List of Hospital-wide/Departmental Policies and Procedures Submitted for JCC Approval on September 12, 2023

Policies Presented at Previous JCC (Revised)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revision	_LHHPP	20-06	Out on Pass	**N. Talai**	1. Minor wording edits 2. Added "the resident may take during the OOP" 3. Deleted "and there have been no changes in condition of the resident since the last RCT. " 4. Added "physician ", "Electronica Health Record", "for each request. The physician order must include", "to be taken while on OOP, "Physicians cannot write a" and "order for OOP". 5. Deleted "physician order cannot be made by a physician." 6. Deleted "To ensure residents will receive sufficient medications for the duration of their OOP, refer ". 7. Replaced "concerning failure to return by " with "of consequences of not returning to the facility at" 8. Added "unless" and "ordering physician. Failure to return at the designated time may result in discharge from LHH" 9. Deleted "if the OOP shall be overight" 10. Added "until the physician evaluation occurs." and "and document. " 11. Deleted "The LN shall complete the Check-In Form – Resident Returning from an Out On Pass " 12. Replaced "Observation of the resident-are they at their baseline? Are there signs of alcohol or drug impairment?" with "Customary routine." 13. Deleted "Does the resident seem more confused than usual? Is the resident having difficulty with" and "? (Such as slurred speech, somnolence)" 14. Added "Vision", " Psychological well-being" and "Disease diagnosis and health conditions" 15. Deleted " Is the resident agitated or withdrawn?", "Is there any bruising, skin issue or new impairment?", and "Has the resident had an opportunity to eat and drink while away? Do they need a snack before the next scheduled meal plan?" 16. Deleted "viii.Medications. Did the resident take all their scheduled medications while OOP? Do they need any medications now, before their next scheduled dose? Do they need any PRN medications?"

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revision	_LHHPP	20-14	Leave of Absence and Bed Hold	N. Talai	1. Replaced "shall submit claims for resident bed" to "may" and "days based on allowable reimbursement" with "a resident's vacant bed during leave of absence and bed hold". 2. Added "The physician will write a discharge order on the Electronica Health Record (EHR) to discharge the resident to an acute facility." 3. Added "Every effort is made for a", "If the room is not ", "will be offered as long as the skilled nursing if " and "resident meets the eligibility". 4. Deleted "is", "the facility to", "or immediately upon", "Availability of a bed in a ", "provided", " facility is eligible", "nursing facility services or", and "skilled nursing facility services". 5. Deleted "or out on pass". 6. Added "For an LOA to a clinic/medical appointment, the Notice of Bed Hold and form is not required. " 7. Added "The Licensed Nurse will indicate the telephone call to the representative on the forms. The original form will be provided to the representative, copy with the resident, and copy to Health Information Management (HIM). Nursing Operations Manager" 8. Deleted "Nursing Operation" 9. Added "Zuckerberg San Francisco General " 10. Replaced "PM" with "Pavilion Mezzanine" 11. Added "– Therapeutic Leave" and "for day, weekend, or overnight" 12. Deleted "LHH will not be reimbursed for bed hold in the event a resident is discharged within 24 hours of return from LOA/OOP. " 13. Deleted "LHH will not receive reimbursement for any LOA days exceeding the maximum number of leave days per calendar year." 14. Deleted "Medicare does not provide for bed hold reimbursement."
Revision	_LHHPP	22-07-A01	Restraint Free Environment	E. Guina	1. Minor edits
Revision	_LHHPP	23-01	Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)	I. Blanco	1. Added "or monthly" 2. Added "during quarterly assessments" 3. Added "during change of condition " 4. Added "Nursing will document these summaries on the Electronic Health Record (EHR). " 5. Added "a permanent " 6. Added "Temporary relocations, I.e. Covid unit" 7. Deleted "for deciding whether " 8. Added "For clinical problems, care planning will be initiated with individualized interventions based on short-term or long-term goals."

New Hospital-wide Policies and Procedures

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
New	_LHHPP	22-19	Family Council	N. Talai J. Carton-Wade	New policy

Revised Hospital-wide Policies and Procedures

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revision	_LHHPP	22-03	Resident/Patient Rights	N. Talai	1. Renamed policy to Resident/Patient Rights 2. Replaced "Resident" with "Resident/Patient" throughout the document.
Revision	_LHHPP	22-03_Appendix A	List of Resident/Patient Rights	N. Talai	1. Renamed policy to List of Resident/Patient Rights 2. Replaced "Resident" with "Resident/Patient" throughout the document.

Revision	_LHHPP	23-03	Screening and Response to Suicidal Ideation	**Y. Qian**	1. Added "or patient". 2. Added "(per C-SSRS screening)" to the low, medium and high rick section headers. 3. Deleted "and Psychiatry consultation". 4. Deleted "Ask the provider to immediately contact LHH Psychiatry for urgent discussion. The provider will call/page LHH Psychiatry". 5. Deleted "Acute or". 6. Added "facility (directly or via an Acute medical facility)". 7. Replaced "the facility" with "LHH" throughout the document. 8. Added "medical". 10. Added "Notify LHH Psychiatry and BERT." 11. Changed "Psych" to "Psychiatric" 12. Added "SERVICE", "ABOUT RESIDENT/PATIENT RETURNING TO LHH", and ", WHO DECIDES" to item 10. 13. Deleted "FOR RETURN CRITERIA". 14. Added "or on-call psychiatrist". 15. Added "(The physician would only accept the resident for return after the clearance by the psychiatry clinician or on-call psychiatrist.)". 16. Added "12.PSYCHIATRY PROVIDER UPDATES" 17. Added "resident/"
Revision	_LHHPP	70-01 C2	Spill Response Plan	**J. Williamson**	1. Replaced "Laguna Honda" with "LHH" 2. Added "3. Body Fluids- Fluids excreted from the human body (ex. Blood, urine, feces, vomitus) that may shed pathogens that may result in healthcare associated infections. Body fluids spills require a two-step process of cleaning followed by disinfection. (LHH 72-01 F10)." 3. Added "4. Emergency spill kits- Kits of long/narrow absorbent pads, other absorbent materials, PPE, disposal bags and containers, and signage, to help isolate, contain, cover, and remove spill materials. They have been issues to multiple departments and placed in areas perceived to be at highest risk for emergency spills.'" 4. Deleted "Do not use Ultrasorbs for spills" 5. Replaced "for spills" with "Where available, utilize emergency spill kits to cordon, cover, remove, and recover spills that are too large and/or complex for personal cleaning." 6. Deleted "EVS personnel are available daily from 6:00 a.m. until 12:00 midnight." 7. Added "EVS mainline: Ext 4-4624 or 415-759-4624 (7:00 am to 3:30 pm)" 8. Deleted "Please secure the area and place wet floor signs near the spill. EVS will clean-up the spill after receiving the report." 9. Added "3:30 pm to 7:00 am: Email DPH-LHH-EVSLeadership@sfdph.org or call Nursing Office." 10. Added "Please secure the area and" 11. Replaced "the next morning" with "the spill after receiving the report." 12. Added "during the day time (415-759-3321)" and "during off hours (415-370-8259)" 13. Added "& Emergency Management (WSEM)" 14. Replaced "Engineering" with "Facilities" 15. Added "n emergency", "Chief Engineer, or Watch Engineer" 16. Added "311 or" in a few places 17. Replaced "8" with "9" and "enter into" with "enter the"
Revision	_LHHPP	70-01 C5	Emergency Responder Antibiotic Dispensing Plan	**T. Rivera**	2. Replaced "415-682-5782" with "628-217-9983" 3. Deleted "Pager: 327-2370" 4. Replaced "Susan Rosen" with "Jennie Chuan" 5. Replaced "Jennie Chuan" with "jennie.chuan@sfdph.org" 6. Replaced "218-1831" with "215-7111" 7. Added "N" to "HICS" throughout the document. 8. Replaced "Hospital" with "Nursing Home" 9. Deleted "Hospital Incident" 10. Deleted "hospital"
Revision	_LHHPP	70-01 C7	Power Outage Response Plan	**T. Rivera**	1. Replaced "Hospital" with "Nursing Home" 2. Added "N" to "HICS" throughout the document. 3. Added "including security/Sheriff conducting patrols to identify any safety and security hazards." 4. Replaced "hospital" with "facility" 5. Replaced "Check" with "Watch engineer or Chief Engineer will check" 6. Added "Command Center will"

Revision	_LHHPP	70-01 C10	Code Silver – Active Shooter	**T. Rivera**	1. Deleted "April 25th, 2023" 2. Replaced "Laguna Honda" with "LHH" 3. Replaced the two" with "all" 4. Deleted "Run...Hide...Fight" 5. Added "In the event of an active shooter, there is no single method that is guaranteed to be effective. LHH has chosen to use the "Four Outs" process for Active Shooter response: Get Out, Hide Out, Keep Out, Take Out. This process includes the actions of "Run, Hide, Fight" , a commonly used response tactic. Those who find themselves in an active shooter situation should choose whichever option is best in their respective environment. In a hospital setting, response will vary depending on the mobility of residents and the area affected by the shooting" 6. Added "Four Outs Resident & Personal Safety Protocol: If the active shooter is close to your location, remember the Four Outs: GET OUT: Evacuate if opportunity allows you to safely leave the facility. HIDE OUT: If unable to evacuate because of the active shooter's position- hide KEEP OUT: If you are hiding, barricade your position by utilizing door locks, furniture, etc. to prevent the active shooter from breaching your position TAKE OUT: As a LAST resort, prepare to fight the active shooter by utilizing weapons such as heavy objects, chairs or anything else in the area of opportunity, surprise, diversion and committed actions" 7. Replaced "try to" with "focus on your survival" 8. Added "attempt to" 9. Added "Sheriff's Office" 10. Replaced "415-759-2301" with "415-759-2319 (from LHH phone 4-2319)" 11. Deleted "Nursing Operations" 12. Replaced "the residents" with "others behind"
Revision	_LHHPP	73-01	Injury and Illness Prevention Program	**J. Williamson**	1. Added "(WSEM)" for "Workplace Safety and Emergency Management" 2. Replaced "The Department of Workplace Safety and Emergency Management" with "(WSEM)" 3. Replaced "periodically" with "annually" 4. Added "and recommending controls up the command chain." 5. Added "and preventative actions." 6. Added "This log should be updated when new notices are received (at least annually)." 7. Replaced "Occupational Safety and Health button" with "WSEM icon" 8. Added "Aggregated incident report/injury information" 9. Added "after washing/flushing the affected area," 10. Added "but should be completed within the timeframes detailed below." 11. Replaced "Occupational Safety and Health button" with "WSEM site" 12. Added "Send" and "DPH-Workcomp@sfdph.org, or fax to"
Revision	_LHHPP	73-02	Asbestos and Lead Management Plan	**J. Williamson**	2. Deleted "An example of this would be replacement of vinyl flooring, typically done by a contracted DPW floor installer...." 3. Added "Department of Workplace Safety & Emergency Management " 4. Added "If WSEM is lacking in these certifications, then they may consult a third party for these assessments." 5. Added "and can obtain permits from BAAQMD" 6. Added "thorough assessment, typically air sampling, is required to determine presence of lead and asbestos, in areas where they can reasonably be expected to occur. For these areas, when a " 7. Deleted "by outside contractors" and "to the contractor" 8. Added "The sign must say the following or something similar: "Danger Asbestos May Cause Cancer. Causes Damage To Lungs. Area Authorized Personnel Only. Wear Respiratory Protection And Protective Clothing.""
Revision	_LHHPP	73-05	Workplace Violence Prevention Program	**N. Talai**	1. Minor grammar updates 2. Replaced "Buddies an/or coaches" with "Coaches" 3. Replaced "the care of residents for whom this is deemed appropriate and effective in preventing aggressive behavior." with "accordance with LHHPP 24-10 Close Observation. " 4. Added "workplace" 5. Added "LHHPP 24-10 Close Observation" to the reference section.

Revision	_LHHPP	73-06	Bloodborne Pathogen Expos	**J. Williamson**	1. Added "Resident/employee" to Work Practice Controls bullet iv 2. Added "Labeled with the universal biohazard sign and the word, "Biohazard," and "If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened." 3. Deleted "without great difficulty" and "labeled appropriately," 5. Added "Clinical staff are responsible for notifying EVS when containers are full and/or need to be replaced." 6. Added "Our medical clinic or the OHS clinic at Zuckerburg San Francisco General Hospital (ZSFG) can offer this vaccination and/or proof of vaccination." 7. Added "Wash and/or flush the affected area immediately." 8. Replaced first instance of "Needlestick" with "Blood and Body Fluid Exposure Hotline (formerly Needlestick Hotline) at" and the remaining instances with "Blood and Body Fluid Exposure" 10. Added "The Sharps Injury Log shall be maintained 305 years from the date the exposure incident occurred." 11. Added "Red bags or red containers may be substituted for labels except for sharp containers or regulated waste red bags. Bags used to contain regulated waste shall be color-coded red and shall be labeled in accordance with subsection (g)(1)(A)2. Labels on red bags or red containers do not need to be color-coded in accordance with subsection (g)(1)(A)3." 12. Added "Individual containers of blood or OPIM that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement." 13. Added "Labels required for contaminated equipment shall be in accordance with this subsection and shall also state which portions of the equipment remain contaminated." 14. Deleted "Regulated waste that has been decontaminated need not be labeled or color-coded." 16. Added "The training must be within one year of the previous training."
Revision	_LHHPP	73-10	Handling and Storage of Medical Gases	**J. Williamson**	safe manner. 2. Smoking is prohibited in any area where compressed gases or liquids are in use in storage." 2. replaced "in" with "with" 3. Added "Smoking is prohibited in any area where compressed gases or liquids are in use or in storage." 4.Added "This program describes how Laguna Honda will store, handle, and use compressed gas cylinders in a manner that ensures employee safety and complies with applicable regulations. In order to ensure a safe environment for residents, visitors, and staff."

Revision	_LHHPP	73-11	Medical Waste Management Program	**J. Williamson**	1. Replaced "PROCEDURE" with "DEFINITIONS" 2. Added "“Medical waste” means any biohazardous, pathology, pharmaceutical, or trace chemotherapy waste not regulated by the federal Resource Conservation and Recovery Act of 1976 (Public Law 94-580), as amended; sharps and trace chemotherapy wastes generated in a health care setting in the diagnosis, treatment, immunization, or care of humans or animals; waste generated in autopsy or necropsy; waste generated during preparation of a body for final disposition such as cremation or interment; waste generated in research pertaining to the production or testing of microbiological; waste generated in research using human or animal pathogens; sharps and laboratory waste that poses a potential risk of infection to humans generated in the inoculation of animals in commercial farming operations; waste generated from the consolidation of home generated sharps; and waste generated in the cleanup of trauma scenes. Biohazardous, pathology, pharmaceutical, sharps, and trace chemotherapy wastes that meet the conditions of this section are not subject to any of the hazardous waste requirements" 3. Replaced "Collection and Disposal Procedures" with "PROCEDURES" 4. Added "Biohazardous" and "Disposable biohazardous", "pharmaceutical waste bags or", "not saturated with blood" and "Sharps" 8. Added "Containment and storage of medical waste shall be in accordance with Chapter 9 (commencing with Section 118275) of the Medical Waste Management Act." 9. Added "No person shall treat medical waste unless the person is permitted by the enforcement agency as required by this part or unless the treatment is performed by a medical waste generator and is a treatment method approved pursuant to Chapter 8 (commencing with Section 118215) of the Medical Waste Management Act of 2017." 10. Added "Don additional PPE if the risk of exposure to splash/spray is high." 11. Replaced "a red bag" with "the appropriate waste container" 12. Replaced "open" with "designated" 13. Added "Wear additional PPE if splash/spray is expected."
Revision	_LHHPP	73-12	Safe Resident Handling	**J. Williamson**	1. Added "has a goal of becoming a restraint-free facility, and", "therefore " and "without restraints". 2. Added "Before mobilization, the employee needs to perform a self-assessment to determine if he/she is able to physically assist in safely performing the mobilization task. If there is any doubt in the physical ability, the employee should seek help". 3. Removed "Although employees are encouraged to do their best to prevent residents from falling, employees are not expected to catch a resident who is falling due to the risk of injury to the employee". 4. Removed "only" and "If the employee risks" and "they should not perform rescue". 5. Replaced "if they feel" with "as much as". 6. Added "Additionally, annual maintenance is required for mechanical lifts, with annual inspection stickers on each lift to indicate the latest maintenance service." 7. Added "(or more)" and "The employee should also evaluate if he/she is physically capable of performing the mobilization task without risk of injury to him/herself." 8. Added "use of appropriate". 9. Replaced "Education Department" with "Department of Education & Training (DET)". 10. Replaced "Education" with "DET".
Revision	_LHHPP	73-13	Employee Annual Health Examination	**J. Williamson**	1. Replaced "N123 (8/87)" with "A601 (8/14)". 2. Replaced "a" with "their annual". 3. Added "and/or".

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revision	_LHHPP	73-14	Personal Protective Equipment (PPE) Policy	**J. Williamson**	2. Replaced "healthful" with "healthy". 3. Added "Illness & Injury Prevention Program". 4. Added "/Infection Preventionist". 5. Replaced "is" with "can" and "sufficiently" with "practically be". 6. Replaced "will" with "should". 7. Replaced "some" with "most". 8. Added "Exceptions to this are elastomeric respirators and PPE clothing and boots expected to be provided by each employee." 9. Replaced "In other cases, disposable" with "Regarding disposable". 10. Added ", and at hire/annual/as needed training on how to use it". 11. Added "their required". 12. Added "training and".
Revision	_LHHPP	73-17	Hazardous Energy Control Procedure (Lock Out/Tag Out)	**J. Williamson**	1. Added "Section 3314". 2. Added "(LOTO)" throughout document beside "lock out/tag out". 3. Added "Isolation may be necessary". 4. Added "with refresher training annually". 5. Replaced "None" with "California Code of Regulations (CCR) Title 8 Section 3314"

Revised EVS Policies and Procedures

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revision	EVS	XI	Environmental Services Policy & Procedures	**S. Wu**	1. Removed "Restroom Cleaning: Cleaning of all fixtures, wall mounted items, walls, doors, floors, restock restroom supplies." 2. Added "This practice will be preformed when the residents are not present in the rooms." 3. Added "furniture surfaces" 4. Replaced "s, and all furniture" with "and other high touched areas". 5. Added "Restroom Cleaning: Cleaning of all fixtures, wall-mounted items, walls, doors, floors, restock restroom supplies. Flush the toilets and keep the water of the sinks and showers running for 2 minutes. Spa rooms: Clean and disinfect the Arjo bathtubs following the manufacture guidelines." 6. Added "Reference: Arjo Parker Quick reference guide- - Cleaning and Disinfection"

Revised Nursing Policies and Procedures

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revision	Nursing	D1 2.0	Residents Activities of Daily Living	**A. Michaud**	1. Added to privacy section for toilet use to maintain privacy "during toileting whether in resident rooms or while in tub, shower and toilet rooms" 2. Added to same section above "Bedpans, urinals, and bedside commodes are emptied and cleaned in toilets when soiled, and replaced when needed" 3. NEC UPDATES: Please see updated changes to include "patients" and Interdisciplinary Team to address Acute

Revision	Nursing	D2 3.0 Attachment 1a	Tub Baths and Showers	**A. Michaud**	looks like each attachment is the same information from the competencies formatted into a policy document. 2. If it is required, 3 additional attachments to this policy are required for the powered shower trolley (Arjo Carevo), powered shower chair (Arjo Carino), and bariatric shower chair (Arjo Carmina). 3. It would be ideal if attachments for each shower equipment aren't required as there are 3 existing ones where only a few remain until the end of their lives (portable tub/shower trolley, shower chair commode, and multipurpose hygiene/shower chair). 4. Additionally, the attachment says we review the shower chair commode and multipurpose hygiene shower/chair competencies in orientation – the equipment is mentioned but competencies are NOT covered. 5. Does there need to be competencies attached to each shower equipment attachment? Only attachment 1 (Arjo Parker Tub) has a sub-attachment for a competency and not the other equipment attachments. – Plan is to remove ALL competencies that are attached to policies as attachments. Since competencies are updated often and are already posted, we will remove competencies as policy attachments 6. Remove competency from policy (this is available elsewhere) 7. NEC Revisions: Preparation of Resident/Patient – The resident's care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's dignity, privacy, safety and
Revision	Nursing	D5 4.0	Arm Sling	**A. Michaud**	1. Minor changes 2. Updated Department names 3. Revised to document in "electronic health record"
Revision	Nursing	D6 1.1	Battery-Operated Lift Transfer	**A. Michaud**	1. Updated attachments within policy 2. Removed section on determining sling size, referred to attachments instead 3. Updated attachment 2 to current operating instructions 4. Remove attachment 3 (competency) 5. Removed section on EZ lift sling assessment form documentation
Revision	Nursing	D6 2.0	Transfer Techniques	**A. Michaud**	Updated documentation location language
Revision	Nursing	D6 5.0	Ambulation	**A. Michaud**	Updated names of policy attachments
Revision	Nursing	D9 2.0	Bed Making	**A. Michaud**	Updated to include bed making for low air loss mattresses
Revision	Nursing	D9 6.0	Water pitchers	**A. Michaud**	No revisions unless frequency changed to changing pitcher liners is daily instead of weekly. Question asked to IPC to check how often liners need to be changed
Revision	Nursing	F 1.0	Assistance with Elimination	**A. Michaud**	1. Added "Privacy shall be maintained during toileting whether in resident patient rooms, or while in tub, shower and toilet rooms. " 2. Revised procedure to state urine collected are "emptied into toilet"
Revision	Nursing	G 4.0	Measuring Height and Weight	**A. Michaud**	Updated title, only covers height
Revision	Nursing	G 5.0	Blood Glucose Monitoring	**A. Michaud**	1. Added lot number management and managing software upgrades to essential duties of POCT 2. Added "including nursing operation, unit mangers, MDS coordinators, DET and CNS" for completing annual competency review of POC blood glucose testing 3. Added adherence to contact time for cleaning glucometer and allowing to dry for 1 minute upon disinfection
Revision	Nursing	K 9.0	Management of Residents on Hemodialysis	**A. Michaud**	1. Added to weighing of hemodialysis residents to weigh daily "or per provider order" 2. Added that if resident misses a meal, then arrange for a tray to be served "on return from dialysis facility" 3. Added communication can be routed via EHR to and from dialysis center 4. Added residents receiving dialysis at ZSFG can have post dialysis care information in EHR 5. Revised Vascular Access Precautions section to indicate "A sign may be posted in the room to alert health team members not to use extremity with shunt or fistula" 6. Documentation section updated to current process with EHR (e.g., LDA for access type, removed neighborhood census report 7. Added to submit to HIM for any received paper documentation of communication from dialysis sites

Deleted Nursing Policies and Procedures					
Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Deletion	Nursing	D2 2.0	Bathing Alternatives	**A. Michaud**	1. Retire the P&P and appendix and moving to Elsevier/Mosby skills quick sheet with illustrations.
Deletion	Nursing	M 15.0	Remove Portable Bed Alarm Skills Checklist	**A. Michaud**	Recommend to remove

Policies Presented at Previous JCC (Revised)

OUT ON PASS POLICY

POLICY:

1. It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) 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.

2. Residents who wish to leave the grounds of LHH shall have written orders from their attending physician and if appropriate ~~pass~~ medications the resident may take during the OOP..~~.~~

3. Determining if an OOP is appropriate for the resident is the responsibility of unit Resident Care Team (RCT) and may be granted in accordance with the resident's plan of care.

PURPOSE:

To provide residents with the opportunity to participate in family and community life in ways that support well-being and optimal functioning.

PROCEDURE:

1. Notification of Out on Pass Policy

a. LHH Admissions & Eligibility department (A&E) and Social Services shall provide each newly admitted resident/surrogate decision maker (SDM) with information regarding the Out on Pass policy.

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

a. A 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.

b. An RCT 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.~~ and there have been no changes in condition of the resident since the last RCT.~~ A new RCT is needed if ANY of the parameters are different.

c. An OOP physician order for each request by ~~the physician~~ shall be written in the Electronica Health Record (EHR) for each request. The physician order must include~~ with~~ medications to be taken while on OOP, if appropriate. Physicians cannot write a ~~A~~ standing order for OOP.~~physician order cannot be made by a physician.~~

d. Refer~~To ensure residents will receive sufficient medications for the duration of their OOP, refer~~ to Pharmacy Services policy and procedure 02.01.04 Pass Medications when the pharmacy is open or closed.

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

f. The RCT shall advise the resident of consequences of not returning to the facility at~~concerning failure to return by~~ the agreed upon data~~duration of the scheduled return date~~ and time, unless ~~may result in discharge from LHH if~~ an extension is ~~not~~ obtained from the ordering physician. Failure to return at the designated time may result in discharge from LHH~~Physician~~.

g. The Medical Social Worker (MSW) will review and provide the bed hold policy and form to the resident, SDM and/or representative~~, if the OOP shall be overnight~~.

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. Documentation

a. Each request will be evaluated on the 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 staff 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.

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

5. Census Management

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

6. Compliance/Adherence with Pass Privilege

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

i. When leaving OOP and on returning from OOP, residents and/or SDM shall check in and out with the nursing staff on their home unit.

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

- Residents who are going 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.

- Resident~~Continued~~ non-adherence,~~ or~~ non-compliance, leaving~~ or if a resident leaves~~ the facility without an OOP order, or in a manner inconsistent with the specified OOP parameters, shall result in the physician discharging ~~shall discharge~~ the resident ~~as~~ Against Medical Advice (AMA).

iii. Residents who violate~~remain~~ OOP ~~in a manner outside of the specified order~~ parameters and/or residents of sound mind~~who can understand the risks of leaving the hospital grounds and~~ who leave the facility~~hospital~~ grounds without 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

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/SDM and the Nursing Unit Staff or Physician.

iii. The reason for extension is appropriate/valid.

b. The Physician shall document the reason for the extension of 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 a minimum, staff to examine for the following:

i. Customary routine.

~~i. Observation of the resident-are they at their baseline? Are there signs of alcohol or drug impairment?~~

~~ii.~~i. Cognitive patterns. ~~Does the resident seem more confused than usual?~~

~~iii.~~ii. ~~Is the resident having difficulty with~~ Communication. ~~? (Such as slurred speech, somnolence)~~

ii. Vision.

~~iv.~~iii. Mood and behavior patterns. ~~Is the resident agitated or withdrawn?~~

iii. Psychological well-being.

~~v.~~iv. Physical functioning and structural~~skin~~ problems. ~~Is there any bruising, skin issue or new impairment?~~

~~vi.~~v. Continence. ~~Did the resident return in a soiled condition?~~

iv. Disease diagnosis and health conditions.

~~vii.~~vi. Dental and nutritional status. ~~Has the resident had an opportunity to eat and drink while away? Do they need a snack before the next scheduled meal plan?~~

v. Skin Conditions.

vi. Medications.

viii. Medications. Did the resident take all their scheduled medications while OOP? Do they need any medications now, before their next scheduled dose? Do they need any PRN medications?

ix. vii. Special treatments and procedures. Did the resident miss any treatments or procedures while OOP?

ATTACHMENT:
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, 23/08/08 (Year/Month/Day)
Original adoption: 99/04/02

LEAVE OF ABSENCE AND BED HOLD

POLICY:

The facility may ~~shall submit claims for resident bed~~ hold a resident's vacant bed during leave of absence and 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, 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. When the resident goes on a therapeutic leave, the facility must provide a 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 resident to be discharged from the SNF. The physician will write a discharge order on the

Electronica Health Record (EHR) to discharge the resident to an acute facility. Further clarification regarding insurance coverage shall be routed to Utilization Management.

~~c.~~ Every effort is made for a~~A~~ resident whose hospitalization exceeds the LOA period to be~~is~~ re-admitted to ~~the facility to~~ their previous room. If the room is not ~~if~~ available, ~~or immediately upon~~ the first ~~availability of a bed in a~~ semi-private room will be offered as long as the skilled nursing ~~if the resident requires the~~ services required~~provided~~ by the resident meets the eligibility~~facility and is eligible~~ for Medi-Cal and ~~nursing facility services or~~ Medicare. ~~skilled nursing facility services.~~

~~d.~~c. 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 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. For an LOA to a clinic/medical appointment, the Notice of Bed Hold and form is not required.

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.

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. The Licensed Nurse will indicate the telephone call to the representative on the forms. The original form will be provided to the representative, copy with the resident, and copy to Health Information Management (HIM). Nursing Operations Manager~~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 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 Zuckerberg San Francisco General (ZSFG),~~,~~ LHH a~~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 – Therapeutic Leave)

a. A bed shall be held during a resident's authorized LOA/OOP for day, weekend, or overnight.

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

i.

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

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

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.

ii. A resident who goes AWOL past midnight 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, 23/08/08 (Year/Month/Day)
Original adoption: 01/07/12

Previously numbered LHHPP 20-02.

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 devices 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:

   a. Decline in physical functioning

   b. Decreased muscle condition

   c. Contractures

   d. Increased risk for infection

   e. Pressure ulcers/injuries

   f. Delirium

   g. Agitation

   h. Incontinence

   i. Accidents such as falls, strangulation, or entrapment

   j. Loss of autonomy and dignity

   k. 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 .
    - 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 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 regardsregard 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, 23/08/08 (Year/Month/Day)
Original adoption: 96/07/15

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 Baseline Plan of Care 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, PASRR recommendation(s).

2. The RCT, in conjunction with the resident or representative, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a timeframes to meet the resident's medical, nursing, and psychosocial 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 during quarterly assessments, and revised as needed during change of condition to serve as an essential resource for improved resident outcomes. Nursing will document these summaries on the Electronic Health Record (EHR).

4. The resident, family and/or representative shall be part of the development and implementation of his or her person-centered plan of care.

5. Care problems require various professional disciplines working together in planning, implementing~~,~~ and evaluating goals and interventions.

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 and/or representative, and RCT to develop a comprehensive care plan 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: 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)

   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 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.

c. In the event a special review meeting is necessary, the following disciplines must be present: nurse, physician, MDS coordinator, and social worker. The remaining RCT members shall be notified of any care plan changes, including the resident and/or representative.

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 a permanent 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
- Temporary relocations, I.e. Covid unit

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 representative. The resident and/or 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 representative about the meeting date and time.

   ii. The resident or 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 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 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. 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. For clinical problems, care planning will be initiated with individualized interventions based on short-term or long-term goals.

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.

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

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.

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

vi. Describe any specialized services or specialized rehabilitative services t LHH shall provide as a result of the PASRR 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.

d. In consultation with the resident and/or 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)".

6. Determining the Goal Statement

a. The goal statement indicates the outcome desired by the resident or representative 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.

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. 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 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.

   iv. Additional information as appropriate.

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

   i. The Team Conference note

   ii. The Nursing Weekly Summary

   iii. Discipline specific progress notes\

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 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.

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

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

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.

e. Changes that affect the resident's care or daily routine shall be communicated to the resident or representative as soon as possible in the method that is most practical for the resident or representative 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, 23/08/08 (Year/Month/Day)
Original adoption: 92/05/20

New Hospital-wide Policies and Procedures

FAMILY COUNCIL

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) supports the rights of residents and residents' family members, friends, and/~~-~~or representatives to organize and participate in family groups within the facility.

PURPOSE:

The purpose is to provide a private space in support of residents and ~~or~~ residents' family members, friends, and/or representatives to organize and participate in family groups.

DEFINITION:

"Family group" is defined as a group of residents and/or residents' family members, friends, and/or representatives that meet regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose.

"Family Council" is defined as a meeting of family members, friends, or representatives of two or more residents to confer ~~in private~~privately at the hospital without facility staff present, unless specifically invited.

