DOES NOT MEET LHH Portable Tub/Shower Trolley COMPETENCY:

REFERRED TO: _____, NURSE MANAGER/NURSING SUPERVISOR ON (DATE) _____FOR FOLLOW UP.

Signed: _____

NURSE MANAGER/NURSING SUPERVISOR FOLLOW UP ACTIONS:

Date: _____ Reassess competency

Date: _____ Consult with DET regarding education plan

Date: _____ Consult with Human Resources regarding performance standards

OTHER:

NURSE MANAGER/NURSING SUPERVISOR_____ DATE _____

Revised 2/2012ER; 9/21/2020 RR; 05/31/2023

ENTERAL TUBE FEEDING MANAGEMENT

POLICY:

1. Enteral nutrition is instituted after careful resident assessment and if clinically indicated for:
    a. Short-term intervention for acute management of nutritional support.
    b. Last resort treatment for insufficient oral nutrition if consistent with the resident's goal of care.

2. Position is confirmed by gastrografin for any tube placement or replacement prior to initial use.

3. Routine enteral tube placement is checked by measuring external tube length and inspecting the mouth for Nasogastric Tubes:
    - upon admission and relocation
    - each shift and as needed
    - after placement or replacement
    - prior to accessing

4. The Licensed Nurse (LN) checks the feeding pump at the beginning of the shift to verify that the pump is functional and programmed per the order.

5. For simple balloon gastrostomy tubes (no PEG or internal bumper) that are older than 6 weeks, a trained Registered Nurse (RN) replaces the tube at least every 3 months due to the balloon failure risk and as needed (i.e., worn, dislodged or clogged), unless ordered otherwise. A foley or gastrostomy tube may be placed in the stoma to keep tract open until tube can be replaced.

6. Gastrostomy tubes less than 6 weeks old are re-inserted by Interventional Radiology (IR) or Gastroenterologist. No attempts should be made by LHH staff to replace tubes less than 6 weeks old (Refer to LHHPP File # 26-03).

7. J-tubes are replaced by IR, although a foley or gastrostomy tube may be placed in the stoma to keep tract open until the resident is seen by surgery or IR.

8. A trained RN or LVN may place and remove a nasogastric tube (NGT) as ordered. Nasointestinal tubes (weighted tubes) are not inserted at LHH.

9. Tap water is used for medication dilution and access device flushes.

10. Reverse Luer lock (ENfit) devices or temporary transition adapters will be used for all enteral nutrition tubes.

PURPOSE:

To ensure safe practice associated with enteral feeding tube use, including the insertion, initial placement verification, ongoing placement verification, maintenance and discontinuation.

DEFINITIONS:

o **Enteral feeding** ("enteral nutrition" or "tube feeding") is the system of providing nutrition or medication directly into the gastrointestinal tract (stomach, duodenum, or jejunum).
o **Nasogastric Tube** ("NGT" or "NG tube") is a tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. NGTs are placed in residents who require enteral nutrition for up to approximately 4-6 weeks.

- o **Gastrostomy Tube** ("G-tube" or "GT") is a tube that is initially placed by surgeons, interventional radiologists (IR), or gastroenterologists through the skin of the abdomen and secured in the stomach. G-tubes include balloon-type G tubes, percutaneous endoscopic gastrostomy (PEG) tubes, pigtails, mushroom tubes, and MIC tubes.
- o **Jejunostomy Tube** ("J-tube") is a specialized feeding tube inserted into the jejunum of the small intestine by surgeons or interventional radiologists (IR), or gastroenterologists.
- o **Transgastric jejunal feeding tube** ("G-J tube" or "GJT") is a feeding tube that is placed through the stomach into the jejunum by surgeons or IR, and that has dual ports to access both the stomach and the small intestine.
- o **External bolster** ("bumper" or "disks") prevent inward migration of percutaneous enteral access device.

PROCEDURES:

A. Insertion of NGT

A licensed nurse replaces dislodged NGTs unless ordered otherwise.

Procedure for Insertion and Removal of NGT:

Refer to "Feeding Tube: Small-bore Insertion, Care and Removal" on Elsevier for detailed information (see references for link).

B. Replacement of GT, JT and GJT

1. Insertion tract <u>< 7-10 days old:</u> immediately notify the physician of dislodgement. This may be a medical emergency if stomach contents leak into the peritoneum. Do not attempt tube replacement because it may be accidently positioned into the peritoneum.

2. Insertion tract <u>< 6 weeks old</u>: tubes shall be re-inserted by Interventional Radiology or the gastroenterologist. No attempts shall be made to replace these newly placed tubes by Laguna Honda staff.

3. Insertion tract <u>> 6 weeks old</u>: only simple balloon GT may be replaced at the bedside. For GTs with internal bumper, inform the physician to request for removal alternative (e.g., removal at Gastroenterology Clinic).
   a. The RN replaces simple balloon GTs that are dislodged or cannot be unclogged unless ordered otherwise.
   b. For expulsion, the RN will <u>immediately</u> insert a balloon-type gastrostomy tube of the same size or smaller to prevent stoma closure and inform the physician.
   c. All gastrostomy tubes reinserted or replaced at LHH will have radiologic confirmation of tube placement (e.g, gastrografin) prior to use.
   d. The LHH physician will check the radiology reading prior to use of a reinserted tube and inform nurses when GT may be used. If there is a question about tube placement, or the licensed nurse is unable to reinsert/replace the GT, the tube will be reinserted in the emergency department (ED) or interventional radiology (IR). Refer to 26-03 Enteral Tube Nutrition.
   e. If the resident can tolerate NGT placement, and NGT may be placed temporarily per physician order until an IR appointment is available. If an NGT cannot be placed and there is a delay in resuming enteral nutrition and medications, intravenous fluids and medications may be required.

2

f. Keep a replacement gastrostomy tube of the same size as resident's existing tube available in the neighborhood for emergency replacement. Gastrostomy tubes are available from Central Supply.
g. Consider tube replacement sooner than routine every 3 months, if any of the following are identified:
    i. Deterioration and dysfunction of the G-tube
    ii. A ruptured internal balloon
    iii. Stomal tract disruption
    iv. Peristomal infection that persists despite appropriate antimicrobial treatment
    v. Skin excoriation
    vi. Non-healing ulcer formation that will not heal despite good wound care technique
h. Complete an Unusual Occurrence (UO) report if the tube replacement was not scheduled (Refer to LHHPPP File 26-03 Enteral Tube Nutrition).

Procedure for Replacement of the Gastrostomy Tube

Refer to "Long Shaft Gastrostomy Tube Replacement or Removal" on Elsevier for detailed information (see references for link).

1. Measure the initial external tube length from insertion site at the stoma to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement. Reusable rulers are single-patient/resident use and should be disinfected before and after use.
2. Slide the GT external bumper approximately 0.5 cm from the stoma to prevent tube migration. If GT does not have an external bumper, use tape or stabilization device to position the balloon against the internal abdominal wall, and prevent migration, dislodgement or excessive traction.

C. Administration of Formula Feeding

1. Types of Enteral Nutritional Support:

a. **Closed System:** formula comes in pre-filled closed containers. Closed systems are preferred due to reduced opportunity for contamination.
    i. Label the container with the resident name, ~~bed number,~~ rate, date and time container is hung. The label on the container also applies to the tubing since both are one closed system.
    ii. Only spike containers once with a new tubing set. Tubing sets are never re-used and are discarded with the used container.
    iii. Shake enteral containers well prior to spiking and occasionally during hanging if settling is noticed.
    iv. Containers and tubing are discarded when the container is empty, OR within 24 hours after closed enteral container is hung.

b. **Open System**: nutritional products are transferred from a can or bottle to a feeding bag. Open enteral nutritional bags come with attached tubing.
    i. Labeled the enteral bag with the resident's name, ~~bed number,~~ formula, rate, date and time the bag is hung. The label on the bag also apply to the tubing as both are one system.
    ii. Open enteral bags used for formula must be discarded after each use.
    iii. Open enteral bags used solely for water must be discarded within 24 hours after they are initially hung.

Refer to Appendix 1 for Preparation for Enteral Nutritional Support – Closed and Open System.

