List of Policies and Procedures Submitted to JCC for Approval on February 13, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Notes
New	_LHHPP	70-01 B4	Request for Operating Under a CMS 1135 Waver	New policy
Revised	_LHHPP	23-01	Resident Care Plan Resident Care Team Resident Care Conference	1. Added "or monthly", "during quarterly assessments", "during change of condition" and "Nursing will document these summaries on the Electronic Health Record (EHR). " 2. Deleted "With discharge planning" 3. Added "Annually, Admission and Significant Change in Status Assessment (Comprehensive MDS with CAA)" 4. Romeved "Within 14-21 days of permanent relocation to another unit in LHH" 5. Deleted "Comprehensive MDS with CAA" 6. Added "Unusual Occurances (e.g. Fall, Abuse, Altercation, wounds, etc.)" 7. Deleted "seven days of new admission" 8. Added "Within 7 days of readmission" 9. Added "PASRR Level 2 Determination Report" 10. Deleted "Significant change in resident condition" 11. Added "Temporary relocations, i.e., Covid unit" 12. Deleted "by completion of the comprehensive care plan" 13. Added "discharge planning, PASRR (if applicable)" 14. Deleted "for deciding whether" 15. Added "For clinical problems, care planning will be initiated with individualized interventions based on short-term or long-term goals" 16. Added "Level 2 determination "
Revised	_LHHPP	23-02	Completion of Resident Assessment Instrument Minimum Data Set	2. Changed "end" to "15th" 3. Added "if leave of absence is more than 30 days" 4. Deleted "The MDS 3.0 data is generated for the Certification and Survey Provider Enhanced Reporting system (CASPER) which provides the quality measures indicating the facility's star rating." 4. Added "IQIES will update the quality measures report that are generated by submitted MDS assessments." 5. Deleted "09/2020 v1.05 Certification And Survey Provider Enhanced Reports MDS 3.0 QM 11-4 CASPER Reporting MDS Provider User's Guide" 6. Added page number to "Refer ti RAI Manual page" section of Attachment A and added "(Return not anticipated and return anticipated)" 7. Minor changes to Attachment C table.
Revised	_LHHPP	26-02	Management of Dysphagia and Aspiration Risk	2. Added to definitions section "2.Individualized Aspiration Precautions" 3. Refined section 5 "1:1 Supervision" 4. Added section "6. Frazier Free Water Protocol" 5. Added clarification and sections i-xiii to Procedures "1.a. Identification of At-Risk Residents" 6. Simplified sections 1.b-1.l into 1.b-1. 7. Many sections rearranged for clarity 8. Added section "2. Dysphagia Evaluation by SLP" 9. Added "Dysphagia diagnostic" 10. Added section "4. Diet Initiation following Dysphagia Evaluation and/or Diagnostic Treatment" 11. Added reference to ASHA

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Revised	_LHHPP	28-05	Custom Wheelchairs	1. Added "DEFINITION: Custom Wheelchairs: A custom wheelchair is defined as one that has been constructed to address a particular resident's individual medical needs for positioning, support, and mobility." 2. Replaced "will remain in the facility provided wheelchair" with "may be approved by LHH organization funding process". 3. Replaced "designated uint records per resident inventory" with "resident's care plan and Kardex" 4. Added "8. Engineering provides a tag to the custom wheelchair and ensure the inventory system is updated with the asset number." 5. Removed "2. Refer to the vendor: The most recent custom wheelchair issued to resident by insurance requiring repairs are referred to the vendor who supplied the wheelchair or vendor of resident's choice. Vendors will be contacted by nursing/unit staff to repair personal custom wheelchairs. This may be dependent on insurance approved vendors. Vendor availability is subject to each company and not related to LHH staffing. " 6. Added "Ensure this is approved as per rehab assessment." 7. Removed "5. Place work order for maintenance or repair of residents own or loaned w/c not provided by insurance or LHH. A work order can be placed to LHH facilities. If LHH facilities is not able to repair the w/c, resident or nursing/unit staff can contact an outside vendor if the resident would like to self-pay for the repairs/maintenance."
Revised	_LHHPP	72-01 B5	Transmission-Based Precautions	1. Added "(TBP)" 2. Added "in a visible location outside of resident room." 3. Deleted "either on the outer room doors for patients placed on transmission-based precautions. The sign shall be limited to the type of precautions." 4. Replaced "transmission precautions" with "TBP" 5. Deleted "If this is no tpossible, the patient may be placed with a patient who has low risk of infection." 6. Deleted "Do not drag the linen bag on the floor while transporting to soiled utility room." 7. Added "Visitors are reminded to keep their hands off of their face and perform hand hygiene prior to entry and upon leaving the room" 8. Added "prior to entry and" 9. Deleted "Enhanced Droplet: Visitation should be limited to only those who Nursing agrees will support patient's safety/well -being. Visitors wear a tight-fitting mask. " 10. Added "Education should be documented in the patient notes and isolation needs added to the plan of care." 11. Added "and/or infection prevention" and "while in use" 12. Replaced "TB" with "ATD Airborne Transmissible Disease" 13. Replaced "TB" with "ATD" " throughout the document 14. Replaced "with tuberculosis or rule out tuberculosis" with "with an ATD" 15. Added "Table 2 shows a sampling of diseases and conditions identified by Cal OSHA as requiring Airborne Isolation. " 16. Added "Table 2. Diseases/Pathogens Requiring Airborne Isolation (Cal OSHA)" table 17. Replaced "qualitive" with "documented" 18. Added "(COVID-19.)" 19. Deleted "worn when working within a 6 foot diameter of the patient. The healthcare worker may choose to put on the mask prior to" 20. Added "freshly cleaned clothing, perform resident hand hygiene and disinfect high touch points of assistive device using hospital approved disinfectant prior to going outside of the patients' room"

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Revised	_LHHPP	72-01 C22	Influenza Immunization	1. Added "and new admissions to LHH" 2. Deleted "Using the Standard Influenza Vaccination Protocol, the LHH RN may order influenza vaccinations under specific criteria provided in this policy. Those patients not meeting that protocol criteria will be referred to a prescriber for follow up." 3. Replaced "HCP information" with "guidance" 4. Added "1. Resident Vaccination" 5. Deleted "Deleted "Standard RN protocol for ordering influenza vaccine annually for patients residing at LHH includes:" 6. Replaced "Registered Nurse (RN)" with "licensed nurse" 7. Added "new residents" and "for the influenza vaccination" 8. Deleted "to order the influenza vaccine using the Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines for Residents Admitted to LHH." 9. Added "A reasonable attempt will be made to determine prior vaccination history. Resident with unknown or unsure vaccination status will not be considered immunized. For those not vaccinated, the reason will be documented. Possible reasons for why the vaccine was not given may include:" 10. Deleted "If any of the following are applicable to the patient, the LHH RN may not order an influenza vaccine but must obtain a physician consultation prior to administration: i. Documented confirmation resident received vaccine this season" 11. Replaced "Patient" with "Resident" 12. Replaced "The licensed nurse shall provide the resident or responsible party with " with "The Physician or licensed nurse, will obtain consent which includes" 13. Added "b.Physicians or designated prescriber orders the appropriate influenza vaccine dose for residents." 14. Deleted "c. Consent is obtained prior to vaccination administration" 15. Added "Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMS-20054 Infection Prevention, Control & Immunizations" 16. Deleted "The licensed nurse shall provide the resident or responsible party with the current year CDC Vaccine Information Statement (VIS) for the influenza vaccine prior to administering the vaccine."
Revised	_LHHPP	72-01 F04	Linen Handling	1. Added "Hamper should not be stored in hallway. "
Deletion	_LHHPP	24-16 Appendix 13	Addendum to Code Blue Policy During Pandemic and Protective Quarantine	1. "Since we no longer are in pandemic and protective quarantine, it no longer applies"
Deletion	_LHHPP	72-01 A10	Infection Outbreak Investigation and SURGE Response	1. Request to delete. 2. Duplicate policy to 72-01 A8 Outbreak/Epidemic investigation policy. 3. Elements of A10 surg were included in A8.
Deletion	_LHHPP	72-01 C01	Alphabetical List of Diseases/Conditions with Required Precautions	1. Request to delete. 2. This policy (C-01) and list of disease is a duplicate policy. Policy 72-01 B5 Transmission Based Precautions and Resident Room Placement has a isolation table listing all infectious agents requiring isolation.
Deletion	_LHHPP	72-01 C20	Monoclonal Antibody Therapy for COVID-19 Infection	1. Request to delete. 2. Policy deleted due to FDA pulling the emergency use authorization for Evusheld due to viral changes inactivating the efficacy of the treatment. LHH using other anti-viral medications that are covered in pharmacy polices.
Deletion	_LHHPP	72-01 C20 Attachment	LHH COVID-19 BAM Consent Form	1. Request to delete. 2. Policy deleted due to FDA pulling the emergency use authorization for Evusheld due to viral changes inactivating the efficacy of the treatment.
Deletion	_LHHPP	72-01 E04	Central Supply/Materials Management	1. Request to delete. 2. Policy sunsetted as materials has own departmental policies that speak to IPC practice when necessary.
Deletion	_LHHPP	72-01 E06	Dental Services	1. Request to delete. 2. Policy sunsetted as Dental Clinic (UCSF Employees) follow and adhere to UCSF dental clinic polices.

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Deletion	_LHHPP	72-01 F05	Standard for Refrigeration Equipment	1. Request to delete. 2. This is a duplicate to EVS policy.
Deletion	_LHHPP	72-01 F13-1	Attachment 1: Non-Critical Resident Care Equipment Disinfectant Exceptions	1. Request to delete. 2. This attachment was incorporated into a new replacement policy 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment.
Deletion	_LHHPP	72-01 F13-2	Attachment 2: Standard Work for Single-Resident Blood Pressure Cuffs	1. Request to delete. 2. This attachment was incorporated into a new replacement policy 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment.
Deletion	_LHHPP	73-07	Aerosol Transmissible Disease Exposure Control Plan	1. "I recommend deleting our existing 73-07 ATD policy and use Jackie's HN-ATD policy instead. "
Revision		NA	Warfarin Collaborative Practice Agreement	
Revised	CPD	MM and CS PP	Policies and Procedures	1. 3.4Processing Purchase Order Using PropQ - Item 4 reference to 12X Banned States has been removed. 12X has been repealed. 2. 3.7Processing Office Depot Non-Catalog Order - General requisition form has been replaced with a specific Office Depot order form. Also removed sending requests through interoffice mail to email only. 3. 3.15Storeroom Supplies - Procedure revised with more clear instructions on how to process a request. 4. 3.21Biomedical Technical Assistance- Changed reference from Agiliti to Cure as our Biomed provider. Also indicated to refer to Biomed P&P since Biomed is no longer under MM purview. 5. F-02CPD Inventory Cycle Count -Changed all references from 1944 Materials Coordinator to Director of Materials Management 6. F-03Inventory Discrepancy Reporting -Changed reference from Pathways Materials Management (PMM)to PeopleSoft. PMM no longer used. Also changed references from 1944 Materials Coordinator to Director of Materials Management 7. F-04Reporting and Disposing of Obsolete and Expired Products - Changed references from 1944 Materials Manager to Director of Materials Management 8. B1PeopleSoft Inventory Management System - Removed reference to a specific contact and updated to MMIS Help Desk. Also revised MMIS contact phone numbers 9. Attachment 4.5Obsolete and Expired Items - Changed referenced from 1944 Materials Manager to Director of Materials Management. Also change PMM item # to DPH item #. PMM is no longer in use. 10. Throughout all P&P sections- Changed references to CSR or Central Supply to CPD. Both were used throughout the document. Changing all references to CPD aligns with all of our Peoplesoft reporting queries which only references CPD, not CSR. This also aligns LHH with rest of SFHN use of CPD, not CSR.
Deletion	CPD	MM and CS PP	Policies and Procedures	[illegible] longer sterilizes or disinfects medical instruments. This is now done at ZSFG. Refer to Clinic Standard of Work "LHH Handling of Surgical Instruments in the General and Dental Clinic" 2. B9 High Level Chemical Disinfection- CPD no longer performs High Level Chemical Disinfection 3. B10 Chemical Sterilization - CPD no longer performs Chemical Sterilization 4. B11 Steam Sterilization - CPD no longer performs steam sterilization

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Revised	Food Services	1.64	Preventative Maintenance	1. Replaced "Assistant Food Service Director" with "Food Service Management" 2. Replaced "contract vendors" with "Facility Service and/or city approved vendors " 3. Added "Below is equipment that are regularly inspected and/or serviced per manufacturer recommendation" 4. Deleted "Hobart Service... etc" 5. Deleted "ACME Pacific Service 6. Added "walk-in refrigerators, walk-in freezers, " 7. Added "filtering system, Fire Extinguishers System, liquid coffee dispenser, juice dispenser, soda dispenser, and any other equipment operating in the department " 8. Deleted "Facility Services: Filter System" section
Revised	Food Services	1.67	Dish Machine QC Checklist	1. Added "or team leader" 2. Replaced "165 F test strip" with "department approved test strip " 3. Replaced "Economics Laboratory or Acme Pacific" with "Facility Services or city approved vendor" 4. Minor spellng and tempreture corrections.
Revised	Food Services	1.139	Pot machine Temperature Checks	1. Deleted "cafeteria" 2. Replaced "Chefs" with "Supervisor or team leader" 3. Added "machine" and "Chef or designee will check" 4. Added "or designee", "pot machine" and "or designee to" 5. Changed "Economic Labs" to Ecolab" 6. Replaced "the Assistant Food Service Director" with "Food Service Management "
Revision	MSPP	D01-05	Psychotropic Medication Management	1. Key change is deleting #5g on page 5, as it was pre-Epic language, and the form referenced ("Nursing Assessment and Progress Note: Potential Emergent/Unplanned Psychotropic Drug Use") is no longer applicable.
Deletion	Nursing	1.0	Oral and Nasopharyngeal Suctioning	1. Request to be deleted, reference Mosby's
Deletion	Nursing	2.0	Tracheobronchial Suctioning	1. Request to be deleted, reference Mosby's

New Hospital-wide Policies and Procedures

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 resident-centered care, 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's rights, that includes measurable objectives and timeframes to meet their ~~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 over their daily lives 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.

~~RCC~~

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 /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 Assessment (if appropriate)
- Smoking Assessment and Plan of Care
- Social Services Psychosocial Assessment
- Fall (Schmid) 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~~Annually, Admission and Significant Change in Staus Assessment (Comphrehensive MDS with CAA)

   ~~ii.~~

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

   ~~iv.~~iii. Special Review(s)

   - ~~Comprehensive MDS with CAA~~Unusual Occurances (e.g. Fall, Abuse, Altercation, wounds, etc.)
   - Within ~~seven days of new admission~~7 days of a permanent relocation to another unit in LHH
   - Within 7 days of readmission

- ~~Annually~~PASRR Level 2 Determination Report
- ~~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 in advance to ensure attendance. The RCC will be rescheduled based on the representative's availability. If the representative is unable to attend in person, attendance can occur via telephone or video call.

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

   iii. The social worker has an option to request for a public patient representative through the California Patient Representative Information System (CAPRIS) when there is no representative.

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, discharge planning, PASRR (if applicable); 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 at LHH shall provide as a result of the PASRR Level 2 determination 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

REQUESTING TO OPERATE UNDER A CMS 1135 WAIVER

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to comply with the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation regulations related to the operations of a hospital under a 1135 Waiver.

SCOPE:

Applies when the City and County of San Francisco is included in a presidential declaration of emergency or disaster and 1135 Waiver scope and when LHH is unable to operate in compliance with CMS requirements due to the impact(s) of that disaster.

PURPOSE:

To provide guidance on how LHH will integrate a 1135 Waiver into emergency operations.

BACKGROUND:

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act, and the Department of Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to their regular authorities. For example, under section 1135 of the Social Security Act, the HHS Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time-periods. This is to ensure that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

1. Examples of these 1135 Waivers or modifications include:
   a. Conditions of participation or other certification requirements

   b. Program participation and similar requirements

   c. Preapproval requirements

   d. Requirements that physicians and other healthcare professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – State law governs whether a non-Federal provider is authorized to provide services in the State without State licensure)

e. Emergency Medical Treatment and Labor Act (EMTALA)

f. HIPAA—Sanctions arising from noncompliance with HIPAA privacy regulations relating to:

   i. obtaining a patient's agreement to speak with family or friends or honoring a patient's request to opt out of the facility directory;

   ii. distributing a notice of privacy practices; or

   iii. the patient's right to request confidential communications.

g. The waiver is effective only if actions under the waiver do not discriminate as to source of payment or ability to pay.

h. Physician self-referral sanctions (Stark)

i. Performance deadlines and timetables may be adjusted (but not waived).

j. Limitations on payment for healthcare items and services furnished to Medicare Advantage enrollees by non-network providers.

2. These waivers under section 1135 of the Social Security Act shall generally end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published. Unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

3. Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPAA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.

   a. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency.

4. While 1135 Waivers can only be authorized by HHS Secretary or their designee, the CMS Regional Offices will report on collected information to determine if an 1135 Waiver is appropriate. This information may include:

   a. Requests by hospitals to provide screening/triage of patients at a location offsite from the hospital's campus.

   b. Hospitals housing patients in units not otherwise appropriate under the Medicare Conditions of Participation for a duration that exceeds regulatory requirements.

c. Hospitals or long-term care facilities requesting increases in their certified bed capacity.