PROCEDURE:

1. Regular Council Meetings:

   a. All residents and residents' family members, friends, and/ or representatives are eligible to participate in family groups.

   b. Family Council meetings shall be held at a cadence and time that is requested by the members. LHH will provide a private space at least once a month during the mutually agreed upon hours.

   c. It is the responsibility of the approved and designated staff to coordinate the Family Council meetings, and to make residents and family members, friends, and/ or representatives aware of the upcoming meetings in a timely manner. The LHH designated staff person shall provide the support and services necessary to the Family Council for it to function appropriately.

   d. The designated LHH staff, if approved by the family group, shall serve as a liaison between the group and the LHH staff members.

e. The family group may designate a resident or resident's family member, friend, or designated representative to take notes/maintain minutes, or to elect the designated LHH staff to take notes/maintain minutes. Meeting minutes may include, but are not limited to:

i. Names of residents/family members in attendance.

ii. Follow up from previous meetings.

iii. Issues discussed.

iv. Recommendations from the group to facility staff.

v. Names of staff members, speakers, and other guests in the meeting (as invited by the group to attend).

f. Staff, visitors, or other guests should only attend if requested by the Family Council.

2. Addressing Concerns or Requests:

a. The Family Council or designated LHH staff shall document concerns or requests in the meeting minutes.

b. LHH shall consider the feedback from the Family Council and act upon the grievances and recommendations concerning proposed policy and operational decisions affecting resident care and quality of life in the facility.

c. The designated LHH staff shall communicate concerns or requests involving other departments to the appropriate department managers.

d. The designated LHH staff shall address the requests or concerns of the Family Council in writing within 10 working days.

e. The facility shall act promptly upon concerns and recommendations of the council, make attempts to accommodate recommendations to the extent practicable, and will communicate its decisions to the council.

3. Communications:

a. LHH shall provide adequate space on a bulletin board or other posting area to display meeting notices, minutes, newsletters, or other information of interest to the family council.

b. LHH shall include notice of the Family Council meetings in at least a quarterly mailing.

i. LHH shall inform family members, friends, and/or representatives of new residents who are identified on the admissions agreement, during the admissions process, or in the resident's records, of the existence of the Family Council. The notice shall include the time, place, and date of meetings, and the person to contact regarding involvement in the Family Council.

ATTACHMENT:
None.

REFERENCE:
All Facilities Letter (AFL) 23-16 Clarification on Family Council Requirements
Title 42 Code of Federal Regulations section 483.10(f)(5)-(7)

Original adoption: 2023/07/11 (Year/Month/Day)

Revised Hospital-wide Policies and Procedures

RESIDENT/PATIENT RIGHTS

POLICY:

1. ~~Patient/~~Resident/Patient rights are honored without regard to cultural, economic, educational, religious background, sexual orientation, gender identity, disability or the source of payment for his/her care.

2. The ~~resident~~ resident/patient has a right to a dignified existence, self-determination, and communication and access to person and services inside and outside Laguna Honda Hospital and Rehabilitation Center (LHH).

    a. The facility shall treat each ~~resident~~ resident/patient with respect and dignity, and care for each ~~resident~~ resident/patient in a manner and environment that promotes maintenance or enhancement of his or her quality of life, recognizing each ~~resident's~~ resident's/patient's individuality.

    b. The facility shall protect and promote the rights of the resident/patient.

    c. The facility shall provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.

3. The facility shall ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of ~~residents~~ residents/patients and the responsibility of the facility to properly care for its residents/patients. Training topics shall be appropriate to the individual's role.

4. LHH upholds ~~patient/resident's~~ resident's/patient's rights to confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

5. Residents~~P~~/patients~~/residents~~ are not to be required to perform services for the facility that are not included for therapeutic purposes in the plan of care.

6. LHH staff collaborates with the San Francisco Ombudsmen Office in their role as ~~residents~~ residents/patients rights advocate.

7. All ~~residents~~ residents/patients of LHH are informed of their rights and responsibilities and are further required to acknowledge receipt of having received a copy of those rights and responsibilities, as well as an explanation if requested.

8. A list of ~~residents'~~ residents'/patients' rights is posted or available in appropriate places within LHH.

PURPOSE:

To assure that each resident resident/patient is knowledgeable about his/her rights and the methods and circumstances by which those rights can be withheld. These rights comply with Title 22, California Code of Regulations Section 70707 and 72527, and Code of Federal Regulations, Title 42, Section 483.10.

PROCEDURE:

1. Prior to, or upon admission to LHH, the (a) Admitting Clerk or (b) a member of the Admission & Eligibility staff shall give to the resident/patient, or her/his representative or responsible relative, a copy of the resident's resident's/patient's rights form and shall have a receipt acknowledged by the signature of the receiving party.

2. If a resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident resident/patient shall be made available.

3. The facility shall have written translations of its statements of rights and responsibilities in commonly encountered foreign languages, if/as applicable.

4. Large print texts of the facility's statement of resident resident/patient rights and responsibilities should be available.

5. The receipt (acknowledgement) is placed in the resident's resident's/patient's medical chart.

6. Discrepancies regarding these procedures should be brought to the attention of the Director of Admissions and Eligibility.

ATTACHMENT:
Appendix A: List of Residents' Residents'/-Patients' Rights
Appendix B: LGBTQ+ Long-Term Care Facility Bill of Rights

REFERENCE:
LHHPP 24-06 Resident Complaints/Grievances
Resident Rights Web address:
http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph327-Attachment-A.pdf
Prohibiting Discrimination Against Lesbian, Gay, Bisexual, and Transgender Residents by Long-Term Care Facilities:
http://sfbos.org/ftp/uploadedfiles/bdsupervrs/ordinances15/o0047-15.pdf

Revised: 02/09/06, 08/09/30, 10/04/27, 15/11/09, 17/09/12, 19/03/12, 19/05/14, 19/07/09, 20/03/17, 23/03/14 (Year/Month/Day)
Original adoption: 98/01/22

Appendix A:

LIST OF RESIDENTS' / PATIENTS' RIGHTS

I. Exercising Your Rights

1. You have the right to a dignified existence, self-determination, and communication and access to people and services both inside and outside of Laguna Honda. You have the right to be free of interference, coercion, discrimination, and retaliation from Laguna Honda in exercising your rights as a ~~resident~~resident/patient of Laguna Honda and as a citizen or resident of the United States, and Laguna Honda shall support you exercising your rights. You have the right to equal access to quality care regardless of diagnosis, severity of condition, or payment source.

2. You have the right to designate a representative if you are competent to do so, who may exercise your rights, in accordance with, and to the extent provided by state law.

    a. Your representative has the right to exercise your rights to the extent you have delegated those rights to your representative.

    b. You retain the right to exercise any right not delegated to your representative, including the right to revoke a delegation of rights, except as limited by state law.

    c. Laguna Honda shall treat the decisions of your representative as your decisions to the extent required by either a court or as delegated by you.

    d. Laguna Honda shall not extend to your representative the right to make decisions on behalf of you beyond the extent required by either a court or as delegated by you. Laguna Honda shall report, as required by law, if it has reason to believe that your representative is not acting in your best interest.

3. ~~Resident~~Residents/Patients adjudged incompetent by a court with jurisdiction to do so, shall have their rights devolve to and exercised by the ~~resident~~resident/patient representative appointed under State law to act on the ~~resident~~resident's/patient's behalf. The court-appointed ~~resident~~resident/patient representative shall exercise your rights to the extent judged necessary by the court with jurisdiction, and in accordance with state law.

    a. In cases where a representative's decision-making authority is limited by state law or court appointment, you retain the right to make those decisions outside of the representative's authority.

    b. Your wishes and preferences must be considered in the exercise of your rights by the representative, and to the extent possible, you shall be provided with the opportunity to participate in the care planning process.

4. You have the right to exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care. The same-sex spouse or a ~~resident~~resident/patient shall be afforded treatment equal to that of an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

II. Planning and Implementing Your Care

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual and personal values, beliefs, and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you, and to be informed of the care to be furnished to you and the type of care giver that will furnish that care. You have the right to be informed and participate in your treatment.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in language you can understand. You have the right to be informed in advance of treatment of the risks and benefits of the proposed care, alternatives or options to the proposed treatment, and to choose the alternative or option if you prefer.

5. You have the right to effective communication and to participate in the development and implementation of your plan of care, and the right to receive the services and/or items included in the plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

6. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

7. 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. You have 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 plan of care.

8. Choose your attending physician, provided that the physician meets the requirements of Code of Federal Regulations, Title 42.

9. See the plan of care and be informed in advance of any changes to the plan of care.

10. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.

11. Self-administer medications if your care team has determined that this practice is clinically appropriate.

12. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

13. Reasonable responses to any reasonable requests made for service.

14. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve the pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

15. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

III. Respect and Dignity

You have the right to:

1. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

2. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

3. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

4. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

5. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided with this information also.

6. Know which hospital rules and policies apply to your conduct while a patient.

7. A safe, clean, and homelike environment including receiving treatment that supports your safe daily living. You have the right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other ~~resident~~residents/patients. Laguna Honda shall exercise reasonable care for the protection of your property from loss or theft.

8. Reside and receive services with reasonable accommodation of your needs and preferences except when to do so would endanger your health or safety or other ~~resident~~residents/patients.

9. Share a room with your spouse if your spouse also resides at Laguna Honda and you both consent to the arrangement.

10. Share a room with the roommate of your choice when practicable, and only when you are both ~~resident~~residents/patients at Laguna Honda and consent to the arrangement.

11. Receive written notice, including the reason for the change, before your room or roommate in the facility is changed.

12. Refuse to transfer to another room in the facility, if the purpose of the transfer is to relocate you from a skilled nursing unit to a non-skilled nursing unit within Laguna Honda, or if the transfer is solely for the convenience of Laguna Honda. This right shall not affect your eligibility or entitlement to Medicare or Medi-Cal benefits.

IV. Self-Determination
You have the right to:

1. Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with your interests, assessments, and plan of care; and to make choices about aspects of your life at Laguna Honda that are significant to you.

2. Interact with members of the community and participate in community activities both inside and outside of Laguna Honda.

3. Organize and participate in ~~resident~~resident/patient groups within Laguna Honda. You have the right to participate in social, religious, and community activities provided that doing so does not interfere with the rights of other ~~resident~~residents/patients.

4. Receive visitors of your choosing at the time of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:

    a. Laguna Honda reasonably determines that the presence of a particular visitor would endanger the health or safety of you, other ~~resident~~residents/patients, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.

    b. You have told Laguna Honda staff that you no longer want a particular person to visit.

    c. However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

5. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household.

6. Participate in family groups and have family members or other representatives' meet with the families or representatives of other ~~resident~~residents/patients of Laguna Honda.

7. Choose to or refuse to perform services for Laguna Honda. You may perform services for Laguna Honda when:

    a. Laguna Honda has documented your need or desire for work in the plan of care;

    b. The plan of care specifies the nature of the services performed and whether the services are voluntary or paid;

    c. Compensation for paid services is at or above prevailing rates; and

    d. You agree to the work arrangement described in the plan of care.

e. At no time shall you be required to perform services for Laguna Honda.

8. Manage your own financial affairs, including the right to know in advance, what charges Laguna Honda may impose against your personal funds.

9. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

V. Information, Communication, Privacy, and Confidentiality

You have the right to:

1. Be informed of your rights and the rules and regulations governing ~~resident~~resident/patient conduct and responsibilities during your stay at Laguna Honda.

2. Access your personal and medical records; and to secure and confidential treatment of all communications, personal records, and medical records pertaining to your care and stay in the hospital. You have the right to refuse the release of personal and medical records unless federal or state law requires the release of those records. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

3. Receive notices both orally and in writing in a format and language that you understand.

4. Have reasonable access to the use of a telephone in a place where you cannot be overheard, including the right to retain and use a cellular phone at your expense. You have the right to communicate with individuals and entities within and outside of Laguna Honda with reasonable access to the internet, to the extent available within Laguna Honda.

5. Send and receive mail, including letters, packages, and other materials delivered to Laguna Honda; and to have those communications be received and sent promptly and in private. You have the right to access stationery, postage, and writing implements at your expense.

6. Have access to, and privacy in, your use of electronic communications such as email and video communications, and internet research to the extent that it is available at Laguna Honda.

7. Privacy in your medical treatment, written and telephone communications, personal care, visits, and meetings of family and ~~resident~~resident/patient groups.

8. Examine the results of the most recent survey of Laguna Honda conducted by Federal or State surveyors and any plan of correction in effect, and to receive information from agencies acting as client advocates including the right to contact such agencies.

9. Voice grievances to Laguna Honda or other agencies that hear grievances without retaliation or discrimination, and without the fear of retaliation or discrimination, including grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other ~~resident~~residents/patients, and any other concern regarding your stay at Laguna Honda.

   If you want to file a grievance with this hospital, you may do so by writing or calling:

   Roland Pickens
   Interim Chief Executive Officer
   Administration Department
   Laguna Honda Hospital
   375 Laguna Honda Boulevard
   San Francisco, CA 94116
   (415) 759-4510

   You have the right to prompt resolution of grievances. The grievance committee will review each grievance and provide you with a written response within 10 business days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process.

10. File a complaint with the state Department of Public Health regardless of whether you use the hospital's grievance process. The state Department of Public Health's phone number and address is:

   Department of Public Health Licensing & Certification
   San Francisco District Office
   150 North Hill Drive Suite 22
   Brisbane, CA 94005
   Phone: (415) 330 6353
   Fax: (415) 330 6350

SCREENING AND RESPONSE TO SUICIDAL IDEATION

POLICY:

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

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

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

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

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

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

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

PURPOSE:

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

DEFINITION:

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

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

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

PROCEDURE:

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

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

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

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

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

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

   a. **LOW RISK (per C-SSRS screening)**

      i. Create a safe environment.

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

         - Consider aeroscout.

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

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

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

v. Notify the Nursing Operations Supervisor.

b. MEDIUM AND HIGH RISK (per C-SSRS screening)

i. Create a safe environment.

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

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

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

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

~~v.~~iv. Immediately notify the Nursing Operations Supervisor.

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

7. IF THE RESDIENT DECLINES C-SSRS SCREENING

a. Create a safe environment:

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

ii. Consider aeroscout.

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

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

8. ATTENDING PHYSICIAN OR ON CALL PHSYCIAN EVALUATION

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

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

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

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

   - If the resident or patient is placed on 5150, the resident/patient will be sent to a ~~n Acute or~~ Psychiatric Emergency facility (directly or via an Acute medical facility).

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

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

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

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

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

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

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

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

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

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

10. IF PSYCHIATRIC EMERGENCY SERVICE CALLS THE UNIT ABOUT RESIDENT/PATIENT RETURNING TO LHH~~FOR RETURN CRITERIA~~, REFER TO PHYSICIAN, WHO DECIDES IN COLLABORATION WITH PSYCHIATRY.

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

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

c. The attending physician or on-call physician will determine if the resident may return, and if so, will provide the order. (The physician would only accept the resident for return after the clearance by the psychiatry clinician or on-call psychiatrist.)

11. IF RESIDENT IS CLEARED TO RETURN TO LHH

a. Maintain a safe environment;

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

      - Refer to the Patient Safety and Ligature Identification Checklist.

   ii. Consider aeroscout.

b. Ensure section 9 is completed.

c. Notify the Nursing Operations Supervisor.

d. Inform the RCT members.

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

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

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

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

12. PSYCHIATRY PROVIDER UPDATES

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

13. DOCUMENTATION REQUIREMENTS

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

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

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

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

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

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

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

SPILL RESPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna HondaLHH) is committed to employee and resident safety, and in an effort to prevent injury and illness, will mitigate hazards associated with spills.

PURPOSE:

The Spill Response Plan has been established to ensure that spills of both hazardous and non-hazardous materials are cleaned up appropriately and that employee health and safety is not compromised in the process.

DEFINITION:

1. Hazardous Materials–– Any material with a hazardous characteristic such as flammable, combustible, oxidizing, or toxic.

2. Non-Hazardous Materials–– Any material that does not have a hazardous characteristic (as described above), such as water, food or, drink, or body fluids.

2. Body Fluids- Fluids excreted from the human body (ex. Blood, urine, feces, vomitus) that may shed pathogens that may result in healthcare associated infections. Body fluids spills require a two--step process of cleaning followed by disinfection. (LHH 72-01 F10).

3.

4. Emergency spill kits- Kits of long/narrow absorbent pads, other absorbent materials, PPE, disposal bags and containers, and signage, to help isolate, contain, cover, and remove spill materials. They have been issues to multiple departments and placed in areas perceived to be at highest risk for emergency spills.'

PROCEDURE:

1. CLEAN UP OF NON-HAZARDOUS MATERIAL SPILLS

a. Spills of non-hazardous materials shall be cleaned up as quickly as possible to remove any slip hazard.

b. If you spill something or notice a spill:

   i. Restrict access to the area around the spill, if possible.

   ii. If you can wipe up the spill with available absorbent material such as paper towels, do this as soon as possible. Do not use Ultrasorbs for spills.

ii.iii. Where available, utilize emergency spill kits to cordon, cover, remove, and recover spills that are too large and/or complex for personal cleaning.

iv. If the spill is too large for you to clean up or you do not have appropriate PPE, such as gloves and/or eye protection, report the spill to Environmental Services (EVS):

- EVS mainline: (Ext).4-4624 or 415-759-4624 (7:00 am to 3:30 pm)
- Off hour37:30 pm to 7:00 am: Email DPH-LHH-EVSLeadership@sfdph.org or call Nursing Office.

iii.v. Make sure that no one enters the area until EVS arrives.

- EVS personnel are available daily from 6:00 a.m. until 12:00 midnight.
- Please secure the area and Between the hours of 12:00 midnight and 6:00 a.m., individuals should place wet floor signs near the spill. EVS will provide clean-up the spills after receiving the report.
- the next morning.

2. RESPONDING TO HAZARDOUS MATERIAL SPILLS

a. Hazardous drug spills will be cleaned up according to LHHPP 25-05 Hazardous Drugs Management.

b. Any employee who spills a hazardous material that they are using will restrict access to the area of the spill and report the spill to the Department of Workplace Safety during the day time (415-759-3321) or the Watch Engineer during off hours (415-370-8259).

c. The Department of Workplace Safety & Emergency Management (WSEM) or EngineeringFacilities will respond with an emergency spill kit or call the SFDPH Environmental Health Section at 415-252-3900 for assistance.

d. After an uncontrolled spill or leak of a hazardous material, the Industrial Hygienist, Chief Engineer, or Watch Engineer will be responsible for calling the following agencies, as necessary:.

   i. SFDPH Environmental Health Section – 311 or 415-252-38900

   ii. California Office of Emergency Services - 800-852-7550

   iii. National Response Center - 800-424-8802

   iv. Toxics Substance Control Division - 1-800-471-7127 800-852-7550

e. In addition to calling the agencies listed above, whenever spilled hazardous materials enter intoenter the sewer, the Chief Engineer or the Industrial Hygienist

will be responsible for calling: the Department of Public Works at 311 or 415-695-2020.

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-05 Hazardous Drugs Management.

Revised: 02/03/06, 12/09/25, 15/01/13, 16/07/12 (Year/Month/Day)
Approved renumbering from 74-01 to 70-07: 15/01/13
Approved for renumbering to 70-01 Section A, B, and C: 18/02/23

EMERGENCY RESPONDER ANTIBIOTIC DISPENSING PLAN

INTRODUCTION

The San Francisco Department of Public Health (SFDPH) is responsible for developing strategies to deliver mass prophylaxis (preventative medications, e.g., antibiotics or vaccines) to *all* residents of San Francisco in the event of a large-scale infectious disease/public health emergency. Although there are many scenarios where mass prophylaxis may be needed, SFDPH has used an anthrax scenario as the planning target since antibiotics would need to be dispensed to all residents of San Francisco within a 48-hour time frame.

In the event of an infectious disease emergency for which antibiotics can provide protection, SFDPH will provide antibiotics first to emergency responders (public health/public safety agencies, critical infrastructure agencies, and critical officials) and their families. The goal is to enable them to come to work to perform their critical public protection duties knowing that they and their families are protected. To prepare for this, emergency responder agencies have developed dispensing plans to describe how they will dispense antibiotics to employees and their household contacts members.

The Local Cache

During a public health emergency requiring mass prophylaxis, San Francisco will request assets from the Strategic National Stockpile (SNS). The SNS will be deployed to San Francisco, through the California Department of Public Health (CDPH). To ensure emergency responders are properly protected so they can continue their work, San Francisco has purchased and is storing a local cache with enough antibiotics to prophylax emergency responders and their families before the federal SNS supplies are expected to be available.

SFDPH will distribute antibiotics to Laguna Honda based on the estimated number of employees and household members. In addition to antibiotics, SFDPH will provide drug information sheets. These materials are available in several languages.

Although a 10-day course is the recommended standard course, the local cache contains only enough antibiotics to dispense a 3-day supply for emergency responders and their families, which will be dispensed to Laguna Honda employees according to this plan. Once the SNS medication arrives, SFDPH will dispense to the general public at pre-identified Points of Dispensing (PODs). Laguna Honda employees and their families will be sent to a public dispensing site for the rest of their 10-day course of medicine.

Emergency Authorization for Antibiotic Dispensing

Declaring a public health emergency involving a mass prophylaxis response is the responsibility of the San Francisco Health Officer (CA Health and Safety Code, Section 101075) and the procedures and authorities set out in the SFDPH Emergency Operations

Plan and the City and County's Emergency Operations Plan. When a public health emergency is declared, special emergency protocols can be put in place that suspend existing regulations or take whatever other actions are necessary to preserve life and health (CA Health and Safety Code, Section 101040, SF Administrative Code, Section 7.6.b.1and Article 17 of Emergency Services Act). In a declared emergency, the San Francisco Department of Public Health under the authority of the Health Officer becomes the prescribing authority for mass antibiotic dispensing. Consequently, normal pharmaceutical dispensing rules are lifted and non-licensed/non-medical staff can dispense antibiotics as long as they follow the protocols and procedures set up by SFDPH.

PROCEDURE

I. Program Responsibility

The agency coordinator is the primary Laguna Honda point of contact with SFDPH for dispensing operations. This position oversees and coordinates the dispensing of antibiotics to employees and household contacts.

Agency Coordinator			
Name	Michelle Fouts	Title	Director of Pharmacy
Address	375 Laguna Honda Blvd.	Email	Michelle.fouts@sfdph.org
Phone	~~415-682-5782~~628-217-9983 office	24/7 Phone	~~Pager: 327-2370;~~ Cell: 415-577-4811
Primary back-up agency coordinator			
Name	~~Susan Rosen~~Jennie Chuan	Title	Pharmacist in Charge
Address	375 Laguna Honda Blvd.	Email	~~susan.rosen@sfdph.org~~jennie.chuan@sfdph.org
Phone	415-682-5780	24/7 Phone	Cell: 415-~~218-1831~~215-7111
Secondary back-up agency coordinator			
Name	Christina Lee	Title	Senior Physician Specialist, Clinic
Address	375 Laguna Honda Blvd.	Email	Christina.lee@sfdph.org
Phone	415-682-5669 clinic	24/7 Phone	Pager: 415-327-4871
Additional back up agency coordinators			
Contact Laguna Honda Hospital Incident Command Center via direct line or 800 MHz radio. Command staff will assign the most appropriate person available to the coordinator role if above staff are not on site.			415-759-4636

II. Activating the Dispensing Plan

A. NHICS Activation and Staffing

1. If mass prophylaxis is initiated, the SFDPH DOC and EOC will be activated to coordinate the distribution and dispensing of appropriate medical countermeasures. SFDPH DOC will contact the Agency Coordinator to alert and notify Laguna Honda to activate and prepare to implement emergency responder dispensing.

2. The Agency Coordinator will notify the Executive Administrator or the Administrator on Duty (AOD) of the need to activate the Nursing ~~Hospital~~ Home Incident Command System (NHICS) according to the Laguna Honda Emergency Response Plan (73-03).

3. The Administrator will designate an Incident Commander. The Incident Commander will activate positions listed in Attachment 1 as needed and the Agency Coordinator will serve as the Operations Section Chief.

4. A template message will be sent by the Command Center or the Nursing Office to all staff using SFDPH Alert notifying all DPH employees assigned to Laguna Honda that the Emergency Dispensing Plan has been activated.

5. Emergency call back will be initiated by the ~~Hospital Incident~~NHICS Command Center using the confidential call back lists upon the direction of the Incident Commander.

6. All staff who are activated in a NHICS role or are called back to the Labor Pool will report to the Command Center to sign in and receive their assignment.

B. Activating the Point of Dispensing (POD)

1. The Logistics Section will be responsible for setting up the POD in Gerald Simon Theater according to the floor plan in Attachment 2.

2. Back-up locations for the POD include Moran Hall and the H3 Training Room.

C. Receiving the Local Cache and Tracking Inventory

1. Antibiotics from the local cache will be packaged at a centralized warehouse and delivered by SFDPH. The DOC will coordinate delivery of the medication with the Agency Coordinator.

2. The Medication Staging Team will be responsible for tracking antibiotic inventory from the time they receive the antibiotics until unused antibiotics are returned to SFDPH after the event.

3. The Inventory Control Group Supervisor will conduct inventory upon receipt of the antibiotics using the Inventory Forms provided by SFDPH in Attachment 3. Notify the Agency Coordinator if there are any discrepancies between the amount of antibiotics received and amount stated on the packing slips provided by SFDPH DOC.

4. Each dispenser shall use the Inventory Control Forms in Attachment 3 to track the type and amount of antibiotics dispensed as well as lot numbers.

D. Just in Time Training

All mobile and stationary dispensing teams will be provided with just in time training on dispensing procedures and inventory tracking prior to dispensing any medications. This training will be performed by staff familiar with this plan and the inventory tracking forms and may include staff from the Pharmacy, Medicine, Nursing, Education, or Emergency Management.

E. Pre-Screening of Employees

Screening is critical to ensure that people receive the right antibiotic. SFDPH has developed an electronic screening form which people can complete online at www.bayareadisastermeds.org for themselves and their household members. This process only takes a couple of minutes and results in a printable form indicating the medication that each individual in the household should receive, including whether they need to seek additional medical consultation due to a contraindication for both antibiotics dispensed. Employees will be encouraged to complete the screening form before proceeding to the POD for dispensing.

III. Dispensing Antibiotics

During a declared public health emergency, special emergency protocols (CA Health and Safety Code, Section 101040, SF Administrative Code, Section 7.6.b.1 and Article 17 of Emergency Services Act) will be put in place to facilitate getting lifesaving medications to people. Such declarations of emergency will allow antibiotic dispensing by non-licensed and non-medical personnel as actions needed “to preserve life and health” (CA Business and Professions Code, Section 4062.b). During a public health emergency non-licensed and non-medical staff may dispense medication provided they follow protocols developed by SFDPH.

Once a person has been screened to determine the appropriate antibiotic, they shall be dispensed the antibiotic and given a drug information sheet for the antibiotic they receive. For staff who are picking up medications for children who need to have their doxycycline

pills crushed, crushing instructions and oral syringes need to be included.

A. POD Dispensing

1. The command Center will coordinate a dispensing schedule by notifying Department Managers when to send their employees to the POD. The schedule will depend on the time of day dispensing occurs and the flow of traffic through the POD, which will be communicated by the Operations Section to the command center.

2. Antibiotic dispensing will occur at the rapid dispensing line and the screening/dispensing line.

3. Employees who have been pre-screened using the online screening form will receive antibiotics from dispensers at the rapid dispensing line.

4. Those who must be screened will be referred to the screening area where computers and staff will be available to guide them through the process so that they can then go to the rapid dispensing line. If internet access is unavailable, they will fill out the paper screening form (Attachment 4) and will have their form reviewed and antibiotics dispensed by the screener/dispenser in the screening/dispensing line according to the Screening Key and instructions in Attachment 4.

5. Those who are referred to medical consultation will receive either receive doxy or cipro if they can take one of the drugs from the rapid dispensing line or a prescription for an alternative antibiotic from the medical consultant.

B. Mobile Dispensing Team Delivery

1. Mobile Dispensing Teams will deliver antibiotics to staff assigned to patient care units, who may stay on their units to complete and print their prescreening forms from any computer with a printer. Team One dispenses to the North Residences (7 floors at approximately 1 floor per hour); Team Two dispenses to the South and Pavilion Residences (7 floors at approximately 1 floor per hour).

2. Back packs with all necessary supplies will be provided to the mobile teams by the Logistics Section and the Medication Staging Team.

3. Printed forms must be presented to the Mobile Triage Dispensing Team when they arrive on the unit. Expected arrival times will be announced; one hour per unit is anticipated.

4. Staff will complete label(s) provided by the Mobile Team and affix the label immediately to the baggie of antibiotics dispensed for each person in their

household. Drug information sheets will be provided.

5. Those who must obtain a medical consultation will be referred for consultation in the Clinic or via phone to the Medical Consultation hotline, which will be established in the Incident Command Center accessible by dialing 4-INFO.

IV. Communication

A. When employees are given their medications, they will be provided with information about where and when they can receive the rest of their ten day course of antibiotics, information about the antibiotics they will be receiving (Attachment 5), and information about the public health emergency.

B. Any additional information that must be conveyed to staff after dispensing will be provided through the use of SFDPH Alert notifications. Staff may also continue to call the NHICS command center for information throughout the event, even after dispensing has concluded.

C. NHICS will remain activated with limited staffing until the public health emergency has been eliminated and the command center will remain the point of contact for employees with questions.

VI. Demobilization of POD

When dispensing operations have concluded, the Agency Coordinator is responsible to ensure that all necessary documentation is completed and will manage demobilization of the POD according to the checklist below. The Inventory Control Group Supervisor will conduct the final inventory for the agency, complete all inventory control forms for the agency and prepare unused antibiotics for return to the SFDPH DOC.

POD Demobilization Check List	
Collect all screening forms	
Take final inventory and complete inventory forms	
Package unused medication for return to SFDPH	
Breakdown POD	
Ensure that POD staff sign out in the command center	
Return all supplies and documentation to command center	

Following POD demobilization, the NHICS command center will remain operational until normal~~l hospital~~ operations are resumed and all NHICS documentation has been completed including forms completed by the Finance Section. Demobilization of the command center will be carried out by the Demobilization Unit of the Planning Section.

ATTACHMENT:
Attachment 1: NHICS Roles

Attachment 2: POD Setup Diagram
Attachment 3: Emergency Dispensing Inventory Receipt and Tracking Forms
Attachment 4: Screening Form, Key, and Instructions
Attachment 5: Antibiotic Information Sheets

REFERENCE:
None.

Revised: 16/09/13 (Year/Month/Day)

Attachment 1: NHICS Roles

Command Positions

- Public Information Officer – responsible for communicating messages from the command center out to the Laguna Honda Community and the public.
- Safety Officer – responsible for ensuring the safety of responders
- Liaison Officer – responsible for collaboration with outside agencies, such as the DOC, DEM, EMS

Planning Section - Responsible for collecting DOSRs, answering command center phone and gathering information from POD and from departments/neighborhoods, customizing the IAP template for each operational period, and demobilizing.