2. **Enteral tube care protocol: Refer to Appendix 2**

   a. Daily stoma care and as needed.
      i. Observe if GT external bumper approximately 0.5 cm from the stoma to prevent external pressure (i.e., buried bumper) or inward tube migration, which can cause leaking of gastric contents through the stoma.
      ii. Fit of the simple balloon GT should allow for easy rotation of the tube and permit cleaning under the bumper. **JT and GJT should not be rotated**.
      iii. For insertion tract <u>< 7-10 days old</u>, stabilize tube with one hand while cleaning skin for the first 7-10 days after initial insertion.
      iv. If GT without a bumper, use a stabilization device (i.e., Statlock or M Fixx) to secure/anchor the tube and prevent excessive tension to the exterior portion of the tube.
   b. Dressing changes
      i. A 4x4 split drain sponge may be <u>over</u> the external bumper <u>as needed</u> (e.g., drainage present) and changed daily.
      ii. If the skin is irritated, a moisture barrier cream or a hydrocolloid dressing may be applied under the external bumper to protect the skin and changed as ordered.
      iii. Refer to "Feeding Tubes: PEG, Gastrostomy, and Jejunostomy Care" on Elsevier for detailed information (see references for link).
   c. Skin assessments every shift skin for redness, tenderness, swelling, irritation, or presence of purulent drainage or gastric leakage. If obscured by dressing, observe if dressing is secure every shift and assess skin with dressing change (ex: daily for split drain sponge dressing, weekly for hydrocolloid dressing or securement device, such as M Fixx). Notify physician for any signs of skin breakdown.
   d. Enteral tube length measurements every shift, prior to accessing, after admission or relocation, and as needed. For NGT, inspect the back of the mouth for coiling of tube.
   e. Check gastric residual volume (GRV) every shift unless specified by order. Schedule the GRV checks prior to initiating intermittent formula or evenly spaced for continuous formula.
   f. Flush enteral tube with a minimum of 30 mL of water using a 60 mL syringe at a minimum of once per shift, before and after intermittent feedings, before a paused feeding is resumed, after GRV measurements, and as needed. Obtain a flush order for patients/residents with fluid restrictions. For medication administration flush protocol, refer to NPP J 1.0 Medication Administration.
   g. Notify the physician for compromised feeding tube integrity or patency issues.
   h. Change the storage container and enteral syringes daily on AM shift. Label syringe (name and date), rinse with water after use, and store syringe at the bedside in clean, labeled (name and date), dry container or storage bag.
   i. Change all closed system tube feeding containers and bags/tubing daily on AM shift using clean technique, even if bottle is not empty or expired. Change open system bags used solely for water on AM shift. Discard open system formula bags after each use.
   j. Change Lopez valve weekly if used
   k. Simple balloon GT replacements every 3 months, as needed for dysfunction, as ordered
   l. NGT replacement every 6 weeks, as needed for dysfunction, or as ordered
   m. Relocate NGT position within same nostril weekly to prevent pressure on the same site in the nostril and skin breakdown
   n. Trace tubes back to their origins to prevent misconnections and ensure lines are secure prior to connections.

o.   Notify the Nutrition Services diet office for any new enteral diet orders or changes in formula or calories.

3.   Positioning

a.   Assess aspiration risk and implement appropriate interventions.
b.   Elevate the resident's head of the bed (HOB) to a minimum of 30 degrees prior to, during, and for 30 minutes after feeding unless otherwise ordered. If the HOB needs to be lowered for a procedure (i.e., linen changes or incontinence care), feedings should only be stopped for the duration of the procedure and restarted with HOB re-elevated as soon as procedure is completed.
  i.   If the resident has difficulty clearing secretions, it may be necessary to clear secretions (e.g., oral suctioning with order) regularly or prior to lowering of the HOB.
  ii. If on bedrest, may limit HOB elevation to 30 degrees and avoid positioning directly on a pressure ulcer/injury.

4.   Checking Enteral Tube for Correct Placement
Enteral tube placement is checked at the bedside via external tube length. Auscultation should not be used to verify tube placement. When verifying tube placement, the nurse should use clinical judgement if concerned about migration to ensure safe patient care.
a.   Measure the external tube length from insertion site at the stoma/nostril to the distal end of tube port(s). Do not include a Lopez Valve, if present, in the measurement.
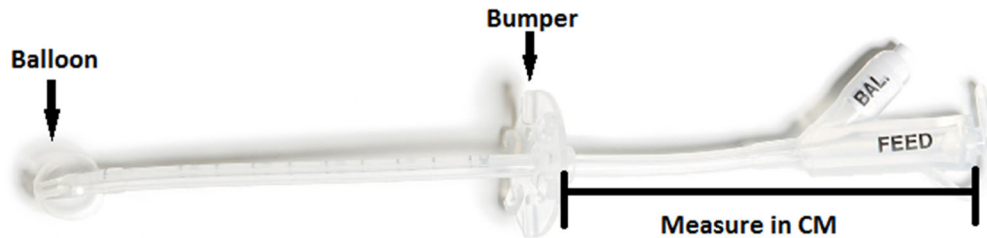
b.   If NGT is in place, examine the oropharynx. External tube length does not guarantee proper position, as tubes can become coiled and or/ the tube tip can become displaced into the esophagus. If there is coiled tubing, gently remove the tubing immediately to prevent airway obstruction. Inform the physician immediately if there are questions about placement.
c.   If there is a question about the enteral tube placement, do <u>not proceed with administration</u> of medication or feeding until correct placement has been verified.
d.   If a change in external tube length is observed, assess the resident for symptoms of possible dislodgement and use visualization of tube aspirate to help determine if tube has become dislocated. Do not attempt to reinsert tube if partially migrated. If in doubt of placement, notify the physician and obtain a radiograph to determine tube location. Refer to section Procedure 5 Procedure for Gastric Residual Visualization.
e.   Respiratory compromise (i.e., increased respiratory rate, difficulty breathing, decreased O2 saturation, or coughing) may indicate tube feeding dislodgement or intolerance.
f.   Document the procedure. Refer to section Procedure J Documentation.

5.   Procedure for Gastric Residual Visualization and Measurement:

Refer to "Feeding Tube: Verification of Placement" on the Elsevier (Mosby's) Clinical Skills for detailed information (see references for link).

a. Checking gastric residual volume (GRV) may be appropriate when initiating tube feedings, if dislodgement suspected, or if the resident/patient reports or displays any signs of intolerance, such as bloating, nausea, vomiting, and complaints of fullness, abdominal distension or abdominal pain.
b. The technique of aspirating gastric juices for GRV checks can increase clogging.
c. Stop continuous feedings for several minutes before aspirating, measuring, and returning gastric residuals.
d. Measure the amount of gastric aspirate and observe for changes in the volume and appearance of the aspirate.
    i. If the gastric residual volume is > 250 ml or the GRV order parameters, hold the tube feeding and notify physician. Aspirate, measure, and return gastric residual every 2-4 hours until resident has exhibited the ability to empty his/her stomach, at which time tube feeding may be continued or re-started with an order.
e. Notify the physician if gastric secretion volume or appearance is concerning.
f. Document the procedure. Refer to section Procedure J Documentation.

6. **If Tube Occlusion Occurs**

    Do not use any non-facility approved devices (i.e., tube brush), cranberry juice, soda or hot water to unclog feeding tubes at the bedside.

    Use a gentle back-and-forth motion with 30- or 60-mL syringe filled with water to dislodge clog or a pancreatic enzyme solution per order to dissolve clog.

    Refer to "Feeding Tube: Small-bore Insertion, Care and Removal" on Elsevier for detailed information (see references for link).

D. **NGT use as Intermittent Gastric Suction**

    Refer to "Nasogastric or Orogastric Tube: Insertion, Flushing, and Removal" Elsevier Clinical Skills for detailed information (see references for link).

    1. Large bore, double lumen NGTs, such as the sump tube, are the preferred tubes for gastric suction. The large lumen allows of suction of gastric contents and medication delivery. The smaller vent lumen allows for atmospheric air to be drawn into the tube and equalizes the vacuum pressure in the stomach once the contents have been emptied. This prevents the suction eyelets from adhering to and damaging the stomach lining.
    2. If using a sump tube, do not clamp the air vent, connect the tube to suction or use it for irrigation. Keep the air vent of the sump tube above the patient's stomach level.
    3. After instilling medication and/or formula and flushing with 30 ml of water, plug the NG tube for 1-1/2 hours or as ordered, before attaching to the suction machine.
    4. Only use low suction unless otherwise ordered.
    5. Monitor for any signs of respiratory distress and stop suction and notify physician immediately if present.
    6. Document any volume of fluid instilled (intake) and suctioned (output).