PROCEDURE:

1. Notification of the authorization of an 1135 Waiver shall be received by the Hospital Incident Command System (~~HICS~~NHICS), any departments or individuals hearing of an authorization of an 1135 Waiver must notify the ~~HICS~~NHICS.

2. Under direction from the Hospital Incident Commander, the Liaison Officer will coordinate with the Director of Regulatory Affairs and the Chief Quality Officer of the Quality Management Department to confirm the scope and implementation of the waiver.

3. Upon confirmation of an 1135 Waiver, LHH's ~~HICS~~NHICS Management Team will assess the need for implementation, and:

   a. In the event that the 1135 Waiver is a "Blanket Waiver," the Liaison Officer or Director of Regulatory Affairs and the Chief Quality Officer shall submit notification to the California Department of Public Health (CDPH) or CMS Regional Office that LHH is operating under the waiver, or

   b. Submit to CDPH or CMS Regional Office a request to operate under the waiver, if the waiver is not considered a "Blanket Waiver". This request must include the hospital's justification for implementing the waiver and an expected duration of the modification requested.

   c. Submit email with Request to Operate under an 1135 Waiver authority to the CMS Regional Office and CDPH:

      Email Address for CMS Regional Office for California:
      ROSFOSO@cms.hhs.gov

      Mailing Address & Phone Numbers for California Department of Public Health:
      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

   d. For after-hour reporting or if the local CDPH Licensing and Certification district office is non-operational due to the emergency or disaster, notify the:
      i. State Office of Emergency Services Warning Center at (916) 845-8911; and

ii. Ask that they notify the CDPH duty officer.

4. Any requests to operate under an 1135 Waiver must also be copied to CDPH to ensure the waiver does not conflict with any State requirements and to address any concerns.

5. Upon approval to operate under the 1135 Waiver the ~~HICS~~NHICS Management Team will communicate to hospital administration and the Chief Quality Officer the approval to operate under the waiver.

6. ~~HICS~~NHICS will notify any departments covered by the waiver (i.e. Medical Staff Office, Emergency Department, Billing, etc.). This notification must include the scope, timeframe, and any restrictions or requirements of the waiver.

7. ~~HICS~~NHICS will conduct operations throughout the emergency within the scope of the 1135 Waiver.

8. Upon cessation of the 1135 Waiver, LHH will ensure compliance with any waived requirements.

ATTACHMENT:
None

REFERENCE:
CMS 1135 Waiver: http://www.cms.hhs.gov/H1N1/
§ 70129. Program Flexibility
70741 Disaster and Mass Casualty Program

Original adoption: (Year/Month/Day)

Revised Hospital-wide Policies and Procedures

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

POLICY:

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

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

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

PURPOSE:

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

2. To utilize the ~~RAI/~~MDS during care planning process.

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

BACKGROUND:

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

PROCEDURE:

1. ~~RAI/~~MDS Accuracy and Completion

a. The MDS Coordinator notifies Resident Care Team members by the ~~end~~15th of each month identifying those residents who are scheduled for assessments the following month. The MDS Coordinators may send an updated list after the initial notification to reflect schedule revisions and additions.

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

c. The Resident Care Team and the Department of Admissions and Eligibility are

responsible for completing respective MDS sections as specified in Attachment C.

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

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

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

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

2. The ~~RAI/~~MDS Assessments

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

Assessment Types:

a. Tracking Records

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

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

b. OBRA Assessments

i. Admission- comprehensive assessment for a new resident or a returning resident if leave of absence is more than 30 days.

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

iii. Significant Change in Status Assessment- comprehensive assessment is completed if RCT determined that a resident meets the significant change guidelines for either improvement or decline (see Standard Work for Significant

Change in Status Assessment)

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

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

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

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

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

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

a. The facility must report data to meet the SNF Quality Reporting Program (QRP). The MDS 3.0 is transmitted to CMS through ~~the Assessment Submission and Processing (ASAP) system to~~ the Internet ~~-~~Quality Improvement Evaluation System (iQIES).

~~b. The MDS 3.0 data is generated for the Certification and Survey Provider Enhanced Reporting system (CASPER) which provides the quality measures indicating the facility's star rating.~~ IQIES will update the quality measures report that are generated by submitted MDS assessments.

i. List of Quality Measures

- High-Risk/Unstageable Pressure Ulcers (L*)
- Physical Restraints (L*)
- Falls (L*)
- Falls with Major Injury (L*) ~~09/2020 v1.05 Certification And Survey Provider Enhanced Reports MDS 3.0 QM 11-4 CASPER Reporting MDS Provider User's Guide~~
- Residents Who Newly Received an Antipsychotic Medication (S*)
- Residents Who Received an Antipsychotic Medication (L*)
- Prevalence of Antianxiety/Hypnotic Medication Use (L*)

- Antianxiety/Hypnotic Medication Use % (L*)
- Behavior Symptoms Affecting Others (L*)
- Depressive Symptoms (L*)
- Urinary Tract Infection (L*)
- Catheter Inserted and Left in Bladder (L*)*
- Low-Risk Residents Who Lose Bowel/Bladder Control (L*)
- Excessive Weight Loss (L)
- Need for Help with ADLs Has Increased (L)
- Percent of Residents Whose Ability to Move Independently Worsened (L)*
- Percent of Residents Who Made Improvements in Function (S)*
- Changes in Skin Integrity Post-Acute Care Pressure Ulcer/Injury* (SNF Only)

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

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

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

Revised: 10/01/20, 12/05/22, 19/05/14, 19/07/09, 22/12/13, 23/03/14 (Year/Month/Day)
Original adoption: 10/01/20

*L-Long Stay
*S-Short Stay

Attachment A: Required OBRA Assessment Schedule for the MDS

ADMISSION	Refer to RAI Manual page 2 – 8 & 2-17
ANNUAL	Refer to RAI Manual page 2 – 179 & 2-23 to 2-24
SIGNIFICANT CHANGE IN STATUS	Refer to RAI Manual page 2-17 & 2 - 224 to 2- 3027
SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT	Refer to RAI Manual page 2-18 & 2-32 – 30
QUARTERLY	Refer to RAI Manual page 2-18 & 2-32 – 31 to 2- 33
SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT	Refer to RAI Manual page 2-18 & 2 – 34-35
ENTRY	Refer to RAI Manual page 2-20 & – 34 to 2 – 35 2-37
DEATH IN FACILITY	Refer to RAI Manual page 2 – 36-20 $ 2-38
DISCHARGE (Return not anticipated and return anticipated)	Refer to RAI Manual page 2-19 & 2-38 to 40 – 36 to 2 – 37

Attachment B: MEDICARE MDS Assessment Schedule

5 Day NPE (Medicare Last Covered Day) IPA (Interim Payment Assessment) Interrupted Stay	Refer to RAI Manual

Attachment C: MDS 3.0 Section by Section

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

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

MANAGEMENT OF DYSPHAGIA AND ASPIRATION RISK

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center shall implement procedures to safely manage the care of residents identified to be at risk for aspiration.

2. The facility recognizes the resident's or designated surrogate decision maker's right to make an informed decision where the resident's enhanced quality of life, provided by eating and drinking, may be of greater importance than reducing the risk of aspiration.

PURPOSE:

To promote resident safety and enhance resident quality of life with respect to diet and feeding interventions.

DEFINITIONS:

1. Standard Aspiration Precautions:

    i. Oral care

    ii. Resident to sit upright as possible (elevate Head of Bed if cannot transfer to chair) with all meals and 20 minutes after eating, including medications

    ~~ii.~~iii. Dentures in place

    ~~iii.~~iv. Minimize distractions

    ~~iv.~~v. Small bites and sips

    ~~v.~~vi. Slow rate of intake

2. Individualized Aspiration Precautions

Individualized aspiration precautions may be recommended by Speech Language Pathology (SLP) following a Dysphagia Evaluation and/or diagnostic treatment; examples include, but are not limited to:

    i. No straw

    ii. Alternating solids and liquids

    iii. Chin tuck

~~iii.~~iv. Head turn

~~iv.~~v. Head tilt

~~v.~~vi. 1:1 Supervision

~~vi.~~vii. 1:1 Assistance

~~vii.~~viii. Cutting food into small pieces

~~viii.~~ix. Liquids by spoon only

~~ix.~~x. Close supervision

~~x.~~xi. Line of sight supervision

~~xi.~~xii. Passy Muir Valve in place for all PO

xiii. Frazier Free Water Protocol

3. Line of Sight: Resident ~~– resident~~ is within view of staff while eating.

4. Close Supervision: One ~~– one~~ staff member sits~~sitting~~ with a limited number of residents ~~no more than 4 residents~~ to provide supervision during mealtime. Staff shall ensure that recommended aspiration precautions (e.g., standard precautions or individualized precautions as recommended by SLP~~speech therapy~~ and ordered by the physician) are followed by actively cueing, assisting, and/or observing the resident during mealtime.

5. 1:1 Supervision: Resident receives ~~– resident needs~~ direct assistance or supervision during oral intake (e.g., cognition adversely effecting swallow function increasing risk of aspiration due impulsive self-feeding, ~~eating beh~~cues required~~needed, unable~~ to follow standard~~feed self, level of risk for~~ aspiration precautions, HIGH risk of aspiration)

6. Frazier Free Water Protocol: Free water is permitted before and between meals with clean oral cavity. Free water is not permitted with meals, medications or other oral intake.

PROCEDURE:

1. Identification of At-Risk Residents

a. Residents shall be evaluated by the Resident Care Team (RCT), at minimum this will include a physician~~)~~ and a nurse, to determine ~~identified as being at~~ risk for aspiration. Clinical ~~if they have clinical~~ signs that suggest risk of aspiration include, but are not limited to the following:

i. drooling and/or poor oral management of secretions and/or bolus;

ii. ineffective chewing;

iii. food or liquid remaining in the oral cavity after the swallow (oral residue);

iv. inability to maintain lip closure, leading to food and/or liquids leaking from the oral cavity;

v. extra time needed to chew or swallow;

vi. food and/or liquids leaking from the nasal cavity;

vii. complaints of food "sticking" or complaints of a "fullness" in the neck;

viii. complaints of pain when swallowing;

ix. changes in vocal quality (e.g., wet or gurgly sounding voice) during or after eating or drinking;

x. coughing or throat clearing during or after eating or drinking;

xi. difficulty coordinating breathing and swallowing;~~/aspiration, demonstrate unsafe eating behaviors or have other conditions that place them at risk (e.g., reduced alertness, need to be fed in a reclined position, partially or completely edentulous with no dentures). At a minimum, the RCT includes a physician and a nurse.~~

xii. acute or recurring aspiration pneumonia/respiratory infection and/or fever

xiii. food or liquid in tracheal secretions

~~a.~~ Once a
~~b. If the~~ resident is ~~partially or completely edentulous with no dentures:~~
~~c.~~
~~d. The RCT shall assess if the prescribed diet is deemed safe;~~
~~e.~~
~~f. The~~ identified as being at risk for aspiration, the physician shall order Dysphagia Evaluation.~~refer~~~~order a dysphagia evaluation if the residents' ability to safely swallow the prescribed diet is in question.~~
~~g.~~

h. The registered dietitian shall assess the residents' ability to tolerate the prescribed diet

i.

j.b. The physician shall document discussion regarding aspiration risk if the resident for a Dysphagia Evaluation by SLP.
is prescribed a diet other than pureed and;
If appropriate, the

i. The physician willshall refer the resident to the dental clinic for evaluation. unless there is documented reason by the physician that the referral is not necessary.

k. Once a resident has been identified as being at risk for aspiration, Nursing shall place a pink dot at the head of the resident's bed and give the resident a pink indicator on their wristband. Staff and volunteers shall be trained on this color coding system and what it means.

l. Residents with individualizedwho are assessed to be at risk for aspiration, excluding those who are unable to eat by mouth (also known as NPO), shall be identified and have a physician's order for standard aspiration precautions, which include the following:

i. Line of sight supervision whose swallow function appears when eating, unless documented otherwise in the Medical Record.

ii. Resident shall be positioned as upright as possible when eating/drinking, and the resident's head prevented from tilting back, as possible.

iii. Resident shall be fed/cued to have improved or declined,eat slowly, taking small bites.

iv. When feeding a resident, make sure that the resident swallows each bite before continuing feeding.

v. Resident shall remain upright for 20 minutes after a meal.

2. Indications for Referral to Speech Pathology for a Dysphagia Evaluation

a.c. Residents who fall into one or more of the following categories shall be referred to SLP for re-, by physician's order, to the Speech Pathology Department for a dysphagia evaluation.:

i. Those admitted with a known swallowing disorder, or history that is suspicious for dysphagia (unless NPO and not a candidate for oral feeding).

ii. As described under Procedure 1 b (ii).

~~iii. Those who have clinical signs of dysphagia or aspiration and are candidates for ongoing oral feeding. Indications for referral to Speech Pathology include, but are not limited to, the following: coughing, choking, holding food in mouth, significant pocketing of food, significantly delayed swallow, significant leakage of food or liquid from mouth, food or liquid coming from tracheostomy, and/or recurrent pneumonias. If in doubt about whether or not a referral is indicated, contact the Speech Pathology Department.~~

~~iv. Alert residents who are being considered for enteral feeding, unless clinically inappropriate (Refer to LHHPP 26-03, Enteral Tube Nutrition), and those on enteral feeding whose clinical condition has improved sufficiently that they may be candidates for oral feeding.~~

~~v. Residents with a known swallowing disorder or clinical signs of dysphagia and/or aspiration who are being considered for a diet upgrade. (If a decision to upgrade a resident's diet has already been made for quality of life reasons, referral is not necessary, but may be indicated in order for a Speech-Language Pathologist to provide training regarding reducing the risk of aspiration on the upgraded diet. All necessary documentation regarding a resident's or surrogate decision maker's understanding of risks vs. benefits of upgrading diet and agreement to accept risks must be in place prior to the Speech Pathologist's intervention).~~

~~b.~~d. Referral to the SLP for **Dysphagia Evaluation** ~~Speech Pathology Department~~ may also be indicated in cases of unexplained weight loss, dehydration, and/or poor oral intake, ~~in order~~ to rule out dysphagia as a contributing factor.

~~Dysphagia evaluation is by physician order only. If the evaluation is considered clinically urgent, the physician shall mark the order "urgent" and call the Speech Pathology Department.~~

~~RCT members shall alert the physician when signs of dysphagia, aspiration, or change in swallowing function are observed.~~

~~**Dysphagia Evaluation**~~

2. Dysphagia Evaluation by SLP

~~c.~~a. Dysphagia Evaluations~~evaluations~~ shall be carried out as per~~by a~~ Rehabilitation Center Policy and Procedure #90-05, Establishment of Treatment Programs and Documentation: Dysphagia.

~~d.~~ When a Dysphagia Evaluation and/~~of Residents for Upgraded Food/Liquid Consistencies~~

~~When a dysphagia evaluation involves upgraded food~~ or diagnostic treatment requires a tray that includes items that are ~~liquid consistencies~~ not consistent with~~currently included in~~ the resident's current diet order, the following tray precautions~~Tray Precautions~~ shall be taken:

i. The SLP~~Speech Pathologist~~ shall contact Nutrition Services and ask them to write "Hold for Speech Therapy" on the tray ticket.

SLP
ii. ~~The Speech Pathologist~~ shall notify Nursing and request that the tray not be served until the SLP~~Speech Pathologist~~ arrives.

iii. Nursing staff shall hold the tray for SLP~~Speech Pathology~~ and shall not give it to the resident.

SLP
iv. ~~The Speech Pathologist~~ is responsible for removing any food or liquid items inconsistent with~~not included in~~ the resident's current diet order before leaving an unfinished tray with the resident upon completion of the session.

3. Dysphagia diagnostic Treatment

a. Following a Dysphagia Evaluation, SLP~~dysphagia evaluation, the Speech Pathologist~~ shall proceed with diagnostic dysphagia treatment as clinically~~swallowing therapy, when~~ indicated.

b. If treatment involves upgraded food/liquid consistencies not currently included in the resident's diet order, tray precautions~~follow Tray Precautions~~ delineated in paragraph 2b~~3b~~i -ii~~-iv~~, above will be followed.~~.~~

4. Diet Initiation following Dysphagia Evaluation and/or Diagnostic Treatment

a. Upon completion of evaluation and or diagnostic treatment, SLP shall document the recommended least restrictive diet including, standard and/or individualized aspiration precautions or if the resident should be NPO in the Dysphagia Evaluation and/or progress notes.

a. SLP will pend diet orders accordingly in EHR for physician review and signature.~~Referral to Occupational Therapy~~

~~Occupational Therapy consultation shall be considered if positioning of the resident during feeding is difficult or body posture increases aspiration risk.~~

~~Occupational Therapy consultation requires a physician order and a referral form.~~

i. The Dietitian and diet tech will be notified via EPIC Secure Chat by SLP regarding individualized aspiration precautions to be printed on the resident's meal ticket.

b. The SLP shall review recommended individualized aspiration precautions with Nursing staff and provide training, as needed. Nursing will update care plan accordingly.