- Section Chief
- Situation Unit
- Documentation Unit
- Demobilization Unit Leader

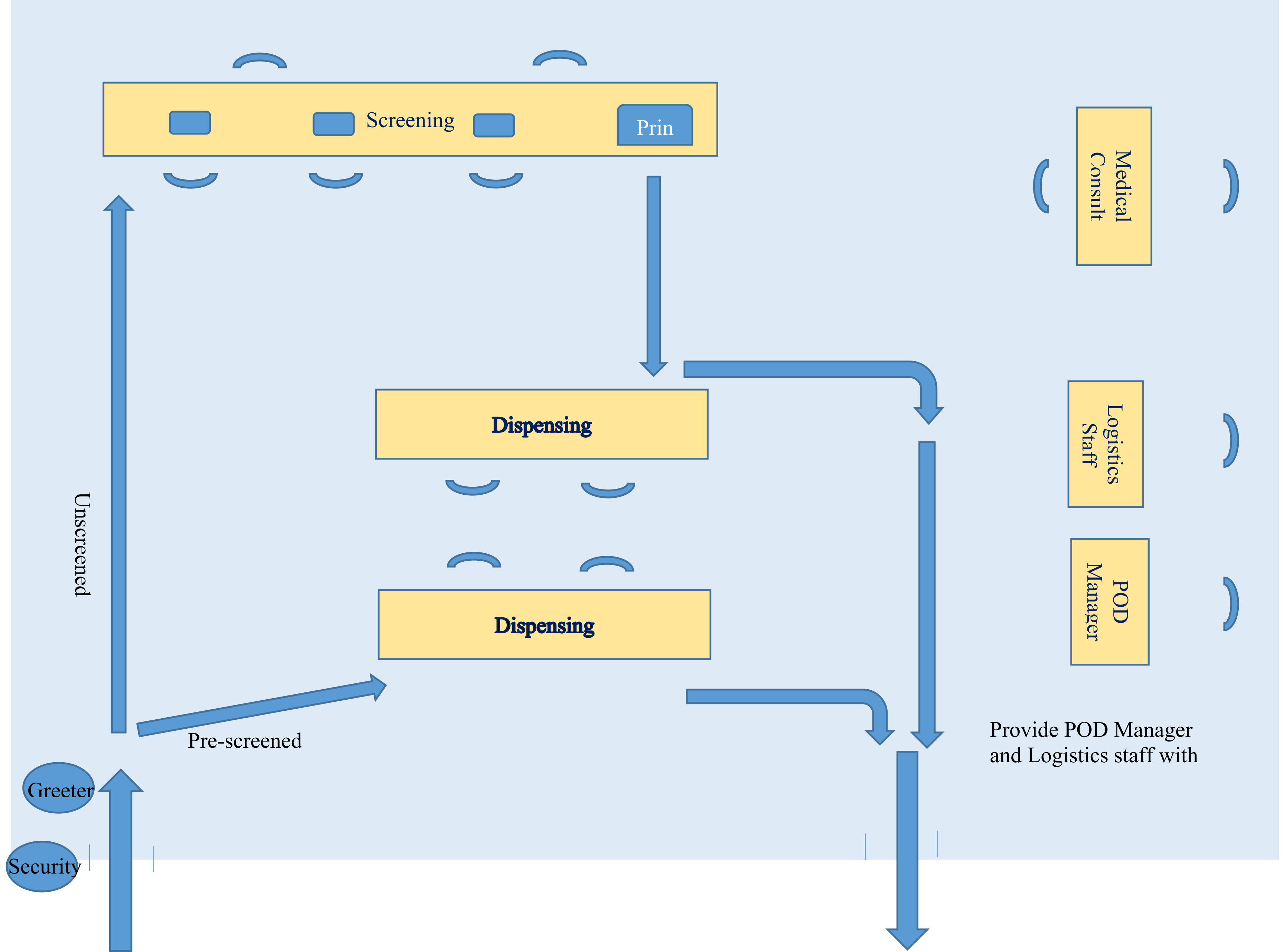
Logistics Section – Responsible for providing all resources required for effective response.

- Section Chief
- Support Branch – Responsible for setting up and providing resources to responders in the command center and the POD
- Labor Pool Unit – Responsible for providing additional staffing for Operations where needed, such as POD staff, dispensing teams, and trainers.

Operations Section (assigned to the POD location) – responsible for carrying out the all objectives laid out in the IAP, most importantly the safe and effective dispensing of medication to staff.

- Section Chief (filled by Agency Coordinator) – responsible for overall coordination of the dispensing operation
- Medical Care Branch – responsible for the well-being of staff, including providing consultation services in the POD and command center hotline
- Medication Staging Team – responsible for inventory and tracking of medications
- Medication Distribution personnel – responsible for handing out medication appropriately
- Security Branch – works with law enforcement to ensure orderly dispensing and crowd control
- Just in Time Trainers – responsible for training dispensing teams
- Runners – collect DOSRs, deliver messages and/or resources between command center and POD.

Attachment 2: POD Setup Diagram


Screening
Prin
Medical Consult
Dispensing
Dispensing
Logistics Staff
POD Manager
Unscreened
Pre-screened
Provide POD Manager and Logistics staff with
Greeter
Security

Attachment 3: Emergency Dispensing Inventory Receipt and Tracking Forms

Emergency Dispensing Inventory Receipt Form

Please verify the information and inventory of supplies received is correct. Sign and date at the bottom of the page.

Agency Name ________________________________ **Designated Representative** ____________________
Date **Contact number**

Drug/ Supplies	**Quantity** (Boxes)	**Courses Per Box** (unit-of-use bottles)	**Lot Number** (Do not include more than one lot number on a line)	**Comments Notes**

DPH Warehouse staff signature ________________________**Agency Representative Signature** ____________________

Emergency Dispensing Inventory Control Form – Doxycycline

Use one line for each person who picks up medication and record aggregate number of people prescribed Doxy in people prescribed column. Use the Ciprofloxacin Inventory control form to record number of person prescribed Cipro. Return completed form to Inventory Control Personnel.

Drug – Doxycycline	Lot Number	# of People Prescribed	# of Crushing Instructions Given	Notes

Dispenser Name ______________________________ **Signature** ________________________________

Date ________________________ **Total Courses Given** ___________________

Emergency Dispensing Inventory Control Form – Ciprofloxacin

Use one line for each person who picks up medication and record aggregate number of people prescribed Doxy in people prescribed column. Use the Ciprofloxacin Inventory control form to record number of person prescribed Cipro. Return completed form to Inventory Control Personnel.

Drug	Lot Number	# of People Prescribed	Notes

Dispenser Name ______________________________ **Signature** ________________________________

Date ________________________ Total Courses Given ___________________

Emergency Dispensing Site Total Inventory Control Form

Complete the inventory control form using information from dispenser inventory control forms. Fill in inventory used column as you get completed inventory forms from dispensers. Contact the Operation Lead when remaining inventory is less than 25%

Doxycycline	Starting Inventory			Ciprofloxacin	Starting Inventory		
Lot Number	Courses Used	Courses Remaining	Notes	Lot Number	Courses Used	Courses Remaining	Notes

Inventory Group ____________________ **Signature** ____________________

Date ____________________ **Total Courses Given** ____________________

Emergency Dispensing Agency Final Inventory Close Out Form

Complete once dispensing operations have completed and inventory is ready for return to SFDPH DOC.

Agency Name ________________________ **Agency Coordinator** ________________________

Contact Phone number ________________________ **Date** ________________________

Drug/ Supply	Lot Number	Quantity Used	Quantity Returned	Notes

SFDPH DOC Staff Signature ________________________ **Agency Representative Signature** ________________________

Date Unused Inventory Picked up ________________________

Attachment 4: Screening Form, Key, and Instructions

MULTI-PERSON ANTIBIOTICS SCREENING FORM*

*Use these forms if unable to access on line screening at www.bayarea disastermeds.org

GENERAL INSTRUCTIONS:

1. In Column B, list each person for whom you are picking up up antibiotics (including yourself).
2. For each person listed, leave columns blank if no conditions apply. ONLY put a check mark ('7) in columns C-H if that person has the condition. If you are picking up for children under age 18, complete columns I and J.
3. Do not write anything in the "For Clinic Use Only" section.
4. Proceed with your completed form to the next Screening station and give this form to the staff person there.
5. Staff will then direct you to the next station.

Use one line for each person.		DOXY CONTRAINDICATIONS		CIPRO CONTRAINDICATIONS				PEDIATRIC INFORMATION						CONSULT		
A	B	C	D	E	F	G	H	I	J		1	2	3	4	5	
		ANTIBIOTIC CONTRAINDICATIONS						AGE	WEIGHT		CIPRO	DOXY				
Person #	Name of each person for whom you are picking up (write your name for person #1)	ALLERGIC TO DOXYcycline or any "CYCLINE" drug?	PREGNANT or BREAST-FEEDING?	ALLERGIC TO CIPROfloxacin or ANY "floxacin" drug?	History of SEIZURES, or EPILEPSY?	Currently taking Tizanidine?	Have Myasthenia Gravis?	AGE (IF under 18)	WEIGHT (IF UNDER 90 POUNDS)		CIPROFLOXACIN	DOXYCYCLINE	SPECIAL INSTRUCTIONS	GO TO CONSULT	CONSULT INITIALS	Consult Notes
1										1						
2										2						
3										3						
4										4						
5										5						
6										6						
7										7						
8										8						
9										9						
10										10						

Date: ______/______/______

Site: _______ Shift: ______

Screener initials ______________

Dispenser initials ______________

Multiperson Screening Form -- KEY (Doxy Dominant)*

*Use these forms if unable to access on line screening at www.bayarea disastermeds.org

Match the each person's response on the screening form to the row that corresponds to the checked boxes on the screening form key. Check the corresponding box in the "For Clinic Use" columns.

Complete the Date, Site, Shift and Screener initial section at the bottom of the page

TRUST THE KEY

FOR CLINIC USE

Use one line for each person.

A	B	C (DOXY CONTRAINDICATIONS / ANTIBIOTIC CONTRAINDICATIONS)	D	E (CIPRO CONTRAINDICATIONS)	F	G	H	I (PEDIATRIC INFORMATION) AGE		1	2	3	4 (CONSULT)	5	J WEIGHT
Person #	Name of Person for whom you are picking up (include yourself in line 1)	ALLERGIC TO DOXYcycline or any "CYCLINE" drug?	PREGNANT	ALLERGIC TO CIPROfloxacin or ANY "floxacin" drug?	History of SEIZURES, or EPILEPSY?	Currently taking Tizanidine?	Have Mysathenia Gravis?	AGE (IF under 18)		CIPROFLOXACIN	DOXYCYCLINE	CRUSHING INSTRUCTIONS	GO TO CONSULT	CONSULT INITIALS	
	No to all conditions in column C-D, age >= 18 --> Check Doxy	Blank or "No"		Doesn't matter what is in column E-H				Blank or >= 18	Blank or Anything						
	No to all conditions in column C-D, age < 18, weight blank or > 90 lbs --> Check Doxy	Blank or "No"		Doesn't matter what is in column E-H				<18	Blank or >= 90						
	No to all conditions in column C-D, age < 18, weight < 90 lbs --> Check Doxy and Crushing Instruction	Blank or "No"		Doesn't matter what is in column E-H				<18							<90
	Yes to any condition in column C-D, but no to all conditions in column E-H, age >= 18 --> Check Cipro	Check/"Yes" in any		All blank or "no"				Blank or >= 18	Blank or Anything						
	Yes to any condition in column C-D, but no to all conditions in column E-H, age <18, weight >= 62lb --> Check Cipro	Check/"Yes" in any		All blank or "no"				<18							>=62
	Yes to any condition in column C-D, but no to all conditions in column E-H, age <18, weight < 62lbs --> Check Go To Consult	Check/"Yes" in any		All blank or "no"				<18							<62
	Yes to any condition in column C-D **AND** Yes to any condition in column E- H --> Check Go To Consult	Check/"Yes" in any		Check/ "Yes" in any				Blank or Anything	Blank or Anything						

Date: ______/______/______

Screener initial

Site: _______ Shift: ______

Dispenser initials __________

GENERAL INSTRUCTIONS FOR INTERPRETING THE MULTI-PERSON SCREENING FORM

Use the key with the Multi Person Antibiotic Screening Form to determine whether or not the client or the person for whom they are picking up antibiotics should receive doxycycline or ciprofloxacin, based on the contraindications that may be listed. For a minority of people, it should be recommended that they have a conversation with the medical consultant.

All children (less than age 18 AND weighing less than 90 pounds) will receive doxycycline unless they are allergic or are pregnant. Any time doxycycline is dispensed for a pediatric dose, it must be accompanied by crushing instructions and an oral syringe must be given.

Basically, when boxes are checked indicating a contraindication to doxycycline, they should be given cipro. When boxes are checked indicating a contraindication to cipro, they should be given doxy. When there are contraindications to both, they should be sent to Medical Consultation.

For any pediatric patients or patients who cannot swallow pills, indicate on the Multi Person Screening Form that the crushing instructions need to be given, so that the dispenser will know to give instructions and an oral syringe.

Anyone who is 18 years old or older is considered an adult.
The weight cutoff for receiving pediatric doxy is 90 lbs.
The weight cutoff for receiving pediatric cipro is 62 lbs. For the exercise on March 19, 2009, crushing cipro is not an option. Therefore, if a person indicates a contraindication to doxy and is less than 18 years old but weighs more than 62 lbs, they can receive an adult dose of cipro.

If a person is 18 or older and weighing less than 90 lbs, they should still receive an adult dose of doxy.

Trust the Multi-Person Screening form. People may say that they have allergies to other drugs (penicillin, e.g.) or that they are currently taking other medications and wonder about the interactions. All of that information is addressed on the drug information sheets, which they will receive at dispensing. It is important for everyone to read the drug information sheet in its entirety. If they are asking about something that is not addressed on the multi-person screening form directly, then it is not considered an issue worthy of including on the form.

Finally, people who have valid allergies to antibiotics such as doxycycline or ciprofloxacin usually know it. If someone says they do not know if they are allergic, some guiding statements are to say that they should consider themselves allergic if a medical doctor has told them they are allergic or if they have experienced a life-threatening reaction to the drug.

After you have screened all people listed on the form, complete the "Screener Initial" section of the form and refer the patient to either "Dispensing C" line or to "Medical Consultation”.

Attachment 5: Antibiotic Information Sheets

A) Doxycycline
B) Ciprofloxacin
C) Doxycycline Crush Sheet

In an Emergency:

How to Prepare **Doxycycline** for Children and Adults Who Cannot Swallow Pills

Mixing Doxycycline Hyclate 100mg Tablets with Food

Once you have been notified by your federal, state or local authorities that you need to take doxycycline for a public health emergency, it may be necessary to prepare *emergency* doses of doxycycline for children and adults who cannot swallow pills.

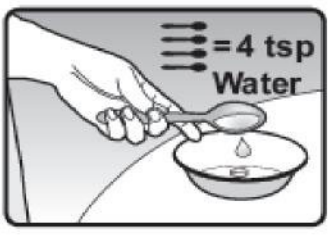
June 2008
Prepared by the U.S. Food and Drug Administration

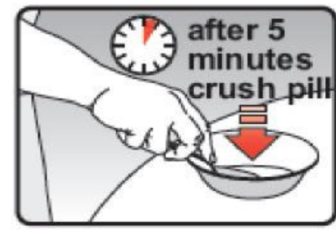
Supplies You Will Need

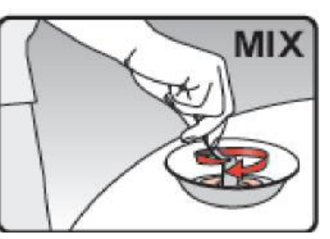
You will need these items to make doses of doxycycline for adults and children who cannot swallow pills:

- 1 doxycycline pill (100 mg) *(Do not take doxycycline if you are allergic to tetracyclines)*
- a metal teaspoon
- 2 small bowls
- Water
- one of these foods or drinks to hide the bitter taste of crushed doxycycline:
  - milk or chocolate milk
  - chocolate pudding
  - apple juice and sugar

Use any metal teaspoon to crush the pill
Use a MEASURING TEASPOON to measure the water. A measuring teaspoon = 5 mL (5 cc) of liquid







Crushing the Pill and Mixing with Water

1. Put 1 doxycycline pill in a small bowl.
2. Add 4 full teaspoons of water to the same bowl.
3. Let the pill soak in the water for 5 minutes so it will be soft.
4. Use the back of a metal teaspoon to crush the pill in the water. Crush the pill until no visible pieces remain.
5. Stir the pill and water so it is well mixed.

You have now made the Doxycycline and Water Mixture.

Child's weight: ________

Adding Food to the Doxycycline and Water Mixture to Make It Taste Better

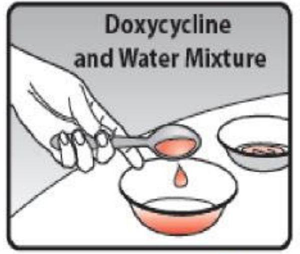
1. Weigh your child.
2. Find your child's weight on the left side of the chart below.
3. Next, look on the right side of the chart to find the amount of the Doxycycline and Water Mixture to mix with food. The chart shows you the amount to give your child for 1 dose. (*For a ½ teaspoon dose, fill the metal teaspoon half way. It is better to give a little more of the medicine than not enough*).

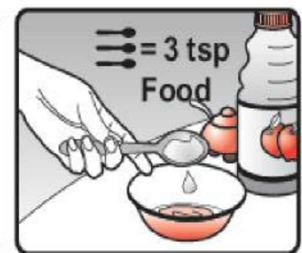
Child's Weight	Amount of Doxycycline and Water Mixture	Teaspoons
12 pounds or less	½ teaspoon	
13 to 25 pounds	1 teaspoon	
26 to 38 pounds	1½ teaspoons	
39 to 50 pounds	2 teaspoons	
51 to 63 pounds	2½ teaspoons	
64 to 75 pounds	3 teaspoons	
76 to 88 pounds	3½ teaspoons	
89 pounds or more and adults	Use the entire mixture	Entire Mixture

4. Add the right amount of the Doxycycline and Water Mixture from the chart above to the second bowl. For adults and children 89 pounds and more, use the entire mixture.

4a. Use a MEASURING TEASPOON to measure out the right amount of the Doxycycline and Water Mixture

5. Add 3 teaspoons of milk **or** chocolate milk **or** chocolate pudding **or** apple juice to the second bowl. If you use apple juice, also add 4 teaspoons of sugar to the second bowl.
   - Stir well.





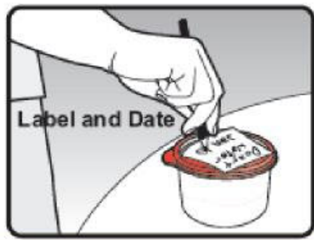
6. Go to Step 4 for dosing.

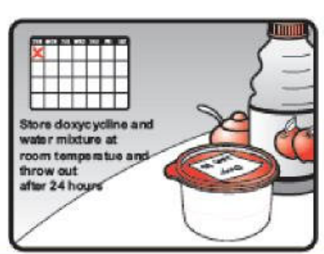
Dosing the Doxycycline and Water Mixture Mixed With Food

1. Give all of the Doxycycline and Water and food mixture in the second bowl. This is one dose.
2. **Each child or adult should take 1 dose in the morning and 1 dose at night each day.**

Storing the Doxycycline and Water Mixture (If There Is Enough for Another Dose)

- **If you have enough leftover doxycycline and water mixture for another dose, you can keep it for the next dose.**
- The doxycycline and water mixture can be stored in a covered bowl or cup. Label and date.
- Keep the mixture in a safe place out of the reach of children.
- Store the Doxycycline and Water Mixture at room temperature for up to 24 hours.
- Throw away any unused mixture after 24 hours and make a new Doxycycline and Water Mixture before the next dose.





Do not take doxycycline if you have an allergy to tetracyclines

Get emergency help if you have any signs of an allergic reaction including hives, difficulty breathing, or swelling of your face, lips, tongue or throat.

Doxycycline may cause diarrhea, skin reaction to the sun, loss of appetite, nausea and vomiting. Birth control pills may not work as well if you take doxycycline.

Food and Drug Administration MEDWATCH

Report any reaction to the medication to MedWatch at www.fda.gov/medwatch or 1-800-FDA-1088

POWER OUTAGE REPONSE PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing safe, quality care to its residents in the event of a power outage by using generator power and/or downtime procedures.

PURPOSE:

To take appropriate action during a power outage to prevent injury and loss of life and to facilitate recovery.

PROCEDURE:

1. The ~~Hospital~~ Nursing Home Incident Command System (NHICS) shall be activated according to the LHH Emergency Response Plan (LHHPP 70-01 B1). The Incident Commander and NHICS team will be responsible for managing the response to the power outage with the following basic objectives:

    a. Ensure safety and security of all residents, staff, and visitors, including security/Sheriff conducting patrols to identify any safety and security hazards.

    b. Minimize damage to property

    c. Facilitate the recovery of power and return to normal operations

2. Communication to Stakeholders – After immediate notification procedures in LHHPP 70-01 B1 Table 1, the NHICS team shall:

    a. Disseminate official notifications and ongoing status updates to residents, staff and visitors throughout the outage using appropriate, functioning means of communication, which may include Department of Public Health (DPH) Alerts, overhead pages, email, and meetings.

    b. Initiate emergency call backs if the implementation of any downtime procedures requires extra labor resources not available on site.

    c. Disseminate information to the public or the media ONLY with the approval of the LHH CEO or DPH Public Information Officer (PIO).

3. Communication with Command Center (phone: 4-4636, fax: 415-504-8313)

    a. All employees shall contact the command center with questions about the power outage, to report hazards, or to request resources to assist with safe, quality delivery of care.

b. Employees shall refer media representatives to the ~~Hospital Incident~~NHICS Command Center at 415-759-4636.

4. Ensure Safety of all Persons and Continue Quality Care of Residents

   a. Neighborhood staff shall account for all residents, staff, and visitors in the neighborhood.

   b. Check for injuries and fall risk. Prioritize checking all bathrooms, which will be very dark, creating a significant fall risk.

   c. Each neighborhood has a supply of emergency lighting equipment, including flashlights and lanterns that may be used to provide care in poorly lit locations.

   d. Complete the Department Operating Status Report (DOSR) and fax it to the command center at 415-504-8313 or deliver to a DOSR bin.

   e. Activate the Continuity of Operations Plan (COOP) 70-01 B2 and follow your department's downtime procedures to continue care without equipment or systems that may be unavailable due to power outage.

5. Mitigate secondary hazards

   a. Follow all directions from the command center and report changes in status.

   b. Keep essential resident care equipment plugged into red outlets, which are powered by the emergency generators.

   c. Turn off unnecessary lights and unplug unnecessary equipment as needed to avoid excess demand when power is restored.

   d. SFSD shall notify incoming visitors of the power outage and restrict ~~hospital~~ facility access if directed by the NHICS Team.

6. Once Power Has Been Restored

   a. When power is restored, the command center will notify the Nursing office and they shall notify building occupants via overhead page.

   b. ~~Check~~ Watch engineer or Chief Engineer will check all equipment and lights and notify the command center of negative effects caused by the power outage.

   c. Command Center will ~~N~~notify the IT Help Desk at 4-3577 or dph.helpdesk@sfdph.org

ATTACHMENT:
None.

REFERENCE:
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 B2 Continuity of Operations Plan (COOP)

Revised: 18/05/08 (Year/Month/Day)
Original adoption:

CODE SILVER – ACTIVE SHOOTER

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to the prevention of workplace violence when at all possible. ~~Laguna Honda~~LHH is also committed to providing a response plan for an active shooter situation.

PURPOSE:

The purpose is to provide guidance for responding to the presence of an active shooter at LHH.

DEFINITION:

An active shooter is defined as any person or persons who is/are actively engaged in killing or attempting to kill people in the hospital or on the hospital campus. The weapon(s) typically involve use of ~~firearms, but~~firearms but may include other weapons such as knives or explosive devices.

PROCEDURE:

1. Situation

This plan applies to situations in which an active shooter is on the LHH campus. An active shooter may have a target victim, but often displays no pattern or method for selection of their victims.

2. Employee Responsibility

All employees shall take responsibility for their own survival in the event of an active shooter entering their work area. You can prepare yourself to maximize your chance of survival by:

a. Being familiar with the work area~~;~~

b. Knowing the route to ~~the two~~all nearest exits~~; and~~

c. Having a plan for barricading in place~~.~~

3. General Response ~~– Run…Hide…Fight~~

In the event of an active shooter, there is no single method that is guaranteed to be effective. LHH has chosen to use the "Four Outs" process for Active Shooter response: Get Out, Hide Out, Keep Out, Take Out. This process includes the actions

of "Run, Hide, Fight" ~~provides three options in order of prefer~~, a commonly used response tactic~~ence~~. Those who find themselves in an active shooter situation should choose whichever option is best in their respective environment. In a hospital setting, response will vary depending on the mobility of residents and the area affected by the shooting.

~~a. **Run:** In the event that a person is actively killing or attempting to kill people in the facility, the best action to take to maximize your chance of survival is to run.~~

~~b. **Hide:** If you cannot escape, the next best option is to hide. Do not come out until the Sheriff from the San Francisco Sheriff Department (SFSD) notifies you that CODE SILVER is all clear.~~

~~**Fight:** As a last resort, and only when you are in imminent danger, try to overpower or incapacitate the shooter.~~

Four Outs Resident & Personal Safety Protocol:

If the active shooter is close to your location, remember the **Four Outs:**

- **GET OUT**: Evacuate if opportunity allows you to safely leave the facility.
- **HIDE OUT:** If unable to evacuate because of the active shooter's position- hide
- **KEEP OUT**: If you are hiding, barricade your position by utilizing door locks, furniture, etc. to prevent the active shooter from breaching your position
- **TAKE OUT:** As a LAST resort, prepare to fight the active shooter by utilizing weapons such as ~~oxygen tanks~~heavy objects,~~,~~ chairs or anything else in the area~~ of opportunity~~, surprise, diversion and committed actions

~~c.~~

4. If a Shooter Enters Your Work Area

a. Run to safety if possible.

b. If you cannot escape, focus on your survival.~~, try to remain calm.~~

c. Hide or get behind something that will provide some concealment if shots are fired in your direction.

d. Try not to do anything that will provoke the shooter(s).

- If there is no possibility of escaping or hiding, as a last resort and only if your life is in imminent danger, ~~you may choose to try to negotiate with or~~ attempt to overpower the shooter(s). If you choose to fight:

    i. Commit to your decision and act as aggressively as possible toward the shooter.

ii. Improvise weapons using things like fire extinguishers or sharp instruments.

iii. Yell and throw things at the shooter.

If the shooter leaves the area, barricade the room or get to a safer location and call the Sheriff's Office 415-759-2319 (from LHH phone ~~415-759-2301~~4-2319).
~~e. Sheriff or 911.the Nursing Operations Office emergency extension 4-2999.~~

5. If You Are In a Location Distant From the Shooter

a. If you can get out of the building to escape the shooter, take care of yourself and get out, even if it means leaving ~~the residents~~others behind.

b. Convince others to come with you if possible. Do not let anyone convince you to stay.

c. Leave your belongings.

d. Call the Sheriff at ~~415-759-2301~~~~the Sheriff or 911~~415-759-2319 (from LHH phone 4-2319), or 9-1-1, when you are safely out of the building.

e. If you cannot get out of the building, close doors and barricade yourself and others in a room if possible.

~~e.~~
f. Hide or get behind something that will provide cover or concealment if shots are fired in your direction.

g. Turn off the ringer on your cell phone and other sources of noise.

h. Call the Sheriff's Office at ~~415-759-2301~~~~Call the Nursing Operations Office emergency extension 4-2999.~~415-759-2319 (from LHH phone 4-2319), or 9-1-1, ~~Call the Sheriff or 911~~ if it is safe to do so (see procedure 6a for information to provide).

a. If speaking will reveal your hiding place, leave the line open so the Sheriff ~~or 911 operator~~ can hear.

~~h.~~i. Do not open the door or leave your hiding place until you hear that Code Silver is all clear.

6. Notification and Incident Command

During any active shooter incident, it is important to notify all hospital occupants of the situation and alert law enforcement as quickly as possible.

a. Call the Sheriff's Office 415-759-2319 (from LHH phone 4-2319), the Nursing Operations Office emergency extension 4-2999 the Sheriff or 911 if you are able to do so safely. Provide as much information as possible to the dispatcher, including:

   i. Location and description of the shooter(s)

   ii. Number of shooters and number and type of weapons

   iii. Movement of shooter

   iv. Number of victims and/or hostages

b. The Sheriff's Office will Nursing Operations will call 911 to report incident.

b. T

c. If you call 911, the dispatchers will notify the Laguna Honda Sheriffs immediately. The Sheriff's Office will formulate an active shooter announcement and callnotify Nursing Operations for a hospital wide overhead page.

c.

d. The LHH Sheriffs' Office will establish the Incident Command Post and the ranking officer on duty will be the Incident Commander.

e. The SFSD Nursing Operations staff will announce via overhead page, the annoucement provided by SFSO. :

d.

ATTENTION: CODE SILVER – ACTIVE SHOOTER [LOCATION].
TAKE COVER. LAW ENFORCEMENT IS ON THE WAY.

If safe to do so, the Nursing Operations staff will send templated message to all staff via Reddinet. The The Sheriff's Operations Center will send a templated message to all staff via Everbridge.

e.

f. All other staff shall attempt to communicate the Code Silver situation with others.

g.f.

The Sheriffs will make other necessary announcements overhead or by any other means available at any time during the incident.

h.g. Staff are to follow the SFSD staff's directions.

h. When the shooter is apprehended or leaves the campus, the Sheriff will announce overhead that Code Silver is all clear.

i. The Executive Administrator or AOD will activate NHICS to manage the recovery, in a unified command with Law Enforcement, until resumption of regular operations.

i. The Executive Administrator or AOD will activate HICS to manage the recovery until resumption of regular operations.

7. Law Enforcement (SFSO) Response

Law Enforcement officers responding to an active shooter are trained to proceed immediately to the area in which shots were last heard, to stop the shooting as quickly as possible.

a. The first responding officers may be in teams. Ts; they may be dressed in normal patrol uniforms, plain clothes with a visible law enforcement badge or other insignias, or they may be wearing external ballistic vests and Kevlar helmets or other tactical gear. The officers may be armed with rifles, shotguns, and handguns.

8. How to react when law enforcement arrives.

a. Remain calm, and follow officers' instructions

b. Put down any items in your hands (i.e., bags, jackets)

c. Immediately raise hands and spread fingers

d. Always keep hands visible

e. Avoid making quick movements toward officers such as attempting to hold on to them for safety

f. Avoid pointing, screaming and/or yelling

g. Do not stop to ask officers for help or direction when evacuating, just proceed in the direction from which officers are entering the area.

h. **Do exactly as the team of officers instruct**. The first responding officers will be focused on stopping the active shooter and creating a safe environment for medical assistance to be brought in to aid the injured.

j. When the shooter is apprehended or leaves the campus, the Sheriff Office will notify the appropriate hospital administrator when the building has been cleared for re-entry. The Executive Administrator or AOD will activate NHICS to manage the recovery until resumption of regular operations.

k. Sheriff officer to notify Nursing Operations to announce all clear via the overhead paging system.

ATTACHMENT:
None.

REFERENCE:

75-10 Security Services Operating Procedures
Laguna Honda Hospital Code Silver Active Shooter Response Guide *(pocket guide)*
The Healthcare and Public Health (HPH) Sector Critical Infrastructure Protection (CIP) Partnership's "Active Shooter Planning and Response in a Healthcare Setting", Draft January 2014.

Revised: 07/06/23,~~23/04/23,~~ 16/01/12, 16/07/12 (Year, Month, Day)
Original adoption: 15/07/14

Approved for renumbering to 70-01 Section A, B, and C: 18/02/23

INFORMATION YOU SHOULD PROVIDE TO ~~759-2319~~ LHH SFSD OPERATOR 759-2319 (4-2319) ~~(AT LHH)~~ OR 911 AND ARRIVING LAW ENFORCEMENT:

Location: Building – Floor - Room
Number of shooters
Descriptions – Race, Gender, Age & Height, Weight, Hair Color
Type(s) of weapon(s)
Carrying backpack or duffel bag?
Where is the shooter now?
Where was shooter last seen?
Direction of travel
Do you recognize the shooter? If so, provide name.
Any explosions besides gunshots?
Number of people at your location.
Any injuries? Number & types.