E. **Administration of Medication(s) Through Enteral Tube** (Refer to J 1.0 Medication Administration)

F. **Reassessment of Enteral Feeding**

1. Enteral Feeding may be held, and physician notified for possible indications listed below:
   a. Aspiration, such as vomiting, choking, coughing, frothy sputum, tachycardia, respiratory distress, or fever.
   b. Fluid and electrolyte imbalance
   c. Intolerance of feedings, using measures such as slow gastric emptying (GI motility status), assessment for abdominal distension, firmness, diarrhea and large GRV, feeling of fullness, or nausea that might lead to gastric reflux.
   d. Peritonitis, such as abdominal pain and/or bloating, constipation, fever, nausea, vomiting, diarrhea, weakness, dizziness, dyspnea, tachycardia, tachypnea, and inability to pass gas or feces, and dehydration. Feeding tubes can perforate the stomach or small intestine, and result in peritonitis.
   e. Esophageal complications, including esophagitis, ulcerations, strictures, and tracheoesophageal fistulas.
   f. Leaking around the insertion site, abdominal wall abscess, or erosion at the insertion site, including nasal areas.
   g. Clogged tube due to plugging by formula, pill fragments, or precipitation of medications incompatible with the formula.
2. Enteral feeds will be resumed by physician order, which may include radiologic evaluation or reassessment of the goals of enteral feeding
3. Notify physician and registered dietitian:
   a. If resident has unplanned significant weight gain or loss or if a reassessment of goals of nutritional support is indicated. Refer to NPP G 7.0 Obtaining, Recording and Evaluating Residents Weights.
   b. If the Intake and Output monitoring indicate the resident is consistently receiving less than the enteral nutrition goal volume.

G. Documentation

Goals of Medical Enteral Feeding
1. Nutritional and Quality of Life goals are documented in the Resident Care Conference (RCC) note.
2. Goals of enteral feeding may be documented in Advance Care Planning by the physician.

EHR Documentation by the Licensed Nurse
1. Flowsheet or Lines, Drain and Airways (LDA) and Flowsheets
   a. Admission and Tube Insertions:
      i. If the tube was inserted at a DPH facility, continue the LDA.
      ii. Document the tube properties and assessment under LDA.
      iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered
   b. Removal and Replacement:
      i. Document the removal of the original tube (permanent removal or planned replacement) under the LDA, including the remove date, removal time, removal reason.
      ii. Document the replacement by initiating a new LDA.
      iii. Document the resident's tolerance of the procedures and any difficulty or complications encountered.
   c. Documentation:
      i. Every shift and as needed: document the tube assessment under LDA.
      ii. Intake and Flush volume: Prior to the end of EACH shift, the Licensed Nurse:
         i.i Checks the feeding pump and documents the volumes for "FED" and "FLUSH" at the end of the shift.
         i.iii Clears the pump of the volumes for "FED" and "FLUSH".

> > > i.iv Documents the volume of fluid used for flushes and medications during the shift.
> > iii. As needed:
> > > i.i Any other problems with enteral tube management (e.g., frequent obstruction, etc.)
> > > i.ii Resident's tolerance or intolerance of feeding.

2. Education: Document any resident or family teaching provided and evaluation of learning
3. Care Plan:
   a. Care plan the clinical indication, as noted by the physician, which necessitates enteral tube placement and enteral nutrition.
   b. Include any related or potential problems, or resident needs.
      Examples of some possible adverse effects of using a feeding tube may include: diminishing socialization, and not having the opportunity to experience the taste, texture, and chewing of foods.

Non-EHR Documentation by the Licensed Nurse

Document daily enteral feeding supplies used on the Enteral Nutrition Charge Form. Refer to LHHPP 50-04 (Enteral Nutrition Charge Procedure).

ATTACHMENTS/APPENDICES:

Appendix 1: Preparation for Enteral Nutritional Support – Closed and Open System
Appendix 2: Enteral Pump Hang Tag provided by the manufacturer
Appendix 3: Enteral Nutrition Chart

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CROSS REFERENCES:

Hospitalwide Policy and Procedure
    26-03 Enteral Tube Nutrition
    50-04 Enteral Nutrition Charge Procedure
Nursing Policy and Procedure
    G 3.0 Intake and Output
    G 4.0 Measuring the Resident's Height and Weight
    J 1.0 Medication Administration and Appendices

Adopted: 2002/08
NEW: 2013/05/28
Revised: 2009/08; 2011/03/10, 2011/07/12; 2015/01/13; 2016/07; 2017/11/04; 2019/05/14; 2022/07/12;
2022/11/08; 2023/04/11
Reviewed: **2022/11/08**
Approved: 2023/04/11

APPENDIX 1 - Enteral Nutritional Support - Closed and Open Systems

A. **Administration of Formula Feeding**

1. **CLOSED SYSTEM**

   a. Equipment

      Gather all equipment needed from neighborhood supply room or Central Supply Room:
      i. infusion pump with tubing set
      ii. 60 ml catheter tip feeding syringe

      Obtain the prescribed enteral formula from the Galley or Dietary Department.

   b. Preparation of Nutritional Products
      i. Wash hands with soap and water or use hand sanitizing product.
      ii. Follow physician orders and nutritional product instructions on container.
      iii. Check expiration date of enteral formula.
      iv. Enteral formula should be at room temperature.
      v. Shake container for 5-10 seconds prior to spiking to mix formula evenly.
      vi. Remove container lid. Do not remove the cap from the container.
      vii. Label container with resident name, bed number, rate, staff initials, date and time container is hung.
      viii. Spike enteral nutrition container using the open port in the cap, not the air vent; and fill water bag with room temperature tap water prior to setting the pump.
      ix. Program the pump per manufacturer instructions. Refer to Appendix 2. Use **"continuous mode"** for both continuous and intermittent feeding.
      x. Confirm proper positioning of the resident and correct placement of enteral feeding tube per nursing and hospital policy (Refer to NPP E 5.0 and LHH File 26-03).

2. **OPEN SYSTEM**

   a. Equipment

      Gather all equipment needed from neighborhood supply room or Central Supply Room:
      i. infusion pump with open system tubing set or gravity feeding bag for bolus feeding
      ii. 60 ml catheter tip feeding syringe

      Obtain the prescribed enteral formula from the Galley or Dietary Department.

   b. Preparation of Nutritional Products
      i. Wash hands with soap and water or use hand sanitizing product.
      ii. Follow physician orders and nutritional product instructions on container.
      iii. Wipe top of unopened container with alcohol wipe before opening. Avoid touching any part of the formula container or the administration set that will come in contact with the formula.
      iv. Make sure formula is at room temperature by any of these means:
         1. Store unopened formula at room temperature.
         2. Place refrigerated formula cans in a pan of warm water.
         3. Add warm water, as ordered, to the formula.

      v. Partial cans of formula:

1. Cover, date and initial container.
2. Place in household refrigerator to use for next formula preparation.
3. <u>Discard unused formula after 48 hours.</u>

vi. Enteral bags are labeled with resident's name, ~~bed number,~~ formula, rate, staff initials, date and time bag is hung.
vii. If using enteral pump, fill the bag with formula and water flush bag with room temperature tap water.
viii. Program the pump per manufacturer instructions. Refer to Appendix 2. Use **"continuous mode"** for both continuous and intermittent feeding
ix. If using gravity feeding bag, fill bag with formula. Prime tube prior to connecting to resident.

c. Administration of high protein powder supplement with water using open enteral system:
   i. Put 60-120 ml of water in the enteral feeding bag.
   ii. Add the amount of protein powder ordered.

   iii. If using enteral pump, fill the bag with formula and water flush bag with room temperature tap water.

   iv. Program the pump per manufacturer instructions. Refer to Appendix 2. Use **"continuous mode"** for both continuous and intermittent feeding.
   v. If using gravity feeding bag, fill bag with formula. Prime tube prior to connecting to resident.

B. Administration of Free Water

1. Using Syringe
   a. Use 60 ml syringe.
   b. Attach the syringe to the tube port.
   c. Pour water from the resident's water pitcher into the feeding syringe.
   d. Administer water by gravity through enteral tubes unless the gastrostomy is short, such as the Bower REG. These tubes do not have adequate length for fluids to flow by gravity from a syringe. In this case, use a 60 ml catheter-tip syringe and, with the plunger, slowly and gently push fluids through the tube into the stomach.

2. Using an Enteral Bag
   a. See above procedures for open & closed systems.

3. In open systems, free water may be added to directly to the feeding bag, unless contraindicated.

C. Charging Slips for Enteral Formula

1. Refer to LHHPP File 50-04 Enteral Feeding Charges.

Changed to Appendix: 05/28/2013 Revised: 06/2004; 03/10/2011, 5/28/2013; 04/23/04/11

Reviewed: 2023/04/11

Approved: 2023/04/11

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, then monthly. 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. 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.