5. Management of Residents Who Are at Risk for Aspiration

a. Once a resident has been identified by SLP as requiring individualized aspiration precautions and being at risk for aspiration, nursing shall place a pink dot at the head of the resident's bed and place a pink indicator on the resident's wristband and/or mobility device as per NPP B5.0 Color Codes. Staff and volunteers shall be trained on this color-coding system and what it means.

i. Residents with a pink indicator on their wristbands and/or mobility device shall be ~~given~~ provided~~or sold food/liquid~~ meals consistent with their individualized aspiration precaution needs~~by anyone who is not aware of the resident's feeding needs.~~

b. Certified and Licensed nursing staff shall be provided with mealtime competency training by Department of Education and Training or designated trainers upon hire and annually. Facility personnel shall be trained on standard aspiration precautions, individualized aspiration precautions and signs/symptoms of aspiration upon hire and annually.

~~a.~~c. Staff who are feeding or supervising residents determined~~designated~~ to be at risk for aspiration are responsible for ~~knowing and~~ complying with the resident's diet order, standard aspiration precautions, and any individualized precautions assigned to the resident.

~~**6.**~~

~~a. Certified and Licensed nursing staff shall be provided with mealtime competency training by Nursing Education or designated trainers upon hire and annually. Facility personnel shall be trained on choking prevention and intervention upon hire and annually.~~

~~**7.**~~

~~a. A sign directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident is located in the Pavilion Lobby and designated areas.~~

~~**8.**~~

~~a.~~d. Nursing is responsible for ensuring that family members and regular visitors who assist residents with their meals have been trained. If a family or volunteer

needs additional training regarding feeding techniques individualized aspiration precautions, nursing may recommend referral to SLP Speech Pathology. Staff shall document family or volunteer training in the medical record Electronic Health Record and resident care plan, including the date of training.

~~9.~~

a. ~~Residents~~ Signage directing visitors to check with the neighborhood nursing staff before serving food or drinks to a resident ~~pink~~ indicator ~~on their wristbands~~ shall ~~not~~ be posted ~~in~~given or sold food/liquid by anyone who is not aware of the ~~resident's feeding needs.~~

~~10.~~

a.~~e.~~ ~~Diet texture modifications (including thickened liquid) or enteral feeding, may be ordered to reduce~~ the Pavilion~~risk of aspiration. These interventions may be suggested by the Speech Pathologist following a swallowing evaluation but shall be implemented only after careful resident assessment by the RCT and orders changed by the physician. Diet texture modification for purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality of life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care Planning, and LHHPP 26-03, Enteral Tube Nutrition).~~
Lobby and designated areas.

~~b.~~f. For residents whose nutrition is via enteral tube, Nurses shall follow interventions to reduce aspiration risk as per Nursing policies and procedures (Refer to NPP E5.0 Enteral Tube Feeding Management).

~~**Individualized Aspiration Precaution**~~

~~Individualized (vs. standard) aspiration precautions may be developed by the Speech Pathologist following a swallowing evaluation; Examples include:~~

~~Close supervision when eating and drinking~~

~~Provide cues/assist for unsafe eating behaviors~~

~~Thin down thick food~~

~~Small~~

6. Referral to Occupational Therapy OT

a. Referral to Occupational Therapy shall be considered if positioning of the resident during feeding is difficult, or body posture increases aspiration risk.

b. If indicated, the physician shall write an order for Occupational Therapy consultation.

~~a. Nutrition Services shall print the list of individualized precautions recommended by speech therapy on the meal ticket, providing an easy reference for caretakers.~~

~~11. Residents with individualized precautions, whose swallow function appears to have improved or declined, shall be referred to Speech Pathology for re-evaluation and updating of precautions, as needed. When a reevaluation is not indicated and Speech Pathology is no longer treating or routinely re-checking the resident, the Speech Pathologist may be invited to attend RCT meetings for that resident with individualized aspiration precautions.~~

~~12.~~

~~13. 8. Follow-Up~~

~~Physician's order is required.~~

~~14. The Speech Pathology Department is available to monitor any resident during a meal who has been seen for a dysphagia evaluation, is on the diet recommended by Speech Pathology, and has not had any change in condition. The request may be made by any member of the RCT. No physician's order is required. The Department shall be contacted directly by phone. A physician's order for a reevaluation is required for patients whose diet was either upgraded or downgraded without the involvement of the Speech Pathology Department, when there has been a change in condition, or when re-evaluation for diet upgrade is being requested.~~

~~15.~~

~~16. When an order with aspiration precautions is discontinued without the involvement of the Speech Pathology Department, the reason(s) shall be documented in the medical record by the physician and licensed nurse. The Diet office shall also be notified in order to delete the information from the tray ticket.~~

~~17.~~

~~18.~~ 7. ~~Documentati~~**Informed Decision** Making for Diet Recommendations outside of SLP Recommendations

a. When the resident or surrogate decision maker chooses not to accept ~~the risks of a diet upgrade, or not to accept~~ the recommendation/benefits of a therapeutic diet and feeding interventions, documentation of discussion regarding the informed decision shall be reflected in the Resident Care Conference by the physician and nursing staff in the meeting notes, advance directives, and the resident care plan.

b. When an order with individualized aspiration precautions is discontinued without the involvement of SLP (e.g. for quality of life reasons) the reason(s) shall be documented in the Electronic Health Record by the physician and licensed nurse. The Diet office shall also be notified to delete the information from the tray ticket.

c. Diet texture modification for the purposes of reducing aspiration risk is a form of treatment and, as with enteral feeding, is subject to quality-of-life considerations/Advance Care Planning (Refer to LHHPP 24-05, Advance Care

Planning, and LHHPP 26-03, Enteral Tube Nutrition).

~~c.~~d. The resident care plan shall include care plan approaches for minimizing the risk of aspiration.

8. Other Considerations

~~**10. Others**~~

a. Regardless of the code status, residents shall be provided with rescue interventions in the case of choking or aspiration events.

b. The Medical Examiner shall be contacted by the physician in the event that~~case of~~ choking, or ~~an~~ aspiration may have been related~~event that leads~~ to the cause of death.

ATTACHMENT:
None

REFERENCE:
ASHA
LHHPP 24-05 Advance Care Planning
LHHPP 24-10 Coach Use for Close Observation~~Close Observation~~
LHHPP 26-03 Enteral Tube Nutrition
LHHPP 26-04 Resident Dining Services
MSPP C01-04 Death Which Must Be Reported to the Medical Examiner-Coroner
NPP A3.0 Nursing Education Programs
NPP B5.0 Color Codes- Resident Identification
NPP E1.0 Oral Management of Nutritional Needs
Rehabilitation Center P&P 90-05 Establishment of Treatment Programs and Documentation: Dysphagia

Revised: 99/01/12, 99/03/25, 99/11/09, 00/03/09, 00/08/04, 02/09/17, 04/08/18, 08/08/26, 09/01/13, 09/10/09, 10/04/20, 10/08/24, 11/09/27, 14/01/28, 16/01/12, 17/07/11, 19/03/12, 21/09/14, 22/07/14, 23/01/10, 26/07/24 (Year/Month/Day)
Original adoption: 98/04/01

CUSTOM WHEELCHAIRS

POLICY:

Custom wheelchairs may be ordered for residents with specialized positioning and seating needs who cannot be safely and adequately positioned in a facility wheelchair, provided a funding source is identified. The funding source must be able to pay for ongoing maintenance and repairs.

DEFINITION:

Custom Wheelchairs: A custom wheelchair is defined as one that has been constructed to address a particular resident's individual medical needs for positioning, support, and mobility.

GOAL:

1. Resident will be able to maintain highest functional level of mobility skills and overall Quality of Life (QOL).
2. Resident will be optimally positioned when up in a wheelchair to participate in functional tasks for QOL.

INCLUSION CRITERIA:

Residents may be considered for custom wheelchairs based on medical necessity and upon the recommendation of the Occupational Therapist/Physical Therapist. The resident must also meet one of the following criteria:

1. A physician's order for a wheelchair evaluation, and a subsequent Occupational Therapy/Physical Therapy evaluation or assessment confirms that proper seating and mobility cannot be achieved with available equipment. For power wheelchairs, the patient must demonstrate the ability to drive and operate the power wheelchair independently.

2. A resident cannot be easily transported to activities in a facility provided wheelchair due to positioning needs.

3. A custom wheelchair is needed for discharge to the community to enable mobility, completion of activities of daily living, or vocational activities and overall QOL.

4. When specific components are needed to position residents to reduce current contractures.

5. A resident has a history of positioning problems. The Occupational/Physical Therapist is unable to position resident safely and adequately in available wheelchairs. Criteria may include, but is not limited to:

a. Supporting midline orientation.
b. Providing normal visual access to the environment.
c. Enabling adequate respiration.
d. Enhancing ability to swallow or improving ability to perform self-feeding.
e. Protecting a resident from injury (e.g., due to movement disorders).
f. Reducing risk of falls to floor due to lateral, posterior, or anterior flexion.
g. Reducing slides from chair due to posterior tilt or trunk extension.

PROCEDURE:

1. If a resident meets any of the criteria for a custom wheelchair, a physician may request for an Occupational Therapy/Physical Therapy evaluation for a functional mobility evaluation through the electronic health record (EHR).

2. On receipt of the physician's order, the Occupational/Physical Therapy Department will conduct an evaluation or assessment of the resident's custom wheelchair needs.

3. Adjustments or modifications may be made to a personal wheelchair, or a facility owned custom wheelchair, pending wheelchair parts and/or insurance to meet the resident's needs.

4. If a wheelchair cannot be modified, a trial with an appropriate custom wheelchair (if available from a vendor or from the Rehabilitation Department) will be conducted to see if it will benefit the resident's condition.

5. If a facility wheelchair and positioning devices are unable to meet a resident's highest functional independence and/or are unable to meet their positioning needs, and a trial of a custom wheelchair has demonstrated medical benefit, the Occupational/Physical Therapist will:

    a. Communicate the assessment or evaluation with the Resident Care Team and/or document in the resident's medical record, the outcome of any trial of the equipment.
    b. Consult with vendor(s) for evaluation of an appropriate custom wheelchair for the resident.
    c. The Occupational/Physical Therapist will facilitate the procurement process and assist with completing and/or obtaining the required forms regulated by specific insurance requirements (i.e. Medi-Cal or Medicare) from the prescribing physician, as needed.
    d. Identifying an appropriate funding source and submit the required documentation to the vendor.
    e. Consider the following when completing the medical record documentation for skilled seating evaluations:

i. Intervention(s) that were tried by Nursing staff and/or rehabilitation department;

ii. Functional deficits due to poor seating or positioning;

iii. Most recent prior functional level;

iv. Postural deficits the patient is unable to self-correct;

v. Recent event(s) that prompted a seating evaluation;

vi. Specific wheelchair, specialty items, dimensions and/or specific cushions that were evaluated and/or recommended;

vii. A clear explanation of how the proposed custom wheelchair or seating device will make a significant improvement in functional abilities versus current wheelchair or seating device;

viii. Transition to caregiver follow-up.

6. If the resident's insurance denies a custom wheelchair while the resident is residing at LHH, the resident may be approved by LHH organization funding process.~~will remain in the facility provided wheelchair.~~

7. If the resident receives a custom wheelchair, the licensed nurse shall document the make, model, and serial number in the resident's care plan and Kardex~~designated unit records per resident inventory~~.

8. Engineering provides a tag to the custom wheelchair and ensure the inventory system is updated with the asset number.

~~8.~~9. For repairs of custom wheelchair on loan from Laguna Honda Hospital Rehabilitation Department, a quote for the repair will be obtained from a vendor and submitted to the supervisor for approval. If the cost of repair is approved, the therapist will contact the vendor to have the parts ordered and schedule for a follow up visit to complete the repair.

- **Nursing/Unit staff will**:

1. Monitor residents' needs and relay this to physicians for a Rehab referral for a wheelchair evaluation if needed.

~~2. Refer to the vendor: The most recent custom wheelchair issued to resident by insurance requiring repairs are referred to the vendor who supplied the wheelchair or vendor of resident's choice. Vendors will be contacted by nursing/unit staff to repair personal custom wheelchairs. This may be dependent on insurance approved vendors. Vendor availability is subject to each company and not related to LHH staffing.~~

~~3.~~2. Address resident's needs and submit work order to Facilities department to obtain a facility wheelchair and/or facility chair repairs (Refer to LHH EM -b0: Manual Wheelchair Maintenance and Repair).

4.3. Submit a work order to LHH Facilities for custom wheelchair repairs that do not affect the integrity or warranty of the wheelchair. This is subject to LHH facility discretion (i.e., inflating air into tires, tightening a screw). Ensure this is approved as per rehab assessment.

5. Place work order for maintenance or repair of residents own or loaned w/c not provided by insurance or LHH. A work order can be placed to LHH facilities. If LHH facilities is not able to repair the w/c, resident or nursing/unit staff can contact an outside vendor if the resident would like to self-pay for the repairs/maintenance.

ATTACHMENT:

REFERENCE:

1. Barclays California Code of Regulations, Title 22 § 51303(a – i).

2. Barclays California Code of Regulations, Title 22 § 51321

3. Physical Therapy, Occupational Therapy and Speech-Language Pathology Outpatient Services Educational Update, United Government Services (fiscal intermediary), 2nd Revision, November 2003.

4. LHH EM -b0: Manual Wheelchair Maintenance and Repair.

5. California Advocates for Nursing Home Reform: Access to Durable Medical Equipment in Nursing Homes.

Most recent review: 17/07/31, 20/04/27, 21/07/22, 22/04/21, 23/05/16
Revised: 04/03/29, 04/08/18, 10/10/21,16/08/05, 18/08/14, 20/05/21, 23/10/10
Original Adoption: 99/08/23

INFLUENZA IMMUNIZATION FOR RESIDENTS

POLICY:

1. Laguna Honda Hospital (LHH) residents and new admissions to LHH will be provided the current influenza vaccine upon their consent during the influenza season which is generally from October to March of each year.
   ~~Using the Standard Influenza Vaccination Protocol, the LHH RN may order influenza vaccinations under specific criteria provided in this policy. Those patients not meeting that protocol criteria will be referred to a prescriber for follow up.~~
2. The resident's electronic health record will include documentation indicating education provided and if the resident received the influenza vaccine or did not due to medical contraindication or refusal.

PURPOSE:

The purpose of this policy is to provide guidance~~HCP information~~ for administration of the annual influenza vaccine to patients / responsible parties including education, annual consent, reporting and documentation.

PROCEDURE:

1. Resident Vaccination

~~Standard RN protocol for ordering influenza vaccine annually for patients residing at LHH includes:~~

The **licensed nurse**~~Registered Nurse (RN)~~ screens **new residents** upon admission during the influenza season and current in-house residents at the start of the influenza season **for the influenza vaccination.**~~to order the influenza vaccine using the Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines for Residents Admitted to LHH.~~

a. A reasonable attempt will be made to determine prior vaccination history. Resident with unknown or unsure vaccination status will not be considered immunized. For those not vaccinated, the reason will be documented. Possible reasons for why the vaccine was not given may include:

Serious reaction (e.g.

~~a. If any of the following are applicable to the patient, the LHH RN may not order an influenza vaccine but must obtain a physician consultation prior to administration:~~

~~i. Documented confirmation resident received vaccine this season~~

~~ii.~~i. ~~Serious reaction (e.g.~~ anaphylaxis) after ingesting eggs or after receiving a previous dose of influenza vaccine or an influenza vaccine component

~~iii.~~ii. History of Guillain-Barre' syndrome

~~iv.~~iii. Resident has had fever >38 degrees Celsius in the last 48 hours

~~v.~~iv. Pregnancy
Resident

i. ~~Patient~~/responsible ~~party~~ requests consult with physician regarding advisability of
~~vi.~~v. taking the vaccine
~~vii.~~vi.

3.

4. Education and Consent:~~The licensed nurse shall provide the resident or responsible party with the current year CDC Vaccine Information Statement (VIS) for the influenza vaccine prior to administering the vaccine.~~

b. Screening for Influenza Vaccination is completed prior to administration of the vaccine.

a. The Physician or licensed nurse, will obtain consent which includes the current year CDC Vaccine Information Statement (VIS) from the resident or surrogate decision maker (SDM) prior to vaccine administration.

b. Physicians or designated prescriber orders the appropriate influenza vaccine dose for residents.

~~c. Consent is obtained prior to vaccination administration~~

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

~~e.~~d. Adverse Event: Nursing completes an Unusual Occurrence report and documents on the electronic health record if there are any unexpected or significant adverse events to the vaccine.

ATTACHMENT:
None.

REFERENCE:
Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines For Residents Admitted to LHH.
Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Register/vol 70, No. 194, 42 CFR Part 483 Medicare and Medicaid Programs, Condition of Participation: Immunization Standard for Long Term Care Facilities.

Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMS-20054 Infection Prevention, Control & Immunizations
CDC Seasonal Influenza Vaccination Resources for Health Professionals available at: https://www.cdc.gov/flu/professionals/vaccination/index.htm
CDC Influenza ACIP Vaccine Recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
CDC Vaccine Information Statements (VIS) available at: https://www.cdc.gov/vaccines/hcp/vis/index.html
Immunization Action Coalition Vaccine Information Statements available at: https://www.immunize.org/vis/
Revised: 11/07/26, 17/09/12, 19/05/14, 20/01/14, 20/10/13, 23/01/10, 23/08/11, 24/01/16 ~~2023/09/14~~ (Year/Month/Day)
Original adoption: 05/11/01

INFLUENZA IMMUNIZATION FOR RESIDENTS

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PURPOSE:

The purpose of this policy is to provide guidance~~HCP information~~ for administration of the annual influenza vaccine to patients / responsible parties including education, annual consent, reporting and documentation.