Code Silver = Active Shooter → Run to Safety or Immediately Barricade in Place.

No Hospital Command Center Activation & No DOSRs Until Shooter Apprehended

Remain Barricaded Until You Are Given Further Instructions.

Laguna Honda Hospital

Code Silver

Active Shooter Response Guide

BE PREPARED TO DEAL WITH AN ACTIVE SHOOTER SITUATION:

Be aware of your environment.
Be vigilant regarding any unusual or suspicious activities.
Be familiar with your usual work area. Know where and how you could barricade in place to protect yourself and your patients.
Look for the two nearest exits in any facility you visit.

IF A SHOOTER ENTERS YOUR VICINITY:

Remain calm.
Try not to provoke the shooter.
Escape or hide if you can.
ONLY AS A LAST RESORT WHEN YOUR LIFE IS IN IMMINENT DANGER, attempt to negotiate with or overpower the shooter.
If you choose to take action, be decisive, quick and physically aggressive trying to incapacitate the shooter.
If the shooter leaves the area, barricade in place or escape to a safer location.

IF THE ACTIVE SHOOTER IS NOT AT YOUR LOCATION:

Remain calm.
Warn others to immediately take cover and barricade in place.
Lock and barricade or block doors and windows.
Keep everyone out of sight. Take cover behind concrete walls, heavy desks, or filing cabinets.
Silence your cell phone & pager.

IF YOU ARE OUTSIDE:

Remain calm.
Move away from the shooter or the sound of gunshots.
Take cover behind thick walls or parked vehicles.

WHEN POLICE ARRIVE:

Remain calm.
FOLLOW OFFICERS' INSTRUCTIONS EXACTLY.
Drop anything you are holding, raise your hands and spread your fingers.
Keep your hands visible.
Don't point, scream, yell or make any quick movements towards officers.
When evacuating, don't stop to ask for help or directions.
Medical assistance will be provided after the scene is safe.

Expect to be held in a safe location until the situation is under control and all witnesses have been identified and questioned.

AFTER A SHOOTING INCIDENT:

Account for all patients, staff and visitors.
Ensure everyone's safety, and provide medical care as needed.
Report anyone missing or injured along with your department's status to the Hospital Command Center / NHICS Team.
Follow instructions from Law Enforcement and the NHICS Team.
Assess the mental health needs of patients, visitors and staff and refer them for support as directed by the NHICS Team.

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

POLICY:

The Laguna Honda Hospital and Rehabilitation Center (LHH) injury and Illness Prevention Program (IIPP) ~~is~~was established to provide a safe and healthy work environment for all LHH employees.

This document is intended to be ever-evolving and shall reflect our progress toward the continuous improvement of the health, safety, and welfare of our employees.

PURPOSE:

The purpose of the IIPP is to implement and maintain effective procedures for preventing workplace injury and illness in accordance with California Occupational Safety and Health Standards, California Code of Regulations (CCR) Title 8, Section 3203 and Section 1509.

PROCEDURE:

1. **Responsibilities**

   a. The Manager of the LHH Department of Workplace Safety and Emergency Management (WSEM) shall be the IIPP administrator and have the authority and responsibility for administering and maintaining the overall program and for updating the program annually ~~periodically~~. (WSEM) ~~The Department of Workplace Safety and Emergency Management~~ shall also be responsible for the following:

      i. Providing initial and ongoing health and safety training to employees during hospital-wide orientation and periodic in-services.

      ii. Providing assistance to Department Managers as requested in implementing the IIPP. This might include assessing hazards, training employees, and investigating accidents.

      iii. Reviewing all incident reports, ~~and~~ investigating when necessary, and r~~.~~ecommending controls up the command chain.

      iv. Analyzing and summarizing injury/illness data. Reports shall be provided to PIPS twice per year and to the Executive Team once per year.

      v. Making recommendations for injury/illness prevention based on hazards and injury/illness data.

   b. Department Managers shall be responsible for implementing the components of the IIPP within their work areas. This shall include the following:

i. Identifying risks and informing workers of risks and how to minimize them.
ii. Providing job-specific health and safety training.

iii. Promoting a positive atmosphere of open communication regarding safety and health that is free from harassment, discrimination, and fear of reprisal.

iv. Making sure that employees follow safety procedures.

v. Conducting incident investigations and identifying corrective actions and preventative actions.

vi. Take appropriate disciplinary action when employees do not comply with LHH health and safety policies and procedures.

c. All employees shall:

i. Comply with LHH health and safety policies and procedures;

ii. Use and maintain required personal protective equipment (PPE), including respirators;

iii. Promote and facilitate a safe and healthy environment for themselves and their co-workers;

iv. Report injuries, illnesses, and incidents involving a risk to health and safety immediately to their supervisor;

v. Report any potential safety or health risk immediately to their supervisor, including perceived physical or emotional risk;

vi. Abate risks immediately when possible and safe to do so;

vii. Not undertake a task or operate equipment unless authorized and trained to do so safely and to ask for assistance when they do not understand how to complete a task safely;

viii. Attend required health and safety training and medical surveillance examinations.

d. The LHH Executive Team shall:

i. Provide the necessary resources to implement and maintain an effective IIPP.

ii. Assign Department Managers responsibilities for implementing the IIPP in their areas of responsibility.

iii. Calendar at least annually a review of a report from the LHH Department of Workplace Safety and Emergency Management including analyses of injury and illness data.

iv. Review recommendations from the Department of Workplace Safety and Emergency Management.

v. Take action as appropriate to minimize health and safety risks.

2. **Communication**

a. LHH promotes a system of open communication between management and staff in which staff are encouraged to report hazardous conditions and near-misses without fear of reprisal. Employees are encouraged to report any hazards immediately to their supervisors, who are expected to investigate and mitigate the hazards.

b. Employees may also choose to report health and safety hazards directly to WSEM or through a hazard reporting form, which is available in hard copy outside WSEM offices located in A401 as well as online. The hazard reporting form may be submitted anonymously.

c. All LHH employees shall receive an introduction to WSEM and an overview of this IIPP during new employee orientation.

d. All LHH employees shall receive health and safety training specific to their jobs on initial hire ~~and in~~and periodic in-service trainings throughout the year.

e. Department Managers shall be instructed on the hazards in their work areas either during Leadership Forum or individually by WSEM staff.

f. Employees shall receive task-specific health and safety training within their departments on initial assignment and additionally when:

i. Assigned to a new job or task for which they have not been trained previously;

ii. New substances, processes, procedures, or equipment are introduced and pose a new hazard;

iii. A previously unrecognized hazard is brought to the attention of the Supervisor.

g. Departmental/neighborhood safety meetings shall be held periodically and/or time shall be allocated in regular staff meetings to discuss health and safety issues. Department Managers are encouraged to invite WSEM staff as technical experts to safety meetings as appropriate.

h. A health and safety bulletin board on the first floor of the main Administration building shall be maintained by WSEM with information about the LHH IIPP, and the most recent Cal/OSHA Form 300A. This log should be updated when new notices are received~~periodically~~ (at least annually).

i. The main page of the LHH Intranet site is accessible to all employees and has a WSEM icon ~~n Occupational Safety and Health button~~ linking users to safety and health resources including injury reporting procedures, safety data sheets, and the online hazard reporting form.

3. **Hazard Identification and Evaluation**

   a. Hazards shall be identified primarily by Department Managers, but may also be identified in any of the following ways:

      i. Health and safety surveys conducted by the LHH Industrial Hygienist either randomly or at the request of an employee or Manager.

      ii. Supervisors introducing new tasks, substances, or equipment into their area.

      iii. Employee(s) bringing the hazard to the attention of the Supervisor, Department Manager, or WSEM.

      iv. Employee(s) using the Workplace Hazard Reporting Form available on the LHH intranet Occupational Safety and Health button and in hard copy in the Admin building lobby. (Appendix A)

      ~~iv.~~v. Aggregated incident report/injury information

New hazards shall be evaluated by the supervisor, the LHH Industrial Hygienist, or the LHH OSH Committee as appropriate to determine necessary safety procedures and training.

4. **Reporting and Investigation of Occupational Injuries and Illnesses**

   a. Notification

      i. All incidents involving health and safety hazards shall be reported immediately to the supervisor of the employee involved.

      ii. In the case of injuries that do not ~~-~~require immediate emergency treatment, the employee shall report the injury to his/her supervisor prior to seeking medical treatment.

iii. In the case of injuries that do require immediate emergency medical treatment, the employee must inform the supervisor as soon as possible. Unless they are medically unable to do so, employees must inform their supervisors on the same day/shift of the injury.

iv. In the case of occupational illnesses, it may be difficult to associate a specific event or exposure. The employee shall report the illness to the supervisor as soon as there is a suspicion of diagnosis of an occupational illness.

v. In the case of needle sticks and blood borne pathogen exposures, after washing/flushing the affected area, the incident should be reported to the supervisor in the same manner as other occupational injuries and illnesses. In addition, there is a 24-hour phone hotline which allows employees to obtain more specific information on follow-up for this type of exposure.

b. Medical Treatment

i. The supervisor shall assist the employee in obtaining prompt medical treatment of occupational injuries and illnesses, as necessary. The employee may proceed to any one of the twelve approved service sites for San Francisco City and County employees. A list of these service sites can be found in Appendix B.

- An ambulance shall be called for transport if the employee's condition is serious or medically unstable.

ii. If the employee's condition is not serious or medically unstable, the supervisor shall arrange for safe and appropriate transportation to designated treatment facilities.

- Incident forms do not have to be completed prior to the employee seeking medical treatment but should be completed within the timeframes detailed below.~~.~~

c. Documentation

i. On the same day/shift of an employee reporting or a supervisor having knowledge of an occupational injury or illness, the Supervisor **(not the employee)** shall complete the following forms found in Appendix C. These forms are available as fillable pdf forms on the LHH intranet WSEM site~~Occupational Safety and Health button~~:

- Supervisor's Incident Investigation Form (SIIR)

- Employer's Report of Occupational Injury or Illness (Form 5020)

- Employee's Claim for Worker's Compensation Benefits form (Form DWC-1).

ii. If the employee loses work time or seeks medical treatment, the employee must complete and sign their section of ~~the Form~~Form DWC-1.

iii. Fax all completed forms to DPH OSH at 415-554-2562 as soon as possible and then send a hard copy in interoffice mail.

iv. If all the details of the incident cannot be obtained quickly or are not known due to the employee's unavailability, submit the form with as much information as possible and submit a written supplement to the form as soon as possible when you have more detail.

d. Fatality / Serious Injury

i. In the event of a fatality or a serious occupational injury or illness requiring hospitalization: the attending supervisor shall complete the LHH Supervisor Serious Injury/Fatality Tool.

ii. The supervisor shall contact the Senior Industrial Hygienist, Industrial Hygienist, Administrator on Duty, or the Nursing Supervisor as indicated on the LHH Supervisor Serious Injury/Fatality Tool.

iii. The Senior Industrial Hygienist, Industrial Hygienist, Administrator on Duty, or the Nursing Supervisor shall notify the nearest Cal OSHA office immediately @415-972-8670.

ATTACHMENT:
Appendix A: Workplace Hazard Reporting Form
Appendix B: List of Workers' Compensation Designated Clinics
Appendix C: Injury Reporting Checklist and Paperwork

REFERENCE:
California Occupational Safety and Health (OSH) Standards, Title 8, *California Code of Regulations (CCR),* section 3203

Revised: 95/05/01, 98/12/24, 99/11/22, 00/03/02, 08/04/29, 14/03/25, 14/05/27, 16/07/12, 17/03/14 (Year/Month/Day)
Original adoption: 92/05/20

Appendix A: Workplace Hazard Reporting Form

LAGUNA HONDA HOSPITAL INJURY & ILLNESS PREVENTION PROGRAM HAZARD REPORTING FORM

Laguna Honda employees and building occupants may use this form to report any unrecognized, or uncontrolled safety issues to the Occupational Safety and Health (OSH) Committee. The Workplace Safety staff shall investigate the reported hazard to determine if mitigations are needed. This form can be submitted anonymously if desired. Employees are advised that it would be illegal for an employer to take any action against an employee in retaliation for exercising their right to report hazards.

HAZARD

Unsafe Condition or Practice:

Specific Location:

Suggestion for Improving Safety:

Has this matter been reported to your supervisor? ❑ Yes ❑ No

Would you like to be notified when this issue has been addressed? ❑ Yes ❑ No

If yes, please provide contact information.

YOUR INFORMATION (OPTIONAL)

Name:

Department:

Phone:

E-mail:

This form may be dropped in the box across from the Volunteer Office on the ground floor of the Administration building, or you may send it directly to the Laguna Honda Industrial Hygienist via interoffice mail.

Appendix B:
Workers' Compensation Designated Clinics

When an employee has an occupational injury or illness, the first concern is to ensure that the employee receives timely medical care. If the employee needs medical care, the supervisor should direct the employee to a Workers' Compensation Designated Clinic.

For Injuries Occurring During Normal Business Hours:

St. Francis Treatment Room
1199 Bush Street, Suite 160
Hours: 7:30 a.m. to 5:30 p.m., Monday through Friday
Telephone: (415) 353-6305

AT&T Clinic – St. Francis Health Center (at the Ballpark)
24 Willie Mays Plaza
Hours: 7:30 a.m. to 5:00 p.m., Monday through Friday
Telephone: (415) 972-2249

Kaiser Occupational Health Clinic (Opera Plaza)
601 Van Ness Avenue, Suite 2008
(Inside the Opera Plaza building, 2nd floor)
Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday
Telephone: (415) 674-7000

California Pacific Medical Center – Davies Campus
Castro & Duboce Streets
Hours: 7:00 a.m. to 11:00 a.m. and 1:00 p.m. to 5:00 p.m., Monday through Friday
Telephone: (415) 600-6600

San Francisco International Airport Medical Clinic
International Terminal, Level 3, "A" Side
(Departures Level, Pre-Security)
Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday and
9:00 a.m. to 1 p.m., Saturday
Telephone: (650) 821-5600

US Healthworks
1893 Monterey Road, Suite 200
San Jose, CA
Hours: 7:00 a.m. to 7:00 p.m., Monday through Friday
Telephone: (408) 288-3800

Valley Care Occupational Health Clinic
5565 W. Los Positas Blvd. Suite 150
Pleasanton, CA
Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday
Telephone: (925) 416-3562

For Injuries Occurring After Normal Business Hours:

San Francisco General Hospital Emergency Department
1001 Potrero Ave
San Francisco, CA
Telephone: (415) 206-8111

California Pacific Medical Center – Davies Campus Emergency Department
Castro and Duboce Streets
Telephone: (415) 600-0600

Kaiser Permanente Medical Center – San Francisco
Urgent Care Clinic
2238 Geary Blvd., 8th Floor S.E.
Hours: 5:00 p.m. to 9:00 p.m.

Kaiser Permanente Medical Center – San Francisco
Emergency Department
2200 O'Farrell Street at Baker
Hours: 9:00 p.m. to 8:00 a.m.
Telephone: (415) 202-2000

Saint Francis Memorial Hospital Emergency Department
1100 Bush Street, between Hyde and Leavenworth Streets
Telephone: (415) 353-6300

Appendix C: Injury Reporting Checklist and Paperwork for Supervisors

Laguna Honda Supervisor's Injury Reporting Checklist

1. Whenever a Laguna Honda employee reports a workplace injury or near miss incident, the supervisor must do the following before the end of the shift:

☐ Complete the Supervisor's Incident Investigation Report (DPH SIIR).

☐ Complete the State of California Employer's Report of Occupational Injury or Illness (DPH OSH Form 5020).

☐ Give the employee a blank Workers' Compensation Claim Form (DWC-1) and Notice of Potential Eligibility.

2. If the employee is going to seek medical treatment for an injury or illness:

☐ Have the employee complete and sign the top section of the DWC-1. You must complete the Employer section (bottom half).

☐ Send~~Fax~~ all three forms (SIIR, 5020, and DWC-1) to DPH OSH at DPH-Workcomp@sfdph.org, or fax to 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail.

☐ Provide the employee with the list of workers' compensation designated clinics. The employee must seek treatment at one of these facilities unless they have submitted a pre-designation form to HR to see their personal physician.

3. If the employee does not intend to seek medical treatment:

☐ Send~~Fax~~ the SIIR and 5020 **ONLY** to DPH OSH at DPH-Workcomp@sfdph.org, or fax to 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail.

☐ If they change their mind and turn in a completed DWC-1, follow the instructions in section 2.

4. If the reported incident involves exposure to blood, body fluids, or other infectious material:

☐ Complete section 1 and the first two steps in section 2 above.

☐ Instruct the employee to call the Needlestick Hotline at 415-469-4411.

☐ Send the employee for follow up care to SFGH Occupational Health Services.

5. If the reported incident involves exposure to an aerosol transmissible disease (ATD), such as TB:

☐ Follow instructions in section 1, but substitute the ATD Exposure Report for the SIIR.

☐ Follow instructions in section 2 or section 3 as appropriate.

6. If the injury is fatal or serious (employee is sent to a hospital):

☐ Complete the first page of the LHH Supervisor Serious Injury/Fatality Tool to determine ~~whether or not~~whether Cal/OSHA notification is required. **This must be done immediately.**

If you answered yes to any questions on the first page of the tool:

☐ Complete the second page.

☐ Follow the instructions for contacting the Industrial Hygienist, AOD, or Nursing Supervisor and provide them with a copy of the completed tool **within 2 hours of the incident, regardless of the time of the incident.**

If you did not answer yes to any questions on the first page, no further action is required.

ASBESTOS AND LEAD MANAGEMENT PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to a policy of safe and effective management of building materials containing asbestos and/or lead to minimize exposure of LHH employees and other building occupants to airborne asbestos fibers and lead dust.

PURPOSE:

1. To establish and administer an effective operations and maintenance plan for LHH pursuant to Cal-~~-~~OSHA, EPA, and Bay Area Air Quality Management District regulations.

2. To establish a process for renovation or demolition of areas of the Administration building that may contain asbestos and/or lead.

3. To implement procedures for LHH Facility Services employees to follow when performing short duration maintenance and repair tasks for which a negative exposure assessment has been completed.

PROCEDURE:

1. Asbestos and Lead-Containing Materials

a. The hospital buildings (Pavilion, North Tower and South Tower) at LHH are LEED certified and were built without the use of any materials containing lead or asbestos.

b. Any construction, alterations, installations, maintenance, or repair work in the Administration building (which has potential ACM) at LHH has the potential to disturb asbestos and/or lead.

   i. The Administration Building was surveyed for asbestos by three different consulting companies between 1990 and 2006. A list of known asbestos-containing construction material and presumed asbestos-containing construction material based on these surveys is included in Appendix A.

   ii. All painted surfaces in the Administration building are assumed to contain lead.

2. Procedures for Work Order Maintenance and Repair Activities

a. Work orders for maintenance and repairs that involve minimal disturbance of building materials, and for which a negative exposure assessment (NEA) has been completed, may be assigned to LHH Facility Services staff who have been trained

according to paragraph 6a. These staff may complete the work following the standard procedures in Appendix B.

b. Projects that are larger in scope or of longer duration than the tasks described above, which are assigned to contract employees, or which do not have a completed NEA, require additional hazard assessment to determine whether they can be done by on-site Facility Services staff, or whether they must be done by an accredited abatement worker. ~~An example of this would be replacement of vinyl flooring, typically done by a contracted DPW floor installer.~~

   i. Hazard assessments, including sampling of building materials, will be completed by a Department of Workplace Safety & Emergency Management (WSEM) employee, who is an accredited Asbestos Building Inspector and a CDPH-certified Lead Inspector/Assessor. If WSEM is lacking in these certifications, then they may consult a third party for these assessments.

   ii. If materials to be disturbed are found not to contain asbestos or lead, the project can proceed in house with LHH employees and/or contractors.

   iii. If materials to be disturbed are found to contain asbestos, procedures for renovation and large-scale maintenance shall be followed.

3. Procedures for Building Renovations and Large-Scale Maintenance

a. When a project involves the potential disturbance of asbestos and/or lead and is not covered by a standard procedure in Appendix B, the Facility Services Director will notify DPW that a contractor with appropriate accreditation for lead and/or asbestos work will be needed to perform the work.

b. DPW will select an environmental consultant who is a CAC and Lead Inspector/Assessor, and can obtain permits from BAAQMD, from their list of approved consultants.

c. DPW will arrange for a pre-job walk that will include representatives from the consultant, DPW, WSEM, and Facility Services.

d. The environmental consultant will collect and analyze samples of building materials and develop a detailed work plan based on information provided at the pre-job walk and the results of sampling. The work plan will include specifics regarding the scope of the job and methods to complete the work safely and in accordance with regulations.

e. The work plan shall be reviewed and approved by DPW, Facility Services, and WSEM.

f. DPW will schedule a bid walk with potential contractors, the environmental consultant, and a representative from Facility Services. A representative from WSEM may also choose, but is not required, to attend.

g. The work plan may be revised based on discussions during the bid walk and any changes must again be approved by DPW, Facility Services, and WSEM.

h. DPW will schedule the work and pre-construction meeting, if necessary.

i. The work will be performed by the contractor with the environmental consultant monitoring the contractor's work to ensure it is done according to the work plan. The consultant shall stop work at any time if the contractor is not in compliance with the work plan such that their workers or building occupants are placed in danger.

j. WSEM is responsible for oversight of the environmental consultant and may stop work if they determine that the consultant is not adequately enforcing the work plan or regulatory standards.

k. Facility Services will ensure that all work is completed satisfactorily according to the scope.

4. Procedures for Addressing Unexpected Asbestos or Lead Encountered by Contractors

a. A thorough~~n~~ assessment, typically air sampling, is required to determine presence of lead and asbestos, in areas where they can reasonably be expected to occur. For these areas, when a ~~y time that a~~ determination is made that neither asbestos nor lead is present in the vicinity of work being done~~ by outside contractors~~, LHH will provide an Asbestos Information Notice~~ to the contractor~~, advising them to stop work and contact the Facilities Director if they feel at any point that they may have encountered asbestos or lead.

b. If asbestos or lead is encountered in the vicinity of the work, but disturbance is not expected, the contractor shall observe specified work procedures to minimize the possibility of disturbance of lead or asbestos-containing construction materials (ACCM). LHH will specify changes to the contractor's scope of work, if necessary, to minimize the disturbance of asbestos. LHH will verify that the contractor's modified work scope is acceptable and monitor the contractor's work to assure that the material remains undisturbed.

c. If asbestos is present in the vicinity of the work and it may be disturbed, asbestos abatement must be completed before the proposed work can be performed. LHH will arrange for the specified asbestos abatement according to paragraph 3 above.

5. Communication of Asbestos Hazard

a. Asbestos Warning Signs listing all materials with ACCM or Presumed Asbestos Containing Construction Materials (PACCM) will be posted in the following locations:

i. In the main entrance Lobby for LHH's Administration building.

ii. At the entrance to all mechanical rooms including steam tunnels.

iii. At entrances to locations of asbestos abatement work.

iii.iv. The sign must say the following or something similar:, "Danger Asbestos May Cause Cancer. Causes Damage To Lungs. Area Authorized Personnel Only. Wear Respiratory Protection And Protective Clothing."

b. All painted surfaces in the Administration building shall be assumed to contain lead paint and Facility Services Staff will be informed of this assumption during their annual training.

6. Education And Training:

a. Facility Services Department

i. The Chief Engineer and Building and Grounds Maintenance Supervisor shall complete AHERA training for Contractor/Supervisors in order to oversee the maintenance work done by Facility Services employees.

ii. All Facility Services employees shall be trained annually on the following topics:

- The requirements of the Cal OSHA asbestos and lead standards and the contents of this Management Plan;
- The health effects of asbestos and lead;
- Recognizing asbestos containing building materials;
- Assumption of lead basedlead-based paint on all painted surfaces in the Administration building;
- The work tasks that might result in exposure to asbestos and/or lead;
- Procedures for performing maintenance tasks causing minimal disturbance of asbestos and/or lead and for which a negative exposure assessment has been completed. This will include hands on practice;
- Information about public health organizations that provide smoking cessation programs;
- Respiratory protection (provided in a separate training session).

b. Environmental Services

i. EVS staff shall receive one hour of Asbestos Awareness Training on initial hire and annually thereafter.

ii. EVS staff shall not disturb asbestos or lead and will be trained to recognize and report damaged material that may contain asbestos.

c. Workplace Safety and Emergency Management (WSEM)

i. Industrial Hygienists in WSEM shall complete the following classes to maintain AHERA accreditation:

- AHERA Contractor/Supervisor
- AHERA Building Inspector
- AHERA Management/Planner
- AHERA Project Designer

ii. Industrial Hygienists in WSEM shall complete training and examination to maintain certification as a CDPH Lead Inspector/Assessor.

ATTACHMENT:
Appendix A: Asbestos Containing Construction Materials (ACCM) and Presumed Asbestos Containing Construction Materials (PACCM)

REFERENCE:
CCR Title 8 Section 1529 - Cal OSHA Asbestos in Construction Standard
CCR Title 8 Section 1532.1 Cal OSHA Lead in Construction Standard
40 CFR Part 61 – National Emissions Standard for Hazardous Air Pollutants (NESHAP)
Bay Area Air Quality Management District (BAAQMD) Regulation 11 Rule 2 – Asbestos Demolition, Renovation, and Manufacturing.

Revised: 13/05/28, 18/09/11 (Year/Month/Day)

Appendix A:

ASBESTOS CONTAINING CONSTRUCTION MATERIALS (ACCM) AND PRESUMED ABESTOS CONTAINING CONSTRUCTION MATERALS (PACCM) ~~(Updated 8/22/12)~~

Materials	Locations
ACCM: Steam & domestic hot water pipe & fitting insulation, and block type insulation on tanks and heat exchangers	Found in mechanical rooms throughout hospital and throughout the buildings. Some piping insulation is concealed in walls and ceiling and in metal cladding.
ACCM: Acoustical Ceiling Plaster	Main hallways on 3rd, 4th, 5th, & 6th Floors
ACCM: Ceiling Tile (transite), screwed-in	Ward G Rooms 301, 401, 501, and 601
ACCM & PACCM: 2’ x 2’ laid-in ceiling tiles	2nd, 3rd, 4th and 5th Floors of patient’s ward C
ACCM: Vinyl floor sheeting, linoleum, vinyl floor tiles, and mastic	Throughout the hospital – consult the survey reports for actual locations
ACCM: Vinyl composite wall Coverings	Various areas of all buildings
ACCM & PACCM: Fire door core insulation	Various areas of all buildings
ACCM: Wall heater transite behind radiators	Throughout building
ACCM: Heater Insulation, behind sheet metal	H-Wing Library
ACCM: Exterior Paint	Ward G exterior
ACCM: Undercoating on Sinks	Throughout building
ACCM: Tar coating, back of splined ceiling tiles	Ward D, Room 314
PACCM: Wall & Ceiling Sheetrock	Throughout building
PACCM: Baseboard glue	Throughout building

PACCM: Insulators/contactors for elevator Control	Elevators & elevator mechanical rooms
PACCM: Ceramic tile grout, mastic and underlying vapor barrier	Throughout building
PACCM: Vapor barrier under concrete floor	Assumed to be present where there are floor drains in concrete floors.
PACCM: Mastic under Formica	Throughout building
PACCM: Asphalt & gravel roofing and vapor barrier under terracotta tiles	On various roofs
PACCM: Caulking & glazing putty on windows and doors	Throughout the exterior
PACCM: Asbestos cement (transite) panels	On bathroom balconies, in Wards

ACCM means any manufactured construction material, including structural, mechanical and building material, which contains more than one-tenth of 1 percent (0.1%) asbestos by weight.

Appendix B: Standard Procedures for Maintenance Tasks Resulting in Minimal Disturbance of Asbestos and/or Lead

Procedures for Small Lead Paint Stabilization Jobs

LHH Painters in the Facility Services Department may complete small paint stabilization projects on surfaces that may contain lead paint. These projects will not involve removal of more than approximately two square feet of peeling paint and will be completed using the following safe practices.

1. Occupants shall not be permitted to enter the worksite during paint stabilization activities until after work has been completed.

2. The worksite shall be prepared to prevent the release of leaded dust, and contain lead-based paint chips and other debris within the worksite until they can be safely removed. Practices that minimize the spread of leaded dust, paint chips, soil and debris shall be used during worksite preparation.

3. The worksite shall be secured against unauthorized entry, and occupants' belongings protected from contamination by dust-lead hazards and debris during paint stabilization activities. Occupants' belongings in the containment area shall be relocated to a safe and secure area outside the containment area, or covered with an impermeable covering with all seams and edges taped or otherwise sealed.

4. Painters will wear disposable nitrile gloves.

5. Use of a half mask respirator with HEPA filters is recommended during paint stabilization.

6. None of the following prohibited methods will be used for preparing surfaces for painting.

   a. Open flame burning or torching.
   b. Machine sanding or grinding without a high-efficiency particulate air (HEPA) local exhaust control.
   c. Abrasive blasting or sandblasting without HEPA local exhaust control.
   d. Heat guns operating above 1100 degrees Fahrenheit or charring the paint.
   e. Dry sanding or dry scraping, except dry scraping in conjunction with heat guns or within 1.0 ft. (0.30 m.) of electrical outlets, or when treating defective paint spots totaling no more than 2 sq. ft. (0.2 sq. m.) in any one interior room or space, or totaling no more than 20 sq. ft. (2.0 sq. m.) on exterior surfaces.
   f. Paint stripping in a poorly ventilated space using a volatile stripper.

7. Paint stabilization will include the application of fresh, non-lead based paint.

8. Upon completion of work, the entire work area must be vacuumed with a HEPA vacuum.

9. Plastic sheeting/drop cloths that have been cleaned of debris and gloves may be thrown out in the regular trash. Paint chips and contents of HEPA vacuum are hazardous waste and must be sealed in plastic bags, labelled as hazardous lead waste and placed in the hazardous waste storage area.

10. Once clean-up is complete, remove gloves and wash hands.

11. Work clothes should not be worn home.

Procedures for Carpentry Work on Asbestos-Containing or Lead-Painted Surfaces

LHH employees other than Painters will not be asked to perform work that requires sanding, scraping, burning, or any other means of intentionally removing paint from surface areas that may contain lead paint. However, in some cases, LHH employees may be required to make repairs on a window or other painted surface that is known or likely to contain lead paint. Such repair may cause inadvertent disturbance, chipping, or flaking of the paint, but is not expected to result in measurable airborne concentrations of lead. In these cases, the employee will follow the procedure below in order to minimize any possible lead exposure.

1. Don disposable, nitrile gloves.

2. Use a vacuum equipped with a HEPA filter to vacuum all painted surfaces that will be disturbed during repair or maintenance.

3. Wipe down surface with a wet rag.

4. Complete work making an effort to leave as much paint intact as possible.

5. Vacuum up any paint chips or dust from work surface and surrounding area using a vacuum equipped with a HEPA filter.

6. Remove and dispose of gloves.

7. Wash hands.

8. Dispose of gloves and rags immediately after use. These can go in the regular trash.

Procedures for Cutting or Drilling Into Asbestos-Containing or Lead-Painted Surfaces

Occasionally, LHH Facility Services employees are required to cut or drill into walls or ceilings in order to complete assigned work. The following procedures must be followed if you will be cutting into a surface that is known or suspected to contain ~~lead based~~lead-based paint.