4. Residents are weighed by the receiving neighborhood upon relocation.

5. 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).

6. Licensed staff will inform the dietitian and physician regarding unintended weight loss or gain.

7. Monthly weights shall be obtained ~~every first weekend~~ by the 7th of each month.

PURPOSE:

To obtain accurate weight measurements and identify unintended weight changes to facilitate effective care planning.

_____

PROCEDURE:

A. <u>Obtaining Weights</u>

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 on Care Plan

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

BLOOD PRODUCT ADMINISTRATION

POLICY:

1. The transfusion of blood products is restricted to Pavilion Mezzanine Acute (PMA).

2. ~~The trained Registered Nurse (RN) is responsible for the safe administration of blood products upon physician orders.~~

2. Packed Red blood cells (RBCs) are the only blood component transfused at Laguna Honda Hospital (LHH).

3. Administration sets are changed with each unit.

4. Physician obtains consent prior to blood transfusion. Signed consent forms remain in effect for 12 months from the date and time that they are signed, provided that specific transfusion risks do not change and the patient or surrogate decision maker (SDM) does not later withdraw the consent.

~~3.~~5. ABO/Rh Confirmation: if a 2nd registered nurse (RN) or phlebotomist is unavailable, the same phlebotomist or RN may draw the 2nd specimen at a different time (at least 5 minutes apart).

4. ~~Staff will observe standard precautions and any indicated enhanced precautions will be observed for all aspects of blood product administration.~~

PURPOSE:

1. To describe the procedure for ordering and receiving of blood products from the Zuckerberg San Francisco General Hospital (ZSFG) Blood Bank/Transfusion Service.

2. To describe the procedure for safe administration of blood products, including pre-transfusion checks, setting-up and starting transfusion, monitoring patients during the procedure, documenting transfusions, and initiating assessment, treatment and laboratory investigation in case of suspected transfusion reactions.

~~2.~~3. This policy supplements the Department of Public Health (DPH) policy 18.05 Blood Product Administration with Laguna Honda Hospital (LHH) specific procedures.

_____

PROCEDURE:

~~A. Equipment~~

~~EQUIPMENT:~~	~~OBTAINED FROM:~~
~~IV pump and stand~~	~~Central Supply (CSR)/PMA~~
~~0.9% Normal saline 250 mL bag~~	~~Omnicell/PMA~~
~~Blood administration set (tubing) with filter for each unit~~	~~CSR/PMA~~
~~IV kit/supplies (angiocatheter, alcohol wipes, etc.)~~	~~Omnicell/PMA~~

A. ~~B.~~ **Physician Orders/Consent**

1. ~~Physician must obtain consent prior to each blood transfusion from the patient or surrogate decision maker (SDM). It is preferred that a Laguna Honda Hospital (LHH) staff sign as a witness.~~

a. ~~LHH provides all patients that require a blood transfusion with information concerning alternative blood donation options.~~

~~i.~~ ~~These options include autologous donation (donating for one's self), designated donation (a friend or relative is donating specifically for the recipient), or volunteer donation (blood donated to the community by a volunteer).~~

~~ii.~~ ~~Exceptions for autologous and designated blood donation include life-threatening emergencies and medical contraindications.~~

~~iii.~~ ~~The patient may waive the right to pre-donate blood if he/she chooses not to delay medical treatment.~~

~~iv.~~ ~~The patient shall be provided with a copy of the brochure "A Patient's Guide to Blood Transfusion." Use of this brochure is required by law; no other information or pamphlet will satisfy the physician's legal obligation. Refer to Appendix D.~~

~~b.~~ ~~The physician will document any refusals.~~

~~2.~~ ~~The physician will order blood electronically.~~

~~a.~~1. If the patient is from the acute unit, the acute physician will enter the order~~s~~ entirely.

~~1.~~ If the patient is from a Skilled Nursing Facility (SNF), either the SNF or acute physician may enter the orders pending handoff discussion. ~~unit:~~

2.

~~i.~~Order must be placed ~~The SNF physician will order:~~

~~1.~~ ~~Type and screen for PRBCs~~

~~2.~~ ~~Number of units for transfusion (prepare and transfuse RBC units)~~

~~3.~~ ~~Transfusion date, if not to be administered when blood is ready from the blood bank. For resident centered care, blood transfusions may be scheduled between the hours of 0900 – 1800 on the day following completion of the type & screen or when the blood is available. Blood transfusions may be performed 7 days/week.~~

~~ii.~~ ~~The acute physician, or SNF physician as needed, will order:~~

~~1.~~ ~~Pre-medication (if indicated) and any ancillary/treatment orders, including IV access, IV fluids, etc.~~

~~2.~~3. ~~Approval~~ to approve administ~~ration~~ of~~er~~ SNF medications while in the acute unit for the come-and-go blood transfusion.

~~3.~~ ~~The SNF physician informs the resident and family or SDM about the transfusion, and when and where it will take place.~~

~~4.~~ ~~The SNF physician will provide a hand off to the PMA physician including any information regarding previous transfusion reactions and any other pertinent information about current medical status and history.~~

~~**C.**~~ ~~**Blood Specimen Collection for Type and Screen**~~

~~1.~~ ~~Obtained by lab technician, RN or physician. If the resident has Central Venous Access Device (CVAD), RN will obtain the tubes from the lab and draw the blood specimen.~~

~~2.~~ ~~Blood specimen must be collected in a 10 mL pink tube, which must be filled completely.~~

~~3.~~ ~~Label the blood specimen with a patient label in the presence of the patient. Date, time and signature on the label if a generic label is used.~~

~~4.~~ ~~All type and screens must be sent with a requisition for blood bank records. Print and sign name and date and time of specimen collection on the requisition.~~

~~5.~~ ~~The Licensed Nurse (LN) will inform PMA that the blood specimen was drawn.~~

~~6.~~ ~~If the blood bank requests a 2nd specimen (ABO-Rh recheck), the 2nd specimen must be collected at a different time (at least 5 minutes apart), preferably by a different RN or phlebotomist. If the lab receives the 2nd specimen with the same collection time as the first specimen, one will be discarded.~~

B. ~~**D.**~~ **ZSFG Blood Bank - Blood Issue and Return**

1. The PMA RN will notify the blood bank when the patient is ready for the transfusion by phone.

2.   The blood bank will arrange ~~for~~ a courier (cab driver) to deliver the blood ~~directly~~ to PMA, and who must sign the Blood Bank Delivery Receipt for Blood or Blood Products form to document timely delivery. ~~.~~

~~3.   When the blood product is delivered to PMA:~~

~~a.   An RN or MD reviews the Blood Bank Delivery Receipt for Blood or Blood Products (attached to cooler) and verifies that the blood has not expired, checks the stamped date and time to determine how long the blood has been in the insulated blood bank cooler.~~

~~b.   An RN or MD must write the time when the blood product was received on the Blood Bank Delivery Receipt for Blood or Blood Products (cooler label), and sign the form.~~

~~4.   The courier must sign the Blood Bank Delivery Receipt for Blood or Blood Products form to document that the messenger has made timely delivery of the blood product. Refer to Appendix C.~~

2.

~~a.~~3. The cooler keeps the temperature safe for administration for 12 hours, or for the duration specified on the cooler. For example, if the blood was placed in the cooler at 8 am, all the blood must be removed from the cooler for administration before 8 pm.

~~5.~~4. PMA RN attaches the delivery receipt and a patient label to a sheet of paper for scanning.

5.   If the blood will not be transfused within the time frame due to late delivery, patient refusal or any other reason, notify the ZSFG Blood Bank for potential return of unused/unopened blood ~~return the unused/unopened blood to the ZFGH Blood Bank~~ via courier.