PROCEDURE:

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Resident

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~~e.~~d. Adverse Event: Nursing completes an Unusual Occurrence report and documents on the electronic health record if there are any unexpected or significant adverse events to the vaccine.

ATTACHMENT:
None.

REFERENCE:
Standardized Procedure Allowing a Registered Nurse to Order Influenza Vaccines For Residents Admitted to LHH.
Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Register/vol 70, No. 194, 42 CFR Part 483 Medicare and Medicaid Programs, Condition of Participation: Immunization Standard for Long Term Care Facilities.

Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMS-20054 Infection Prevention, Control & Immunizations
CDC Seasonal Influenza Vaccination Resources for Health Professionals available at: https://www.cdc.gov/flu/professionals/vaccination/index.htm
CDC Influenza ACIP Vaccine Recommendations available at: https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
CDC Vaccine Information Statements (VIS) available at: https://www.cdc.gov/vaccines/hcp/vis/index.html
Immunization Action Coalition Vaccine Information Statements available at: https://www.immunize.org/vis/
Revised: 11/07/26, 17/09/12, 19/05/14, 20/01/14, 20/10/13, 23/01/10, 23/08/11, 24/01/16 ~~2023/09/14~~ (Year/Month/Day)
Original adoption: 05/11/01

Deletion Hospital-wide Policies and Procedures

Appendix 13: Addendum to Code Blue Policy During Pandemic and Protective Quarantine

The following changes and modifications to the code blue policy will take effect during a pandemic and when Laguna Honda Hospital and Rehabilitation has been placed under protective quarantine.

Policy:

1. Personnel responding to code blue calls will be modified to a minimal number of responding healthcare providers that is required to provide necessary care.

2. All resident code blue calls will be considered COVID-19 positive and will require staff to don personal protective equipment (PPE) prior to entering the room or area of the emergency.

3. Attempt to minimize viral aerosolization during emergency situations.

Purpose:

1. Provide all residents with emergency care per existing policy.

2. Minimize staff movement throughout the hospital and reduce the risk of spreading infection.

3. First Responder

    a. The staff responder who determines resident requires CPR per BLS guidelines and scope of practice, will initiate hands only CPR until appropriate PPE arrives.

        i. During hands only CPR, cover mouth and nose with face covering such as gown, t-shirt, pillowcase or surgical mask.

        ii. Additional staff who respond will don PPE and relieve the first responder to leave room or don PPE.

4. Physician Staff Response Daytime 8-5pm Monday-Friday
    a. Non-Quarantined units and Quarantined units
        i. Both Urgent Care physicians (North Side 415-327-4914, South Side 415-327-4912)
        ii. All physicians in the tower.(For PMS/PMA-All PM physicians and S2 physicians)
        iii. Code Blue Committee Physicians
    b. Physicians of quarantined units are exempt from responding to Codes outside of their units.
5. Physician Staff Response Nights/Weekends
    a. Non-Quarantined units and Quarantined Units
        i. All In house physicians.
6. Nursing Staff Response
    a. South Building
        i. Nursing staff from the unit and a Registered Nurse (RN) from Pavilion Mezzanine.
    b. North Building
        i. Nursing staff from the unit and an RN from Pavilion Mezzanine.
    c. Pavilion Mezzanine Skilled Nursing Facility (PMS) and Pavilion Acute
        i. RNs from PMS and Pavilion Acute
    d. Wellness Center and Serenity Park (Harmony Park)

i. One RN from PMS and one RN from Pavilion Acute

e. Managers and directors as available will respond to all calls.

f. Nursing supervisors will respond to all calls during their shift.

7. Other Healthcare Responders

   a. Please refer to Nursing Policy

   b. Respiratory Therapist for assigned tower when available.

   c. Pharmacy for Quarantined and Non-Quarantined Wards Daytime 8-5pm Monday-Friday.

8. Units Under Quarantine

   a. Units under quarantine shall attempt to manage the emergency utilizing their own staff.
      i. A staff person should remain at entry door and only allow necessary staff to enter after first identifying if they can safely enter.
      ii. If two or more units are under quarantine, the quarantined units will respond to only other quarantined units.

9. Monitoring of entrance into isolation room or entry point of quarantined unit.

   a. A monitor will wait at the entry of room or unit to announce if the patient is in isolation, and if patient is a suspected PUI or confirmed case.

   b. The monitor will ensure each responder has donned appropriate PPE prior to entry.

   c. The monitor will control the flow of responders into the room to the minimal number of responders necessary for essential patient care.

10. Calls requiring additional assistance

    a. When additional assistance is required, unit staff will call the nursing office to page overhead “additional nursing and/or physician support is needed for Code Blue ‘at location’.”

        i. Nurses within the tower should go to the unit and assess if they are needed.

11. Additional Protective Measures to Minimize Transmission

    a. PPE including gowns, facemasks and respirator masks in various sizes can be found in code cart.

        i. Only necessary staff should don PPE and be in room during code blue event.

INFECTION OUTBREAK INVESTIGATION AND SURGE RESPONSE

POLICY:

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

DEFINITIONS:

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

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

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

PROCEDURE:

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

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

3. Outbreak investigation:

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

4. SURGE Protocol:

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

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

ATTACHMENT:
NONE

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

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

TRANSMISSION-BASED PRECAUTIONS AND RESIDENT ROOM PLACEMENT

POLICY:

The facility uses a coordinated process of standard and transmission-based precautions to reduce the risk of transmission of communicable diseases to patients, employees, and visitors.

RESPONSIBILITES:

A. This policy applies to all employees of Laguna Honda Hospital and Rehabilitation and to all medical staff, volunteers, contract workers and students.
B. Supervisors, managers, and directors are required to enforce the provisions of this policy in their areas. Employees who do not follow the contents of this plan may be subject to disciplinary action.
C. The Infection Prevention Department is available to provide consultation regarding transmission-based precautions.
D. Any patient known or suspected to have a disease or condition that warrants transmission-based precautions will be placed in the appropriate transmission precautions upon admission. Physicians and/or nurses will promptly order the precautions category for newly diagnosed or suspected cases.
    1. The nurse is responsible for ensuring that the precautions are initiated and maintained according to the specified protocol.
    2. The infection prevention staff or the patient's nurse may initiate transmission -based precautions without the physician's order based upon a lab report, or patient's changing status (e.g., diarrhea) or based on a prior known admission infectious status. In those instances, the physician will be notified that the patient was placed on transmission-based precautions, and a note for the rationale will be entered in the nurse's notes.
E. PPE will be located in each Resident unit and care location/department.

PROCEDURE:

TRANSMISSION Based Precautions (TBP) are designed for patients documented or suspected to be infected/ colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission. The three categories of Transmission Based Precautions include: Contact, Droplet, and Airborne.

A. Signs. TBP s~~S~~igns will be placed in a visible location outside of resident room.~~either on the outer room doors for patients placed on transmission-based precautions. The sign shall be limited to the type of precautions.~~

B. Patient Transport. If a patient placed on TBP ~~transmission precautions~~ requires transport, notify the area prior to transport about the patient's condition and the requirement for transmission-based precautions.

C. Room Selection. Patients placed under transmission-based precautions will be placed in a private room if possible or cohorted with another patient

infected with the same pathogen. ~~If this is not possible, the patient may be placed with a patient who has low risk of infection.~~ Consult Infection Prevention Department. ~~place the tray on a clean barrier instead of on a contaminated environmental surface.~~

D. Linen. All soiled linen will be handled in the same manner regardless of the patient's specific diagnosis. Although the risk of disease transmission from soiled linen is minimal, the following infection prevention guidelines apply to the management of linen and laundry.

1. Handle soiled linen as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen.
2. Linen will not be sorted or rinsed in patient care areas.
3. Place all linen in the designated leak-proof, laundry bags. It is not necessary to put any linen in a red bag.
4. Caution must be exercised to help prevent laundry bags from being OVERFILLED~~. Do not drag the linen bag on the floor while transporting to soiled utility room~~.
5. Filled linen bags will be closed securely.
6. Linen should not be stockpiled in rooms.
7. Double bagging will be utilized only when the original linen bag is torn, punctured, or visibly contaminated on the outside; or if the linen contains such a large amount of fluid that the original bag may leak.

E. Foodservice. Disposable trays and utensils for foodservice are not necessary for patients under transmission-based precautions. Dietary carts are cleaned per hospital-approved policy.

F. Visitors

- **Airborne**: Visitation should be limited to only those who Nursing agrees will support patient's safety/wellbeing. Visitors should wear a tight fitting mask (N95 - perform seal check) if visitor is unable to tolerate a surgical mask can be used (Sfeir, 2018). Visitors are reminded to keep their hands off of their face and perform hand hygiene prior to entry and upon leaving the room.
- **Droplet:** Visitation should be limited to only those who Nursing agrees will support patient's safety/well -being. Visitors wear a surgical mask. Visitors are reminded to keep their hands off of their face and perform hand hygiene prior to entry and upon leaving the room.
- ~~**Enhanced Droplet**: Visitation should be limited to only those who Nursing agrees will support patient's safety/well -being. Visitors wear a tight-fitting mask.~~
- **Contact**: Visitors are not required to wear PPE for contact precautions unless the visitor is going to participate in direct resident care or visit another patient in the hospital. An information sheet is available to educate families of patients on contact precautions to determine if the

visitor is at risk for infection (e.g., visitor has an open wound, catheter, etc.).

G. Terminal Room Cleaning

1. When patients are discharged or transferred, the TBP ~~precaution~~ sign must stay in place until the designated employee has cleaned the room.
2. All room surfaces and equipment are terminally cleaned according to EnvironmentalServices cleaning procedures. Privacy curtains are removed and sent to the laundry.

H. Education. The nurse will educate the patient and/or visitors about hand hygiene, respiratory hygiene (if applicable) and the type of transmission precautions. Education should be documented in the patient notes and isolation needs added to the plan of care.

I. Environmental Services. EPIC notification automatically populates on the EVS bed board patients on transmission-based precautions. EVS staff shall follow TBP signage posted outside rooms and seek guidance from nursing and/or infection prevention for any question.

CATEGORIES OF PRECAUTIONS

AIRBORNE Precautions are designed to reduce the risk or eliminate the airborne transmission of infectious agents. Airborne transmission occurs by dissemination of either airborne droplet nuclei (small particle residue - 5um or smaller sized evaporated droplets which remain suspended in the air of long periods of time) or dust particles containing the infectious agent.

All patients who are:
a) diagnosed with confirmed active ATD Airborne Transmissible Disease~~TB~~ and are infectious, or b) under clinical suspicion of active pulmonary ATD~~TB~~ or who show signs or symptoms indicative of a possible ATD~~TB~~ infection should be placed in airborne precautions (i.e., negative pressure, private room with the door kept closed, N-95 particulate respirator for those entering the room).

Patients who have signs and symptoms compatible with tuberculosis, and who have a diagnostic test for TB (i.e., AFB sputum smear or culture) shall be placed under airborne precautions until TB has been ruled out as a diagnosis.~~).~~

A. Patients will be placed in an airborne infection~~infections~~ transmission (negative pressure) room with a minimum of 6 – 12 air exchanges per hour with ventilation either outside or through a high efficiency particulate air filter.

B. When a patient is placed in an Airborne Precaution room, Plant Facilities must be notified, as these rooms must be tested daily using a physical test while in use.~~.~~ Nursing will notify on-call engineer upon admission or transfer of

a patient requiring air negative pressure. If the patient is currently in a room that is air negative pressure and then the patient's status changes to need air negative pressure, the nurse needs to notify on-call engineer to check the room for correct pressure daily.

C. Patients diagnosed with an ATD ~~with tuberculosis or rule out tuberculosis~~ will be placed in the following respiratory isolation rooms:

Location	Room(s)
South 4	28, 48
South 5	28, 48
South 6	28, 48
Pavilion Mezzanine	48

D. Table 2 shows a sampling of diseases and conditions identified by Cal OSHA as requiring Airborne Isolation.

E. Table 2. Diseases/Pathogens Requiring Airborne Isolation (Cal OSHA)
Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g.
Anthrax/Bacillus anthracis
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any
patient. Localized disease in immunocompromised patient until disseminated infection ruled out
Measles (rubeola)/Measles virus
Monkeypox/Monkeypox virus
Novel or unknown pathogens
Severe acute respiratory syndrome (SARS)
Smallpox (variola)/Varioloa virus
Tuberculosis (TB)/Mycobacterium tuberculosis -- Extrapulmonary, draining lesion; Pulmonary or laryngeal
disease, confirmed; Pulmonary or laryngeal disease, suspected
Any other disease for which public health guidelines recommend airborne infection isolation

~~D.~~F. Doors must remain closed for the airborne negative pressure rooms to work. This includes doors to ante rooms.

~~E.~~G. An N-95 particulate respirator must be worn when entering the room of a patient in Airborne Precautions. Personnel will have a documented~~qualitative~~ fit test prior to being assigned duties requiring the use of an N-95 particulate

respirator and will perform a fit check (put mask on and make sure that no air escapes while exhaling) prior to each use. NOTE: Gloves and gowns are not required for airborne precautions unless standard precautions require them (COVID-19.)~~.~~

~~F.~~**H.** Susceptible persons will not enter the room of patients known or suspected to have measles (rubeola) or varicella (chickenpox). Employees who do not know their status may contact the Employee Health Department.

~~G.~~**I.** Only transport the patient to other areas if it is essential. If transport is necessary, schedule a time slot to avoid other patients (e.g., last patient of the day) if possible and notify the area regarding patient's precautions prior to patient transport.

~~H.~~**J.** Patient will wear a surgical or procedural mask during transport and any time he/she is out of the airborne negative pressure room.

DROPLET Precautions are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large particle droplets (larger than 5 um in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated by the source person during coughing, sneezing, or talking and/or during the performance of certain procedures such as suctioning and bronchoscopy. Transmission via large particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 6 feet or less.

A. A surgical or procedural mask shall~~must~~ be donned before~~worn when working within a 6 foot diameter of the patient. The healthcare worker may choose to put on the mask prior to~~ entering the patient room. An airborne transmission negative pressure room is unnecessary. NOTE: Gloves and gowns are not required for droplet precautions unless standard precautions require them.

B. Patients will be transported only when medically necessary. Inform the receiving area that the patient is under droplet precautions. Patient will wear a surgical mask during transport.

Airborne/Contact/Droplet ~~ENHANCED DROPLET~~ Precautions are used when patients with suspected novel pathogens (such as COVID-19) are placed in rooms that are not AIIRs. Patients in Airborne/Contact/Droplet ~~Enhanced Droplet~~ precautions require:

A. Private room if available

B. A portable HEPA filter unit may be added to the room.

C. Care providers must wear a fit-tested N-95 respirator, eye protection, powered air purifying respirator (PAPR), gown and gloves.

D. Patients should stay in their room except for essential purposes, in which case, a regular mask (surgical) is worn by the patient at all times outside their room.

E. Visitors will be instructed to wear a tight-fitting mask (if N-95 mask, no fit testing required for visitors). They should be instructed on how to don the mask and how to form a good seal. (See Appendix B: Donning and Doffing Mask)

F. Discontinuing Precautions:

1. Airborne/Contact/Droplet~~Enhanced Droplet~~ precautions for COVID-19 positive patients may be discontinued following current CDC and regulatory guidance. Consultation with infection control is encouraged if questions arise.

CONTACT Precautions are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person, such as occurs when personnel turn patients, bathe patients, or perform other patient care activities that require physical contact. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, in the patient's environment. Contact precautions are issued for patients infected or colonized with:

A. Gloves will be worn when having contact with patient care equipment that has been used by a patient on contact precautions (e.g., cleaning a wheelchair).

B. Staff will wear a clean, non-sterile gown when entering the patient room for any reason. The HALLWAY PPE cart will remain stocked; nursing personnel caring for the patient shall ensure that items on the cart remain stocked including Regular and XL sized gowns.

C. ANY reusable patient equipment must be cleaned after use with hospital approved disinfectant products.

D. Soiled linen~~Linen~~ will be stored in a regular linen bag. When the bag is filled, the bag will be closed securely and put in the soiled utility room.

E. Solid waste generated by isolation procedures (e.g., gowns and gloves) shall be disposed of in a regular waste bag inside the patient's room.

F. Immediately prior to exiting the patient room, PPE will be removed. Gowns will be taken off prior to gloves, rolling inwards. Gloves will be taken off taking

care to avoid contamination of the hands. At that time, hands will be immediately washed with soap and water, or an alcohol antiseptic gel will be used. Avoid recontamination of hands from environmental surfaces.

G. Transport of patients under contact precautions requires that the resident must be wearing freshly cleaned clothing, perform resident hand hygiene and disinfect high touch points of assistive device using hospital approved disinfectant prior to going outside of the patients' room. The accepting department will implement contact precautions according to policy when the patient arrives in their department.

~~**G.** Transport of patients under contact precautions requires that the patient must be wearing a fresh contact transmission gown outside of the patients' room. The accepting department will implement contact precautions according to policy when the patient arrives in their department.~~

H. Patients under contact precautions will be allowed outside of the room at the discretion of the unit supervisor with consultation of MD, and Infection Prevention Team. The resident must be wearing freshly cleaned clothing, perform resident hand hygiene, and disinfect high touch points of assistive device using hospital approved disinfectant prior to going outside of the patients' room. Acceptable behavior might include walks in the hallway of their unit for exercise.