1. Don disposable, nitrile gloves.

2. For cutting into surfaces, use a saw equipped with a shroud attached to a HEPA vacuum.

3. For drilling into surfaces, use a drill equipped with a shroud attached to a HEPA vacuum or drill through a wet sponge.

4. Use a HEPA vacuum to clean up any dust or debris generated by your work.

5. Wipe around edges of cut surface and any area that was vacuumed with a wet rag.

6. Remove and dispose of gloves.

7. Wash hands.

8. Dispose of gloves and rags immediately after use. These can go in the regular trash.

WORKPLACE VIOLENCE PREVENTION PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and secure environment of care consistent with our mission, the Department of Public Health (DPH) regulations, Title 22, California Occupational Safety and Health Administration (Cal-OSHA) regulations and other applicable local, state and federal laws.

2. LHH employees, residents and visitors are prohibited from bringing weapons to the LHH campus and worksites. Weapons include, but are not limited to, firearms, knives or weapons defined in the California Penal Code Section 12020.

3. The City and County of San Francisco has a ~~zero tolerance~~zero-tolerance policy for assaults, battery or threats or acts of violence by employees in the workplace. Employees are expected to behave in a professional and courteous manner in the workplace at all times. This includes carrying out their duties on or offsite. A LHH employee who physically or verbally threatens, harasses, or abuses someone in the workplace, or uses hospital resources such as work time, workplace phones, fax machines, mail, e-mail, or other means for such activity, will be subject to corrective or disciplinary action, up to and including dismissal, and may be subject to criminal and/or civil action.

PURPOSE:

To inform the LHH community of the hospital's policy towards violence in the workplace, to implement procedures for the prevention of workplace violence, and to provide support for employees who have been subject to a verbal or physical threat and/or violent behavior.

DEFINITION~~S~~:

1. *Violence*: Behavior involving the exercise or exhibition of physical force intended to hurt, damage, or intimidate someone or something.

2. *Threat of Violence*: A statement or conduct that causes a person to fear for his or her safety.

3. *Workplace Violence*: Any act of violence or threat of violence that occurs at the work site, including the following:

   a. Type 1 Violence: Workplace violence committed by a person who has no legitimate business at the work site.

b. Type 2 Violence: Workplace violence directed at employees by residents or visitors.

c. Type 3 Violence: Workplace violence against an employee by another employee or former employee.

d. Type 4 Violence: Workplace violence committed by someone who is not an employee, but has or had a personal relationship with an employee.

4. *Psychological First Aid:* A supportive response to a fellow human being who is suffering and who may need support, including attending to employee needs for information, comfort, and time to process.

PROCEDURE

1. Workplace Violence Prevention Program Responsibilities

a. Department of Workplace Safety and Emergency Management (WSEM):

WSEM is responsible for the overall administration and maintenance of the workplace violence prevention program, for the tracking and analysis of workplace violence incidents and for eliciting the input of employees in making improvements to the program. WSEM shall maintain a log of workplace violence incidents and report incidents involving physical force to the California Department of Industrial Relations Division of Occupational Safety and Health according to CCR Title 8 Section 3342 Violence Prevention in Healthcare

b. Resident Care Teams (RCTs):

RCTs are responsible for developing and implementing resident care practices and plans aimed at prevention of Type 2 violence by minimizing aggressive behavior in LHH residents and for reviewing and for revising plans in response to aggressive behavior. Care plans shall include medically and cognitively appropriate behavioral interventions for residents who repeatedly commit acts of workplace violence. RCTs are also responsible for ensuring appropriate assignment and training of staff to care for residents at risk for aggressive behavior.

c. Department of Human Resources (HRS):

HRS is responsible for developing and implementing policies and procedures for preventing Type 3 violence and for following up with corrective/disciplinary action in the event that such violence does occur.

d. DPH Security Services Department and San Francisco Sheriff’s Department (SFSD):

i. The Security Services Department will develop processes to safeguard all persons, patients, visitors, and employees 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.

ii. The DPH Security Director in collaboration with HRS and SFSD provides specialized personnel protection services, and specialized investigations, including conducting a risk assessment. Risks are assessed based upon all relevant information available and after consultation with experts where appropriate, a risk level will be assigned, and protection plan developed.

iii. SFSD staff also has responsibility for responding to employee calls for law enforcement assistance when experiencing violence or threat of violence. SFSD staff will take the lead in managing Code Silver (Active Shooter) situations that occur on the campus.

e. Campus Safety and Security (CSS) Committee

The LHH CSS Committee is comprised of clinical, administrative, health and safety, and human resources representatives who ensure that the security management program administered by the DPH Security Director, and the contracted security provider (SFSD) is aligned with the core values and goals of the organization by providing direction, set strategic goals, determine priority and assess the need for change. The committee ensures coordination, communication and integration of performance improvement for campus security and injury prevention. See LHHPP 75-01 Security Management Plan.

f. Department Managers and Supervisors:

As per the LHH Injury and Illness Prevention Program, managers and supervisors are responsible for providing a secure work environment for their staff, including the identification of security risks, staff training needs, the development and management of departmental security policies and procedures, and incident reporting, investigation and follow up.

g. All LHH Employees, DPH Employees on Campus, and Tenants:

All LHH employees and building occupants are responsible for reporting hazards and injury or illness incidents per the IIPP, including hazards and incidents related to workplace violence.

2. Prevention of Violent Incidents

a. LHH admissions criteria in LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units preclude the admission of patients with a significant likelihood of unmanageable behavior.

b. Access to LHH by visitors and the public is controlled by SFSD according to LHHPP 75-11 Public Access and Defined Restricted Areas and LHHPP 75-02 Public Access and Night Security in order to prevent entrance of persons with no legitimate business at LHH.

c. LHHPP 75-03 Disorderly or Disruptive Visitors specifies procedures for the removal of disorderly or disruptive visitors and the Department of Security Services has developed a threat management plan that is incorporated into LHHPP 75-10 Security Services Standard Operating Procedures in order to manage potential threats from anyone entering the facility.

d. History of aggressive behavior and any incidents of aggressive behavior shall be documented by the RCT and the care plan shall include measures to be taken for prevention and management of these behaviors.

e. Objects that could be used as a weapon shall be removed from rooms of potentially aggressive residents.

f. ~~Buddies and/or coaches~~Coaches shall be utilized in accordance with LHHPP 24-10 Close Observation.~~ the care of residents for whom this is deemed appropriate and effective in preventing aggressive behavior.~~

g. Incidents of aggressive behavior by residents shall be communicated to care providers at change of shift.

3. Incident Reporting and Response

a. Any employee who experiences workplace violence of any type shall report the incident immediately to their manager or supervisor. If the incident involves Type 3 violence perpetrated by a supervisor, the incident may be reported to another supervisor or directly to HRS.

b. Any LHH employee who observes violence in the workplace that involves residents, staff members, volunteers, visitors and/or vendors shall:~~;~~

i. If the threat of violence is immediate or life threatening, immediately call the SFSD (ext. 4-2319) or SFPD at 911.

ii. Inform a manager/supervisor or designee.

iii. Complete an Unusual Occurrence report.

c. Upon admission to LHH, residents are informed of the policy of non-violence. Residents who violate this policy with aggressive acts toward staff or other residents shall be given immediate feedback including appropriate consequences

(as spelled out in the policy), review of expectations and rules, and review of potential consequences of future recurrence of aggressive behavior. Behavioral interventions developed by the RCT shall be implemented immediately.

d. Any manager/supervisor who receives a report from an employee of an incident involving violence in the workplace shall investigate and take the following actions:

   i. Provide Psychological First Aid as appropriate for affected individuals including victim, aggressor, and by-standers.

   ii. Refer employees to the Employee Assistance Program (EAP) as appropriate to provide additional support sessions for LHH employees and their families following a threat or violent behavior incident. EAP is contacted by calling (800) 795-2351.

   iii. Immediately complete and submit an incident report to DPH OSH according to injury reporting procedures in LHHPP 73-01 Injury and Illness Prevention Program. A copy of the report shall also be scanned to the WSEM Director by the end of the shift for logging and reporting to Cal OSHA as appropriate.

   iv. Consult with appropriate resources via HRS, EAP, WSEM, SFSD, and/or LHH Administrator on Duty (AOD).

   v. Check in with the threatened person and offer support services periodically following the incident.

e. The AOD who receives a report of violence in the workplace shall ensure that the following actions have been taken:

   i. Notification of the Director of Human Resources if the incident involves Type 3 violence.

   ii. Notification of LHH Psychiatry Consultant for evaluation, treatment, and follow up recommendations of involved resident(s), as indicated.

   iii. Notification of the SFSD if there is imminent danger or a possible crime has been committed.

   iv. Notification of DPH Security Services if an incident involves an aggressor for whom a threat assessment is appropriate.

e. The Deputy Sheriff who receives notification of an act or threat of violence will intervene according to SFSD policy.

4. Response to Threats of Violence from a Third Party

In situations where a resident's family member or other visitor is determined to be a threat to employee safety, the CEO and DPH Security Services shall be notified and a threat assessment will be completed according to the Threat Management Plan and LHHPP 75-10 Security Services Standard Operating Procedures). The following action(s) may be taken depending on the situation and level of threat.

a. A stay-away letter may be issued by the CEO notifying the individual that he/she is not to enter the LHH grounds.

b. Once a stay-away letter has been issued, it is reviewed by the RCT on a quarterly basis to assure accuracy and consistency. If revision is needed, the LHH Deputy City Attorney must be notified.

c. If a visitor poses an imminent or continuing threat to employee safety, a Temporary Restraining Order (TRO) may be secured by Deputy City Attorney. A TRO is a court order signed by a judge, which orders an individual to stop contacting, telephoning, threatening, harassing, or stalking another individual. It can also order an individual to stay a certain distance away from another individual and his/her workplace or home.

d. A TRO will remain in force until a hearing is conducted on the matter; at which time a judge can continue, make permanent, or terminate the provisions of the order. The individual requesting a TRO will be asked to sign a declaration and to testify at a court proceeding where the accused will be present.

e. Employees who are being threatened by someone with whom they have a personal relationship should notify the CEO and DPH Security Services and are encouraged to obtain a TRO preventing the threatening individual from entering their workplace.

5. Education

a. All new employees receive training during hospital wide orientation on:

   i. LHHPP 73-01 Injury and Illness Prevention Program (IIPP)

   ii. The details of this Workplace Violence Prevention Program

   iii. Procedures for reporting incidents of workplace violence

b. All employees with direct resident care responsibilities receive initial and annual non-violent crisis intervention -training, including the following topics:

   i. Aggression and violence predicting factors

   ii. The assault cycle (CPI Crisis Development Model)

iii. Verbal intervention and de-escalation techniques and physical maneuvers to prevent physical harm, including role plays and hands-on practice.

iv. Inappropriateness of use of restraints at LHH

c. All other employees also receive annual training on workplace violence appropriate to their responsibilities.

d. Clinical staff assigned to work on units with residents at risk for unintentional aggressive behavior due to health conditions affecting the brain shall receive additional education that includes role playing to increase confidence in handling these residents.

e. Managers and Supervisors shall be provided with training in Psychological First Aid by Employee Assistance Program staff annually at Leadership Forum.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-01 Admission to LHH Acute and SNF Services and Relocation Between SNF Units
LHHPP 22-08 Threat of violence to residents by an external party
LHHPP 22-10 Management of Resident Aggression
LHHPP 24-10 Close Observation
LHHPP 60-04 Unusual Occurrences
LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 75-01 Security Management Plan
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-04 Calls for SFSD Assistance
LHHPP 75-10 Security Services Standard Operating Procedures
LHHPP 75-11 Public Access and Defined Restricted Areas
LHHPP 75-12 Firearms, Dangerous Weapons and Contraband Policy
LHHPP 75-13 Forensic Residents/Patients
CCR Title 8 Section 3342. Violence Prevention in Healthcare

Revised: 05/12/20, 08/09/23, 09/01/13, 10/08/01, 10/11/09, 15/01/13, 16/03/08, 18/09/11, 19/03/12 (Year/Month/Day)
Original adoption: 05/12/20

BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and healthy workplace by minimizing employee exposures to bloodborne pathogens.

PURPOSE:

1. To implement procedures for controlling exposure to bloodborne pathogens and for follow up of exposures that occur in the workplace.

2. To comply with the California Code of Regulations, Title 8, Section 5193 Bloodborne Pathogens and Section 3203 Injury/Illness Prevention.

SCOPE:

1. The LHH Bloodborne Pathogen Exposure Control Program (BBP Plan) applies to LHH employees whom, as a result of the performance of their job duties, are reasonably expected to be occupationally exposed to human blood, body fluids, or other potentially infectious materials (OPIM). A list of job classes expected to be occupationally exposed is provided in Appendix A: Exposure Determination.

2. Non-LHH personnel, including but not limited to, contract employees, registry personnel, and professional or student affiliates shall:

   a. Be covered by their primary employer's plan for annual training, vaccines, exposure reporting, and post exposure follow-up by their primary employer.

   b. Be provided with site-specific training and personal protective equipment by LHH.

PROCEDURE:

1. Methods of Compliance

a. Engineering Controls

   i. All employees shall use standard precautions according to 72-01 Infection Control Manual B1 Standard Precautions.

   ii. When feasible, engineering controls will be implemented to limit employee exposures to blood and OPIM. An engineering control is not required if a licensed healthcare professional ~~reasonably determines,~~reasonably determines that the use of the control will jeopardize the resident's safety or the success of the procedure. Such resident safety determinations will be

documented and provided to LHH Infection Control Committee (ICC) and DPH Bloodborne Pathogen Safe Device Committee (BPSDC) for review.

iii. Needleless Systems will be used for:

- Withdrawal of body fluids,
- Accessing a vein or artery,
- Administration of medications or fluids,
- Any procedure involving the potential for an exposure incident for which a needleless device is available.

iv. Safe needle devices shall be used if needleless systems are not available for the above-mentioned procedures.

v. If sharps other than needle devices are used, these items shall include engineered sharps injury protection.

b. Work Practice Controls

i. Employees shall follow the hand hygiene and PPE procedures, safe injection practices, and environmental controls detailed in 72-01 Infection Control Manual B1 Standard Precautions.

ii. Needle clippers and other devices which shear, bend, or break contaminated needles or other contaminated sharps are prohibited.

iii. Eating, drinking, smoking, applying cosmetics and lip balm and handling contact lenses in any work areas where there is a reasonable likelihood of occupational exposure is prohibited.

iv. Resident/employee food and drink shall not be kept in freezers, refrigerators, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.

c. Cleaning

i. Equipment, linens, resident clothing, and blood spills shall all be handled according to the procedures in Section F of 72-01 Infection Control Manual.

d. Sharps Disposal:

Sharps that are contaminated with blood or any other body substance shall be placed in appropriate disposal containers. The containers shall be:

- P~~p~~uncture resistant;~~,~~
  - Rigid;
  - Labeled with the universal biohazard sign and the word~~,~~ "Biohazard~~,~~";

- If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened.~~ without great difficulty.~~

- ~~labeled appropriately,~~
- leak-proof on the sides and bottom, and
- provide for safe handling by housekeeping staff.

~~ii.~~i. Sharps disposal containers shall be easily accessible in areas where sharps waste may be generated. Sharps disposal containers shall be placed or positioned as close as possible to the site of the procedure so that contaminated sharps are easily disposed of immediately after use.

~~iii.~~ii. Employees shall never reach by hand into a sharps disposal container.

~~iv.~~iii. Sharps containers, when three quarters (3/4) filled, shall have their tops securely closed so that no spillage can occur and shall be replaced.

iv. The Environmental Services Department shall be responsible for appropriate disposal of filled biohazard sharps disposal containers.

v. Clinical staff are responsible for notifying EVS when containers are full and/or need to be ~~replaced~~replaced.

vi. Broken glassware that may be contaminated with body substances shall not be directly handled with a gloved or bare hand. It shall be handled by mechanical means such as tongs or dustpan and broom. Contaminated broken glass shall be placed in a puncture-resistant container and disposed of as biohazardous waste.

vii. Sharps containers will not be opened, emptied or cleaned in any manner that may expose an employee.

2. Hepatitis B Vaccination

a. The Hepatitis B vaccine shall be offered to all employees and hospice volunteers who are at risk of occupational exposure to transmissible bloodborne pathogens within 10 working days of hire or reassignment to a job or tasks that place the employee at risk of exposure to blood and body fluids. Our medical clinic or the OHS clinic at Zuckerburg San Francisco General Hospital (ZSFG) can offer this vaccination and/or proof of vaccination.

b. If the individual initially declines the Hepatitis B vaccine series but at a later date decides to accept it, then the vaccination shall be provided.

c. Any individual who declines the Hepatitis B vaccination shall sign the Hepatitis B informed consent/refusal form (Appendix B). This declination will be kept in the employee health record.

c.

3. Post-Exposure Evaluation and Follow-Up:

a. Wash and/or flush the affected area immediately.

a.b. In the event of an exposure incident, the involved employee must call the Blood and Body Fluid Exposure Hotline (formerly Needlestick Hotline) at Needlestick Hotline (415-469-4411) as soon as possible and report the exposure to the Needlestick hHotline on-call clinician.

i. The Blood and Body Fluid Exposure Needlestick Hotline is available 24 hours/day, 7 days a week. The Needlestick Hotline will advise the employee to report the specifics of the incident to the Manager/-Supervisor.

ii. The Blood and Body Fluid Exposure Needlestick Hotline on-call clinician will request the name of the exposed employee, their work location, telephone number, and a history of the exposure event. If the Needlestick Hotline on-call clinician agrees that the exposure poses a possible risk for the transmission of bloodborne pathogens, Post-Exposure Prophylaxis (PEP) will be initiated, as medically indicated. The supervisor is responsible for providing and/or completing the DPH Occupational Safety and Health Section (DPH OSH) Worker's compensation Forms.

iii. The Blood and Body Fluid Exposure Needlestick Hotline on-call clinician will advise the employee to as appropriate for immediate Post-Exposure Prophylaxis (PEP).

iv. The Blood and Body Fluid Exposure Needlestick Hotline on-call clinician will contact and inform the Department of Public Health Occupational Health Service (OHS) provider.

v. Testing of the source individual for HIV will be coordinated and performed by a designated LHH physician who is informed of the exposure by the OHS Clinic.

vi. Results of the source individual's testing shall be made available to the exposed employee as well as the clinicians caring for the employee, and the employee shall be informed of the laws/regulations regarding the privacy rights for disclosure of the identity and infectious status of the source individual.

~~b.~~c. The employee will report to the OHS Clinic located in Bldg. 9, 2nd floor Room 200, at ZSFG. The OHS provider will:

i. Provide risk assessment of the specific exposure and provide information about infection risk for HIV, HBV, and HCV.

ii. Discuss the risks and benefits of the recommended treatment plan.

iii. Obtain and order the appropriate laboratory tests with the employee's consent. HIV pretest counseling is provided prior to obtaining consent to HIV serological testing. Laboratory specimens will be sent to the ZSFG clinical lab with a coded number system without any personal identifiers. If the employee elects to have blood drawn but not to consent for HIV testing, the serum sample shall be stored for at least 90 days. If, within that 90 days the employee chooses to have the baseline sample tested, such testing shall be completed as soon as feasible.

iv. Have the employee complete the DPH Blood or Body Fluid Exposure Report (Appendix C) and document the circumstances of the exposure, treatment given, in the employee's medical record.

v. Complete the "Doctor's First Report of Injury" form; and

vi. If the employee refuses treatment, document all relevant information given to the employee, including the potential consequences of declining to follow the recommended course of action.

~~c.~~d. The evaluating OHS health care clinician shall provide the exposed employee the following information:

i. Documentation of the route(s) of exposure and circumstances under which exposure occurred.

ii. Results of the source individual's blood testing for HIV, HCV and HBV, if available, or documentation that testing was not done due to lack of consent or other reasons.

iii. Medical records information relevant to the appropriate treatment of the employee, including vaccination status.

~~d.~~e. When laboratory test results become available, the OHS provider shall inform the employee of the test results and evaluate the need to have the employee continue the PEP in relation to the employee's test results and the source patient's bloodborne infection status, if available. The OHS clinician will arrange to continue follow-up care, if indicated.

~~e.~~f. The evaluating OHS clinician shall provide the employee with a copy of a written opinion within 15 days of the completion of the evaluation.

i. The written opinion for Hepatitis B vaccination shall be limited to whether the vaccine is indicated and if the employee has received such vaccination.

ii. The written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

- The employee has been informed of the results of the evaluation.
- The employee has been told about any medical conditions resulting from the exposure, which require further evaluation or treatment.

iii. Other findings or diagnoses shall remain confidential and shall not be included in the written report.

~~a.~~g. Sharps Injury Log:

i. The OHS provider will send a copy of the Blood or Body Fluid Exposure Report Form completed by the employee to the DPH OSH Section. This information is entered into an exposure database within 14 days and the Sharps Injury Log is generated. Data is compiled by calendar year.

ii. The ICC and BPSDC shall review the Sharps Injury Log data as described above to analyze and update work practices and safety device use.

~~ii.~~iii. The Sharps Injury Log shall be maintained 30~~5~~ years from the date the exposure incident occurred.

4. Communication of Hazards:

a. Labels

i. Warning labels incorporating the universal biohazard sign and the word, "B~~b~~iohazard," shall be printed on or affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material or any other containers used to store, transport or ship blood or other potentially infectious materials outside of the LHH campus.

ii. Labels shall be affixed to contaminated equipment and/or equipment containers.

iii. Containers of blood, blood products, or blood components that are labeled as to their contents and have been released for transfusion or other clinical use are ~~exempted~~exempt from labeling requirements.

iv. The labels shall be fluorescent orange or orange-red with lettering or symbols in a contrasting color.

Labels shall be affixed as securely as possible to the container, preferably by adhesive, or by wire, string or other method that prevents their loss or unintentional removal.

b. R~~R~~ed bags or red containers may be substituted for labels except for sharp containers or regulated waste red bags. Bags used to contain regulated waste shall be color-coded red and shall be labeled in accordance with subsection (g)(1)(A)2. Labels on red bags or red containers do not need to be color-coded in accordance with subsection (g)(1)(A)3.

c. ~~7.~~ Individual containers of blood or OPIM that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

d. ~~8.~~ Labels required for contaminated equipment shall be in accordance with this subsection and shall also state which portions of the equipment remain contaminated.

~~9. Regulated waste that has been decontaminated need not be labeled or color-coded.~~

~~v.~~

~~5.~~

5. Training:

i. LHH shall provide training to occupationally exposed employees at the time of initial assignment and annually.

ii. Annual training will be required and may be live or computer-based. In the case of ~~computer based~~computer-based training, LHH shall provide a phone or pager number to provide immediate access to a qualified individual to which questions can be addressed. The training must be within one year of the previous training.

iii. Additional training shall be provided whenever modifications of work practices or engineering controls are introduced.

iv. The Bloodborne Pathogen Exposure Control Training will include:

- Copy and Text of Standard for Bloodborne Pathogen Exposure Control explanation of the contents and accessibility of the applicable CalAL-OSHA Regulations.

- Epidemiology and Symptoms: a general explanation of the epidemiology and symptoms of bloodborne diseases.

- Modes of Transmission: an explanation of the modes of transmission of bloodborne pathogens.

- LHH BBPECP: an explanation of the LHH exposure control plan and its availability to each employee.

- Risk Identification: an explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM.

- Methods of Compliance: an explanation of the use and limitations of methods that may prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.

- Decontamination and Disposal: information on the selection and maintenance of PPE including types, proper use, location, removal, handling, decontamination and disposal.

- Personal Protective Equipment: an explanation of the basis for selection of personal protective equipment.

- Hepatitis B Vaccination: information on the hepatitis B vaccine, including information on its safety, efficacy, method of administration, the benefits of being vaccinated.

- Emergency: information on the appropriate actions to take and the persons to contact in an emergency involving blood or other potentially infectious materials.

- Exposure Incident: an explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.

- Post-Exposure Evaluation and Follow-Up: information on the post-exposure evaluation and follow-up that OHS Clinic will provide.

- Signs and Labels: an explanation of the signs and labels and/or color coding.

- Interactive Questions and Answers. An opportunity for interactive questions and answers with the person conducting the training session.

- The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

6.

6. Recordkeeping

b.a. Employee Health Records

i. The OHS Clinic shall establish and maintain an accurate medical record for each employee with occupational exposure in accordance with Section 3204.of California Code of Regulations .

ii. Ensure that the health care employee records are kept confidential and are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this Standard and by law.

iii. Maintain the records for at least the duration of employment plus 30 years in accordance with this Standard.

iv. The LHH Medical Clinic will maintain records of immunization and declination forms pertaining to Hepatitis B vaccinations.

b. Training Records

Training records shall include the following information:

1. The dates of the training sessions;
2. The contents or a summary of the training sessions;
3. The names and qualifications of persons conducting the training; and
4. The names and job titles of all persons attending the training sessions.

LHH-DET will maintain all employee training records for three (3) years after training is provided.

7. Program Evaluation:

b.e. The LHH Occupational Safety and Health Committee and the ICC will review the BBP Plan annually and whenever the following circumstance(s) occur:

i. Introduction or modification of work practices.

ii. Introduction or modification of technologies or engineering controls.

iii. Introduction or modification of classifications.

iv. Indications of deficiencies.

c.f. Input from employees providing direct patient care will be solicited by the committees during each annual review.

ATTACHMENT:
Appendix A: Determination of Exposures (classification list)
Appendix B: Hepatitis B Informed Consent/Refusal Form- need to add current form
Appendix C: Blood/Body Fluid Exposure Report Form- need -to add current form

REFERENCES:
Cal-OSHA Title 8, 5193
Cal-OSHA Title 8, 3204

Revised: 07/08/28, 13/05/28, 15/01/13, 16/11/08, 23/05/30 (Year/Month/Day)
Approved for renumbering from 72-02 to 73-06: 15/01/13

Appendix A: Determination of Exposure

Exposure Category 1: Employees providing direct resident care with possible exposure to blood and/or other potentially infectious ~~material~~material.

Class	Title
2202	Dental Aide
2210	Dentist
2230	Physician Specialist
2232	Senior Physician Specialist
2302	Nursing Assistant
2303	Patient Care Assistant
2312	Licensed Vocational Nurse
2320	Registered Nurse
2322	Nurse Manager
2323	Clinical Nurse Specialist
2324	Nursing Supervisor
2326	Nursing Supervisor Psychiatric
2390	Central Processing & Dist Tech
2392	Sr Cent Proc & Dist Tech
2536	Respiratory Care Practitioner
2583	Home Health Aide
2736	Porter
2740	Porter Supervisor 1
7324	Beautician
P103	Special Nurse

Exposure Category 2: Employees with resident contact or other job duties that may result in exposure to blood and/or other potentially infectious ~~material~~material.

Class	Title
1428	Unit Clerk
2424	X-Ray Laboratory Aide
2430	Medical Evaluations Assistant
2450	Pharmacist
2454	Clinical Pharmacist
2468	Diagnostic Imaging Tech II
2469	Diagnostic Imaging Tech III
2542	Speech Pathologist
2548	Occupational Therapist
2550	Senior Occupational Therapist
2554	Therapy Aide

2555	Physical Therapist Assistant
2556	Physical Therapist
2558	Senior Physical Therapist
2574	Clinical Psychologist
2576	Sprv ~~Clincal~~Clinical Psychologist
2587	Health Worker 3
2588	Health Worker 4
2591	Health Program Coordinator 2
2593	Health Program Coordinator 3
2604	Food Service Worker
2622	Dietetic Technician
2624	Dietitian
2626	Chief Dietitian
2738	Porter Assistant Supervisor
2785	Asst General Services Manager
2846	Nutritionist
2903	Eligibility Worker
2908	Hospital ~~Eligiblity~~Eligibility Worker
2913	Program Specialist
2920	Medical Social Worker
2922	Senior Medical Social Worker
2924	Medical Social Work Supervisor
2930	Psychiatric Social Worker
2931	Marriage, Family & Child Cnslr
4321	Cashier 2
6138	Industrial Hygienist
6139	Senior Industrial Hygienist
7334	Stationary Engineer
7335	Senior Stationary Engineer
7347	Plumber
7524	Institution Utility Worker

Exposure Category 3: ~~Employees who~~All other job classifications, to include the following, do not provide direct resident care and do not have job duties that require contact with residents or potentially infectious ~~material~~material.

Class	Title
0922	Manager I
0923	Manager II
0931	Manager III
0932	Manager IV
0933	Manager V

0941	Manager VI
0943	Manager VIII
1022	IS Administrator 2
1042	IS Engineer-Journey
1043	IS Engineer-Senior
1044	IS Engineer-Principal
1052	IS Business Analyst
1053	IS Business Analyst-Senior
1054	IS Business Analyst-Principal
1070	IS Project Director
1071	IS Manager
1093	IT Operations Support Admn III
1165	Manager, Department Of Public Health
1202	Personnel Clerk
1204	Senior Personnel Clerk
1220	Payroll Clerk
1222	Sr Payroll & Personnel Clerk
1226	Chief Payroll & Personnel Clerk
1241	Personnel Analyst
1244	Senior Personnel Analyst
1404	Clerk
1406	Senior Clerk
1408	Principal Clerk
1429	Nurses Staffing Assistant
1430	Transcriber Typist
1440	Medical Transcriber Typist
1630	Account Clerk
1632	Senior Account Clerk
1634	Principal Account Clerk
1635	Health Care Billing Clerk 1
1636	Health Care Billing Clerk 2
1652	Accountant II
1654	Accountant III
1657	Accountant IV
1662	Patient Accounts Asst Sprv
1663	Patient Accounts Supervisor
1664	Patient Accounts Manager
1708	Senior Telephone Operator
1820	Junior Administrative Analyst
1822	Administrative Analyst
1823	Senior Administrative Analyst

1824	Pr Administrative Analyst
1825	Prnpl Admin Analyst II
1842	Management Assistant
1934	Storekeeper
1942	Asst Materials Coordinator
1944	Materials Coordinator
2105	Patient Svcs Finance Tech
2106	Med Staff Svcs Dept Spc
2110	Medical Records Clerk
2112	Medical Records Technician
2114	Medical Records Tech Sprv
2119	Health Care Analyst
2406	Pharmacy Helper
2409	Pharmacy Technician
2453	Supervising Pharmacist
2606	Senior Food Service Worker
2608	Supply Room Attendant
2618	Food Service Supervisor
2619	Senior Food Service Supervisor
2620	Food Service ~~Mgr~~Mgr. Administrator
2650	Assistant Cook
2654	Cook
2656	Chef
2818	Health Program Planner
2909	Hospital Elig Wrk Supervisor
3417	Gardener
7120	~~Bldgs~~Bldgs. & Grounds Maint Supt
7203	~~Bldg~~Bldg. & Grounds Maint Sprv
7205	Chief Stationary Engineer
7342	Locksmith
7344	Carpenter
7345	Electrician
7346	Painter
7355	Truck Driver
9910	Public Service Trainee
9924	PS Aide Health Services

HANDLING AND STORAGE OF MEDICAL GASES

POLICY:

1. ~~All medical gases and compressed air shall be handled and stored in a safe manner.~~
2. ~~Smoking is prohibited in any area where compressed gases or liquids are in use or in storage.~~

Laguna Honda Hospital (Laguna Honda) will comply with the California Code of Regulations, Article 76, Section 4650, with ~~in~~ regards to the storage, handling, and use of compressed gas cylinders. Smoking is prohibited in any area where compressed gases or liquids are in use or in storage.

PURPOSE:

To ensure a safe environment for residents, visitors and staff.
This program describes how Laguna Honda will store, handle, and use compressed gas cylinders in a manner that ensures employee safety and complies with applicable regulations. In order to ensure a safe environment for residents, visitors, and staff.