~~6.~~

~~E.~~C.   **Resident Preparation**

1.   The SNF neighborhood LN will:
   a.   Provide a hand off to the PMA RN prior to sending the patient to PMA.
   ~~b.   Coordinate with the PMA RN for the administration of SNF medications during the transfusion.~~
   ~~c.~~b. Verify that the patient has a legible identification band.
   ~~d.   Not transfer the patient to PMA until the blood has arrived on PMA.~~
   ~~e.~~c. Verify that the patient has a valid, signed consent. Send a copy of the consent with the patient to PMA if the consent has not been scanned.
   ~~f.~~d. Send the medication cassette with the patient.
   ~~g.   Update the resident's location in the Electronic Health Record (EHR).~~

2.   In preparation for the transfusion, the PMA RN will complete the following:
   ~~A.   Verify that the resident has an identification band securely attached to his/her body.~~
   ~~B.~~A.   Notify the kitchen if the blood transfusion will occur during a meal time.
   ~~C.   Orient the resident to the unit and the transfusion procedure.~~
   ~~D.   Ask about previous transfusion reactions or allergies if the resident is able to provide a reliable history.~~
   ~~E.   Educate the resident about any changes or new signs and symptoms to report to the nurse during the transfusion and documents in EHR.~~
   ~~F.~~B.   Perform and document resident physical assessmen~~t~~t ~~and document in EHR~~, including vital signs (temperature, blood pressure, pulse, respiratory rate, and oxygen saturation) and other baseline body system assessments as appropriate (e.g., cardiovascular, respiratory, genitourinary, skin, intake and output)
   ~~G.   Administer any pre-medication as ordered.~~

~~F.   Required Pre-Transfusion Verification~~

~~At the bedside, 2 staff (RN/RN or RN/physician) will positively identify the patient and verify all the information linking the order, blood product, and intended recipient matches. One person will read out loud the information (item by item) from one source (patient ID or container label), while the 2nd person verifies the information against the Blood Bank Transfusion Report (red slip attached to blood container). Refer to Appendix C.~~

C.

1. ~~**Check the medical record for signed informed consent**.~~
2. ~~**Name, medical record and Blood Bank Transfusion Report**: Positively identify the patient and verify that the resident's first and last name and medical record number matches the Blood Bank Transfusion Report. Positive patient identification sources are identification band, patient correctly stating his/her first and last name and birthdate, or patient photo in the EHR.~~
3. ~~**Donor and patient ABO/Rh compatibility**:~~
    a. ~~Verify the blood component on the container label and any applicable special requirements match the physician's order and crossmatch results in the EHR.~~
        i. ~~Special requirements include autologous, designated, irradiated, sickle cell screen negative or RBC antigen matched~~
        ii. ~~Autologous or designated blood units are labeled with an extra tag signifying autologous (green tag) or designated donor (orange tag). These tags must not be removed from the blood units.~~
4. ~~**Donor ABO/Rh type on Blood Bank Transfusion Report match the unit label**: Compare the blood type (ABO) and Rh type on the container label with the ABO/Rh of the intended recipient on the Blood Bank Transfusion Report.~~
    a. ~~Blood types do not need to be identical, but must be compatible. However, the donor blood type on the container label must match the donor blood type on the Blood Bank Transfusion Report.~~
    b. ~~O-negative blood can be given to any patient. However, the blood bank may release O- blood to female patients and O+ blood to male patients.~~
    c. ~~Rh negative blood can be given to an Rh positive patient.~~

~~ABO Group of Recipient~~	~~Compatible Donor ABO Group for Red Blood Cells~~
~~A~~	~~A, O~~
~~B~~	~~B, O~~
~~AB~~	~~A, B, AB, O~~
~~O~~	~~O~~

5. ~~**Unit numbers on the container label match the Blood Bank Transfusion Report.**~~
6. ~~**Scan barcodes on the blood container label.** Barcode scanning of the unit number and product code verifies that the unit of blood being scanned matches what the blood bank sent for the patient.~~
7. ~~Verify blood expiration date on the container label has not been exceeded.~~
8. ~~Inspect the blood product for clots/clumps or discoloration (purplish/black color).~~
9. ~~If any discrepancies with the blood order or patient/blood identification are identified, or if the blood bag integrity or appearance of the blood raises suspicion that the unit may not be suitable for transfusion:~~
    a. ~~DO NOT BEGIN THE TRANSFUSION.~~
    b. ~~Notify the physician, nursing supervisor and blood bank, and return the blood to ZSFG Blood Bank via courier.~~
    c. ~~Document in the medical record.~~
10. ~~A Checker and a transfusionist must each certify integrity and successful completion of pre-transfusion checks by signing their legal names in the provided fields on the front of the Blood Bank Transfusion Report. Both signatures must be present (i.e., 2 signatures are required) and the date and start time of the transfusions must be filled in. The checker will also be required to sign in the EHR.~~
11. ~~Tear off the top of the Blood Bank Transfusion Report (chart copy), making sure that the last copy (unit tag) remains firmly attached to the container. Attach the transfusion report (chart copy), along with the delivery receipt and a patient label to a sheet of paper for scanning.~~
12. ~~Both individuals who performed the resident/blood unit double-checks will sign off in the EHR.~~

~~G.~~D.   Blood Administration

1. Complete required pre-transfusion verification

1. Universal precautions are employed for all aspects of blood and blood product administration.
2. If the patient does not have a CVAD, the PMA RN will initiate IV access with gauge 18-22 catheter size. The risk for hemolysis increases as catheter size decreases.
   a. Perform hand hygiene and don gloves.
   b. Prime a Y-blood administration tubing set and in-line filter with a 0.9% Normal Saline (NS) 250 mL IV bag. Blood transfusions must be administered through a blood administration set with an in-line blood filter designed to retain particles potentially harmful to the recipient. Each unit of blood requires a new administration set.
   c. Gently invert the bag a few times to undo settling of blood components and to help facilitate flow.
   d. Prime the tubing with blood and ensure that the blood level in the drip chamber is above the filter. RBCs can be damaged if blood drips directly onto the filter.
   e. Use an IV infusion pump to ensure steady flow and a controlled rate of infusion. Transfusionists using infusion pumps should be trained and competent on their use.
1. At the resident's bedside, before connecting the blood tubing to the patient – perform the two staff verification of the blood product as detailed above under *Required Pre-Transfusion Verification*.
2. Obtain vitals (e.g., blood pressure, pulse, respiration and temperature):
   a. baseline (within 1 hour) prior to initiating the blood transfusion to serve as a reference point in case of suspected transfusion reaction
   b. 15 minutes after the start of the transfusion
   c. 1 hour after the start of the transfusion
   c.d. At transfusion completion
   d.e. 20 minutes post-transfusion
3. The RN will remain at the resident's bedside for the first 15 minutes of the transfusion for each unit to monitor the resident's response and to assess for the signs and symptoms of a transfusion reaction.
   a. During the 1st 15 minutes of transfusion, the rate of infusion is slow: 1-2 mL per minute.
   b. If there are no signs of blood transfusion reaction or intolerance, the rate may be increased so the transfusion is completed within 2 hours, or according to physician orders.
   3.

TIME	RATE
0-15 minutes	30 mL/hr (1-2 mL/min)
15-120+ minutes	~175 mL/hr (use a slower rate if the ordered infusion time is > 2 hours)

4. Transfusion of each blood unit must be initiated within 30 minutes and completed within 4 hours of being removed from the cooler. This is to minimize the risk of bacterial contamination and growth and red cell hemolysis.
5. Warning: Do not add any medications to blood or blood components.
6. Record intake and output. Each unit of blood is approximately 350 mL.
7. When the transfusion is completed, run 0.9% NS through the IV line to clear the tubing and then discontinue the IV unless resident needs a TKO line.
8. If ordered, additional units may be infused through the same needle/catheter, but the administration set will be changed for each unit.
9. Complete documentation in the EHR, including the time the transfusion(s) were completed, and intake and output.
10. Once the blood is discontinued, double bag the container and tubing and discard in the red infectious waste container.

H.E.   Post transfusion Observations

1. Acute:
   a. Monitor according to regular vital sign schedule.

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~~b.~~a. The resident shall remain on PMA for 1 hour after transfusion has been completed. The resident may stay longer for resident centered care.

b. If vital signs are stable, the resident may return to SNF neighborhood.

c. The PMA RN will provide a hand off report to the SNF LN prior to sending the resident back to the SNF neighborhood.

~~c.~~

2. SNF:

   a. Vital signs on the SNF neighborhood will be performed once per shift for a minimum of 48 hours. Monitoring may be more frequent or extended if indicated.