ENHANCED CONTACT Precautions are designed to reduce the risk of transmission of C.difficile by direct or indirect contact spread throughout the healthcare environment. Enhanced contact precautions are issued for patients with active infectious colitis not colonization.

A. Private room if available.

B. Follow and adhere to PPE usage as outlined under contact precautions.

C. Perform hand hygiene preferably with soap and water. Alcohol based hand rubs are an alternative substitute when hand washing sinks are not in close proximity to patient care locations.

D. Use hospital-approved **sporicidal** (bleach) disinfecting wipes on surfaces and equipment.

E. Patients should stay in their room except for essential purposes, in which case, patient should be continent and ability to contain liquid stool is possible. Patient shall wash hands with soap and water and place a clean gown prior to leaving room.

ENHANCED Standard~~BARRIER~~ Precautions- Long Term Care for residents with wounds or indwelling medical devices during specific high-contact resident care activities commonly associated with MDRO transmission.

A. Private room if available or cohort with compatible roommate based on MDRO status.

B. Wear gowns and gloves while performing high-risk tasks:
1. ~~1.~~ Morning and evening care
2. ~~2.~~ Device care (Urinary, Feeding tube, etc.)
~~3.~~ Close contact resident care (Bathing, peri-care, toileting, changing Briefs, bed linens and
3. ~~briefs,~~ respiratory care).
4. Cleaning and disinfecting the environment.
5. Wound Care
6. Mobility assistance and preparing to leave the room

~~4. Changing bed linens~~

C. In multiple resident rooms~~multi bedrooms~~, consider each bed space as a separate room and change gowns, gloves and perform hand hygiene when moving from contact with one~~on~~ resident to contact with another resident.

D. Gowns and Gloves should always be removed inside the room when care activity is complete. Gowns and Gloves should not be routinely worn outside the room ~~when resident care is not being performed~~.

E. Visitors do not need to routinely wear gown and gloves when visiting a resident unless the visitor is assisting~~on EBP. However, visitors who participate~~ in a~~close~~ resident care activity then they~~,~~ should wear gowns and gloves when providing care.

DISCONTINUATION of TRANSMISSION BASED PRECAUTIONS: Transmission based precautions remain in effect for a limited period~~periods~~ (while risk of transmission of infectious agent persists during the period of infectivity).

A. Empirically initiated transmission-based precautions may be adjusted or discontinued when additional clinical information becomes available (confirmatory laboratory results).

B. Strategies for determining when to discontinue precautions are organism specific and summarized in Appendix A

ATTACHMENT:

Appendix A: Type and Duration of Transmission Based Precautions Recommended for Selected Infections and Conditions

Appendix B: Donning and Doffing Mask

Appendix C: Isolation Signage

REFERENCE:

CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)

CDC.gov/COVID in Healthcare settings (updated 2022)

Minnesota Department of Health (CDPH cited) **Isolation Precautions in LTCF for CDI** health.state.mn,us

CDC: Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO) July 12,2022

Sfeir, M., Simon, M.S., Banach, D. (2018). Isolation Precautions for Visitors to Healthcare Settings. In: Bearman, G., Munoz-Price, S., Morgan, D., Murthy, R. (eds) Infection Prevention. Springer, Cham. https://doi.org/10.1007/978-3-319-60980-5_4

Revised: 18/11/13, 20/10/13, 22/9/13, 22/12/13, ~~23/09/18~~ (Year/Month/Day)
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Appendix A:
Type and Duration of Transmission Based Precautions Recommended for Selected Infections and Conditions

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Standard Precautions are to be used on every patient. These precautions protect you from exposure to body fluids that could potentially be infectious. ALWAYS protect yourself and wear a mask, eye shield, gloves, and gown when anticipating contact with body fluids.

Some of the organism/syndromes below require a higher level of protection above Standard. This is because of contamination of the environment (making transmission extremely easy), the mode of transmission (contact, droplet, airborne), or the epidemiological significance of the organism (i.e. antibiotic resistance, high virulence). Noted in this table ~~transmission~~ transmission-based precautions (Enhanced Contact, Enhanced Standard, Contact, Droplet, Airborne) are always in addition to Standard Precautions.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Acquired immunodeficiency syndrome (AIDS), Human Immunodeficiency Virus (HIV)	**Standard**		
***Acinetobacter baumannii*:**			
Multi-drug resistant	**Contact**	Active Infection – ~~Duration of illness~~Contact *Colonization – Enhanced Standard precautions. Determination is made by primary care MD and ICC chair/ID MD.	Place patient in a private room. Epidemiologically significant organism.
Antibiotic sensitive	**Standard***		

Aspergillosis (*Aspergillus sp.*)	**Standard**		Consult IPC if massive soft tissue infection with copious drainage may consider higher level of TBP.
Botulism	**Standard**		Not transmitted from person to person.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Campylobacter gastroenteritis (See gastroenteritis)			
Candida auris (C. auris)	**Contact***	Duration of isolation is determined by primary care MD in consultation with ICC chair/ID MD/IPC. ~~Duration of Illness*~~	*For new C. auris cultures~~colonization or infection~~: 1. Contact Infection Control/Nursing Operations Immediately. 2. Private room required. DO NOT COHORT unless cleared though infection control. 3. Hand hygiene~~washing with soap~~ and environmental cleaning~~water as alcohol-based hand rubs~~ are key.~~ineffective against C. auris.~~ 4. Disinfect all high touch surfaces with ~~Clean resident environment daily with Bleach or~~ hospital approved BLEACH wipes/sporicidal cleaner/disinfectant once per shift~~effective against C. auris and throughout after interacting with resident or environment.~~ 5. Assume indefinite colonization. 6. Notify receiving facility of C. auris status on transfer or discharge. ~~7.~~ Consult with Infection Control with questions.
Candidiasis (*Candida sp.*), all forms including mucocutaneous	**Standard**		

~~**Carbapenem-resistant Enterobacteriaceae (CRE)**~~	~~**Contact**~~	~~Duration of Stay*~~	~~*For colonization or infection:~~ ~~1. Contact Infection Control/ Nursing Operations Immediately.~~ ~~2. Place patient in private room, private bathroom, and dedicated medical equipment. Do not cohort until cleared through infection control.~~ ~~3. Assume indefinite colonization.~~ ~~4. Hand hygiene and environmental cleaning are key.~~ ~~5. Notify receiving facility of CRE status on discharge or transfer.~~ ~~6. Requires serial surveillance cultures 3-6 months after initial positive to consider discontinuation of precautions.~~

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Carbapenem-resistant Enterobacteriaceae (CRE) **(Examples: E. coli, Enterobacter cloacae, Klebsiella pneumoniae)**	**Contact***	Duration of isolation is determined by primary care MD in consultation with ICC chair/ID MD/IPC. *Carbapenemase-producing organisms of concern (CP-CRE) will require an ID consult and contact precautions indefinitely.	For new CRE cultures (pending carbapenemase producing test results): 1. Contact Infection Control/ Nursing Operations Immediately. 2. Place patient in private room, private bathroom, and dedicated medical equipment. Do not cohort until cleared through infection control. 3. Hand hygiene and environmental cleaning are key. 4. Notify receiving facility of CRE status on discharge or transfer. 5. If CRE i**s** carbapenemase producing, then assume indefinite colonization. The resident will require contact precautions. 6. If CRE i**s not** carbapenemase producing, then assume colonization and consider implementing Enhanced Standard Precautions

Carbapenem-resistant Organisms (CRO) **(Example: Pseudomonas, Acinetobacter)**	**Contact***	Duration of isolation is determined by primary care MD in consultation with ICC chair/ID MD/IPC. *Carbapenemase-producing organisms of concern (CP-CRO) will require an ID consult and contact precautions indefinitely.	For new CRO cultures (pending carbapenemase producing test results): 1. Contact Infection Control/ Nursing Operations Immediately. 2. Place patient in private room, private bathroom, and dedicated medical equipment. Do not cohort until cleared through infection control. 3. Hand hygiene and environmental cleaning are key. 4. Notify receiving facility of CRO status on discharge or transfer. 5. If CRO i**s** carbapenemase producing, then assume indefinite colonization. The resident will require contact precautions. 6. If CRO i**s not** carbapenemase producing, then assume colonization and consider implementing Enhanced Standard Precautions

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Clostridium:			
*__C. difficile__ **gastroenteritis**, enterocolitis (Clostridioides difficile – C. diff - Acute Infection e.g., active colitis).	**Enhanced Contact**	Remain on Enhanced Contact Precautions until 2 days after last unformed stools.	• Private room: door may remain open • Dedicated equipment • Soap and water for hand hygiene • DISINFECT all high touch surfaces with hospital approved BLEACH wipes/sporicidal • cleaner/disinfectant once per shift. *Consult Infection Control for questions related to room placement/cohorting guidance following active infection.

Conjunctivitis:			
Acute bacterial	**Standard**		
Chlamydia	**Standard**		
Gonococcal (including gonococcal opthalmia) neonatorum)	**Standard**		
Viral	**Standard**		
COVID-19 (Novel Coronavirus 2019) (SARS-CoV2)	**Airborne/Contact-/Droplet~~with eye protection~~**	Suhfdxwlrqv#vkrxog#eh#lp sohp hqwhg# iru#43#gd|v#diwhu#looqhvv#rqvhw#ru# xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri# ihyhu#dqg#uhvsludwru|#v|p swrp v/# z klfkhyhu#lv#orqjhu~~refer to current LHH COVID-19 prevention and management~~	N-95/PAPR + gown + gloves + eye protection, Private Room with door closed.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Cytomegalovirus (CMV) or immunosuppressed	**Standard**		Standard precautions for contact with all body fluids. No additional precautions necessary for pregnant HCWs.
Diarrhea, acute, of unknown etiology, infective etiology suspected *(see gastroenteritis)*			
Endometritis	**Standard**		
~~**Enterococcus sp, vancomycin resistant (VRE)**~~	~~**Standard***~~		~~*Depending on transmission risk- addition of transmission based precautions might be necessary. Consult Infection Control with questions.~~
Epstein-Barr virus (including infectious mononucleosis)	**Standard**		
Food poisoning:			
Botulism	**Standard**		Not transmitted from person to person
Clostridium perfringens or	**Standard**		Not transmitted from person to person

welchii			
Staphylococcal (*Staphylococcus aureus*)	**Standard**		Not transmitted from person to person
Gastroenteritis (*C. difficile see Clostridium; Norovirus- see Norovirus)*			
Adenovirus	**Contact**	Duration of illness (until diarrhea resolves)	Place patient in private room. Hand Hygiene with soap and water (***not alcohol gel***) is recommended until diarrhea resolves.
Campylobacter sp.			
Cholera (Vibrio cholerae)			
Cryotosporidiosis (*Cryptosporidium sp*.)			

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Gastroenteritis cont. (*C. difficile see Clostridium; Norovirus- see Norovirus)*			
Escherichia. Coli (Enterohemorrhagic O157:H7)			
Escherichia. Coli Other species	**Contact**	Duration of illness (Until~~until~~ diarrhea resolves) *Rotavirus: Duration of illness (until diarrhea resolves) **AND** one negative rotavirus test is obtained	Place patient in private room. Hand Hygiene with soap and water (***not alcohol gel***) is recommended until diarrhea resolves.
Giardiasis *(Giardia lamblia)*			
Rotavirus*			
Salmonella (including S. typhi)			

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Hepatitis, viral:			
Type A, chronic	**Standard**		
Type B (HBsAg positive)	**Standard**		
Type C and other unspecified non-A, non-	**Standard**		
Type E	**Standard**		
Herpes simplex (*herpesvirus hominis*):			
Mucocutaneous, disseminated or primary, severe	**Contact**	Until lesions dry and crusted	Place patient in a private room.
Mucocutaneous, recurrent (skin, oral, genital)	**Standard**		
Herpes zoster (see varicella zoster)			
Human Metapneumovirus	**Droplet/Contact**	Duration~~8 Days from symptom onset or~~ until symptoms resolve~~. regardless of test result~~	Place patient in a private room if possible.
Impetigo, diffuse	**Contact**	Until 24 hours after initiation of effective therapy	Place patient in a private room if possible.
Shigella species			
Vibrio parahaemolyticus			
Yersinia enterocolitica			
Gonorrhea (*Neisseria gonorrhea*)	**Standard**		
Guillain-Barre syndrome	**Standard**		Not an infectious condition.
Helicobacter pylori	**Standard**		

Influenza:			
Human (seasonal influenza)	**Droplet**	Gursdhw#suhfdxwlrqv#vkrxog#eh#lp sohp hqwhg#iru#:# gd|v#diwhu#loghvv#rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh# uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|p swrp v/# zklfkhyhu#lv#orqjhu ~~and fever free >24 hours~~	Place patient in a private room or cohort (with verified same viral strain).
Legionnaires' disease (*Legionella sp.*)	**Standard**		Not transmitted from person to person.
Leprosy (*Mycobacterium leprae*)	**Standard**		
Lice (pediculosis)	**Contact**	Until 24 hours after initiation of effective therapy. One treatment is usually sufficient.	Place patient in a private room.
Molluscum contagiosum	**Standard**		
Monkeypox	**Airborne Contact ~~Enhanced Droplet~~**	Until all lesions have crusted, and crusts have separated, and a fresh layer of healthy skin has formed.	Place patient in a private room. Dedicated equipment.

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Multidrug resistant organisms (MDRO) infection and colonization:			
Enterococcus, vancomycin resistant (VRE)	**Enhanced Standard Precautions***		*Depending on transmission risk (uncontained wounds/urine)- addition of transmission -based precautions might be necessary. Consult Infection Control with questions.
Extended Spectrum Beta-Lactamase eg. *E. coli* or *Klebsiella pneumonia*, all sites ~~Gram negative organisms, MDR (also see *Acinetobacter baumannii*)~~	**Enhanced Standard Precautions***		
Gram negative organisms, MDR (also see *Acinetobacter baumannii*)~~Staphylococcus aureus, nafcillin/methicillin resistant~~	**Enhanced Standard Precautions***		
Staphylococcus aureus, nafcillin/methicillin resistant (MRSA)~~Carbapenem Resistant Enterobacterales (CRE)~~	~~Contact~~ **Enhanced Standard Precautions***		

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Noroviruses	**Enhanced Contact Precautions**	Patient remains on precautions until discharge. Consult with Infection Control for extended inpatient stays at hospital, SNF, or Subacute units.	• Gloves and gowns for all persons entering the patient's room for any reason • Private room; door may remain open • Dedicated equipment • Soap and water for hand hygiene • DISINFECT all high touch surfaces with BLEACH once per shift
Pediculosis (Lice)	**Contact**	Until 24 hours after initiation of effective therapy. One treatment is usually sufficient.	Place patient in a private room.
Pressure ulcer (decubitus, pressure sore) Infected Major	**Enhanced Standard~~Barrier~~**	Until drainage stops or can be contained by dressing.	

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Respiratory Viruses:			
Coronavirus (Seasonal)	**Droplet** ~~(See comment)~~	Suhfdxwlrqv#vkrxog#eh#lpsohphqwhg#iru#:#gd|v#diwhu#loqhvv#rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|pswrpv#zklfkhyhu#lv#orqjhu ~~Until symptoms resolve regardless of test result~~	Place patient in a private room if possible. Add Contact Precautions if copious moist secretions and close contact likely to occur.
Human Metapneumovirus	~~Droplet/~~**Contact**	Suhfdxwlrqv#vkrxog#eh#lpsohphqwhg#iru#:#gd|v#diwhu#loqhvv#rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|pswrpv#zklfkhyhu#lv#orqjhu ~~Until symptoms resolve regardless of test result~~	Place patient in a private room if possible.
Influenza (Human/seasonal influenza)	**Droplet**	Gursohw#suhfdxwlrqv#vkrxog#eh#lpsohphqwhg#iru#:#gd|v#diwhu#loqhvv#rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|pswrpv#zklfkhyhu#lv#orqjhu ~~and fever free >24 hours~~	Place patient in a private room or cohort (with verified same viral strain). See Appendix B for additional Postpartum instructions
Parainfluenza	~~Droplet/~~**Contact**	Suhfdxwlrqv#vkrxog#eh#lpsohphqwhg#iru#:#gd|v#diwhu#loqhvv#rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|pswrpv#zklfkhyhu#lv#orqjhu ~~Until symptoms resolve regardless of test result~~	Place patient in a private room if possible.
Respiratory syncytial virus (RSV)	~~Droplet/~~**Contact**	Suhfdxwlrqv#vkrxog#eh#lpsohphqwhg#iru#:#gd|v#diwhu#loqhvv ~~8 Days from symptom~~ #rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|pswrpv#zklfkhyhu#lv#orqjhu ~~resolve regardless of test result~~	Place patient in a private room if possible.
Rhinovirus	**Droplet** ~~(see comment)~~	Suhfdxwlrqv#vkrxog#eh#lpsohphqwhg#iru#:#gd|v#diwhu#loqhvv#rqvhw#ru#xqwlo#57#krxuv#diwhu#wkh#uhvroxwlrq#ri#ihyhu#dqg#uhvsludwru|#v|pswrpv#zklfkhyhu#lv#orqjhu ~~Until symptoms resolve regardless of test result~~	Place patient in a private room if possible. Add Contact Precautions if copious moist secretions and close contact likely to occur.
Scabies	**Contact**	Until 24 hours after initiation of effective therapy	
Syphilis:			
Skin and mucous membrane, including congenital, primary, secondary	**Standard**		

Latent (tertiary) and seropositivity without lesions	**Standard**		

Organism/Syndrome	Precautions	Duration of Precautions	Comment
Tuberculosis (*M. tuberculosis*):			
Skin-test (PPD) positive with no evidence of current pulmonary disease	**Standard**		
Pulmonary (suspected or confirmed) OR laryngeal disease	**Airborne**	Discontinue precautions only when ATD~~TB~~ patient is: 1. On effective therapy x14 days 2. Improving clinically 3. Has 3 consecutive negative sputum smears collected on different days or when ATD~~TB~~ is ruled out	Place patient in a negative air pressure room, staff to wear N95 or PAPR.
Varicella (chickenpox)	**Airborne/Contact/Droplet**	Until ALL lesions are crusted over	Place patient in a negative air pressure room. Susceptible HCWs should NOT enter the room if other, immune caregivers are available.
Wound Infections	**Enhanced Standard~~Barrier~~ Precautions**	Until healed	
Varicella zoster (herpes zoster, shingles):			HCWs susceptible to varicella are also at risk for developing varicella when exposed to patients with herpes zoster lesions; therefore, susceptible HCWs should not enter the room if other immune caregivers are available.
Disseminated (across multiple dermatomes) disease in any patient.	**Airborne/Contact/Droplet**	Place patient in a negative air pressure room until ALL lesions are crusted over	

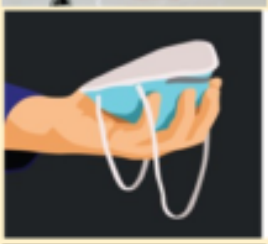
Localized in normal patient and lesions can be contained/covered	**Standard**		

Appendix B: Donning and Doffing Mask

Putting on a mask with head straps

Inspect the mask. Before putting on a mask, first inspect it for damage. Do not use a mask that appears damaged.