PROCEDURE:

1. A "No Smoking" sign shall be placed on oxygen carriers or holders and posted in areas where compressed gases or liquids are stored. Before issuing each cylinder, Central Supply Room staff shall place a "No Smoking" sign around the cylinder neck. Department heads in charge of storage and use of compressed gases or liquids will be held responsible for placing of signs.

2. Persons transporting full or empty "H" gas cylinders must ensure that the cap is secured at all times except when cylinders with regulators in place are prepared and transported in the care units. "E" cylinders do not require capping for transport.

3. The gas cylinders valve protection devices shall not be used for lifting cylinders.

4. All cylinders, empty or full, shall be properly fastened at all times during site delivery and storage.

5. Empty cylinders are segregated from full cylinders

6. To prevent cylinders from falling over, the care unit personnel and staff from other areas where cylinders are used must ensure that each cylinder remains on its carrier and that each carrier rests on its wheels at all times.

7. Cylinders stored in the open are protected from weather.

ATTACHMENT:
None

REFERENCE:
Title 8, CAC Article 76, Section 4650

Revised: 99/08/23, 12/09/25, 15/01/13, 22/01/11 (Year/Month/Day)
Original adoption: 92/05/20
Approved for renumbering from 71-07 to 73-10: 15/01/13

MEDICAL WASTE MANAGEMENT PROGRAM

POLICY:

Laguna Honda Hospital (Laguna Honda) will comply with the California Medical Waste Management Act with regards to managing medical waste..

PURPOSE:

This program describes how Laguna Honda will collect, store, and dispose of medical waste in a manner that ensures employee safety and complies with applicable regulation. s.

DEFINITIONSPROCEDURE:

Medical Waste Definitions

1. **"Medical waste" means any biohazardous, pathology, pharmaceutical, or trace chemotherapy waste not regulated by the federal Resource Conservation and Recovery Act of 1976 (Public Law 94-580), as amended; sharps and trace chemotherapy wastes generated in a health care setting in the diagnosis, treatment, immunization, or care of humans or animals; waste generated in autopsy or necropsy; waste generated during preparation of a body for final disposition such as cremation or interment; waste generated in research pertaining to the production or testing of microbiologicals; waste generated in research using human or animal pathogens; sharps and laboratory waste that poses a potential risk of infection to humans generated in the inoculation of animals in commercial farming operations; waste generated from the consolidation of homegenerated sharps; and waste generated in the cleanup of trauma scenes. Biohazardous, pathology, pharmaceutical, sharps, and trace chemotherapy wastes that meet the conditions of this section are not subject to any of the hazardous waste requirements**

a. Medical Waste specific to Laguna Honda includes:

i. Biohazardous waste (Regulated Medical Waste)

- Waste that at the point of disposal or thereafter contains recognizable blood, fluid blood products, containers or equipment containing blood that is fluid.
- Waste containing discarded materials contaminated with excretion, exudate, or other secretions in which the resident was required to be isolated by the LHH infection control authorities.

ii. Sharps waste

- Syringes, hypodermic needles, blades, needles with attached tubing, or broken glass that has been in contact with biohazardous waste.

iii. Contaminated Solid Waste

- All moist waste including products that have been in contact with bodily fluids or waste that might attract vermin (i.e., tongue blade, diaper, urine cup, moist blood-~~ ~~stained dressing, non-sharp disposable instrument, or food waste that have been in contact with bodily fluids).

iv. Pharmaceutical waste

- Waste that is hazardous only because it is comprised of prescription or over-the-counter drug.

v. Chemo-contaminated waste

- Any waste that previously contained, or has come into contact with, a chemotherapeutic agent. For the purpose of waste handling, "chemotherapeutic agent" means a cytotoxic drug, or an agent that kills or~~f~~ prevents the reproduction of malignant cells.

~~2.~~ PROCEDURES:~~Collection and Disposal Procedures~~

~~a.~~1. General procedures are listed below and detailed procedures for each type of waste is given in Table 1.

~~b.~~a. Biohazardous Waste

i. Waste material must be segregated at the point of generation and placed in a labeled red biohazard bag. The bag should have sufficient strength and be impervious to moisture to preclude ripping, tearing, or bursting under normal waste handling conditions.

ii. Biohazardous w~~W~~aste ~~material~~ containers shall be leak-~~ ~~resistant with tight fitting covers. Disposable biohazardous w~~ or w~~aste bags must be tied secure~~d~~ly to prevent expulsion of contents.

~~c.~~b. Body Fluids/Suctioned Fluids

i. Any volume of fluids that are not absorbed by other waste materials such as sponges and dressings must be contained in leak and break resistant containers.

ii. Liquid blood or semi-liquid waste can be poured down a public sewage system

~~d.~~c. Sharps Waste

i. All sharps must be placed in approved and labeled sharps containers.

ii. Sharps should not be disposed of directly in biohazard waste bags.

iii. Needles from syringes should not be removed or clipped.

iv. See the LHH Bloodborne Pathogen Occupational Exposure Control Plan for information on sharps injury prevention.

~~e.~~d. Pharmaceutical Waste

i. Pharmaceutical wastes should be segregated from other types of medical wastes. They should not be placed into red biohazardous bags, but placed in pharmaceutical waste bags or disposable containers marked with the words “INCINERATION ONLY.”

~~f.~~e. Chemo-Contaminated Waste

i. Chemo-contaminated wastes should be segregated and collected in yellow waste containers. This includes all waste generated while caring for a resident who has taken cytotoxic drugs within 48 hours.

Table 1. Alphabetical Listing of Waste Types and Disposal Guidelines

	Waste Type (Alphabetical)	Disposal Category	Collection Method
1.	**Biologicals** Serums, vaccines, antigens, antitoxins, and all preparations made from living organisms used in treatment, immunization, or diagnosis	Regulated Medical Waste	For non-sharps, discard into covered waste container lined with a red bag. For sharps, discard into plastic puncture-resistant "Sharps" container.
2.	**Blood, blood products and other body fluids considered potentially infectious** Suction containers, pleural evacuation containers, human lab specimens, cultures and stock of infectious agents or other receptacles containing: amniotic fluid, cerebrospinal fluid, pericardial fluid, pleural fluid, saliva during dental procedures semen, synovial fluid, vaginal secretions, and any other body fluid if visibly contaminated with blood and items saturated or visibly dripping with those fluids.	Regulated Medical Waste	If free-flowing, and in a container which can be safely handled and closed, discard into red bag container. If soiled item is saturated or visibly dripping*, discard into container lined with a red bag (available in high-use areas, and all dirty utility rooms).
3.	Culture containers / mediums/ devices (used)	Regulated Medical Waste	Non-sharp items are placed into container lined with a red bag. Sharps are placed into designated plastic, puncture-resistant "Sharps" container
4.	**Chemo – contaminated waste.** This includes all waste generated in the care of residents receiving antineoplastic drug treatment for the duration of treatment plus 48 – 168 hours, depending on the drug.	Chemo-contaminated waste.	Dispose of waste in yellow pharmaceutical waste container.
5.	Diapers not saturated with blood	Standard Waste	Disposed into a container that is lined with a non-red plastic bag.
6.	Disposable gowns or dressings saturated / visibly dripping blood or other	Regulated Medical Waste	Discard into container lined with a red plastic bag.

	potentially infectious body fluid (see #2)		
7.	Disposable gowns or dressings NOT saturated with blood	Standard Wasted	Disposed into a container that is lined with a non-red plastic bag.
8.	Feces	Standard Waste	Flush down hopper/toilet into the municipal sewer system. Note: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood.
9.	Gloves NOT saturated with blood	Standard Waste	Discard into waste container lined with a non-red plastic bag.
10.	Human Pathology Waste Includes tissue, body fluid specimens, body parts or organs (excluding urine and feces except as lab specimens)	Regulated Medical Waste	If solid specimen, place in covered container lined with a red bag. If free-flowing liquid, flush down hopper/ toilet into municipal sewer system.
11.	Isolation Room Waste – not considered Regulated Medical Waste except as items fit into specific categories (i.e. sharps, blood, dressings saturated with blood or other designated body fluid)	Standard Waste	Dispose into waste container lined with a clear or white plastic bag, except as isolation waste fits into other categories.
12.	Isolation Room Wasted derived from highly dangerous communicable disease such as Class IV etiologic agents (Ebola, Marburg viruses, Lassa fever, etc.)	Regulated Medical Waste	Discard into covered waste container lined with a red bag which has been placed in the resident / clinic room.
13.	Instruments (Disposable) includes trocars, IV insertion guidewires, and other sharp disposable instruments	Regulated Medical Waste-Sharps	Discard into plastic, puncture-resistant “Sharps” container immediately after use.
14.	IV tubing and bags not visibly contaminated	Standard Waste	Dispose into waste container lined with a non-red bag.
15.	IV tubing and bags with visible blood	Regulated Medical Waste	Discard into container lined with a red bag (in the dirty utility room).
16.	Lab Waste – see Cultures, #3		
17.	Masks	Standard Waste	Dispose into waste container lined with a non-red plastic bag.

18.	Menstrual / Peri Pads	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
19.	Pharmaceutical waste – includes unused pharmaceuticals or any pharmaceutical that has residual, free-flowing medication in it. This includes IV bags, tubing, and needles/syringes used for drug administration.	Pharmaceutical waste	Dispose in pharmaceutical waste container (white with blue top)
20.	Sharps - includes hypodermic, intravenous, and other medical needles and attached syringes, scalpel blades, disposable sharp instruments, blood vials, and other glass in contact with infectious agents (slides & cover slips) used in medical care, and also discarded unused sharps	Regulated Medical Waste _Sharps	Discard immediately after use into plastic, puncture-resistant designated "Sharps" container.
21.	Shoe covers not saturated (rarely indicated at LHH except for Norovirus)	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
22.	Urine - NOTE: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood or other potentially infectious fluid	Standard Waste	Flush liquid urine hopper/toilet into municipal sewer system. For items contaminated with urine, discard into waste container lined with a non-red plastic bag.

2. Storage

~~3.~~ **Containment and storage of medical waste shall be in accordance with Chapter 9 (commencing with Section 118275) of the Medical Waste Management Act.**

a. Medical waste storage locations are present on each neighborhood.

b. All medical wastes to be stored on site will be held no more than seven days in labeled containers.

c. Medical waste that is to be transported offsite shall not be subjected to trash chutes, compaction or grinding.

d. Pharmaceutical wastes may be stored on site for up to 90 days before sending them offsite for destruction by incineration. Pharmaceutical wastes totaling 10 pounds or less can be stored for up to one year~~r.~~

Disposal

~~**4.**~~ **No person shall treat medical waste unless the person is permitted by the enforcement agency as required by this part or unless the treatment is performed by a medical waste generator and is a treatment method approved pursuant to Chapter 8 (commencing with Section 118215) of the Medical Waste Management Act of 2017.**

a. Waste Hauler Information:
Stericyle, Inc. - Alameda County
30542 San Antonio Street
Hayward, CA 94544
510-471-0920
866-978-3744
866-783-7422
Transfer Permit Station #: P-114, TS - 114
EPA Identification Number: #CAD 980890321

b. All required hazardous waste manifests will be completed per Department of Transportation regulations.

~~5.~~3. Spill Cleanup

a. In the event of a spill of medical wastes:

i. Use latex or vinyl gloves as barrier. Don additional PPE if the risk of exposure to splash/spray is high.

ii. Use tongs, shovel, or other mechanical means to pick up solid waste, especially for sharps.

iii. Re-bag any regulated medical waste into the appropriate waste container~~a red bag~~.

iv. Secure the bag with tape or other means to prevent leakage.

v. Apply household bleach disinfectant to the area affected by the spill or contact EVS for assistance.

b. Sharps Container Spill

   i. Recover the sharps using tongs, forceps, pliers, or other mechanical means. Do not use your hands to pick up sharps- even if gloves are worn.

   ii. Place the sharps into the designatedopen sharps container. If the sharps container is 2/3 filled, place the sharps into another sharps container. Do not fill the container over 2/3 full.

   iii. Secure the lid and tape if necessary.

   iv. Apply disinfectant in affected area if necessary.

c. Blood Leak

   i. Place cones or other warning devices around the area to prevent people from walking through the blood spill and tracking blood throughout the area.

   ii. Apply absorbent towels. Blood spill kits with appropriate absorbent cloths are available in CSR. Do not use UltraSorbs.

   iii. Allow 10–20 minutes for the blood to be absorbed.

   iv. Vinyl or latex gloves shall be worn when mopping a spill. Wear additional PPE if splash/spray is expected.

   v. Place the blood--soaked absorbent materials in the biohazard bag.

   vi. Mop the area with disinfectant and water. The mop shall be soaked in disinfectant bleach for 10–20 minutes after use, and then rinsed with clean water before using it again.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual
LHHPP 73-06 Bloodborne Pathogen Occupational Exposure Control Plan
California Health and Safety Code Sections 117600 – 118360: Medical Waste Management Act of 2017.

Revised: 13/05/28, 15/01/13, 16/03/08 (Year/Month/Day)
Original adoption:

SAFE RESIDENT HANDLING

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) has a goal of becoming a restraint-free facility, and is therefore committed to a policy of safe resident handling without restraints for the prevention of musculoskeletal injuries attributable to resident mobilization among LHH healthcare workers.

PURPOSE:

1. To implement procedures for safe resident handling consistent with Title 8 of California Occupational Health and Safety Administration (Cal-OSHA), and LHHPP 73-01 Laguna Honda Injury and Illness Prevention Program.

2. To establish a process for assessing resident mobility needs and to determine safe resident handling procedures~~. ~~.

3. To establish procedures to minimize hazards of manual resident handling using appropriate equipment, ~~personnel~~personnel, and training.

DEFINITIONS:

1. *Resident Mobilization:* putting into movement or assisting in the putting into movement, ~~part~~part, or all of a resident's body.

2. *Manual resident handling:* lifting, transferring, repositioning, or mobilizing part or all of a resident's body done without the assistance of equipment.

3. *Equipment:* a powered or non-powered device that effectively reduces the forces exerted by or on employees while they perform resident handling activities.

4. *Musculoskeletal injury*: acute injury or cumulative trauma of the muscles, tendons, ligaments, bursa, peripheral nerves, joints, ~~bone~~bone, or blood vessels.

PROCEDURE:

1. Control Strategies/Prevention Techniques

   a. A registered nurse (RN) shall complete an initial and ongoing assessment regarding the resident's ambulation needs and assistive devices required. The RN shall communicate with the resident care team and maintain documentation of ambulation needs, ~~devices~~devices, and preferences on the resident care plan in accordance with the NPP D6 5.0 Ambulation Policy.

b. Employees shall use assistive devices during resident mobilization in accordance with the resident care plan. Devices available to Laguna Honda employees are listed in Appendix A.

~~b.~~c. Before mobilization, the employee needs to perform a ~~self assessment~~self-assessment to determine if he/she is able to physically assist in safely performing the mobilization task. If there is any doubt in the physical ability, the employee should seek help.

~~c. Although employees are encouraged to do their best to prevent residents from falling, employees are not expected to catch a resident who is falling due to the risk of injury to the employee.~~ If a resident is observed to lose his/her balance and fall, the employee should ~~only~~ assist in rescue or catching the resident, as much as ~~if they feel~~ they are physically capable and can~~of~~ safely do~~ing~~ so without~~. If the employee risks~~ injury to themselves~~, they should not perform rescue~~.

d. The Facility Services Department shall maintain the mechanical lifts on nursing floors.

e. The Nursing Department shall submit work orders to Facility Services for equipment repairs and/or replacing damaged equipment, and shall order any new equipment deemed necessary for safe resident handling. Additionally, annual maintenance is required for mechanical lifts, with annual inspection stickers on each lift to indicate the latest maintenance service.

f. Charge Nurses shall update assignment sheets and care plans to communicate the need for buddy system for safe resident handling~~. ~~.

g. Employees shall use their assigned buddy for assistance if the resident care plan states the need for a ~~two person~~two-person (or more) assist, or as needed~~. ~~. The employee should also evaluate if he/she is physically capable of performing the mobilization task without risk of injury to him/herself.

h. Any employee who experiences a resident handling injury shall report according to procedures listed in LHHPP 73-01 Injury and Illness Prevention Program.

2. Education and Training

a. All new employees receive training during new employee orientation on:

   i. LHH Injury and Illness Prevention Program

   ii. Employees right to refuse unsafe work unless proper training is provided

   iii. Recognizing musculoskeletal pain as a workplace injury.

b. All new employees with resident care responsibilities shall attend health and safety orientation provided by the Department of Workplace Safety and Emergency Management (WSEM) that includes the following topics:

   i. LHH Ergonomics Program

   ii. Recognizing and reporting musculoskeletal injuries that result from resident handling tasks.

   iii. Hazards and risk factors associated with poor ergonomics during resident mobilization including lifts, ~~transfers~~transfers, and repositioning.

   iv. Other risk factors for injury such as patient size, mobility, willingness to cooperate and clinical ~~conditions~~conditions.

   v. Injury prevention methods including use of appropriate equipment, proper body mechanics and buddy system.

   vi. Hands on training on operating powered and non-powered assistive devices including mechanical lifts, ceiling lifts, gait belts, transfers.

c. All employees with resident care responsibilities shall complete online annual ~~refreshers~~refresher that review topics covered in the initial training. WSEM contact information is provided for questions.

d. All Nursing Department employees with resident care responsibilities are evaluated on their ability to demonstrate the use of assistive devices initially and annually using a competency checklist. If employees fail to successfully demonstrate these skills, additional training shall be provided.

e. Records of training shall be maintained by the Department of Education & Training (DET) ~~Education Department~~ and WSEM.

3. Program Administration and Maintenance

WSEM is responsible for the overall administration and maintenance of the Safe Resident Handling Program, for the tracking and analysis of resident handling incidents, and for eliciting the input of employees in making improvements to the program. WSEM shall also collaborate with DET~~Education~~ and departments providing resident care to develop and deliver educational programs for staff on strategies and procedures to minimize the risk of musculoskeletal injuries associated with resident handling.

ATTACHMENT:

Appendix A: Assistive Devices Available for Safe Resident Handling

REFERENCE:

LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 73-15 Ergonomics Program
NPP D6 1.1 Battery Operated Lift Transfer
NPP D6 1.4 Battery-Operated Ceiling Lift
NPP D6 2.0 Transfer Techniques
NPP D6 5.0 Ambulation Policy

Original adoption: 19/03/12 (Year/Month/Day)

Appendix A: Assistive Devices Available for Safe Resident Handling

1. Mechanical Lifts
2. Ceiling Lifts
3. Slide Sheets
4. Gait Belts
5. Slide Boards
6. Floor protectors

~~5. Slide Boards~~

EZ Lift

Slide Sheet

EMPLOYEE ANNUAL HEALTH EXAMINATION

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) and a state licensing requirement that all employees have an annual physical examination.

PROCEDURE:

1. Employees are encouraged to have their own personal physicians who will follow them for medical problems and provide preventive health care.

2. Annual physical exams performed by an employee's personal physician satisfy the Hospital requirement.~~.~~ The employee must have the physician complete form A601~~N123~~ (8/14~~87~~) and bring the form to the Medical Clinic for filing in the employee's health record.

3. Annual physical exams can also be done in the Medical Clinic by Laguna Honda Hospital staff physicians~~.~~. Appointments are made by calling the Medical Clinic (x4 2538).

4. Medical Clinic nursing staff contacts employees who are due for their annual~~a~~ physical examination~~.~~. If the employee does not have a physical examination within the next three months, a notice is sent to the employee to have the examination within two months~~.~~. A copy is sent to the department manager.

5. If the employee does not have the physical examination within the two-month period, a notice is sent to the department manager, giving one more month during which the employee must comply.

6. If the employee fails to comply with the second notice, the department manager will be notified by the Medical Clinic nursing staff.

7. Employees who are noncompliant with hospital policies will receive counseling and/or disciplinary action in accordance with the Department of Public Health's Uniform Disciplinary Guidelines.

REFERENCES:
None

Revised: 97/06/11, 15/01/13 (Year/Month/Day)
Original adoption: 96/07/15
Approved for renumbering from 72-04 to 73-13: 15/01/13

SAN FRANCISCO HEALTH NETWORK
OCCUPATIONAL HEALTH SERVICES
PERSONAL PHYSICIAN MEDICAL FORM

Employee Name (please print) **Date**

Job Classification **Department**

All skilled nursing facility employees are required by California State law (Title 22) to have **an annual health examination and update of immunizations**. The above named employee has elected to have his personal physician perform this annual exam and immunization update.

Please return this form and all documentation of the physical examination and immunization update/status to the San Francisco Health Network Occupational Health Services Clinic.

Required exam and immunizations:
Medical hx/Physical Examination (VS included): Date completed:__________

Tuberculin test: Date:_____________ **Result:**__________ **(record size of induration)**
If positive Tuberculin test – please provide CXR date & results: __________________
For a past history of a positive Tuberculin test please provide date and size of induration on record. If none, the employee will require a 2-step tuberculin test or quantiferon test.

2 step Tuberculin test: Date of 1st test:_________ **Results:**__________
Date of 2nd test:_________ **Results:**__________
Quantiferon test: Date:____________ **Results:**____________

Please use the following chart as a guide for the required immunizations. For any "yes or unknown" answers please provide titer results. For any "no" answer please order vaccination. If titers are ordered and results are "negative" the employee will require vaccination. Vaccinations may be completed at the place of work, once the series has started.

IMMUNIZATION	IMMUNE?	LAB TITER	VACCINE ORDERED
RUBELLA (GERMAN MEASLES)	YES/NO/UNKNOWN	RUBELLA TITER: POS/NEG DATE:	DATE:
MUMPS	YES/NO/UNKNOWN	MUMPS TITER: POS/NEG DATE:	DATE (1st): DATE (2nd):
RUBEOLA (MEASLES)	YES/NO/UNKNOWN	RUBEOLA TITER: POS/NEG DATE:	DATE (1st): DATE (2nd):
VARICELLA NOT MANDATORY	YES/NO/UNKNOWN/ DECLINES	VARICELLA TITER: POS/NEG DATE:	DATE (1st): DATE (2nd):
HEPATITIS B NOT MANDATORY	YES/NO/UNKNOWN/ DECLINES	HEPATITIS B SURFACE ANTIBODY: POS/NEG DATE:	DATE (1st): DATE (2nd): DATE (3rd): *DATE (4th): *DATE (5th): *DATE (6th):
FLU VACCINE NOT MANDATORY	YES/NO/ DECLINES N/A	N/A	DATE:
TDaP (REQUIRED EVERY 10 YRS) NOT MANDATORY	YES/NO/ DECLINES N/A	N/A	DATE:

*Hepatitis B vaccination: If titer result is negative after a series of 3 vaccinations must do another series with proof of positive titer.

Page 1 of 2

I certify that the above named person has no evidence of disease that affects his/her ability to perform his/her job and he/she is free of communicable diseases that would create a hazard to him, fellow employees, or patients.

Physician Name (please print) **Physician signature**

Address **Date**

A 601 (rev 08/18/2014)

Page 2 of 2

PERSONAL ~~ersonal~~ PROTECTIVE ~~rotective~~ EQUIPMENT~~quipment~~ (PPE)~~ Policy~~

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH~~aguna Honda~~) shall provide appropriate and effective personal protective equipment (PPE) to employees whenever a hazard is present, or likely to be present, which necessitates the use of PPE pursuant to CA Occupational Safety & Health Standards, CA Code of Regulations (CCR), Title 8, Section 3380.

PURPOSE:

To provide a safe and ~~healthful~~healthy work environment for employees.

PROCEDURE:

Each Department at Laguna Honda will implement departmental procedures for providing PPE to employees that are consistent with the following hospital-wide procedures.

1. Hazard Assessment and Equipment Selection

a. Per the LHH~~aguna Honda~~ Illness & Injury Prevention Program (IIPP), Department Managers are responsible for identifying hazards to which their employees may be exposed.

b. Where hazards cannot be eliminated with the implementation of engineering and/or administrative controls, the Department will provide appropriate PPE to protect employees.

c. All PPE shall be approved for its intended use.

d. All PPE will be selected such that it fits each affected employee properly.

e. Department of Workplace Safety & Emergency Management staff are available for technical consultation in selecting appropriate PPE.

2. Required vs. Voluntary Use of PPE

a. Use of PPE is required when the Industrial Hygienist/Infection Preventionist or the Department Manager makes a determination that a hazard can~~is~~ not practically be ~~sufficiently~~ controlled without it, or when PPE is required by regulatory standard or infection control guidelines.

b. Some PPE is available for voluntary use for employees who wish to further minimize exposure to hazards that do not require the use PPE, but for which PPE

is an effective control measure.

c. Each Department should ~~will~~ keep an up-~~-~~to-~~-~~date table indicating what PPE is available to their staff and whether or not its use is required. A template for this table is included in Appendix A.

3. Availability and Use of PPE

a. In most~~some~~ cases, reusable PPE will be provided to individual employees for their sole use or as a required part of their uniform. Exceptions to this are elastomeric respirators and PPE clothing and boots expected to be provided by each employee. ~~In other cases, disposable~~Regarding disposable PPE, it will be available to all employees either in the work area or from Central Supply.

b. All affected employees shall be made aware of PPE available to them, h~~ and h~~ow to obtain it, and at hire/annual/as needed training~~ed~~ on how to use it.

c. Employees are responsible for proper use of all required PPE as part of their job duties.

d. Defective or damaged PPE shall not be used and will either be repaired or discarded.

e. All respirators will be selected and used in accordance with the Laguna Honda Respiratory Protection Program (LHH 73-09).

4. Employee Training

a. Staff will be trained on the following topics during their department orientation or by their supervisor prior to performing any task that requires the use of PPE.

i. When PPE is required;

ii. What PPE is required;

iii. What other PPE is available to use voluntarily;

iv. How to properly don, doff, adjust, and wear their required PPE;

v. The limitations of the PPE; and

vi. The proper care, maintenance, useful life, and method of disposal of the PPE.

b. PPE training is the responsibility of the Department Manager or Supervisor, but Workplace Safety & Emergency Management and Education staff are available to assist with training and curriculum development.

ATTACHMENT:
Appendix A: Department PPE Table Template

REFERENCES:
California Occupational Safety and Health (OSH) Standards, Title 8, California Code of Regulations (CCR), section 3380.

Original adoption: 16/03/08 (year, month, day)

Appendix A: Department PPE Table Template

Personal Protective Equipment List

Department: ________________________________ Revision Date: _____________

PPE	When/What Task	Required Yes/No	Reusable Yes/No	Uniform Yes/No	How to Obtain
~~e.g.~~e.g., exam gloves	Whenever providing resident care	Yes	No	No	Available in neighborhoods and from CSR

HAZARDOUS ENERGY CONTROL PROCEDURE (LOCK OUT/TAG OUT)

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to protecting the health and safety of its employees and compliance with Cal/OSHA standards specified in the California Code of Regulations (CCR) Title 8 Section 3314.

PURPOSE:

The purpose of this policy is to set forth required procedures according to CCR Title 8 Section 3314 for ensuring the isolation of hazardous energy during cleaning, repair, servicing, and maintenance procedures on equipment when the unexpected energization or start-up of the equipment or release of stored energy may cause injury to an employee.

PROCEDURE:

1. **General Hazardous Energy Control Program**

   a. Whenever machines or equipment are being cleaned, repaired, serviced, set-up, or adjusted and the unexpected energization or start-up of the machine or equipment, or release of stored energy may cause injury to the employee(s) working on the equipment, the machines or equipment shall be stopped and the power source de-energized or disengaged. If necessary, moveable parts shall be mechanically blocked or locked out to prevent movement or release of stored energy.

   b. Each machine or equipment that is covered by the Hazardous Energy Control Procedure has a specific lock out/tag out (LOTO) procedure. Copies of the specific procedures for each piece of equipment are kept at the equipment location and in a binder located in the office of the Chief Engineer in Facility Services.

   c. Where equipment is lockable, the use of a lock is required. Every effort shall be made to provide a means to lock out equipment and/or systems whenever possible.

   d. Where equipment or machinery is not lockable and cannot be readily adapted to lockable controls, positive means shall be taken to de-energize or disconnect the equipment from its source of power or a similar action shall be taken to prevent inadvertent movement. In all such cases, tags shall be placed on the controls of the equipment or machinery during repair work.

   e. Some exposures may require additional protective techniques or mechanical safeguards as follows:

Exposure	**Protection**
Hydraulic/Pneumatic Rams	Blocks, pins, etc.
Chemicals, Steam, etc.	Blinding/blanking, chained valves, etc.
Hydraulic/Pneumatic Systems	Automatic bleeding devices, blanking, etc.

2. General Lock Out/Tag Out Program

a. “Authorized Employees” are employees who are qualified to lock out or tag out equipment for cleaning, service, or repair operations.

b. Facility Services work orders involving work on equipment requiring lock out shall specify this requirement in the work order assignment.

c. Authorized employees shall have their own, individually keyed lock(s) and personalized tag(s).

d. Lock out stations with extra locks and tags are placed in the following locations:

   i. Facility Services Engineering Department

   ii. Facility Services carpentry shop

   iii. Roof of North Tower

   iv. Roof of South Tower

   v. All boiler rooms

e. Individual locks and tags shall be applied and removed by each person potentially exposed to the unexpected release of energy, except those special situations where specific facility procedures have been developed that equally protect all exposed workers.

f. If more than one employee works on the equipment and/or system, a lock out adaptor suitable for installation of several locks shall be used thereby enabling all workers to lock out the machine with their individual locks. Each employee’s lock shall remain until they complete their work.

g. Tag out may only be used in lieu of lock out in cases where the equipment and/or energy source cannot be locked out and where tag out procedures are described in the specific procedure for the equipment or equipment type.

h. Tags used for tag out in lieu of lock out shall be specifically designed for this purpose and shall include the user's name and phone number and the date and time the equipment was tagged out.

i. When a lock or tag is attached for energy isolating means, it is not to be removed without authorization from the person responsible, and it is not to be bypassed, ignored, or otherwise defeated except as outlined in Section 5 of this procedure.

j. If an unauthorized employee removes any lock or tag from the energy isolating device of equipment, and/or operates a locked out/tagged out system or piece of equipment, the employee shall be disciplined, up to and including termination.

3. Lock Out/Tag Out Procedures

a. Notify affected employees that a lockout is required and the reason for it.

b. If the equipment is in operation, shut it down through normal stopping procedure such as depressing the stop button or opening the toggle switch.

c. Operate the switch, ~~valve~~valve, or other energy isolating devices so that all energy source(s) (electrical, mechanical, ~~hydraulic~~hydraulic, and other) are disconnected or isolated from the equipment. Stored energy found in equipment such as capacitors, springs, elevated machine members, rotating fly wheels, hydraulic systems and air, gas, ~~steam~~steam, or water pressure shall be dissipated or restrained by methods such as grounding, repositioning, ~~blocking~~blocking, or bleeding down.

d. Lock out energy isolating devices with an assigned individual lock. The authorized employee shall place his/her own personal lock and tag on the energy isolating device(s).

e. When an energy isolating device cannot accept multiple locks and tags, a multiple lock out/tag out device such as a lock box or locking hasps may be used.

f. All energy isolating devices involved with the system or equipment being worked on shall be locked and/or tagged according to the specific procedure for the equipment.

g. After lock out/tag out application and prior to starting work, the following actions shall be taken to verify the effectiveness of the energy isolation:

   i. Ensure that no personnel are exposed to the equipment or system process. Isolation may be necessary.

   ii. Operate the equipment/process controls such as push buttons, switches, etc. to verify that energy isolation has been accomplished.

iii. Return all operating controls to the off position after the test.

iv. Check the equipment by use of test instruments such as a volt-meter and/or visual inspection to verify that energy isolation has been accomplished.

v. Examine the equipment/process to detect any residual energy. If detected, action shall be taken to relieve or restrain the energy.

h. The equipment is now locked out and work can begin.