   ~~b. The PMA RN will provide a hand off report to the SNF LN prior to sending the resident back to the SNF neighborhood.~~

   ~~c. The SNF LN will update the resident's location in the EHR.~~

3. ~~Acute transfusion reactions may manifest themselves during transfusion or up to 6-24 hours after transfusion. Follow instructions in the *Transfusion Reaction* section below if signs or symptoms suggest a transfusion reaction in a recently transfused patient.~~

~~I.   Transfusion Reaction~~

1. ~~Transfusion reactions are any adverse reaction to blood products. Less than 10 mL of an incompatible product may cause a severe reaction. Patients with a history of previous transfusion reaction have a greater change of reaction with future transfusions.~~

~~Transfusion reaction signs and symptoms:~~			
~~Chills~~	~~Anxiety~~	~~Headache~~	~~Chest tightness/pain~~
~~Dyspnea~~	~~Back pain~~	~~Shock~~	~~Hemoglobinuria~~
~~Pruritis~~	~~Urticarial~~	~~Hypotension~~	~~Fever (> 1°C increase from baseline)~~
~~Nausea~~	~~Flushing~~	~~Oliguria~~	~~Generalized bleeding~~

2. ~~If the resident develops an adverse reaction – Refer to Appendix A Management of Transfusion Reactions for more information.~~

   a. ~~STOP THE TRANSFUSION IMMEDIATELY~~

   b. ~~DISCONNECT THE BLOOD TUBING FROM THE IV OR CVAD PORT. Save the blood bag and IV tubing.~~

   c. ~~**DO NOT** discontinue IV access.~~

   d. ~~Set up a new IV administration set and IV bag of 250 mL 0.9% NS at TKO (30 mL/hr).~~

   e. ~~NOTIFY THE PHYSICIAN and Nursing Supervisor. The physician may order a "Transfusion reaction workup" to generate a specimen and order for the blood bank workup.~~

   f. ~~Check all labels, forms and resident identification to determine whether the resident received the correct blood.~~

   g. ~~From the onset of the reaction, take vital signs every 15 minutes until vital signs stabilize. Monitor strict I/Os every hour. Monitor for other signs/symptoms for a possible transfusion reaction.~~

   h. ~~If ordered, collect 1st urine specimen and a 10 mL blood specimen (pink top) for transfusion reaction work up. Label the samples at the bedside in the presence of the resident.~~

   i. ~~After assessing the patient, the physician will determine if the blood transfusion can be continued.~~

      i. ~~Discontinuing the transfusion is based upon the presence of any signs of a potentially life threatening transfusion reaction (i.e., anaphylactic shock, intravascular hemolysis, sepsis or pulmonary edema). In general, transfusions associated with febrile reactions should be discontinued and investigated, unless the fever can be clearly attributed to a cause unrelated to the transfusion.~~

~~ii.~~ ~~Continuing the transfusion may be done if the resident has had previous mild allergic reactions, and can be treated with an antihistamine (i.e., diphenhydramine/Benadryl).~~
~~j.~~ ~~Notify the blood bank.~~
~~k.~~ ~~The physician will complete the Transfusion Reaction Form. Make a copy of the form for LHH records.~~
~~l.~~ ~~Save the tubing and blood container – double bag in red plastic bags and send to ZSFG Blood Bank with the Transfusion Reaction Form and blood specimen. Notify the blood bank if the physician decides not to send product back.~~
~~m.~~ ~~Document transfusion reaction, resident's symptoms, time of physician notification and all interventions in the EHR.~~
~~n.~~ ~~Resident should be monitored on their regular/SNF unit for the at least 48 hours post-transfusion for possible acute reactions, and (optionally) 5-7 days after transfusion for a possible delayed reaction (hemoglobin check).~~

~~Transfusion Reaction Type~~	~~Time Frame~~	~~Symptoms~~
~~Acute~~	~~Presents < 8 hours post-transfusion~~	~~Fever, shortness of breath, hypo- or hyper-tension, aches and pains, rash, gastrointestinal symptoms~~
~~Delayed~~	~~Presents 3-7 days (up to 14-21 days) post-transfusion~~	~~Falling hemoglobin, rarely oliguria, anuria, hemoglobinuria, jaundice~~

~~J.~~F. Downtime Documentation

~~1. A checker and transfusionist must each certify integrity and successful completion of pre-transfusion checks by signing their legal names in the provided fields on the Blood Bank Transfusion Report. The Transfusionist will document the date and start time of the transfusion.~~
~~2. Tear off the top of the Blood Bank Transfusion Report (chart copy), making sure the last copy (unit tag) remains attached to the blood container. Affix the chart copy and a patient label to a sheet of paper for scanning. Do not overlap these sheets.~~
~~3.~~ Record vital signs and other required information for the blood transfusion (Appendix C~~E~~) Attach a blood bag unit sticker from each unit transfused to the documentation form. The completed paperwork will be scanned into the patient's medical record per standard unit procedure.

APPENDICES:

Appendix A: Blood Bank Cooler and Unit Tags ~~Management of Transfusion Reactions~~
Appendix B: A Patient's Guide to Blood Transfusion (English & Spanish) ~~Blood Bank Transfusion Reaction Report~~
Appendix C: Downtime paperwork (blood bank requisition, blood transfusion administration record)~~Blood Bank Cooler and Unit Tags~~
Appendix D: Blood Bank Consent ~~A Patient's Guide to Blood Transfusion (English & Spanish)~~
~~Appendix E: Downtime paperwork (blood bank requisition, blood transfusion administration record)~~
~~Appendix F: Blood Bank Consent~~

REFERENCES:

Elsevier Clinical Skills: Blood Product Administration: Red Blood Cells and Whole Blood

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https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco

Department of Public Health Administrative Policies 18.05 Blood Product Administration (2019)

Paul Gann Blood Safety Act, California Health and Safety Code Section 1645

Revised: 2000/08; 2008/09; 2015/02; 2015/10/23; 2016/07; 2020/03/17; 2022/10/11

Reviewed: 2022/10/11

Approved: 2022/10/11

San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
Department of Education and Training

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

_____

Portable Bed Exit Alarm Competency Checklist

EMPLOYEE NAME:_____ CLASS (circle)**: RN LVN CNA PCA HHA**
                               Last   First

SHIFT (circle): **AM   DAY   PM**   **DATE**:_____

Direction: Check **S** (able to state or demonstrate) to indicate satisfactory or **U** (unable to state or demonstrate) to indicate unsatisfactory performance.

Procedure Steps	S	U	Comments
A. Bed Check Alarm Installation and Set Up			
1. Verbalize how to install the portable bed exit alarm: • Connecting alarm to Nurse Call System • Dating Sensormat • Placing Sensormat at appropriate location			
B. Operating Bed Check Alarm			
1. Monitoring Mode: Verbalize and demonstrate how to set the alarm to Monitoring Mode.			
2. Repositioning or Removing the Resident Off The Bed: • Able to press "Reset" and verbalize that staff has 25 seconds to assist resident off the bed before alarm goes back to Monitoring Mode • Able to state difference between Standby Mode and Monitoring Mode			
C. Day/Nite Mode: Verbalize and demonstrate how to switch alarm to Nite Mode or Day Mode.			

DESCRIBE ALL INDICATORS WHEN UNSATISFACTORY IS CHECKED:

☐ **Meets LHH standards for Portable Bed Exit Alarm Competency**

☐ **Does not meet LHH standards for Portable Bed Exit Alarm Competency**

NAME/TITLE OF OBSERVER_____   **DATE _____**

REFERRAL FOR _____(classification) WHO DOES NOT MEET LHH (equipment/protocol) _____
COMPETENCY:

REFERRED TO: _____, NURSE MANAGER/NURSING SUPERVISOR ON (DATE) _____FOR
FOLLOW UP.

Signed: _____

NURSE MANAGER/NURSING SUPERVISOR FOLLOW UP ACTIONS:

Date: _____   Reassess competency

Date: _____   Consult with DET regarding education plan

Date: _____   Consult with Human Resources regarding performance standards

OTHER:

NURSE MANAGER/NURSING SUPERVISOR_____   DATE _____

Revised: 05.31.23 DET

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, 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 accomplished in various milieus including continuing education courses, Skills Days, and in collaboration with local colleges, universities, and other community organizations.

2. 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.

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.

MONITORING BEHAVIOR AND THE EFFECTS OF PSYCHOTROPIC MEDICATIONS

POLICY:

1. Behavior is monitored to assist the Resident Care Team (RCT) in assessing the response to treatment, which includes the gradual reduction of psychotropic medication dosage.

2. Behaviors shall be monitored for each resident who receives psychotropic medication(s) and/or for those with challenging behaviors identified by the Resident Care Team but not requiring management by the use of psychotropic medications.

3. All Patient Care Assistants (PCAs)/Certified Nursing Assistants (CNAs) staff will observe for presence of target behavior (and/or side effects of psychotropic medication) and report to the licensed nurse if observed.

4. The licensed nurse (LN) will review the behavior monitoring record and compare it to the goals of Nursing Care Plan to assess whether the goals of target behavior symptoms, as identified by provider, have been adequately addressed and assessing new behavior and/or symptom not previously identified.