1. **Wash your hands** or use hand sanitizer before putting on your mask.



2. **Position the mask in your hand with the nose pieces at your fingertips.** (Most masks designed to seal to the face have a thin metal or plastic bar at the top of the device)

3. **Cup the mask in your hand** allowing the headbands to hang below your hand. Hold the respirator under your chin with the nosepiece up.

4. **The top strap (on single or double strap respirators) goes over and rests at the back of your head near the crown.** The bottom strap is then positioned around the neck and below the ears. Do not crisscross the straps.

5. **Place your fingertips from both hands at the top of the nose clip. Slide down both sides of the strip to mold the nose area to the shape of your nose.**

Check the Seal. Check the seal of the mask to the face. Place both hands over the mask, take a quick breath in to check the seal. Breathe out. If you feel a leak when breathing in or breathing out, there is not a proper seal.

Image credit: The CDC (https://blogs.cdc.gov/publichealthmatters/2019/06/using-a-respirator/)

Taking off a mask with head straps

Do NOT TOUCH the front of the mask!
It may be contaminated.

1. **Wash your hands** or use hand sanitizer before taking off your mask.

2. **Remove by pulling the bottom strap over the back of your head,** followed by the top strap. Remember, do not touch the facepiece of the mask.

3. **For reusable masks wash and safely store after use.** For single use masks, safely discard after removal.

4. **Wash your hands** or use hand sanitizer after taking off your mask.

Image credit: The CDC (https://blogs.cdc.gov/publichealthmatters/2019/06/using-a-respirator/)

Appendix C: Signs

STOP

VISITORS: See a nurse BEFORE entering room.
VISITANTES: Por favor ver a un(a) enfermero(a) ANTES de entrar en la habitación.
訪客：進入房間之前先見護士。

AIRBORNE ISOLATION

Perform Seal Check Prior to Entering the Room:

Clean Hands

Fit-tested N95 Respirator or PAPR

Please see reverse for instructions.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

AIRBORNE AND CONTACT PRECAUTIONS WITH EYE PROTECTION

STOP

ALTO

PRECAUCIONES CONTRA ORGANISMOS QUE SE MANTIENEN EN EL AIRE Y SUPERFICIES CON PROTECCIÓN PARA LOS OJOS

TO PREVENT THE SPREAD OF INFECTION,

***ANYONE ENTERING THIS ROOM MUST**

PARA PREVENIR EL ESPARCIMIENTO DE INFECCIONES,

***TODAS LAS PERSONAS QUE ENTREN EN ESTA HABITACION TIENEN QUE:**

HAND HYGIENE
HIGIENE DE LAS MANOS ✓

GOWN
BATA ✓

N-95 RESPIRATOR
RESPIRADOR N-95 ✓

EYE PROTECTION
PROTECCIÓN DE OJOS ✓

GLOVES
GUANTES ✓

Ensure that the door to the patient's room remains closed at all times.

*Patient must wear surgical mask during transport. Check with RN for assistance.

Asegurese de mantener la puerta de esta habitacion cerrada todo el tiempo.

*El paciente debe usar mascarilla quirúrgica durante el transporte. Consulte con la enfermera para asistencia.


STOP
VISITORS: See a nurse BEFORE entering room.
VISITANTES: Por favor ver a un(a) enfermero(a) ANTES de entrar en la habitación.
訪客：進入房間之前先見護士。
AIRBORNE + CONTACT+ DROPLET ISOLATION
Prior to Entering the Room:
Clean Hands
N95 + Eye Protection
or
PAPR
Gown
Gloves
Please see reverse for instructions.
San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

STOP

DROPLET PRECAUTIONS

ALTO

PRECAUCIONES CONTRA PARTICULAS O GOTITAS

TO PREVENT THE SPREAD OF INFECTION,
***ANYONE ENTERING THIS ROOM MUST**
PARA PREVENIR EL ESPARCIMIENTO DE INFECCIONES,
***TODAS LAS PERSONAS QUE ENTREN EN ESTA HABITACION TIENEN QUE:**

HAND HYGIENE ✓
HIGIENE DE LAS MANOS

SURGICAL MASK ✓
MASCARA QUIRURGICA

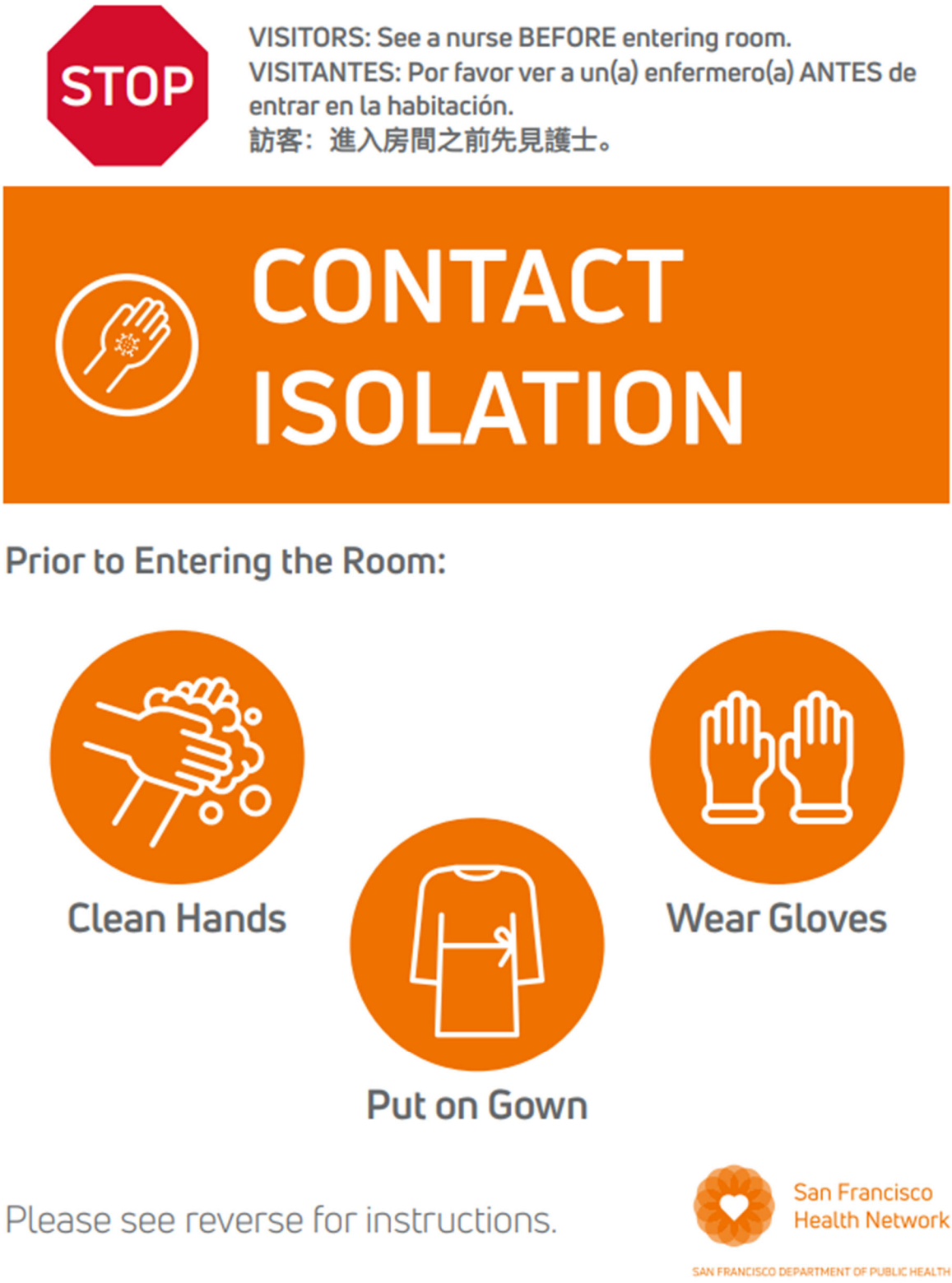
EYE PROTECTION ✓
(IF HIGH RISK EXPOSURE),
PROTECCIÓN DE OJOS
(EN CASO DE EXPOSICIÓN DE ALTO RIESGO)

N-95 Respirators should not be used for personal protection for patients on droplet precautions.

Los Respiradores N-95 no se deben utilizar para la protección personal de pacientes con precauciones contra particulas o gotitas.


STOP
VISITORS: See a nurse BEFORE entering room.
VISITANTES: Por favor ver a un(a) enfermero(a) ANTES de entrar en la habitación.
訪客：進入房間之前先見護士。
DROPLET ISOLATION
Prior to Entering the Room:
Clean Hands
Mask
Eye Protection
Please see reverse for instructions.
San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH


STOP
CONTACT PRECAUTIONS
PRECAUCIONES DE CONTACTO
ALTO
TO PREVENT THE SPREAD OF INFECTION,
*ANYONE ENTERING THIS ROOM MUST
PARA PREVENIR EL ESPARCIMIENTO DE INFECCIONES,
*TODAS LAS PERSONAS QUE ENTREN EN ESTA HABITACION TIENEN QUE:
HAND HYGIENE
HIGIENE DE LAS MANOS
GLOVES
GUANTES
GOWN
BATA
▪ Applies whether or not contact with the patient or the patient's environment is anticipated.
▪ Patient transport: clean patient hands, clean patient gown, empty/contain all drainage, secretions and excretions.
▪ Visitors must wash hands and put on gloves and gown before entering patient's room. Remove gloves and gown, and then wash hands before leaving room.
▪ Esta regla se aplica aunque no anticipe contacto con el paciente on con el ambiente del paciente.
▪ Translado del paciente: limpiar las manos y la bata del paciente, vaciar / contener todo el drenaje, secreciones y excreciones del mismo.
▪ Los visitantes deben lavarse las manos y usar guantes y bata antes de entrar al cuarto del paciente. Quitarse los guantes y la bata, y lávarse las manos antes de salir del cuarto.


STOP
VISITORS: See a nurse BEFORE entering room.
VISITANTES: Por favor ver a un(a) enfermero(a) ANTES de entrar en la habitación.
訪客：進入房間之前先見護士。
CONTACT ISOLATION
Prior to Entering the Room:
Clean Hands
Put on Gown
Wear Gloves
Please see reverse for instructions.
San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

CONTACT ENHANCED PRECAUTIONS

STOP ALTO

PRECAUCIONES DE CONTACTO

TO PREVENT THE SPREAD OF INFECTION,

***ANYONE ENTERING THIS ROOM MUST**

PARA PREVENIR EL ESPARCIMIENTO DE INFECCIONES,

***TODAS LAS PERSONAS QUE ENTREN EN ESTA HABITACION TIENEN QUE:**

HAND HYGIENE
HIGIENE DE LAS MANOS ✓

GLOVES
GUANTES ✓

GOWN
BATA ✓

SPECIAL ENTERIC: PERFORM HAND HYGIENE BEFORE ENTERING ROOM AND WASH HANDS WITH SOAP AND WATER ONLY BEFORE LEAVING ROOM. ✓

PRECAUCIONES GASTROINTESTINAL: LAVARSE LAS MANOS ANTES DE ENTRAR AL CUARTO Y LAVARSE LAS MANOS CON AGUA Y JABON ANTES DE SALIR DEL CUARTO.

EVS: SPECIAL CLEANING INDICATED ✓

EVS: INDICACIONES ESPECIALES DE ASEO

- Applies whether or not contact with the patient or the patient's environment is anticipated.
- Patient transport: clean patient hands, clean patient gown, empty/contain all drainage, secretions and excretions.
- Visitors must wash hands and put on gloves and gown before entering patient's room. Remove gloves and gown, and then wash hands before leaving room.

- Esta regla se aplica aunque no anticipe contacto con el paciente on con el ambiente del paciente.
- Translado del paciente: limpiar las manos y la bata del paciente, vaciar / contener todo el drenaje, secreciones y excreciones del mismo.
- Los visitantes deben lavarse las manos y usar guantes y bata antes de entrar al cuarto del paciente. Quitarse los guantes y la bata, y lávarse las manos antes de salir del cuarto.


STOP
VISITORS: See a nurse BEFORE entering room.
VISITANTES: Por favor ver a un(a) enfermero(a) ANTES de entrar en la habitación.
訪客：進入房間之前先見護士。
ENHANCED CONTACT ISOLATION
Prior to Entering the Room:
Clean Hands
Gown
Gloves
On Exit:
Clean Hands with Soap and Water
Use Hospital Approved Bleach Wipes
Please see reverse for instructions.
San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

Enhanced Standard Precautions

EVERYONE MUST: Perform hand hygiene before entering the room

ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: Don gown and gloves

Change and discard gown and gloves and perform hand hygiene between each resident and before leaving room.

ALPHABETICAL LIST OF DISEASES/ CONDITIONS WITH REQUIRED PRECAUTIONS

POLICY:

1. Standard Precautions shall be followed for all residents regardless of diagnosis.

2. Physicians will utilize the following alphabetical list of diseases and conditions to assist with decisions regarding additional transmission-based precautions in accordance with Centers for Disease Control and Prevention (CDC) recommendations.

3. The Infection Control Nurse shall be contacted as indicated in this guideline and as needed in order to collaborate regarding individualized and additional transmission-based precautions or room placement recommendations.

PURPOSE:

To reduce the likelihood of disease transmission, physicians shall determine and implement appropriate transmission-based precautions.

PROCEDURE:

1. For diseases and conditions requiring Standard Precautions, staff will care for these residents in the same manner as all hospitalized residents, and no sign shall be posted.

2. Additional personal protective equipment (PPE) indicated (e.g. gloves, eye protection) for the task will be used by staff as needed.

3. Appropriate signage is required to be posted on or next to the door to the resident's room for additional transmission-based precautions.

4. Instructions for each type of additional transmission-based precaution are indicated on the sign, and must be adhered to by all persons entering room.

5. Careful consideration must be given to achieve appropriate room placement to prevent the spread of infection. A private room may be necessary for conditions requiring more than Standard Precautions, unless the resident can be cohorted. In many cases a private room must include a private bathroom, particularly when the pathogen is enteric, such as *Clostridioides difficile* or norovirus.

6. The Infection Control Nurse is available during business hours and the Nursing Operations Manager during off-business hours for questions or clarification of additional transmission-based precautions.