4. Restoring Equipment to Service

After the work is completed and the equipment or system is ready to be returned to normal operation, the following procedure shall be used.

a. Verify that all equipment components are operationally intact including guards and safety devices.

b. Check the equipment area to make sure that no one is exposed to potentially hazardous energy on start-up.

c. The authorized employee removes their own personal lock and tag.

d. The equipment is restarted.

5. Supervisor Removal of Locks or Tags

A supervisor may remove the tag and personal lock out device belonging to an authorized employee or contractor, if necessary, only after making absolutely certain that the employee is not in the workplace. Prior to pulling the tag and personal lock, the supervisor shall take the following actions.

a. Check to see if the owner of the lock has left the premises.

b. Call the phone number on the tag, the employee's home, or contractor's place of employment to locate him/her. The supervisor shall speak with the owner of the lock to verify that he/she is no longer on the LHH campus.

c. Inspect the equipment and surrounding area to be certain that no one will be in danger if the equipment is re-energized.

d. Remove the lock and tag.

e. Make sure that the lock owner knows that their lock has been removed and where they can retrieve it.

~~e.~~

6. Employee Training

a. LHH employees shall be trained during orientation, with refresher training annually, on the purpose of the hazardous energy control procedure and the prohibition of restarting or re-energizing machines that are locked out or tagged out.

b. Employees who are authorized to work on equipment that requires lock out and/or tag out procedures shall be trained on initial work assignment on the following topics:

   i. Hazards related to working on machinery and equipment covered by this policy.

   ii. The general lock out/tag out procedures to be followed when working on equipment covered by this policy.

c. In addition, supervisors shall ensure that each authorized employee understands the specific procedures to be used on machinery or equipment that the employee is assigned to work on.

d. Retraining shall be provided by the supervisor whenever:

   i. There is a change in job assignments, machines, ~~equipment~~equipment, or processes that present a new hazard, or when changes are made to the energy control procedures.

   ii. There is a new or previously unrecognized hazard.

   iii. Periodic evaluation indicates that retraining is needed.

7. Annual Inspection and Review of Policy

a. The LHH Chief Engineer and staff from the Department of Workplace Safety and Emergency Management (WSEM) shall conduct periodic inspection and review of this policy at least annually to evaluate its effectiveness.

b. The inspection shall include observation of at least three different employees performing lock out/tag out (LOTO) ~~-~~procedures on at least three different types of equipment and a review of the employee's responsibilities under the hazardous energy control procedure.

8. Documentation

a. Records of training during orientation of new employees on the purpose of the policy shall be maintained by the Department of Education and Training.

b. Records of training of authorized employees shall be maintained by WSEM and shall include the following:

   i. Employee name

   ii. Date of training

   iii. Name of instructor

c. WSEM shall maintain reports of the annual inspection and review of this policy, which shall include the names of the inspector and the employees observed, the equipment involved, the date(s) of the inspection, and any recommended retraining or procedural changes.

ATTACHMENT:
None

REFERENCE:
~~None~~ California Code of Regulations (CCR) Title 8 Section 3314

Original adoption: 17/05/09 (Year/Month/Day)

Revised Environmental Services Policies and Procedures

XI. Standard Cleaning Procedure

The cleaning steps outlined below applies to all areas of the facility daily including: Resident, Staff, and Public Areas.

The following is based on Unit Cleaning Procedures as cleaning procedures may slightly differ in offices of the hospital and administration building.

Procedure:

1. **Trash Removal /Walkthrough**: Collection of trash, relining of receptacles, and restock supplies.

2. **Restroom Cleaning**: Cleaning of all fixtures, wall-mounted items, walls, doors, floors, restock restroom supplies.

2. **High Dusting**: High dust everything above shoulder level, this includes the following: Televisions, ceiling vents, door frames, blinds, and windowsills.

   3. ❖ This practice will be performed when the residents are not present in the rooms.

3. **Surface Cleaning (high and low touch)**: damp wipe the following with disinfectant: light switches, phones, doorknobs, and desks, chairs, desk, handrails, furniture surfaces, - elevator button, and other high touched areas.s, and all furniture.

4. **Restroom Cleaning**: Cleaning of all fixtures, wall-mounted items, walls, doors, floors, restock restroom supplies. Flush the toilets and keep the water of the sinks and showers running for 2 minutes.

Spa rooms: Clean and disinfect the Arjo bathtubs following the manufacture guidelines.

4.

5. **Floor Cleaning**: sweeping, mopping, vacuuming, carpet cleaning/floor buffing when needed

6. **Policing of Room/Area**: Making a second round to your assignment, ensuring supplies are stocked, trash is removed, spot mop as needed.

6.

Previous Revisions: May 97, Jan. 07, June 10, April -2022

Reference: Arjo Parker Quick reference guide- - Cleaning and Disinfection

Revised Nursing Policies and Procedures

RESIDENT/PATIENT ACTIVITIES OF DAILY LIVING

POLICY:

1. Registered Nurse assesses the functional ability of each resident/patient to perform the activities of daily living (ADL) upon admission, quarterly, annually and when a significant change in condition occurs.

2. The Licensed Nurse in collaboration with the resident care team (RCT)/interdisciplinary team meeting (IDT) develops a plan of care to meet the resident's/patient's ADL needs, while promoting as much functional independence as possible.

3. All nursing staff except Home Health Aides may be assigned to provide assistance with ADL care.

4. Under the supervision of the Licensed Nurse, the Home Health Aide may assist with feeding.

5. Non-medicated personal hygiene items may be stored at the bedside in a bag and placed in a closed drawer. Non- medicated personal oral hygiene items must be kept in another bag separate from topical personal hygiene items. (Refer to B 6.0 Items Allowed at The Bedside)

6. When an unanticipated significant decline in ADL function is noted, the RCT will meet to review the plan of care.

PURPOSE:

1. To promote resident/patient comfort and hygiene.

2. A program of ADLs is provided to residents/patients to maintain or prevent decrease in functional status and/or return resident/patient to their highest level of independence.

PROCEDURE:

A. Preparation of Resident/Patient – The resident's/**patient's** care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's/**patient's** dignity, privacy, safety and confidentiality.

1. Gather all anticipated hygiene and grooming supplies before approaching the resident/patient.
2. Knock before entering the room and introduce yourself to the resident/patient.
3. Explain care activities to the resident/patient and engage their participation.
4. Maintain privacy during care and keep the resident/patient warm and covered as much as possible during care.
5. Engage the resident/patient in a manner that is appropriate to their cognitive and communication abilities using appropriate language, and communication aides as needed.
6. The individualized resident/patient care plan is followed by all nursing staff, and updated as needed.

B. Activities of Daily Living – Activities of daily living are tasks related to personal care: bed mobility, ambulation, locomotion, dressing, eating, toileting, eating, transferring, personal hygiene, and

bathing. Basic nursing care procedures are to be followed utilizing Mosby's Textbook for Nursing Assistants and related nursing and hospital-wide procedures as a guide.

1. **Personal Hygiene**

    a. Individualized restorative nursing programs, for Skilled Nursing residents, for dressing / grooming are implemented as indicated on the care plan to maintain or improve resident's abilities.
    b. Resident/patient is positioned at the sink or bedside with all necessary equipment within reach.
    c. Equipment and instruction provided to maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excluding baths and showers).
    d. Skin care routinely includes teaching and assisting the resident/patient to gently cleanse under breasts, chest, back, buttocks and genitals, thoroughly patting dry and application of lotion to back and buttocks.

2. **Dressing**

    a. Residents/patients are encouraged to participate in putting on, fastening, and removing all items of clothing (includes donning/removing prosthesis or TED hose).
    b. Residents/patients are encouraged to choose their clothing.
    c. Adaptive equipment is provided and used as needed.
    d. Alternative methods of dressing are taught as needed.
    e. Occupational therapy consultation is requested as needed through the primary physician.

3. **Eating**

    a. Food preferences are to be respected to the extent possible and are brought to the attention of dietary staff as needed.
    b. Residents/patients are encouraged to eat preferably in the dining room.
    c. Residents/patients are to be in an upright 90-degree position for eating unless contraindicated or refused and so documented on the care plan.
    d. Specialized feeding plans, standard precautions, and restorative eating programs are to be followed. Refer to related procedures as needed.
    e. Dentures and adaptive devices are provided and utilized as needed.
    f. Oral care after each meal is strongly encouraged. When residents/patients do not want oral care the reasons are explored and the team is consulted to negotiate the best possible oral care under the specific circumstances. The dental hygienist and dentist are consulted as needed. Mouthwash and lemon glycerin swabs are not to be used in place of good oral care with a toothbrush and toothpaste.

4. **Toilet Use**

    a. Cognizant residents/patients are instructed on the purpose and use of diet, exercise, and medications in the elimination process by licensed nurses. Nursing caregiver may reinforce this information within their scope of practice and related policies.

b. Privacy and comfort during elimination must be maintained during toileting whether in resident/patients rooms or while in tub, shower and toilet rooms.
c. When placing resident/patient on the toilet or commode, the employee is to ensure resident/patient safety until resident/patient is ready to leave, then assist resident/patient to stand and walk or transfer as needed.
d. Incontinent residents/patients are cleaned promptly with soap and water, rinsed thoroughly and patted dry. Sensitivity to related discomfort and embarrassment is to be provided.
e. Use of incontinence products such as pads, briefs, and barrier creams is based on individual resident/patient need. Factors such as skin condition and ability to retrain are to be considered and related policies followed.
f. Residents/patients with indwelling urinary catheters receive perineal care each shift and as needed.
f.g. Bedpans, urinals, and bedside commodes are emptied and cleaned in toilets when soiled and replaced when needed,

5. **Transfer, Ambulation**

a. Follow related procedures, including transfers, ambulation, range of motion and Restorative Nursing.
b. Follow basic safety principles for transfer and ambulation such as coaching the resident /patientto rise slowly to gain balance, providing non-skid footwear, obtaining adequate assistance and providing adaptive devices as prescribed.
c. The minimum frequency of range of motion requiring staff coaching or physical assistance is noted on the care plan and is to be followed.

6. **Bed Mobility**

a. Nursing standards for every two-hour turning/ repositioning of dependent residents/patients are to be followed.
b. Exceptions to the above-noted standard related to resident/patient preferences not to be disturbed during hours of sleep are to be discussed with the Resident Care Team (RCT)/Interdisciplinary Team (IDT) members in relation to individual skin condition and other factors with care decisions noted on the care plan.
c. Resident/patient may be taught and assisted to shift their weight, particularly when seated and when turning is limited by existing pressure areas, unless the resident/patient has limited weight bearing status.

C. Organization of Resident/Patient Care Assignments

1. **Call lights** are to be kept within reach and periodic rounds are to be done to facilitate prompt identification of needs, including incontinence or toileting needs.

2. **Initial Rounds** are done by the nursing caregivers at the start of each shift on all assigned residents/patients on the neighborhood to let each resident/patient know who is caring for them and to identify priorities for care based on immediate safety and comfort needs.

a. Rounds are to include the resident's/patient's rooms, bathrooms, and other areas on the neighborhood where residents/patients are residing.
b. Immediate interventions during rounds frequently include repositioning for comfort, toileting/incontinent care, and providing water and call lights within reach.

c. To ensure safety, reassure dependent residents/patients to request for assistance to move or get up.
d. Before beginning a lengthy procedure with a resident/patient, it is usually appropriate to check on the other residents patients first to promote regular monitoring of residents.

3. **Time preferences:** Check in with residents/patients for preference of bathing time. Refusals of care or resident/patient requests that place an undue burden on the staff are negotiated to achieve a reasonable compromise with RCT/IDT members' support as needed.

D. Environment of Care

1. **Personal supplies**- Refer to B 6.0 Items Allowed At The Bedside. Personal supplies or items may include, non-medicated personal hygiene items, oral hygiene equipment, washbasins, adaptive eating utensils, brush, combs, bedpans and urinals. Electric shavers and personal razors are not allowed to be kept at the bedside. These items shall be stored in a locked drawer in the unit after each resident's/patient's use for safety.

   a. Items such as oral hygiene equipment, washbasins, and adaptive eating utensils are labeled with the resident's/patient's initials, rinsed after each use, allowed to air dry and returned to resident's/patient's bedside.
   b. Clean urinal, bedpan, and bedside commode with facility-approved disinfectant.
   c. Clean bedpans or urinals may be kept in the lower drawer of bedside cabinet. If resident/patient prefers, clean urinals may be kept within reach of resident/patient.
   d. Oral hygiene equipment, bedpans or urinals are changed as needed.

2. **Combs and brushes** are to have hair removed and are to be cleaned as needed and replaced when broken or worn.

3. **Resident's/Patient's area** is to be kept orderly and clean including:

   a. Overbed tables are wiped off with facility-approved disinfectant after use during bathing or incontinence care and as needed, and weekly as part of bed stripping and room cleaning.
   b. Spills or unclean floors are brought to the attention of EVS staff. Nursing shall clean the spill, then EVS shall mop and disinfect spill area.
   c. Resident/patient preference to keep their private area cluttered with belongings is to be negotiated with sensitivity to the resident's/patient's feelings about the loss of their usual environment with RCT assistance as needed. Allowing for personal preferences in a way that does not impede safety and infection control is preferable to restricting residents/patients unnecessarily, for example:

      i. Provide containers for non-perishable food.
      ii. Offer regular snacks and provide a realistic means for able residents/patients to obtain nutritious snacks independently.
      iii. Offer assistance in tidying up with the resident/patient/family/responsible party.
      iv. Offer assistance in prioritizing items if resident/patient feels strongly about having items at the bedside versus those that can be stored in the wardrobe or sent home.
      v. Communicate regularly with residents/patients regarding which items they value so that items are not inadvertently discarded as trash.

vi. Unsafe or prohibited items such as spoiled food, drug paraphernalia, or weapons are **not** permitted and related policies are to be followed, (i.e. Infection Control, STAT notification of Institutional Police, and Prohibition of Illicit Drugs or Paraphernalia Possession / Use by Residents or Patients / Visitors.)

4. Resident's/patient's **personal clothing** is laundered per facility ~~red in the neighborhood or on site~~. See Cross References to Nurse Guidelines and Facility Services Equipment Management Program.

5. **Linen** and other **personal care items** are not to be brought to another resident's/patient's area once such items are brought into a resident's/patient's room.

   a. The linen is to be handled with appropriate infection control precautions including keeping the clean linen room door closed, hand washing before handling clean linen and discarding contaminated linen in the hamper.
   b. The soiled linen hamper is to be covered at all times and is to be emptied before it is more than ¾ full or when it is malodorous.
   ~~c.~~ Linens carts are distributed to each neighborhood by laundry staff once a day.
   d. Gather supplies needed for each resident/patient prior to beginning care.

E. Instrumental Activities of Daily Living (IADLs)

1. IADLs include activities that occur in addition to basic hygiene and grooming procedures and include activities of choice, use of the telephone, and other functions that are usually done at home and the community, such as housework, shopping, and meal preparation.

2. Nursing collaborates with other disciplines, such as Activity Therapy, Occupational Therapy, and Social Services, to support IADLs and to specifically plan and provide activities that are interesting and satisfying to individual residents/patients.

3. IADL programming that specifically supports resident/patient comfort and hygiene and may be provided in whole or in part by nursing may include:

   a. Manicures
   b. Make-up application
   c. Walking, including walk to dine programs
   d. Exercise programs
   e. Practice folding garments or linen
   f. Grooming activities
   g. Off neighborhood visits, strolls, and activities

F. Reporting and/or Documentation

1. **Electronic Health Record (EHR):)**
   CNA or PCA: Record level of function for each ADL. Report any physical or behavioral changes to the charge nurse and document.

2. Licensed nurse: Record and report any changes in condition to physician, supervisor, family and charge nurse of oncoming shift. Review resident/patient ADLs and additional entries and document resident/patient status on the weekly summary, as directed by the documentation policy.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policy and Procedure
22-03 Resident Rights

Nursing Policy and Procedure
B 5.0 Color Codes –Resident Identification
B 6.0 Items Allowed at the Bedside
C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
C 3.2 Documentation of Resident Care Nursing Assistant
E 1.0 Oral Management of Nutritional Needs
Section F: Elimination Procedures

Facility Services Policy and Procedure
EM-6 Laundry Equipment Repairs and Clean Up

Revised: 2005/12, 2006/01, 2009/09, 2010/04, 2016/07, 2019/03/12; 2022/11/08; 2023/04/11

Reviewed: 2023/04/11

Approved: 2023/04/11

TUB BATHS AND SHOWERS

POLICY:

1. Licensed Nurse in collaboration with the Nursing Assistant, and if appropriate Rehabilitation Staff, and/or Resident Care Team (~~RCT) are~~RCT) are responsible for assessing, planning, meeting bathing needs, and accommodating preferences of residents.

2. Bathing includes nail care, hair care, shaving, and cleansing of skin surfaces.

3. Bathing alternatives will be offered if resident finds a tub bath or shower distressing or unacceptable.

4. A resident who requires assistance shall not be left unattended for safety reasons.

5. Nursing staff are responsible for cleaning and disinfecting the shower chair and tub. All care equipment used for bathing are cleaned and disinfected after each resident's use.

PURPOSE:

To meet resident's hygiene needs.

PROCEDURE:

A. Preparation

1. Gather all equipment prior to bathing the resident.

2. Check with the Licensed Nurse for any preparation needs.

~~2.~~3. **Preparation of Resident/Patient –** The resident's care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's dignity, privacy, safety and confidentiality

B. Bathing the Resident using the Tub

1. Use appropriate transfer technique per resident ~~Front Card RCP~~care plan.

2. Resident has a preference to use a regular tub or portable tub. For guidelines using these tubs, please refer to:

   a. Attachment 1: Operating and Cleaning of Tub (Arjo Parker Tub), or
   b. Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)

3. Refer to NPP D 6 1.1 Battery-Operated Lift Transfer and LHHPP 24-19 The C-625 Battery-Operated Ceiling Lift. Slings used for bathing are labeled per individual resident.

4. Follow recommendations for bathing in the resident care plan~~RCP~~.

5. If the resident has a bowel movement in the tub, take resident out of the tub. Put the resident in a wheelchair or commode chair for cleaning; and cover the resident to keep warm.

a. Remove feces and deposit in the toilet if possible.
b. Disinfect the tub with facility approved cleaning agent. Follow directions.
c. Refill the tub with water and check the temperature.
d. Return the resident to the tub and continue with the bath.

D. Bathing Resident using the Shower

1. Shower can be provided to a resident using an appropriate shower chair based on function and resident preference. For guidelines using these shower chairs, please refer to:

   a. Attachment 3: Operating and Cleaning of Shower Chair Commode
   b. Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair

2. Use appropriate transfer technique per resident ~~Front Card RCP~~care plan.

3. Resident who is independent in showering:

   a. Teach resident about safety precautions such as having all necessary materials within reach, applying all brakes to shower chair if used, and to test water temperature prior to showering.
   b. Instruct resident to call for assistance using nurse call system when needed.
   c. Periodically check resident for any assistance needed.

E. Grooming

1. Gently apply lotion on resident's back, legs, and feet.

2. Dress resident or assist with dressing as needed.

3. Clip toenails straight across and shape fingernails. Refer to NPP D5 1.0 Foot Care.

4. Comb hair. Handle hair gently when combing, brushing, or styling to avoid damage.

5. Assist the resident to shave facial hair.

6. Apply makeup with resident's consent according to ~~her~~ their preference.

F. Reporting / Documentation

1. Report any abnormal skin changes or any discomfort shall be reported to the Licensed Nurses and documented in the medical record.

2. Bathing preferences and needs are indicated in the Care ~~Plan of~~Plan of the electronic health ~~recordand~~record ~~and are included as a care plan problem as needed~~.

G. Environmental Infection Control

1. Refer to Infection Control Manual

2. The nursing staff are responsible for cleaning and disinfecting the shower chair and tub.

~~3. Wash nail clippers and soak in approved germicide before using for another resident.~~

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-19 The C-625 Battery Operated Ceiling Lift

Nursing Policy and Procedure
D5 1.0 Foot Care
D6 1.1 Battery Operated Lift Transfer
D2 2.0 Bathing Alternative and Bed Baths

ATTACHMENTS/APPENDICES:

Attachment 1: Operating and Cleaning of Tub (Arjo Portable Tub)
Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)
Attachment 3: Operating and Cleaning of Shower Chair Commode
Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair
Attachment 5: Shower Tilt Chairs (Combi Tilt Chairs)

Revised: 8/2002, 2/2010; 05/12/2015; 2016/09/13; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

ATTACHMENT 3 - SHOWER CHAIR COMMODE

A. Operating Guidelines

1. As part of orientation, the competency of all bedside nursing staff to use shower chair commode is validated; and annually thereafter as part of their performance appraisal.

2. The shower chair commode is a portable and comfortable shower and hygiene aid designed for residents with limited mobility.

3. Prior to a resident's use of the shower chair commode, nursing staff must assess and ensure that the resident fits the following criteria in order to provide resident safety :

   a. Weight does not exceed 250 lbs.,
   b. Has good trunk control and does not lean sideways or forward,
   c. Does not exhibit involuntary movements,
   d. Is not restless and is able to follow directions,
   e. Resident care plan states that the resident prefers and may use the shower chair commode for bathing.

B. Operating Shower Chair Commode

1. Before each use of the shower chair commode, nursing staff must:

   a. Check the seat cushion to ensure that it is properly installed and firmly clipped to the back of the seat frame to prevent the seat from slipping forward.
   b. Check the side knobs to ensure that they are tightly screwed to the seat frame to prevent the seat belt from disengaging.

2. Transfer and transport of resident:

   a. When transferring a resident in and out of the shower chair commode, lock all four wheels on shower chair by depressing each of the red foot pedals located on all four wheels.
   b. Resident may transfer in and out of the shower chair via E-Z lift, ceiling lift, or transfer from chair to shower chair.
   c. Apply and adjust the seat belt according to resident size and comfort, ensure that the belt snaps on and the resident is not leaning forward.
   d. For resident privacy and dignity, ensure the resident is properly clothed / covered during transport.

3. Shower

   a. Park the shower chair commode by locking its wheels to prevent shower chair from rolling away.
   b. Do not leave resident unattended while in the shower chair.
   c. Continually monitor resident to ensure safety.

C. Cleaning and Disinfecting of Shower Chair Commode

1. The shower chair commode must be cleaned after each use with the facility approved disinfectant.

D. Maintenance

1. CNA/PCA/HHA to inform licensed nurse if the shower chair commode is broken.

2. Licensed Nurse will call Plant Services for any repair or services as needed.

3. The Licensed Nurse may also submit a “work order web request” by clicking “Plant Services Work Request” on the Laguna Honda Intranet. An email alert will be sent on change of status.

REFERENCES:

Aquatec Manual

Adopted from D2 4.7 created on 10/2010

Revised: 05/12/2015

Reviewed: 05/12/2015

Approved: 05/12/2015

ARM SLING

POLICY:

1. The Licensed Nurse (LN) shall collaborate with Rehabilitation Services and Physician to determine what the type of sling is to be used. Physician will determine duration of use.

2. Any member of the nursing staff (RN, LN, CNA, or PCA) may apply a sling as ordered.

3. Each sling will be individually labeled with the resident's name.

PURPOSE:

To provide proper use and care of an arm sling.

PROCEDURE:

A. General

1. Obtain from either Occupational Therapy Department (OT) or Central Purchasing Department (CPD)~~Supply Room (CSR)~~ the prescribed sling.

2. Follow ~~rehab~~ Rehabilitation Services staff or manufacturer's instructions for proper application, use, and maintenance, including replacement, of an arm sling.

3. Perform daily skin checks and as needed.

B. Documentation

1. Licensed Nurse documents in the ~~Interdisciplinary Progress Notes~~electronic health record for any abnormal findings and non-adherence to treatment.

2. CNA or PCA documents use of sling in the ~~DNCR~~electronic health record.

REFERENCES:

Sling Application: Performing. Smith, N. and Kornusky, J. authors. Cinahl information Systems, a division of EBSCO Information Services; 2013 – electronic access on March 18, 2014.

Sorrentino and Remmert, Mosby's Textbook for Nursing Assistants, 8th edition, 2012

Revised: 8/2000, 2/2010, 05/27/2014; 07/14/2015

Reviewed: 07/14/2015

Approved: 07/14/2015

BATTERY OPERATED LIFT TRANSFER

POLICY:

1. The licensed nurse or designee will assess each resident to be transferred by the EZ Lift to determine the most appropriate material, style and size of sling. The results of their assessment will be entered on electronic health record (EHR).

2. Two nursing staff members are always required for operation of the EZ Lift.

3. Residents will be reassessed for appropriate slings after a change of condition including but not limited to ability to control the head, an amputation, leg sores, significant weight change, difficulty or refusal to follow directions.

4. For residents with aggressive behavior, lacking the ability to follow directions, or whenever otherwise clinically indicated, additional nursing staff will assist with lift transfer (see also #2).

5. Each resident will have his/her own sling(s) which will be identified with his/her name.

6. All nursing staff will receive training and demonstrate competency in the safe use of the equipment prior to transferring a resident at a minimum during new employee orientation and annually thereafter.

7. EZ Lift slings should only be used for the EZ Lift.

PURPOSE:

To provide safe transfers.

PROCEDURE:

A. The licensed nurse or designee will assess each resident prior to the first transfer and reassess as needed to determine the most appropriate sling for the battery operated lift.

1. Resident factors to be considered regarding type of sling:

    a. Resident’s weight
    b. Resident’s measurements:
        i. Length of Trunk: maximum distance 2 inches from resident’s tailbone to base of neck.
        ii. Resident’s girth / width of shoulders – resident’s body should not overlap the sides of the sling
    c. The resident’s ability to support and control his/her head
    d. If the resident has an amputation(s) above the knee or contractures
    e. If the resident has large fleshy thighs or delicate skin or sores on the legs
    f. Difficulty or refusal to follow directions

2. Determining type of sling ~~(See Attachment 1b: EZ Way Sling Sizing Chart)~~

    a. Regular
        i. Without padded legs
        ii. Made of canvas or mesh for bathing and quick drying
    b. Deluxe (standard)
        i. Have padded legs for comfort and support

ii. Made of canvas

c. Multi-purpose

i. Made of canvas with padded legs or mesh

ii. Use for persons with –

- Lower body contractures
- With amputation
- Large fleshy thighs
- Delicate skin

iii. Special Head Support slings are available on special order for residents with weak head control

~~3.~~ Determining the sling size

~~a.~~d. ~~Select size of sling based on:~~ (Refer to~~See~~ Attachment 1a & b: EZ Way Sling Sizing Chart):

~~i. Weight of the resident, and/or~~

~~ii. Measurement from maximum distance from resident's tailbone to base of neck (see attachment 1). ***Not applicable with belted mesh or multipurpose slings*~~

~~iii. When determining the appropriate sling size, based on resident's measurement, it is important to evaluate the width of the resident's shoulder in relation to the width of the sling and no portion of the resident's body should overlap the sides of the sling.~~

~~*Note: The size/weight designations stated by the manufacturer are merely estimates and basic guidelines. A proper and safe fit will depend on factors in addition to weight measurement including the height and girth of a resident.~~

~~b. How to measure resident:~~

~~i. The base of the sling must be positioned 2 inches below the tailbone and top of the sling parallel with the top of the shoulder (base of neck). See attachment 1.~~

B. Documentation

1. Care Plan

a. Document the type of transfer technique used.

~~2. EZ Lift Sling Assessment Form (See Attachment 1a: EZ Lift Assessment Form)~~

~~a. Complete prior to use of sling and EZ lift and include in RCP.~~

~~b. Licensed Nurse to update any sling changes based on significant change in resident's condition (Refer to Procedure A: Section 1 "Resident factors to be considered when selecting a sling").~~

C. Prior to transfer

1. Check the resident's care plan.

2. Inspect the lift for damage and the sling for fraying or other signs of wear.

3. Identify the resident's sling by name and check style and size using the information in the resident's care plan.

4. Prepare the surface the resident is being transferred to and lock all the wheelchair gurney brakes.

5. Positioning the sling:

a. Position sling under the resident with the handles facing outward from the resident's skin.

b. Check that the resident is centered on the sling:
    i. The sling wraps around the shoulders like a shawl.
    ii. Is not more than 3 inches below the coccyx.
    iii. The resident will not be sitting on the sling.
    iv. The resident's body and arms fit and remain in the sling during transfer.

c. Lift the resident's left thigh; and pull the left wing of the sling under the thigh. Then place it on top of the left thigh. Repeat for the other leg. You may choose to do the right leg first, using the right wing and placing it over the right thigh.

6. Positioning the lift:

    a. Wheel must be unlocked during the transfer.
    b. Position the green nosecone 2 inches above the abdomen.

7. Attaching the Regular and Deluxe Sling to the lift:

    a. First attach the two shortest loops at the shoulders. (The other loops are used to move from a reclining position to a reclining position).
    b. Take the wing lying on the left thigh and using the middle loop attaches it to the right lift hook. Repeat for the other leg. You may choose to do the right leg first attaching the loop to the left lift hook.

8. Attaching the Multipurpose Sling to the lift:

    a. Check that the center of the commode hole is one inch below the tailbone.
    b. The wings of the sling are threaded through each other.
    c. The middle or longest loop may be used depending upon the resident's comfort and sense of comfort.

9. Moving the resident to the chair:

    a. Ensure that the resident's arms are in the sling.
    b. Push the "Up button" on the hand control.
    c. Once there is tension and the resident is 1 inch off the mattress:
        i. Check that loops are secure in the hooks
        ii. The sling is smooth under the resident
    d. Move the lift to the chair and standing behind the chair use the handles to guide the resident.
    e. Push the "down" button.

10. Emergency Lowering:

    a. If the hand held controls or the controls on the lift fail:
        i. Pull up on the emergency button 1-3 times
        ii. Pull up on the emergency lowering handle until the resident is placed on the desired surface.

REFERENCES:

EZ Lift Operating Instructions [Manufacturers Manual]. (2005). Clarinda, IA: EZ Way, Inc.

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Nursing P&P D6 2.0 Transfer Techniques
Nursing P&P D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

Attachment 1a: EZ Lift Sling Assessment Form
Attachment 1b: EZ Way Sling Sizing Chart
Attachment 2: EZ Lift Operating Instructions
~~Attachment 3: Competency Check List for Battery-Operated Lift~~

Revised: 2008/01, 2010/04, 2010/06, 2010/08, 2011/02/14; 2014/07/22; 2016/09/23; 2019/09/10

Reviewed: 2019/09/10

Approved: 2019/09/10

TRANSFER TECHNIQUES

POLICY:

1. The Licensed Nurse and/or Rehab staff assesses the resident's ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. All residents who require battery-operated lift transfer must have their own assigned sling for transfer and bathing. Each sling must have resident's name and room number.

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. Any member of nursing staff (LN, CNA, or PCA) may perform transfer procedure. Check care plan for required number of staff assistance during transfer.

PURPOSE:

To ensure resident's and staff's safety when moving the resident from one surface to another.

PROCEDURE:

A. Prior to Transfer

Review ~~Front Card of Resident Care Plan~~care plan prior to transfer of resident

B. Transfer Techniques

1. **Slide Transfer Technique** (Gurney to Bed and Vice Versa)

   a. Place the gurney parallel to the bed.
   b. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.
   c. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.
   d. Set all brakes on all equipment in a "locked" position after the equipment is positioned. Lock all bed brakes.
   e. Use a draw sheet or slider sheet to assist with transfer.
   f. Always have drainage bags lower than the area being drained.