5. Care Plans should include target behaviors for behavior monitoring, individualized nonpharmacological interventions and any potential side effects.

5. ~~The electronic health record flowsheet will be used to monitor the effectiveness of medications prescribed to induce sleep when ordered by physician. If resident is on sleeping aid, nursing shall document on Laguna Honda Hospital and Rehabilitation Center (LHH) Nursing Weekly Summary.~~

PURPOSE:

To document the effectiveness of pharmacological and non-pharmacological interventions, such as:
   a. the increase/decrease of observable target behavior symptoms
   b. effectiveness of a prescribed psychotropic medication
   c. effectiveness of any non-pharmacological interventions in the management of behavior/ mood.
   d. any observed side effects of psychotropic medications.

_____

BACKGROUND:

Psychotropic medications are medications that affect brain activities associated with mental processes and behavior. Psychotropic medications also include any other drugs used for the purpose of effecting mental status or behavior. These include medications used to treat anxiety, depression, mania, schizophrenia, psychosis or to induce sleep. (Refer to MSPP D01-05 Psychotropic Medications**)**

The goal with the use of psychotropic medications is to use the lowest dose possible for the shortest amount of time to effectively manage behaviors.

DOCUMENTATION:

A. Monitoring and documenting behaviors using Behavior Monitoring Record (BMR) flowsheet in EHR:

1. Documenting target behavior(s) in the BMR:

   a. The, licensed nurse ~~will~~ ~~collaborates with the CNA/ Patient Care Assistant (PCA) and/or other members of the Resident Care Team (RCT) to~~ identify and document the target behavior trigger(s), side effects, and the effectiveness of interventions and the prescribed medications. The nurse may collaborate with the CNA/ Patient Care Assistant (PCA) and/or other members of the ~~Resident Care Team (~~RCT~~)~~ to achieve this.

2. The licensed nurse will summarize the presence or absence of target behavior(s) and side effects on the LHH NSG Weekly Summary and communicate any changes to the provider.

B. Monitoring and documenting presence of side effects

1. The nurse will identify and observe the resident for known common medication side effects ~~in the EHR~~and document any follow up interventions in the EHR.

2. For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect in the LHH NSG weekly summary.

C. **Monitoring and documenting presence of tardive dyskinesia (TD).**

1. The Department of Medicine/Department of Psychiatry shall use of AIMS (abnormal involuntary movement scale) for residents on antipsychotic medications to monitor for the potential of TD as follows:
   a. During 1st month of admission (if new to facility)
   b. Thirty days of starting an antipsychotic at the facility
   a. Every 6 months since the last AIMS assessment
   When clinically indicated

2. Nursing shall develop an individualized care plan for those with tardive dyskinesia including interventions to support the resident's unique challenges related to ADLs, social and emotional well-being.

- ~~The nurse will indicate the side effects and the follow up nursing interventions.~~

   ~~8.   For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect in the nursing summary.~~

3. Unit Based QAPI will include prompt for residents on antipsychotic to review is TD present; update care plan.

~~1. The nurse will identify and observe the resident for known common medication side effects and document any follow up interventions in the EHR.~~

2. ~~For medication side effects that the physician has determined are stable, well-managed and acceptable in view of the medication benefits, the nurse may record the side effect in the LHH NSG weekly summary.~~

CROSS REFERENCES:

Hospitalwide Policies & Procedures
    25-10 Use of Psychotropic Medications

Nursing Policies & Procedures
    C 3.0   Guidelines for Documentation of Resident Status/Care by Licensed Nurses
    C 3.2   Documentation of Resident Care by Nursing Assistant
    J 1.0   Medication Administration

Medical Staff Policies & Procedures D01-05
    Psychotropic Medications

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Revised: 2010/10; 2013/01/29; 2015/07/19; 2019/05/14; 2023/01/10

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Approved: 2023/01/10

Revised Pharmacy Services Policies and Procedures

LAGUNA HONDA HOSPITAL   **06.01.01**
DEPARTMENT OF PHARMACEUTICAL SERVICES

POLICY AND PROCEDURE FOR PSYCHOTROPIC MEDICATIONS

Policy:
In accordance with federal and state regulations, the pharmacist will include as part of the monthly medication regimen review, a review of each resident's psychotropic medications.

Purpose:

To ensure rational psychotropic medication use and to avoid unnecessary medication use.

Procedure:
    A. Medication Regimen Review: Pharmacists will review the medical chart of each resident monthly. Regimen will be reviewed for:

        1. Diagnosis and target symptoms for each med.

        2. Appropriate dose including ensuring that the dose is not excessive.

        3. Appropriate duration including that the duration is not excessive.

        4. Adequate monitoring, including side effects or adverse consequences.

        5. Gradual dose reduction (GDR).

        6. Appropriate documentation.

            a. A review of psychotropic medication regimen shall be completed at least quarterly by the attending physician and/or prescribing psychiatrist.
            b. If GDR is not planned, a statement identifying the clinical contraindication is included in the assessment.
            c. As Needed psychotropics shall have clear documentation of an assessment of adverse consequences, effectiveness and ongoing need at least quarterly or more frequently as required by CMS regulations. As Needed psychotropics shall be subject to automatic stops per CMS regulations as outlined in policy Stop Orders (01.02.02).
            d. Informed Consent

    B. Any recommendations related to the psychotropic medication will be conveyed to the physician and nursing staff as per policy on Medication Regimen Review (06.01.00)

Revision History: 8/11, 1/18, 3/19, 11/22
Reference Policies:
  HWP 25-10 Use of Psychotropic Medications
  MSPP-D01-05 Psychoactive Medications Policy and Procedures
  Nsg J1.0 Medication Administration

Nsg J2.5 Monitoring Behavior and the Effects of Psychotropic Medications
Pharm 01.02.02 Stop Order
Pharm 06.01.00 Medication Regimen Review

Revised Medical Services Policies and Procedures

PSYCHOTROPIC MEDICATION MANAGEMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) provides psychotropic medications for LHH residents as clinically indicated.

PURPOSE:

To provide appropriate care to residents and to conform to State and Federal regulations relating to the use of psychotropic medications in skilled nursing facilities.

DEFINITION:

1. Psychotropic medications are drugs that affect brain activities associated with mental processes and behavior. They are divided into four broad categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic medications ("Psychotropic Drug Use in Nursing Homes," Department of Health and Human Services, Office of Inspector General, November 2001 OEI-02-00-00490). For the purpose of this policy, psychotropic medications also include any other drugs used for the purpose of effecting mental status or behavior.

2. LHH providers of psychotropic medications include all LHH Medical Staff members with prescribing authority as defined by the State of California.

PROCEDURE:

1. ASSESSMENT PRIOR TO PRESCRIBING

   a. The resident shall receive proper clinical assessment prior to being prescribed psychotropic medications.

   b. The assessment may be performed by the Primary Care Physician or by a LHH consulting psychiatrist. For initiating services by a LHH consulting psychiatrist, please refer to MSPP D08-03, Access to LHH Psychiatry Services.

   c. The assessment shall include documentation of the medical indication for prescription of psychotropic medications based on diagnostic criteria in Diagnostic and Statistical Manual of Mental ~~Health~~ Disorders (DSM).

   d. All new residents admitting on psychotropic medications shall be assessed, and all residents returning from acute care stays on psychotropic medications shall be reassessed, for the benefits and risks of continuing those psychotropic medications prescribed by the previous setting.

   ~~d.~~e.   If the assessment is performed by a LHH consulting psychiatrist, the psychiatrist will discuss the findings of the assessment with the referring physician including diagnosis, medical necessity (Specialty Mental Health, Non-specialty

Mental Health, Substance Treatment And Recovery Services, Primary Care Behavioral Health - see MSPP D08-02 Attachment 1, Behavioral Health Medical Necessity) and the suggested treatment plan. The referring physician and the consulting psychiatrist will determine whether the referring physician or the psychiatrist will assume responsibility for prescription of psychotropic medication, but for residents whose mental health conditions meet medical necessity for Specialty Mental Health, psychotropic medication management shall be assumed by the psychiatrist, with the consent of the resident or surrogate decision maker. This is to ensure that the resident's clinical needs can be met by direct psychiatrist services and other mental health services under the Specialty Mental Health program. In the case of urgent situations, or if a psychiatrist is unavailable, psychotropic medication management may be provided by a covering member of the medical staff until a psychiatrist is available.