7. Diseases requiring a report to the Department of Public Health (DPH) are done by following LHHPP 72-01 A7 Reportable Communicable Diseases.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A7 Reportable Communicable Diseases
LHHPP 72-01 B1 Standard Precautions

Revised: 15/11/09, 17/09/12, 18/09/11, 18/11/13, 19/05/14, 20/10/13 (Year, Month, Day)
Original adoption: Est. 05/11/01

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Abscess	Where dressing covers and contains drainage adequately	Standard Precautions	
	Where there is no dressing or dressing cannot cover or contain drainage	CONTACT PRECAUTIONS under some circumstances	Until drainage ceases CONTACT INFECTION CONTROL/NURSING OPERATIONS
Acquired Immune Deficiency Syndrome (AIDS)		Standard Precautions	DPH Reportable disease
Actinomycosis		Standard Precautions	
Adenovirus Infection	In adults	Standard Precautions	Duration of illness
	In immunocompromised patients - acute respiratory infection, tonsillitis, pneumonia or kerato-conjunctivitis	CONTACT PRECAUTIONS AND DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Amebiasis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Anthrax	Cutaneous or pulmonary	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS IMMEDIATELY In the event of potential aerosolizable spores other precautions also needed. DPH Reportable disease
Arthropod-borne viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St. Louis, California encephalitis; West Nile Virus)		Standard Precautions	DPH Reportable disease
Arthropod-borne viral fevers (dengue, yellow fever, Colorado tick fever)		Standard Precautions	DPH Reportable disease
Ascariasis		Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Aspergillosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS if massive soft tissue infection with copious drainage and repeated irrigations required
Avian influenza (or other "novel" influenza with a high mortality rate as determined by the CDC or other credible guidelines)		AIRBORNE RESPIRATORY ISOLATION **AND** CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS IMMEDIATELY DPH Reportable disease
Babesiosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Bed bugs		Standard Precautions	Isolate/remove all belongings CONTACT INFECTION CONTROL/NURSING OPERATIONS
Blastomycosis		Standard Precautions	
Botulism		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Bronchiolitis	(See RSV)		
Brucellosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Campylobacter gastroenteritis	(See gastroenteritis)		CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Candida auris (C. auris)	e.g. *Candida* that has been identified as *Candida auris*, does not include unidentified *Candida* species, all sites	Private room or cohort with *C. auris* infected or colonized resident CONTACT PRECAUTIONS ENHANCED with hand washing with soap and water and environmental cleaning with bleach solution. (Alcohol-based hand sanitizers are ineffective against *C. auris*)	CONTACT INFECTION CONTROL/NURSING OPERATIONS IMMEDIATELY DPH Reportable disease – REPORT IMMEDIATELY to Communicable Disease Unit (CDU) at 415-554-2830. Assume indefinite colonization; teach resident hand hygiene. Private room or cohort. Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.
Candidiasis	All forms, including oral	Standard Precautions	
Carbapenem-Resistant Enterobacteriaceae (CRE)	e.g. *E. coli*, *Klebsiella*, *pneumonia*, or *Enterobacter*, all sites	Private room or cohort with CRE infected or colonized resident CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS Assume indefinite colonization; teach resident hand hygiene. Private room or cohort. Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Carbapenem-Resistant *Pseudomonas aeruginosa* (CRPA)	e.g. *P. aeruginosa*, all sites, not including ertapenem resistance as *P. aeruginosa* has natural resistance to ertapenem	Private room or cohort with CRPA infected or colonized resident CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS Assume indefinite colonization; teach resident hand hygiene. Private room or cohort. Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.
Cat-scratch fever		Standard Precautions	
Cellulitis	Where no drainage or dressing contains drainage adequately.	Standard Precautions	
	Where dressing cannot cover or contain drainage.	CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Chancroid	(Soft chancre)	Standard Precautions	DPH Reportable disease
Chickenpox	(See varicella)		
Chlamydia trachomatis	Conjunctivitis, genital, respiratory	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Cholera Gastroenteritis	(See gastroenteritis)		
Closed cavity infection		Standard Precautions	
Clostrioides infections	*C. botulinum*	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS, DPH Reportable Disease (if foodborne or wound)
	C. difficile (see gastroenteritis)		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
	C. perfringens Food poisoning or gas gangrene	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Coccidioidomycosis (valley fever)		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Causing draining lesions or pneumonia	Standard Precautions	DPH Reportable disease
Colorado Tick Fever		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Conjunctivitis	Acute bacterial, including chlamydia, gonococcal	Standard Precautions	
	Acute viral (acute hemorrhagic)	CONTACT PRECAUTIONS	Duration of illness- CONTACT INFECTION CONTROL/NURSING OPERATIONS
Coronaviruses HKU1, NL63, 229E, and OC43	In adults	DROPLET PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Immunocompromised or non-compliant with hygiene	DROPLET PRECAUTION & CONTACT ISOLATION (private room or cohort with similar case(s)	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Coronavirus Disease 2019 (COVID-19) caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)	In adults	AIRBORNE AND CONTACT ISOLATION WITH EYE PROTECTION (private room or cohort with similar case(s)	Until 10 days have passed since symptoms first appeared or since test was performed if asymptomatic, resolution of fever for ≥24 hours (without fever-reducing medication), and symptoms have improved.
	Severely immunocompromised or have severe to critical illness (refer to current LHH COVID-19 Prevention and Management Protocol for definitions)	AIRBORNE AND CONTACT ISOLATION WITH EYE PROTECTION (private room or cohort with similar case(s)	Until 20 days have passed since symptoms first appeared or since test was performed if asymptomatic, resolution of fever for ≥24 hours (without fever-reducing medication), and symptoms have improved. CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Coxsackie virus disease		(See Enteroviral infections)	
Creutzfeldt-Jacob disease (CJD)		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Note: Additional precautions are necessary for handling CJD pathological specimens and contaminated items. Consult Infection Control/Nursing Operations before invasive procedures.			
Cryptococcosis		Standard Precautions	
Cryptosporidiosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
	For diapered or incontinent residents unable to maintain hygiene	CONTACT PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL/NURSING OPERATIONS
Cyclosporiasis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Cysticerocosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Cytomegalovirus infection immunosuppressed		Standard Precautions	
Decubitus ulcer (see pressure ulcer)			
Dengue		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Diarrhea, acute	Infective etiology suspected. If resident has uncontrolled diarrhea which cannot be contained and continues to grossly contaminate the environment	CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Diphtheria	Cutaneous Pharyngeal	DROPLET RESPIRATORY ISOLATION	For both forms, isolate until off antimicrobial treatment and culture-negative. CONTACT INFECTION CONTROL/NURSING OPERATIONS IMMEDIATELY DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Ebola, viral hemorrhagic fever	For persons who screens positive to current Ebola screening: suspected viral hemorrhagic fever with prominent cough, vomiting, diarrhea, or hemorrhage.	Follow Ebola protocol utilizing Ebola Response Standard Operating Procedure including: Screen clinic outpatients and use posters to screen others to identify possible Persons Under Investigation (PUI). **Do not touch PUI.** Have PUI mask and isolate in clinic. Notify 9-1-1 and DPH CDU to arrange for transport to approved Ebola screening hospital (includes ZSFG).	CONTACT INFECTION CONTROL/NURSING OPERATIONS IMMEDIATELY DPH Reportable disease – REPORT IMMEDIATELY to Communicable Disease Unit (CDU) at 415-554-2830.
Echinococcosis	(Hydatid disease)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Echovirus		(See Enteroviral infections)	
Encephalitis or encephalomyelitis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Endometritis		Standard Precautions	
Enterobiasis (pinworm disease, oxyuriasis)		Standard Precautions	
Enterococcus faecalis or *faecium, vancomycin-resistant* (VRE)		(See VRE)	
Enterocolitis, Clostridioides difficile		(See Gastroenteritis and C18 *Clostridioides difficile* guideline)	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Enteroviral Infections (i.e. Group A and B Coxsackie viruses and Echo viruses)	Adults Incontinent persons	Standard Precautions CONTACT PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL/NURSING OPERATIONS
Epiglottitis	*Haemophilus influenzae*	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy
Epstein-Barr virus infection including mononucleosis		DROPLET RESPIRATORY ISOLATION	Respiratory secretions may be highly infectious for 7 days after onset of illness
Erythema infectiosum		DROPLET RESPIRATORY ISOLATION	Respiratory secretions may be highly infectious for 7 days after onset of illness
Escherichia coli gastroenteritis	(See gastroenteritis)		
ESBL producing organisms	e.g. *E. coli* or *Klebsiella pneumonia*, all sites If resident with ESBL has uncontrolled diarrhea or infected sites with fluids which cannot be contained	Standard Precautions CONTACT Precautions Private room or cohort with ESBL infected or colonized residents	CONTACT INFECTION CONTROL/NURSING OPERATIONS Assume indefinite colonization. Private room or cohort. Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results. Continue contact precautions until site of colonization or infection can be appropriately contained and able to maintain hygiene.
Food poisoning	Botulism	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
	Clostridioides perfringens or welchi	Standard Precautions	
	Staphylococcal	Standard Precautions	
Furunculosis (*staphylcoccal*)	Adults	Standard Precautions	Duration of illness
Gangrene	Gas gangrene	Standard Precautions	
Gastroenteritis	Adenovirus	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Campylobacter	CONTACT PRECAUTIONS if incontinent and unable to maintain hygiene.	DPH Reportable disease
	Cholera		
	Clostridioides difficile (C. diff) See also C18 *Clostridioides difficile* Guideline	CONTACT PRECAUTIONS ENHANCED with hand washing with soap and water and environmental cleaning with bleach solution. (Alcohol-based hand sanitizers are ineffective against spores) Room placement in private room with private bathroom (or place in cohort with like-cases).	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable if outbreak Continue precautions until resident receives 5 days of antimicrobial therapy AND no diarrhea for 48 hours. Inform EVS upon initiation and termination Follow Bleach cleaning policy and procedures including bleach wipes for high touch surfaces.

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Escherichia coli, including Enterohemorrhagic 0157:H7	For all of the following except Noroviruses, Standard Precautions; CONTACT PRECAUTIONS if incontinent and unable to maintain hygiene.	If outbreak or if 0157:H7, CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease For all of the following except Rotavirus: CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
	Giardia lamblia		
Gastroenteritis (continued)	Norovirus	CONTACT PRECAUTIONS – ENHANCED (as per *C. diff*)	
	Rotavirus		
	Salmonella species, including *S. typhi* *Shigella* species		
	Vibrio parahaemolyticus		
	Viral (not covered elsewhere)		
	Yersinia enterocolitica		
German measles (rubella)		DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Note: Respiratory secretions are highly infectious until 7 days after onset of rash.			
Giardiasis (see gastroenteritis, *Giardia lamblia*)			DPH Reportable disease
Gonorrhea		Standard Precautions	
Granuloma inguinale	(Donovanosis, granuloma venereum)	Standard Precautions	
Guillain–Barre syndrome		Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Hand, foot & mouth disease	(See Enteroviral infection)		
Hantavirus	Pulmonary syndrome	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Helicobacter pylori		Standard Precautions	
Hemorrhagic fevers	See Ebola for suspected Ebola, Marburg, Lassa, or Yellow Fever		
Hepatitis, viral infections		Standard Precautions	All hepatitis cases are DPH Reportable Diseases
	Hepatitis A	Standard Precautions	
	Hepatitis A in resident with diarrhea	CONTACT PRECAUTIONS	Duration of illness CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Hepatitis B	Standard Precautions	
	Hepatitis C	Standard Precautions	
	Hepatitis E	Standard Precautions	
	Hepatitis, unspecified non-A, non-B	Standard Precautions	
Herpangina	(See Enteroviral infection)		
Herpes simplex infections	*Herpesvirus hominis*		
	Mucocutaneous, recurrent, localized (skin, oral, genital)	Standard Precautions	
	Mucocutaneous, IF disseminated or severe primary infection	CONTACT PRECAUTIONS	Duration of illness – CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Herpes encephalitis	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Herpes zoster	(Varicella-zoster, shingles) Localized zoster	Standard Precautions	
	Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)	AIRBORNE RESPIRATORY ISOLATION	Duration of illness – People susceptible to varicella/chicken pox (employees with no history of chickenpox and no documented positive varicella antibody), pregnant or immunocompromised employees who are antibody negative should not enter the room CONTACT INFECTION CONTROL/NURSING OPERATIONS
Histoplasmosis		Standard Precautions	
HIV (Human Immunodeficiency Virus)		Standard Precautions	DPH Reportable disease upon initial diagnosis
Hookworm disease	(Anacylostomiasis, Uncinariasis, Necatoriasis)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Impetigo *Staph, strep, or MRSA* Note: may occur in adults usually after other infections		CONTACT PRECAUTIONS	Until 24 hours after initiation of appropriate antimicrobial therapy. CONTACT INFECTION CONTROL/NURSING OPERATIONS
Infectious mononucleosis		Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Influenza	Confirmed or highly suspected See also C22 Influenza Immunization and 72-05 Employee Influenza Vaccination Policy and Use of Surgical Mask when Vaccination Declined	DROPLET RESPIRATORY ISOLATION, including private room or isolation room (preferred) or in cohort with like cases if private / isolation rooms unavailable. Other precautions, such as preventive antiviral therapy for ill resident and resident contacts, generally advised by Infection Control, based upon current CDC guidelines for each flu season.	Until 7 days after onset of symptoms or until 24 hours after resolution of fever and respiratory symptoms, whichever is longer. May be extended longer in immunocompromised residents. CONTACT INFECTION CONTROL/NURSING OPERATIONS 1 lab confirmed case plus 1 case of influenza – like illness (ILI) in the setting of 2 or more total cases within 72 hours OR 2 or more linked cases of ILI are considered an outbreak in LTC. DPH Reportable Disease
Kawasaki syndrome		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Lassa fever	See Ebola, viral hemorrhagic fever		
Legionnaire's disease		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Leprosy		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Leptospirosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Lice	(Pediculosis)	CONTACT PRECAUTIONS	Until 24 hours after initiation of pediculosis therapy and no live lice detected.
Listeriosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Lyme disease		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Lymphocytic choriomeningitis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Lymphogranuloma venerum		Standard Precautions	DPH Reportable Disease
Malaria		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Marburg virus disease	See Ebola, viral hemorrhagic fever		
Measles (rubeola), all presentations		AIRBORNE RESPIRATORY ISOLATION Persons susceptible to measles should not enter room. Employees born after 1957 will be considered susceptible unless they have had physician diagnosed measles or a measles immunization.	Duration of illness. CONTACT INFECTION CONTROL/NURSING OPERATIONS IMMEDIATELY DPH Reportable disease
Melioidosis	All forms	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Meningitis			CONTACT INFECTION CONTROL/NURSING OPERATIONS for all forms of meningitis
	Aseptic (nonbacterial or viral meningitis)	Standard Precautions	
	Bacterial, including gram-negative enteric	Standard Precautions	
	Fungal	Standard Precautions	
	Haemophilus influenzae, type b known or suspected Common cause of bronchitis in adults	DROPLET initiation of RESPIRATORY ISOLATION	Until 24 hrs. after appropriate antimicrobial therapy
	Note: Respiratory secretions may be highly infectious until resident has been on 24 hours of appropriate antibiotic therapy.		
	Listeria monocytogenes	Standard Precautions	
	Neisseria meningitis (meningococcal)	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
	Pneumococcal	Standard Precautions	
	Tuberculosis	Standard Precautions	Evaluate for current (active) TB and use Airborne Level Respiratory Isolation accordingly. Report to TB Clinic
	Other diagnosed bacterial meningitis	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Meningococcal (Pneumonia, meningitis, sepsis)		DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
MERS Co-V (Middle Eastern Respiratory Syndrome Coronavirus)		AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Metapneumo Virus		DROPLET PRECAUTIONS	At least 7 days from symptom onset and symptoms resolve
Molluscum contagiosum		Standard Precautions	
Monkey pox		AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Until lesions crusted CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
MRSA (methicillin-resistant *Staph aureus*) see *Staphylococcus aureus* diseases			
Mucormycosis		Standard Precautions	
Multidrug-resistant organisms, infection and/or uncontrolled body fluids	(MRSA, VRE, CRE, ESBL, C. DIFF)	CONTACT PRECAUTIONS	Until drainage and/or secretions cease or can be contained CONTACT INFECTION CONTROL/NURSING OPERATIONS
Mumps	(Infectious parotitis)	DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious for 9 days after onset of parotid swelling.	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Mycobacteria, pulmonary or nontuberculosis wound site (atypical)		Standard Precautions	
Mycoplasma pneumonia		DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious.	Duration of illness
Necrotizing enterocolitis		Standard Precautions	
Neutropenia	Absolute neutrophil count (ANC) <500 per µL or as defined by residents physician	Neutropenic Precautions, if ordered (The effectiveness of neutropenic precautions is controversial, however some clinicians may put these precautions in place on a case by case basis).	If clinicians choose NOT to place patient on Neutropenic Precautions then utilize Standard Precautions and restrict ill persons from entering room at least until neutropenia is resolved.
Nocardiosis	Draining lesions and other presentations	Standard Precautions	
Norovirus	(See gastroenteritis, viral)		
Orf Virus		Standard Precautions	
Parainfluenza virus (all types)		DROPLET PRECAUTIONS	At least 7 days from symptom onset and symptoms resolve.
Parvovirus B19		DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious for 7 days after onset of illness.	
Pediculosis	(See lice)		
Pertussis	(Whooping cough)	DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious for 5 days after initiation of appropriate antimicrobial therapy.	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
Pinworm infection		Standard Precautions	
Plague	Bubonic	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
	Pneumonic	DROPLET RESPIRATORY ISOLATION	Until three days after initiation of appropriate antimicrobial therapy CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Note: Respiratory secretions may be highly infectious for 5 days after initiation of appropriate antimicrobial therapy.		
Pleurodynia	(See Enteroviral infection)		
Pneumonia	Adenovirus	DROPLET RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Duration of illness
	Bacterial, not listed elsewhere, including gram-negative bacterial (*Enterobacter, Serratia, Acinetobacter sp*.)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Burkholderia cepacia without cystic fibrosis	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS Avoid placement of cystic fibrosis patients colonized with *B. cepacia* in cohort
	Chlamydia	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
	Fungal	Standard Precautions	
	Haemophilus influenzae in adults	Standard Precautions Note: Respiratory secretions may be highly infectious until resident has been on 24 hrs. of appropriate antimicrobial therapy.	Until 24 hrs. after initiation of appropriate antimicrobial therapy
	Legionella	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Pneumonia (continued)	Meningococcal pneumonia	DROPLET RESPIRATORY ISOLATION and CONTACT PRECAUTIONS during first 24 hrs. of antibiotic therapy, then Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Multi-drug resistant bacteria (see multi-drug resistant organisms)	Standard Precautions	
	Mycoplasma (primary atypical Pneumonia)	DROPLET RESPIRATORY ISOLATION Note: Respiratory secretions may be highly infectious.	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Pneumocystis carinii (PCP)	Standard Precautions	Avoid placement in the same rooms with immune-compromised resident
	Pseudomonas cepacia (*Burkholderia cepacia*)	Standard Precautions	
	Staphylococcus aureus	Standard Precautions	
	Streptococcus, Group A	DROPLET RESPIRATORY ISOLATION	Until 24 hrs. after initiation of appropriate antimicrobial therapy
	Viral pneumonia	Standard Precautions	
Pneumonia (continued)	Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood and no cough)	AIRBORNE RESPIRATORY ISOLATION	Until a respiratory diagnosis is confirmed and TB is ruled out (see Policy C5, Airborne Respiratory Isolation)
Poliomyelitis		CONTACT PRECAUTIONS AND DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Pressure ulcer (decubitus)	Infected, where dressing covers and contains drainage adequately.	Standard Precautions	
	Infected, where there is no dressing or dressing cannot cover or contain drainage.	CONTACT PRECAUTIONS	Until drainage ceases or can be contained CONTACT INFECTION CONTROL/NURSING OPERATIONS
Psittacosis (ornithosis)		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Q fever		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Rabies		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Rat-bite fever	(*Streptobacillus moniliformis* disease, *Spirillum minus* disease)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Relapsing fever		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Resistant bacterial infection or colonization	(See multi-drug resistant organisms)		
Respiratory syncytial virus (RSV)		DROPLET CONTACT ISOLATION	At least 8 days from symptom onset and symptoms resolve
	Immunocompromised	DROPLET PRECAUTION & CONTACT ISOLATION (private room or cohort with similar case(s)	Duration of illness. Immunocompromised adults can shed virus for up to 4 weeks.
Reye's syndrome		Standard Precautions	
Rheumatic fever		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Rhinovirus/Enterovirus		DROPLET PRECAUTIONS	At least 7 days from symptom onset and symptoms resolve.