2. **Pivot transfer Technique**

   a. At the time of transfer, resident should have shoes and socks on.
   b. Position wheelchair or chair at head of bed, parallel to the bed. If the resident has one non-functioning upper or lower extremity, place the chair on the resident's unaffected side.
   c. Lock all bed and wheelchair brakes and fold wheelchair footrests back.
   d. Adjust height of the bed to what is appropriate for the resident.
   e. Help the resident sit on the side of the bed with feet touching the floor.
   f. Use a gait belt as needed.
   g. If transferring resident without the gait belt, support the resident by placing your hands under the arms and around the shoulder blades of the resident.

h. During transfer, block resident's feet and knees with your feet and knees to prevent falling.

3. Sliding Board Transfer Technique

a. Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.
b. Lower the bed to the same height as the seat of the chair or wheelchair.
c. Assist the resident in a seated position.
d. Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.
e. Slide the resident along the board to reach the chair.
f. Lock all bed and wheelchair brakes and fold wheelchair footrests back.

4. **Transfer Techniques using Mechanical Lift** (Refer to NPP D6 1.1 Battery Operated Lift Transfer and NPP D6 1.4 Battery Operated Ceiling Lift)

C. Reporting and/or Documentation

1. Reporting

All care team will communicate to the physician and rehab staff when further transferring training is warranted.

2. Documentation

a. Electronic Health Record (EHR)

i. The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer.
ii. The Licensed Nurse documents on weekly ~~or monthly~~ summary any change in functional level.

b. Care Plan

i. The Licensed Nurse documents in the Care Plan the type and level of assistance needed for transfer.
ii. All residents who require battery-operated lift transfer must be documented on the Care Plan indicating what type of lift is used, type and size of slings used, and number of persons required to assist in transfer.
iii. For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry.

REFERENCES:

Transfer of Patient, Manual: Bed to Chair/Commode or Gurney. 2013. Smith, N. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 – electronic access on February 14, 2014

Transfer of Patient: Use of Assistive Devices. 2013. Smith, N. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 –electronic access on February 14, 2014

CROSS REFERENCES:

Hospitalwide Policy and Procedure

24-19 The C-625 Battery Operated Ceiling Lift Nursing

Nurisng Policy and Procedure

D1 1.0 Restorative Nursing Program
D6 1.1 Battery Operated Lift Transfer Nursing
D6 1.4 Battery Operated Ceiling Lift
D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

None

Revised: 2000/08, 2008/01, 2014/07/22, 2016/09/13, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

AMBULATION

POLICY:

1. The Registered Nurse assesses the resident's ability to ambulate and need for adaptive devices in collaboration with resident care team upon admission and any change of condition.

2. Any member of the nursing staff except Home Health Aides (HHA) may ambulate resident as indicated on the resident's plan of care.

PURPOSE:

To prevent complications of immobility & deconditioning.

PROCEDURE:

A. Assessment

1. Upon completion of the initial & on-going assessment the RN will communicate to the care team members regarding the resident's ambulation needs and assistive/adaptive devices required.

2. See Restorative Policy and Procedure (NPP D1.0)

B. Documentation

1. Resident Care Plan

   a. Include ambulation needs, devices, and preferences on the Resident Care Plan.

2. Electronic Health Record

   a. At minimum, include documentation addressing declines from baseline when ambulation is ~~written only on the front card and~~ not part of a restorative program.

REFERENCES:

CMS Long -Term Care Resident Assessment User's Manual (2007)

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policy and Procedure
23-01 Resident Care Plan (RCP), Resident Care Team (RCT), ~~and~~ & Resident Care Conference (RCC)

Nursing Policy and Procedure

- C1.0 Resident Admission and Readmission Procedures for Skilled Nursing Facility
- C1.2 ~~Nursing Guidelines for~~ Relocation between Laguna Honda SNF Neighborhoods
- C1.3 Discharge Procedure to Acute
- C3.0 Documentation of Resident Care/Status by the Licensed Nurse
- C3.2~~1~~ Documentation of Resident Care by the Nursing Assistant
- D1.0 Restorative Nursing ~~Programs~~Care
- D5 2.0 Limb Care Following Amputation
- D5 5.0 Application and Management of Braces

Revised: 2004/12; 2008/01; 2014/03/25; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

BED MAKING

POLICY:

1. Any nursing staff including Home Health Aides (HHA) may make the resident's bed.

2. Beds will be routinely stripped and wiped and all linens changed once a week as scheduled by the neighborhood.

3. Linen change is performed daily and as needed for residents who are total bed rest and incontinent,.

4. Gloves will be worn to remove linen soiled with body secretions.

PURPOSE:

To provide the resident with a clean bed.

EQUIPMENT:

2 large sheets (1 fitted, 1 flat)
1 linen draw sheet
1 bed pad
1-2 pillow cases
1 bed spread
Facility-approved disinfectant wipes
Dirty linen hamper

PROCEDURE:

Standard bed:

1. Change wet, damp and soiled linens right away (Refer to Bed Stripping Policy).

2. Bring only the linens needed.

3. Raise bed to a comfortable working height and keep bed flat.

4. Reposition bed as needed to ensure proper body mechanics.

5. Maintain proper body mechanics at all times.

6. Follow Standard Precautions.

7. Place clean linens on a clean surface

8. Place fitted sheet on mattress, applying one side of the bed first, then folding over to the other side to cover mattress pad.

9. Apply open draw sheet on top of fitted sheet using same procedure as fitted sheet. Tuck both sides of draw sheet under mattress.

10. Apply flat sheet on top of fitted sheet and draw sheet using same procedure as fitted sheet.

11. Place blanket on the bed. Tuck in top linens together at foot of bed and make a mitered corner.

12. Straighten all top linen.

13. Apply pillow case to pillow(s) and place pillow(s) on bed.

14. Straighten loose sheets, blankets and bed spreads.

15. Keep bed at low position, return bed to desired position and lock all wheels when done.

16. Immediately report defective equipment to the nurse manager/charge nurse who will order a replacement or submit a work order to Facility Services by telephone or online.

Low Air Loss Mattress

1. Use 1 draw sheet or 1 ultrasorb only
2.
1.3. No fitted sheet

CROSS REFERENCE:

Nursing Policy and Procedure
D9 3.0 Bed Stripping and Bedside Cleaning

REFERENCE:

Bedmaking, Unoccupied. 2014. Beddoe, A. and Caple, C. authors. CINHAL Information System, a division of EBSCO Information Services, 2014 –electronic access on June 6, 2014.

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

Revised: 2000/08; 2010/04; 2014/09/09; 2019/03/12

Review: 2019/03/12

Approved: 2019/03/12

WATER PITCHERS

POLICY:

1. Water pitchers with liners are provided to all residents unless contraindicated.

2. Water pitchers are to be labeled with the resident's initials and date changed.

3. Water pitchers and water pitcher liners are changed weekly and as needed.

PURPOSE:

To provide fresh water and clean drinking supplies for the resident.

PROCEDURE:

1. Equipment:

   Water pitcher with lid
   Water pitcher liner
   Straws
   Disposable drinking cups

2. Wash hands before beginning to replace new liners and pitchers.

3. Replenish water pitcher every shift and as often as necessary. Consider resident's preference when refilling water.

4. Change disposable drinking cups or straws as needed.

5. Discard and replace broken water pitchers and liners.

Revised: 2001/03; 2006/03; 2006/09; 2009/09; 2014/09/14; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

ASSISTANCE WITH ELIMINATION

POLICY:

1. All nursing staff, including Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA), except Home Health Aide (HHA), may assist residents with elimination needs.

2. Residents who require assistance with toileting will be supervised when using the bathroom and/or commode.

3. Perineal care is provided to all residents who are incontinent and unable to perform toileting self care.

4. Each bedpan or urinal will be labeled with the resident's last name and first name initial.

PURPOSE:

1. The resident will be clean, dry, comfortable and odor-free.

2. Assistance with elimination will be provided in a manner that conveys respect, promotes dignity, functional independence, and safety.

PROCEDURE:

A. Assistance with Toileting

1. Refer to current reference text for Nursing Assistants for procedural information about use of bedpan, commode and urinal.
2.
~~1.~~3. Privacy shall be maintained during toileting whether in resident patient rooms, or while in tub, shower and toilet rooms.

~~2.~~4. Bedpans, urinals, and bedside commodes are emptied into toilet and cleaned when soiled and replaced when needed. A urinal may be kept within the resident's reach.

~~3.~~5. See Cross-References below for nursing-related procedures with management of incontinence and restorative programs.

B. Documentation

1. The CNA or PCA documents elimination in the electronic health record (EHR).

2. The licensed nurse (LN) documents any unusual physical or behavioral observations related to elimination. Interventions implemented to address these will be included in the EHR progress notes.

3. The LN records resident specific elimination interventions for the CNA or PCA to implement on the health record.

4. The LN documents the effectiveness of the resident care plan in meeting elimination needs in the Resident Care Plan.

REFERENCES:

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

Nursing Policy and Procedure
- D1.0 Restorative Nursing Program
- F2.0 Assessment and Management of Urinary Incontinence
- F3.0 Assessment and Management of Bowel Function

Revised: 2000/08; 2005/03; 2008/09; 2010/10; 2014/07/22; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

MEASURING THE RESIDENT'S HEIGHT ~~& WEIGHT~~

POLICY:

1. Licensed Nurses, Patient Care Assistants, and Certified Nursing Assistants may measure resident's height.

2. Residents' height is measured on admission, annually, and as indicated.

PURPOSE:

To obtain accurate height measurements of the resident to facilitate effective care planning.

PROCEDURES:

A. Measuring and Recording the Height:

1. If resident is able to stand, resident is instructed to stand against the wall with feet flat on the floor and height is measured using tape measure.

2. To measure the height of a resident, who is unable to stand**,** assist the resident to lie flat on his/her back on a firm mattress or gurney. Determine the height in inches using a tape measure from the crown of the head to the soles of the feet.

3. To estimate the height of a resident who is contracted or bedridden, use one of the formulas in Appendix 1.

4. The height is recorded on the Nursing Admission Assessment form, in the MDS, and electronic health record.

APPENDIX 1:

Height Measurement Guidelines for Bedridden Residents or Residents with Contractures

REFERENCES:

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

Long-Term Care Resident Assessment User's Manual, October 2018 Edition

Revised: 20018/01, 2010/03, 2012/01/31; 2019/03/12

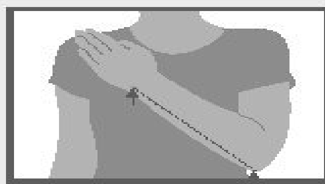
Reviewed: 2019/03/12

Approved: 2019/03/12

APPENDIX 1: Height Measurement Guidelines for Bedridden Resident or Resident with Contracture

A. FOREARM LENGTH

Estimating height from ulna length



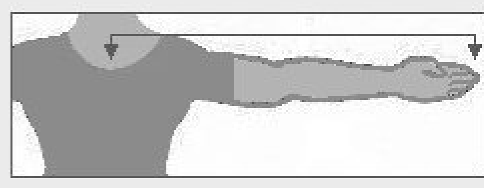
Measure between the point of the elbow and the midpoint of the prominent bone of the wrist (left side if possible). Height in meters is determined from the following chart, based on the ulna length as measured in cm.

Men(<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
Men(>65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
Ulna length(cm)	32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
Women(<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
Women(>65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63

Men(<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
Men(>65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
Ulna length(cm)	25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
Women(<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
Women(>65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

B. DEMISPAN

Estimating height from demispan



Measure the distance from the middle of the sternal notch to the tip of the middle finger (left arm if possible). Check that patient's arm is horizontal and in line with shoulders. Calculate stature (in cm) from the formula below:

Females
  Height in cm = (1.35 x demispan (cm)) + 60.1
Males
  Height in cm = (1.40 x demispan (cm)) + 57.8

REFERENCE:

Estimating Height in Bedridden Patient
Accessed August 8, 2011, http://www.rxkinetics.com/height_estimate.html

NEW: 2012/01/31

Reviewed: 2012/01/31, 2019/03/12

Approved: 2019/03/12

BLOOD GLUCOSE MONITORING

POLICY:

1. A bar code scanner is used to enter patient ID and/or operator ID in the facility-approved glucometer machine.

2. Physician order indicates hypoglycemic value to treat hypoglycemia and hyperglycemic value for which requires physician notification.

3. Hypoglycemia is considered <70mg/dL, and hyperglycemia is considered >400mg/dL, unless otherwise specified in order. Whenever blood glucose values change from the resident's usual range, or the blood glucose value is not consistent with resident condition, the nurse is to repeat the test, assess for symptoms of hypoglycemia or hyperglycemia, treat according to order and inform the physician STAT.

4. Glucometer machine is cleaned after each use and in between patient with facility-approved disinfectant wipes for the glucometer.

5. Daily quality control (QC) test with low and high glucose solutions will be performed daily by LN on AM shift.

6. LN will perform a QC:
   a. If a test strip vial has been left opened.
   b. Anytime a LN wants to test the performance of the meter.
   c. Each time a new vial of tests strips is opened.

7. Quality control tests that fall outside of designated parameters are reported to Point of Care Services.

8. The Point of Care Coordinator or designee coordinates any updates or changes to the initial setup of the facility-approved glucometer machine, lot number management, and manages software upgrades .

9. The Point of Care Coordinator or designee is responsible for coordinating facility-approved glucometer machine quality management tracking and reporting.

10. AC (Meal time) blood glucose checks should be taken no more than 30 minutes before meal.

11. Insulin being administrated prior to meal:

    a. Regular insulin should be given no more than 30 minutes before meal unless otherwise specified
    b. Rapid Insulin (Lispro /Humalog and Aspart/Novolog) should be given no more than 15 minutes before or immediately after a meal.

12. If fasting blood glucose check is missed and taken instead after resident has already eaten, and the order was to check blood glucose pre meal (AC), do not give rapid insulin (Lispro/Humalog, Aspart/Novolog), regular insulin or intermediate(NPH) acting insulin per the scale. Notify physician.

13. Long acting insulin is not held unless patient is hypoglycemic. After treatment per protocol and BG ≥100, it can be given unless there is an order to hold by physician.

14. All licensed nurses including nursing operation, unit mangers, MDS coordinators, DET and CNS will complete an annual competency review of Point of Care blood glucose testing. Newly hired LN's will complete the competency at time of hire, 6 months after, then annually.

15. Meter should be placed on docking station after use and when not in use.

PURPOSE:

1. To accurately monitor blood glucose levels using facility-approved glucometer machine.

2. To initiate appropriate nursing intervention when blood glucose levels are not within normal range. Refer to medication orders for treatment of hypoglycemia and hyperglycemia.

PROCEDURE:

A. Equipment:

Refer to the facility-approved glucometer machine user's manual for the following procedures:

1. Patient Preparation
2. Coding (Calibration)
3. Patient Testing
4. Quality Control Testing
5. Facility approved disinfectant wipes for the glucometer for infection prevention
6. Instrument Care/Maintenance
7. Linearity (performed by Point of Care Coordinator or designee)
8. Troubleshooting

B. Blood Glucose Check

1. Test strip
   a. Test strips are available through the Central Processing Distribution (CPD).
   b. Test strips must be stored at room temperature. Test strips are stored in the same tightly capped vial in which they are packaged. The vial cap is immediately replaced after removal of a test strip. Test strips are stable until the expiration date on the vial. Outdated test strips are discarded. The entire test strip vial should be used prior to opening a new vial, even if the barcode number is the same.
   c. The test strip code displayed by the facility-approved glucometer machine must match the code of the test strips in use.
   d. Test strip code information must be verified in the facility-approved glucometer machine by the operator whenever a patient or quality control test is performed.

2. Proper infection control procedures are followed when using the facility-approved glucometer machine and testing with blood glucose monitoring equipment.
   a. Glucometer machine is cleaned after each use and in between patient with facility-approved disinfectant wipes (such as Super Sani-Cloth Germicidal Disposable Wipes® or Clorox Germicidal Wipes®) for the glucometer. Adhere to the contact time per manufacture's recommendation
      i. Use a damp wipe to clean entire machine. Never drench machine with cleaning solution.
      ii. Allow to dry for 1 minute in order to disinfect machine.
      iii. Verify that the meter is dry and there is no solution left on the meter. If meter is still wet use gauze to thoroughly dry the glucometer after cleaning and disinfecting.
      iv. Disinfectant wipes are available from CPD.

3. If the meter is not functioning properly:
   a. Consult the "Trouble Shooting" section of the User's Manual.
   b. For problems that cannot be resolved, contact POCS.
   c. Meters that are not functioning properly will be exchanged through POCS.

4. The most recent facility-approved glucometer machine available on each neighborhood is referenced for procedural information.

5. When preparing a resident for discharge, glucose monitoring teaching must be done using the type of device that the resident will be using when discharged.

C. **Hypoglycemia**:

For blood glucose less than 70 mg/dL or for value identified by physician order, treat with 8 oz of juice orally if resident is able to take PO or if resident has G tube, via G tube. Recheck BG in 15 minutes. Repeat treatment and fingerstick every 15 minutes until blood glucose is greater than or equal to 100 mg/dL.

   a. Notify physician if resident does not respond to treatment or condition worsens.

D. Documentation

1. Check mark date column on the emergency equipment checklist to indicate quality control tests on the glucometer were done.

2. Guidelines for Hypoglycemia Documentation:
   (1) Dock the meter after use to upload blood glucose values into EHR.

   (2) Hypoglycemia event should be documented in Hypoglycemia flowsheet in the EHR.
      (a) Additional actions can be documented in progress notes

   (3) Review and/or update care plan with individualized goals and interventions.

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins
http://www.accu-chekinformii.com/pdf/05234654001_ACI2_QRG_forWEB.pdf

Reviewed: 2002/08, 2010/03, 2010/10 2014/03/25, 2016/09/13, 2017/03/14; 2019/05/14; 2020/03/17

Revised: 2020/03/17

Approved: 2020/03/17

MANAGEMENT OF RESIDENTS ON HEMODIALYSIS

POLICY:

1. A physician's order by a LHH physician or a nephrologist is required for hemodialysis and related lab work, diet orders, and medications.

2. All residents on hemodialysis are weighed daily (or per provider order) at the same time each day, on the same scale with the same amount of clothing.

3. Coordination of nursing care for the resident undergoing hemodialysis is the joint responsibility of the LHH licensed nurse (LN) and the hemodialysis nurse.

4. Nursing interventions for pre and post hemodialysis care are care planned. The dialysis center phone numbers for routine and emergency consultation are listed in the care plan.

5. The licensed nurse will communicate to the dialysis nurse any clinically relevant change in the resident's condition via dialysis communication progress note in EPIC.

6. Dialysis catheters are NEVER used for blood draws or IV hydration, unless ordered by physician during life threatening situations.

7. The licensed nurse will monitor the AV shunt and fistula for audible bruit and palpable thrill every shift and report absence of bruit and/or thrill to the LHH physician.

8. Dialysis schedule may be adjusted based on clinic visits or planned surgical procedures. Consult with physician and team.

PURPOSE:

To coordinate care of residents receiving hemodialysis treatment at an outside agency location through collaboration with the dialysis agency, its nephrologists, the Laguna Honda Hospital ward physician and nursing staff.

PROCEDURE:

A. Care Before Dialysis

1. LHH staff prepare resident for transport to dialysis treatment.
   a. Notify physician and dialysis nurse prior to transporting if resident has symptoms of acute illness.
      ~~b.~~i. The team may decide that transporting to the clinic is still necessary, but precaution such as a patient mask, may be indicated. For cases of contagious illness – such as the flu or COVID, notification/consultation with the infection control nurse ~~is~~ may also be appropriate to contain the spread of infection.
   ~~c.~~b. Vital signs prior to sending resident to dialysis.

2. Consult with the pharmacist and/or physician regarding timing of anti-diabetic medications and water soluble medications as needed.

3. Report any change in the resident's physical and emotional status or any new physician's orders to the dialysis nurse or technician. Send the primary physician's phone number and pager

4. If the resident is unable to eat during dialysis and missed a meal, arrange for a tray to be served ~~later/~~ on return from dialysis facility. Send a bag meal with the resident when indicated.

5. Securely fax or route via EHR the Dialysis Communication Note to the dialysis center for any pertinent information that the dialysis center needs regarding current condition of the resident.

B. Care Immediately After Dialysis

1. The LN reviews the Dialysis Communication Note received from dialysis center for any changes in condition of the resident post-dialysis. For residents who receive dialysis at ZSFG, information can be found in the EHR.

2. The LN documents in the EHR any clinically relevant communication that is sent/faxed/obtained between LHH and the dialysis center.

3. The LN notifies the LHH physician immediately of changes in dialysis venous access device patency and laboratory values outside acceptable ranges for the resident. Consultation with the dialysis clinic nurse or physician is done as needed.

4. The LN receives a resident status report from the dialysis nurse to include:
   a. dry weight from dialysis
   b. fluid status/balance
   c. vital signs/tolerance of procedure
   d. lab tests and results
   e. medications given or with held
   f. blood transfusion if given
   g. unusual events
   h. type of temporary hemodialysis access

5. The LN observes for any bleeding at the access site upon return from dialysis.

6. The LN observes fistula for thrill and bruit. If thrill or bruit is absent, notify the physician immediately.

7. Perform vital signs upon return from dialysis and prn unless ordered otherwise. Report any significant changes to the physician.

8. Fluid Monitoring (refer to NPP G 3.0 Intake & Output).

C. Vascular Access Precautions

1. Constrictive clothing or jewelry cannot be worn on the extremity with dialysis access.

2. Venipuncture for laboratory tests, I.V. fluids, or taking blood pressure may not be performed on the extremity with dialysis access.
   a. A sign may ~~should~~ be posted ~~at the head of the bed~~in the room to **alert** health team members not to use extremity with shunt or fistula.

D. Tunneled Dialysis Catheter Care

1. The dialysis nurse performs the dressing change of the shunt or dialysis catheter during each treatment at the dialysis center.

2. Neighborhood RN may perform dressing reinforcement if dressing is soiled or loosened.

E. Resident Education

1. Explain precautions for the extremity with the vascular access.

2. Educate resident to report any changes or problems to vascular access.

3. Educate importance of following fluid intake limitations and appropriate diet.

F. Documentation in EHR to include:

1. Resident Care Plan – Ensure hemodialysis is care planned in EHR
~~2.~~ LDA to identify ~~T~~type of Access
~~3.~~ Presence or absence of AV shunt/fistula audible bruit and palpable thrill
2. Condition of dialysis access site.
~~4.~~ Vital signs
3. Weight

~~5.~~4. Progress Notes
~~6.~~5. Resident response to dialysis treatments in weekly~~/ monthly~~ summary.
~~7.~~6. Assessment of ability to comprehend and follow precautions needed for venous access, dietary and fluid requirements.
~~8.~~7. Documentation of any health education or teachings given to resident.

~~9.~~8. ~~Neighborhood Census Report: Outpatient hemodialysis is considered a clinic visit and therefore, is to be documented on the unit census report.~~

9. ~~I~~Dialysis Communication Note: Communication via secured fax between dialysis nurse and unit nurse resident's information or changes in condition such as lab, weights, vital signs or any unusual drainage, bleeding from the dialysis site. Describe any need to reinforce site dressing. (See Appendices)

~~10.~~**a. If paper copy received, submit to HIM for scanning.**

REFERENCES:

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

Nursing P&P G 3.0 Intake and Output
Nursing P&P J 7.0 Central Venous Access Device (CVAD) Management

APPENDICES:

Attachment 1: Coordination of Care for LHH Residents Requiring Outpatient Hemodialysis

Adopted: 2000/08

Revised: 2006/03, 2008/04, 2010/10, 2015/07/14, 2016/09/13, 2017/01/10; 2019/05/14, 2023/06/23

Reviewed: 2019/05/14

Approved: 2019/05/14

Deleted Nursing Policies and Procedures

TUB BATHS AND SHOWERS

POLICY:

1. Licensed Nurse in collaboration with the Nursing Assistant, and if appropriate Rehabilitation Staff, and/or Resident Care Team (~~RCT) are~~RCT) are responsible for assessing, planning, meeting bathing needs, and accommodating preferences of residents.

2. Bathing includes nail care, hair care, shaving, and cleansing of skin surfaces.

3. Bathing alternatives will be offered if resident finds a tub bath or shower distressing or unacceptable.

4. A resident who requires assistance shall not be left unattended for safety reasons.

5. Nursing staff are responsible for cleaning and disinfecting the shower chair and tub. All care equipment used for bathing are cleaned and disinfected after each resident's use.

PURPOSE:

To meet resident's hygiene needs.

PROCEDURE:

A. Preparation

1. Gather all equipment prior to bathing the resident.

2. Check with the Licensed Nurse for any preparation needs.

~~2.~~3. **Preparation of Resident/Patient –** The resident's care is individualized to include personal, cultural and religious preferences and is to be provided in a manner that is respectful of the resident's dignity, privacy, safety and confidentiality

B. Bathing the Resident using the Tub

1. Use appropriate transfer technique per resident ~~Front Card RCP~~care plan.

2. Resident has a preference to use a regular tub or portable tub. For guidelines using these tubs, please refer to:

   a. Attachment 1: Operating and Cleaning of Tub (Arjo Parker Tub), or
   b. Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)

3. Refer to NPP D 6 1.1 Battery-Operated Lift Transfer and LHHPP 24-19 The C-625 Battery-Operated Ceiling Lift. Slings used for bathing are labeled per individual resident.

4. Follow recommendations for bathing in the resident care plan~~RCP~~.

5. If the resident has a bowel movement in the tub, take resident out of the tub. Put the resident in a wheelchair or commode chair for cleaning; and cover the resident to keep warm.

a. Remove feces and deposit in the toilet if possible.
b. Disinfect the tub with facility approved cleaning agent. Follow directions.
c. Refill the tub with water and check the temperature.
d. Return the resident to the tub and continue with the bath.

D. Bathing Resident using the Shower

1. Shower can be provided to a resident using an appropriate shower chair based on function and resident preference. For guidelines using these shower chairs, please refer to:

   a. Attachment 3: Operating and Cleaning of Shower Chair Commode
   b. Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair

2. Use appropriate transfer technique per resident ~~Front Card RCP~~care plan.

3. Resident who is independent in showering:

   a. Teach resident about safety precautions such as having all necessary materials within reach, applying all brakes to shower chair if used, and to test water temperature prior to showering.
   b. Instruct resident to call for assistance using nurse call system when needed.
   c. Periodically check resident for any assistance needed.

E. Grooming

1. Gently apply lotion on resident's back, legs, and feet.

2. Dress resident or assist with dressing as needed.

3. Clip toenails straight across and shape fingernails. Refer to NPP D5 1.0 Foot Care.

4. Comb hair. Handle hair gently when combing, brushing, or styling to avoid damage.

5. Assist the resident to shave facial hair.

6. Apply makeup with resident's consent according to ~~her~~ their preference.

F. Reporting / Documentation

1. Report any abnormal skin changes or any discomfort shall be reported to the Licensed Nurses and documented in the medical record.

2. Bathing preferences and needs are indicated in the Care ~~Plan of~~Plan of the electronic health ~~recordand~~record ~~and are included as a care plan problem as needed~~.

G. Environmental Infection Control

1. Refer to Infection Control Manual

2. The nursing staff are responsible for cleaning and disinfecting the shower chair and tub.

~~3. Wash nail clippers and soak in approved germicide before using for another resident.~~

REFERENCES:

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-19 The C-625 Battery Operated Ceiling Lift

Nursing Policy and Procedure
D5 1.0 Foot Care
D6 1.1 Battery Operated Lift Transfer
D2 2.0 Bathing Alternative and Bed Baths

ATTACHMENTS/APPENDICES:

Attachment 1: Operating and Cleaning of Tub (Arjo Portable Tub)
Attachment 2: Operating and Cleaning of Portable Tub (Shower Trolley)
Attachment 3: Operating and Cleaning of Shower Chair Commode
Attachment 4: Operating and Cleaning of Multipurpose Hygiene (Shower) Chair
Attachment 5: Shower Tilt Chairs (Combi Tilt Chairs)

Revised: 8/2002, 2/2010; 05/12/2015; 2016/09/13; 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

ATTACHMENT 3 - SHOWER CHAIR COMMODE

A. Operating Guidelines

1. As part of orientation, the competency of all bedside nursing staff to use shower chair commode is validated; and annually thereafter as part of their performance appraisal.

2. The shower chair commode is a portable and comfortable shower and hygiene aid designed for residents with limited mobility.

3. Prior to a resident's use of the shower chair commode, nursing staff must assess and ensure that the resident fits the following criteria in order to provide resident safety :

   a. Weight does not exceed 250 lbs.,
   b. Has good trunk control and does not lean sideways or forward,
   c. Does not exhibit involuntary movements,
   d. Is not restless and is able to follow directions,
   e. Resident care plan states that the resident prefers and may use the shower chair commode for bathing.

B. Operating Shower Chair Commode

1. Before each use of the shower chair commode, nursing staff must:

   a. Check the seat cushion to ensure that it is properly installed and firmly clipped to the back of the seat frame to prevent the seat from slipping forward.
   b. Check the side knobs to ensure that they are tightly screwed to the seat frame to prevent the seat belt from disengaging.

2. Transfer and transport of resident:

   a. When transferring a resident in and out of the shower chair commode, lock all four wheels on shower chair by depressing each of the red foot pedals located on all four wheels.
   b. Resident may transfer in and out of the shower chair via E-Z lift, ceiling lift, or transfer from chair to shower chair.
   c. Apply and adjust the seat belt according to resident size and comfort, ensure that the belt snaps on and the resident is not leaning forward.
   d. For resident privacy and dignity, ensure the resident is properly clothed / covered during transport.

3. Shower

   a. Park the shower chair commode by locking its wheels to prevent shower chair from rolling away.
   b. Do not leave resident unattended while in the shower chair.
   c. Continually monitor resident to ensure safety.

C. Cleaning and Disinfecting of Shower Chair Commode

1. The shower chair commode must be cleaned after each use with the facility approved disinfectant.

D. Maintenance

1. CNA/PCA/HHA to inform licensed nurse if the shower chair commode is broken.

2. Licensed Nurse will call Plant Services for any repair or services as needed.

3. The Licensed Nurse may also submit a “work order web request” by clicking “Plant Services Work Request” on the Laguna Honda Intranet. An email alert will be sent on change of status.

REFERENCES:

Aquatec Manual

Adopted from D2 4.7 created on 10/2010

Revised: 05/12/2015

Reviewed: 05/12/2015

Approved: 05/12/2015

Laguna Honda Hospital and Rehabilitation Center

Potable Bed Exit Alarm

SKILLS CHECK LIST

EMPLOYEE NAME: ______________________________ **Shift** (circle): Days Evenings Nights

Last First

ASSIGNMENT REGULAR STAFF or Float

Directions: Staff must be able to demonstrate steps	S = Satisfactory	U = Unsatisfactory	
INDICATOR	S	U	COMMENTS
Bed Check Alarm Installation and Set Up			
Verbalize how to install the portable bed exit alarm: Connecting alarm to Nurse Call System, Dating Sensormat, and Placing Sensormat at appropriate location.			
Operating Bed Check Alarm			
A. Monitoring Mode: Verbalize and demonstrate how to set the alarm to Monitoring Mode.			
B. 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 Bed Check Alarm skills competence ________

Does not meet LHH standards for Bed Check Alarm skills competence ________

NAME/TITLE OF OBSERVER__________________________ DATE ______________

REFERRAL FOR PARTICIPANT WHO DOES NOT MEET LHH BED CHECK ALARM SKILLS 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 ___________