2. RESPONSIBILITIES RELATED TO PSYCHOTROPIC PRESCRIBING

a. The LHH prescriber of psychotropic medications, whether primary care provider or psychiatrist, will follow all LHH documentation practices related to psychotropic medications including, but not limited to, review and use of:
   i. LHH psychiatric/psychotropic medication consent form and procedures
   ii. Physician Quarterly Psychotropic and Sedative/Hypnotic Regimen Review
   iii. Behavioral monitoring procedure
   iv. Licensed Nurse Weekly Behavior Summary
   v. Gradual dose reduction implementation and documentation
   v.vi. Perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications
   vi.vii. Regulatory guidelines regarding the use of psychotropic medications in skilled nursing facilities

b. LHH psychiatrist prescribers of psychotropic medications will also follow documentation guidelines of San Francisco Health Network Behavioral Health Services (SFHN BHS) including, but not limited to, guidelines in "SFDPH, Community Programs Outpatient Services Documentation Manual" and instructions for relevant electronic health record (EHR). LHH psychiatrists will document in the designated EHR. LHH Psychiatry will ensure appropriate storage of any necessary hard copy documents related to Specialty Mental Health and STARS.

c. For psychotropic medications the prescriber shall will review the regulatory guidelines for use (Attachment A) to ensure that the use of the medication is clinically appropriate and only after inadequate response to non-pharmacologic interventions. Use of antipsychotic medications for dementia-related behaviors should be avoided unless there is a strong clinical indication, and in those instances, should be used at the lowest possible doses, for the shortest possible period of time, and with clearly documented discussion of risk versus benefit.

3. INFORMED CONSENT

(Refer to MSPP C02-01 Patient's Consent for Treatment and Operation. HWPP 25-10 Use of Psychotropic Medications.)

a. Resident with decision making capacity or resident without decision making capacity but with a surrogate decision maker (SDM):

   i.   The resident or SDM will be informed by the prescribing physician about the reasons for the medication, the goals of therapy, the probable and potential side effects and the reasonable alternative treatments. The resident or SDM will be informed about the right to accept or refuse the proposed treatment and informed that consent may be withdrawn at any time. The resident or SDM may state their desire to withdraw consent to any member of the treating staff.

   ii. The type of medication, frequency of administration, dosage amount, method of administration, and duration of taking the medication will be described.

   iii. The resident or SDM and the physician will sign the informed consent form for psychotropic medications.

   iv. Informed consent may be obtained from the SDM over the phone, in which case "telephone consent" should be noted on the informed consent form.

   v.   Informed consent is required for sedative hypnotics used to aid sleep.

   vi. A written copy of the consent form will be maintained in the medical record. If a resident verbally consents to the medication but does not wish to sign the form, the unsigned form will be placed in the medical record with a note indicating that the resident understands the nature & effect of the medication, consents to the administration of the medication, but does not wish to sign.

   vii. Any time a psychotropic medication is increased beyond the limit set in the consent, a new consent must be obtained.

   viii. Informed consent must be obtained by the prescriber prior to the administration of the first dose for all new orders, except in an emergency situation as described in Section 5.

b. Resident without decision making capacity, without a surrogate decision maker, and unable to understand the proposed treatment. Per California Health and Safety Code Section 1418.8:

   i.   Prior to the initiation of psychotropic medications, attempts should be made by the Resident Care Team (RCT) to identify a person with legal authority to make health care decisions for the patient.

ii. If no SDM can be identified, the attending physician will convene a meeting of the RCT prior to the administration of the medication, except in an emergency situation as describe din Section 5. The RCT shall include the attending physician, the nurse responsible for the resident and other appropriate staff as determined by the resident's needs. A patient representative must be included on the RCT, where practicable. This patient representative may be a family member or friend who is unable to assume decision-making responsibility, or another person authorized by law such as the public guardian or ombudsman. The RCT must:
  • review the resident's medical condition;
  • discuss the reason for use of a psychotropic agent;
  • discuss the resident's desires, if known;
  • discuss the type of psychotropic medication planned, including the probable impact on the resident's condition with and without the medication, and the probable frequency and duration; and
  • discuss reasonable alternative interventions considered or utilized and reasons for their discontinuance or inappropriateness.

The prescribing physician will note in the resident's medical record, which may include on the informed consent form itself, that the resident does not have capacity to make decisions concerning his or her health care, that there is no person with legal authority to make those decisions on behalf of the resident, and that resident's interdisciplinary team reviewed the prescribed medication intervention.

iii. The resident may seek judicial review of the RCT decision to provide the resident with such psychotropic medication(s).

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iv. The RCT will evaluate the use of the psychotropic drug at least quarterly or upon a significant change in the resident's medical condition.

v. The determinations required to be made pursuant to this section 3(b), as required under California Health & Safety Code Section 1418.8 (l), and the basis for those determinations shall be documented in the patient's medical record and shall be made available to the patient's representative for review

4. Family Notification Regarding Antipsychotic Medications for Residents with Decision Making Capacity

The prescribing physician shall seek the consent of the resident to notify the resident's interested family member, as designated in the medical record. If the resident consents to the notice, the physician or psychiatrist shall make reasonable attempts, either personally or through a designee, to notify the interested family member, as designated in the medical record, within 48 hours of the prescription, order, or increase of an order. Notification of an interested family

member is not required if any of the following circumstances exist:
- There is no interested family member designated in the medical record.
- The resident has not consented to the notification.

As used in this section, the following definitions shall apply:
- "Resident" means a patient of a skilled nursing facility who has the capacity to consent to make decisions concerning his or her health care, including medications.
- "Designee" means a person who has agreed with the physician or psychiatrist to provide the notice required by this section.
- "Antipsychotic medication" means a medication approved by the United States Food and Drug Administration for the treatment of psychosis.
- "Increase of an order" means an increase of the dosage of the medication above the dosage range stated in a prior consent from the resident.

5. EMERGENCY USE OF PSYCHOTROPIC MEDICATIONS

a. In an emergency situation, psychotropic medications may be ordered by the physician electronically or in writing when necessary to ensure the physical safety of the resident, other residents, or members of the staff. This shall be done in accordance with all applicable state and federal regulations.

b. There should be appropriate documentation in the EHR of the specific circumstances for which the medication is prescribed.

c. The resident will be monitored by the nursing staff for the effectiveness of the medications and any adverse reactions.

d. Emergency orders will be continued only as required to treat the emergency condition.

e. Before continuing psychotropic medications which were initiated on an emergency basis, informed consent must be obtained.

f. When psychotropic medications have been used in an emergency situation and the resident is unable to consent and there is no surrogate, informed consent must be obtained through the RCT.

g. The form, Nursing Assessment and Progress Note: Potential Emergent/Unplanned Psychotropic Drug Use, will be completed by nursing and signed by the prescribing physician when psychotropic medications are used in emergency situations.

6. ONGOING MONITORING

a. The prescribing physician will review the psychotropic medications quarterly and document in the EHR the review of psychotropic medications, noting efficacy and possible side effects.

b. In accordance with regulatory guidelines, an attempt shall be made for gradual dose reduction of all psychotropic medications. Tapering shall be attempted in conjunction with the RCT quarterly meeting and documentation shall be placed in the chart quarterly when there are strong clinical indications for not tapering.

c. The prescribing physician will perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications:
   ▪ Within the first 30 days of admission (if new to LHH) or within the first 30 days of starting or discontinuing an antipsychotic medication at LHH.
   ▪ Every 6 months while on an antipsychotic.
   a.▪ When clinically indicated.

c.d.   For all residents on psychotropic medications, the nursing staff shall monitor resident behavior, observe for drug side effects according to nursing procedure and notify the primary physician as indicated.

ed. ────The electronic copy of the written consent form must be kept in the resident's EHR. A new consent form for the same medication need not be completed when a resident is discharged and re-admitted; however, changes in medication dosing should be discussed with the resident or SDM, and a new consent should be obtained if the dose change is beyond the limit set in the previous consent (see Section 3 above).

REFERENCES:
1. Psychotropic Drug Use in Nursing Homes, Department of Health and Human Services, Office of Inspector General, November 2001 OEI-02-00-00490
2. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities §483.45(d) Unnecessary drugs and §§483.45(c)(3) and (e) Psychotropic Drugs
2.3.   MSPP C02-01 Patient's Consent for Treatment and Operation
3.4.   MSPP D08-02 Attachment 1, Behavioral Health Medical Necessity
4.5.   MSPP D08-03 Access to LH Psychiatry Services
5.6.   California Health and Safety Code Section 1418.9
6.7.   HWPP 25-10 Use of Psychotropic Medications

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