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Rickettsial fevers, tick-borne	(Non-Rocky Mountain spotted fever, tick-borne typhus fever)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Rickettsialpox	(Vesicular rickettsiosis)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Ringworm	(Dermatophytosis, dermatomycosis, tinea)	Standard Precautions	
Ritters Disease (see *Staphylococcal* disease, Scalded Skin Syndrome)			
Rocky Mountain spotted fever		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Rotavirus infection	(See gastroenteritis)		
Rubella	(German measles)	DROPLET RESPIRATORY ISOLATION	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Note: Respiratory secretions are highly infectious until 7 days after onset of rash.			
Salmonellosis	(See Gastroenteritis, *Salmonella* species)		
SARS - Severe acute respiratory syndrome		AIRBORNE RESPIRATORY ISOLATION **AND** CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Scabies		CONTACT PRECAUTIONS	Until 24 hrs. after treatment with effective agent.
Norwegian scabies		CONTACT PRECAUTIONS PRIVATE ROOM	Maintain isolation until negative skin scrapings obtained by qualified individual.
Scalded skin syndrome	See *Staphylococcal* disease, scalded skin syndrome		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Schistosomiasis (bilharziasis)		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
Shigellosis	(See gastroenteritis, *Shigella* species)		CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Shingles (zoster, varicella zoster)			
	Localized zoster	Standard Precautions	
	Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)	AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Duration of illness. People susceptible to varicella/chicken pox (employees with no hx of chicken pox and no documented positive varicella antibody, pregnant or immunocompromised employees who are antibody negative) should not enter room. Maintain isolation until lesions dried and crusted.
Smallpox	Suspected or confirmed smallpox	AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS Maintain isolation until lesions dried and crusted. DPH Reportable Disease
Sporotrichosis		Standard Precautions	
Spirillum minus disease	(See rat-bite fever)		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Staphylococcal aureus diseases	Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately	Standard Precautions	
	Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage	CONTACT PRECAUTIONS	Until drainage ceases or can be contained
	MRSA (Methicillin-resistant *S. aureus*) in body site / fluid where drainage is adequately contained	Standard Precautions HAND HYGIENE IS CRITICAL Ensure hands are clean prior to entering each resident's room or bedside. Wash hands promptly after contact with residents and residents' immediate environment. Avoid touching equipment and surfaces with potentially contaminated hands.	
	MRSA (Methicillin-resistant *S. aureus*) in body site / fluid where drainage cannot be controlled or adequately contained	CONTACT PRECAUTIONS	Until drainage and/or secretions cease or can be contained, CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Staphylococcal pneumonia	Standard Precautions	
	Scalded skin syndrome (Ritter's disease)	CONTACT PRECAUTIONS	Duration of illness
	Toxic shock syndrome	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Streptobacillus moniliformis disease	(See rat-bite fever)		
Streptococcal disease, Group A			

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS

Infection	Condition	Type of Precautions	Notes / Reporting Required
	Minor skin wound, or burn infection, with dressing which covers and contains drainage adequately	Standard Precautions Note: HANDWASHING IS CRITICAL	Report to DPH when outbreak or single case in food handlers or dairy workers.
	Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage	CONTACT PRECAUTIONS	Until drainage ceases or can be contained, CONSULT INFECTION CONTROL/NURSING OPERATIONS
	Endometritis (puerperal sepsis)	Standard Precautions	
	Pneumonia	(See pneumonia)	
Strongyloidiasis		Standard Precautions	
Syphilis	Skin and mucous membrane, including congenital, primary, secondary, latent (tertiary), and seropositivity without lesions	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease to STD clinic
Tapeworm disease	Including *Hymenolepis nana, Taenia solium* (pork), and others	Standard Precautions	DPH Reportable Disease
Tetanus		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Tinea	(Athlete's foot, ringworm)	Standard Precautions	
Toxoplasmosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Toxic shock syndrome	(See *Staphylococcal* disease)		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Trachoma, acute		Standard Precautions	
Trench mouth	(Vincent's angina)	Standard Precautions	
Trichinosis		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Trichomoniasis		Standard Precautions	
Trichuriasis	(Whipworm disease)	Standard Precautions	DPH Reportable Disease
Tuberculosis (TB)	*Mycobacterium* tuberculosis	Varies based upon location of disease, clinical symptoms, stage or treatment; as follows:	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease (TB Control)
	Pulmonary, confirmed or suspected, AFB smear positive, including laryngeal disease	AIRBORNE RESPIRATORY ISOLATION	Discontinue isolation only when TB resident on effective therapy (usually two weeks after start of appropriate therapy; extended if subclinical drug regimen), improving clinically, and resident has three consecutive negative sputum smears, collected on different days, or TB is ruled out.
	Where bacterial or other pneumonia or respiratory disease is suspected but physician also orders specimens to rule out AFB in sputum (low likelihood)	AIRBORNE RESPIRATORY ISOLATION	Until a respiratory diagnosis is confirmed

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
	Extra pulmonary TB, no draining lesion, including scrofula (TB infection of lymph nodes in the neck)	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS
	Extra pulmonary TB meningitis	Standard Precautions Note: Resident should also be evaluated for current (active) pulmonary TB. If evidence exists, Airborne precautions necessary (see Tuberculosis)	
	Skin-test positive, with no evidence of current pulmonary disease	Consider TB Clinic referral if any suspicion especially for immunocompromised (symptoms may be masked) Airborne Respiratory Isolation while ruling out pulmonary TB; Standard Precautions once cleared	
Tularemia	Including draining lesions and pulmonary presentations	Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable Disease
Typhoid fever	(*Salmonella typhi*, see gastroenteritis)		
Typhus (Louse-borne typhus)	*Rickettsia typhi*	Standard precautions	DPH Reportable Disease
Urinary Tract Infections (UTI)	UTI; including pyelonephritis, with or without urinary catheter	Standard Precautions	

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Vancomycin resistant *Enterococcus* (VRE)	*e.g. Enterococcus faecalis* or *E. faecium* If resident with VRE has uncontrolled diarrhea or infected sites with fluids which cannot be contained	Standard Precautions CONTACT PRECAUTIONS Private room or cohort with VRE infected or colonized residents	CONTACT INFECTION CONTROL/NURSING OPERATIONS Assume indefinite colonization. Private room or cohort Modification of precautions should be decided on the basis of risk factors for transmission and not on the basis of culture results.
Vancomycin-resistant *S. aureus* (VRSA) or Vancomycin-intermediately resistant *S. aureus* (VISA) Note: Infection Control/Nursing Operations must notify Public Health authorities for any suspected case.		CONTACT PRECAUTIONS	Duration varies; CONTACT INFECTION CONTROL/NURSING OPERATIONS
Varicella (chickenpox)	Confirmed or suspected case	AIRBORNE RESPIRATORY ISOLATION And CONTACT PRECAUTIONS	CONTACT INFECTION CONTROL/NURSING OPERATIONS Maintain isolation until lesions are crusted. Susceptible persons should not enter the room
	Susceptible persons exposed to chickenpox	AIRBORNE RESPIRATORY ISOLATION	Susceptible persons exposed to chickenpox must be isolated days 10 through 21 post exposure. Report Varicella-related deaths to DPH
Vibrio parahaemolyticus (See Gastroenteritis)			
Vincent's angina	(See trench mouth)		

ALPHABETICAL LIST OF DISEASES/CONDITIONS WITH REQUIRED PRECAUTIONS			
Infection	**Condition**	**Type of Precautions**	**Notes / Reporting Required**
Viral disease, respiratory (See Respiratory Infectious disease, acute)			
	Diseases not covered elsewhere	Standard Precautions	
	(See respiratory infectious disease, acute)	Note: Respiratory secretions may be highly infectious for duration of illness.	
Whooping cough	(Pertussis)	DROPLET RESPIRATORY ISOLATION	Until 5 days after initiation of appropriate antimicrobial therapy. CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Wound Infections	Major skin wound, or burn infection, with no dressing or where dressing cannot contain excessive drainage	CONTACT PRECAUTIONS	Until drainage ceases or can be contained – CONTACT INFECTION CONTROL/NURSING OPERATIONS
Yersinia enterocolitica	(See gastroenteritis)		
Zika virus		Standard Precautions	CONTACT INFECTION CONTROL/NURSING OPERATIONS DPH Reportable disease
Zoster (shingles, varicella zoster)	Localized zoster	Standard Precautions	Duration of illness
	Disseminated zoster (many lesions; not unilateral appearance; spread over multiple body surfaces)	AIRBORNE RESPIRATORY ISOLATION AND CONTACT PRECAUTIONS	Duration of illness. People susceptible to varicella (chickenpox) should not enter room. Maintain isolation until lesions dried and crusted.
Zygomycosis (*Phycomycosis mucormycosis*)	Standard Precautions		

MONOCLONAL ANTIBODY THERAPY FOR COVID-19 INFECTION

POLICY:

1. Monoclonal antibody therapy may be prescribed for treatment of COVID-19 under the Emergency Use Authorization (EUA) issued by the Food and Drug Administration (FDA).

2. The FDA issued guidance on appropriate use of monoclonal antibody therapy, addressing prioritization in its use and allocation systems for limited supplies.

3. Specific procedures will be followed to ensure safe and fair practices for monoclonal antibody therapy.

4. The physician will determine the minimum inclusion criteria for a resident to be eligible to receive monoclonal antibody therapy, and in consultation with pharmacy (see Table 1).

5. Monoclonal antibody therapy may only be administered by a Registered Nurse (RN) who has met a skills competency in the intravenous administration of such therapy.

6. Monoclonal antibody therapy must be double checked at the bedside by two RNs who are skilled and competent in the administration of monoclonal antibody therapy prior to the infusion (ONS, 2019).

7. Monoclonal antibody therapy may only be administered on the South 5 COVID-19 unit/neighborhood.

8. Serious adverse events and medication errors potentially related to monoclonal antibody therapy must be reported to the FDA MedWatch within 7 days of onset (See Adverse Event Reporting).

PURPOSE:

This policy and procedure outline the minimal eligibility, disease severity classifications, and prioritization, and required procedures for the safe administration of monoclonal antibody therapy for Laguna Honda residents with COVID-19 infection.

BACKGROUND:

The U.S. FDA issued a EUA for monoclonal antibody therapy, a humanized monoclonal antibody to treat mild to moderate COVID-19 infection. Monoclonal antibodies have long been used for their ability to mimic antibodies and enhance an immune response. The goal of this treatment is by administering virus-neutralizing monoclonal antibodies, viral load may be reduced, symptoms ameliorated, and acute hospitalization prevented (NEJM, 2020). Globally, due to the rapidly changing virus variants, changes in which monoclonal antibody treatment are effective and available are also dynamic.

PROCEDURE:

1. **Physician: Determining Eligibility**
   a. Per the EUA, residents must meet the minimum inclusion criteria to be eligible to receive monoclonal antibody therapy (see Table 1).
      i. Additional criteria for exclusion are noted to minimize adverse events and provide fair allocation of the drug.
      ii. Please note that the eligibility criteria may change based on variations in the virus occurring, and thus the effective monoclonal antibody/antibodies are revised.

iii. **Table 1**. Eligibility Criteria for monoclonal antibody therapy are as follows:

Minimum Inclusion Criteria	Exclusion Criteria
1. Patients/Residents ≥ 12 years old and body weight ≥ 40kg, deemed high-risk for developing severed COVID-19 and/or hospitalization*	1. Acute hospitalization due to COVID-19 **OR**
2. Confirmed SARS-CoV-2 by PCR **AND** within 10 days of onset	2. Needing oxygen therapy for COVID-19 infection **OR**
3. Mild-moderate infection, as defined by:	3. Requiring a higher oxygen flow rate (from baseline) due to COVID-19 in patients/residents on chronic oxygen therapy for underlying non-COVID-19 related comorbidity **OR**
a. Fever **OR**	4. Known hypersensitivity to any ingredient of Monoclonal antibody therapy injection **OR**
b. Cough **OR**	5. Patients/Residents who are terminally ill and their death is imminent.
c. Sore throat **OR**	
d. Malaise **OR**	
e. Headache **OR**	
f. Muscle pain **OR**	
g. Nausea **OR**	
h. Vomiting **OR**	
i. Diarrhea **OR**	
j. Loss of taste or smell **OR**	
k. Shortness of breath on exertion **OR**	
l. Lower respiratory disease during clinical assessment or imaging, with SpO2 ≥ 94% on room air at sea level	

These criteria are subject to change without notice and may be subject to additional considerations and limitations. If a patient/resident does not meet these minimum inclusion criteria, do not submit a request. *Note that meeting theses minimum criteria does not guarantee approval of a request for Monoclonal antibody therapy.*

***High risk is defined as having at least one of the following criteria:**

1. **Body mass index (BMI) ≥ 35 kg/m2**
2. **Chronic kidney disease (estimated GFR < 90 mL/min)**
3. **Diabetes mellitus (fasting plasma glucose ≥ 126 mg/dL OR hemoglobin A1c ≥ 6.5% OR random glucose ≥ 200 mg/dL OR documented in electronic medical record with medication therapy)**
4. **Immunosuppressive medical condition**
5. **Currently taking an immunosuppressant**
6. **Age ≥ 65 years**
7. **Age ≥ 55 years of age AND have**
   a. **Cardiovascular disease, OR**
   b. **Hypertension (systolic blood pressure ≥140mmHg OR diastolic blood pressure ≥90mmHg, OR**
   c. **Chronic obstructive pulmonary disease (COPD) or other chronic respiratory disease.**

2. Physician: Resident Eligibility Screening

a. The physician will review the resident's eligibility criteria outlined in Table 1 prior to ordering monoclonal antibody therapy.
b. The physician will document the resident's eligibility in the EHR progress note.

3. Physician: Consent for Monoclonal Antibody Therapy

a. The physician will obtain consent from the resident, SDM, or guardian utilizing the Monoclonal Antibody Consent (**Attachment 1**).

4. Physician: Ordering Monoclonal Antibody Therapy

a. The physician will consult with pharmacy prior to submitting an order for monoclonal antibody therapy and to determine which monoclonal antibody/antibodies are available based on the current virus variant(s) in California.
b. The physician will utilize the EHR pre-built monoclonal antibody order panel.
c. The physician will document the following in the order:
    i. Confirm that the monoclonal antibody therapy 'Fact Sheet' for Health Care Providers' has been reviewed by the provider
    ii. Confirm that the monoclonal antibody therapy 'Fact Sheet for Residents/Representative has been provided' to the resident or their representative
    iii. Referenced 'Fact Sheet' links can be found on the FDA EAU website: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs
d. The physician will also enter an order to manage hypersensitivity and other infusion reactions that are associated with monoclonal antibody infusions.
    i. Note that the pre-built EHR monoclonal antibody order panel includes rescue medication choices

5. Pharmacy: Medication Order Review

a. Pharmacy will also review and confirm that the resident meets eligibility criteria as outlined above in **Table 1**.
b. Confirm available inventory to complete the one-time infusion.

6. Pharmacy: Drug Preparation

a. Follow sterile compounding policy and procedures.
b. Review the compounding instructions in the monoclonal antibody therapy Fact Sheet and the inpatient pharmacy master compounding formula for Monoclonal antibody therapy.
c. Review summary monograph for dosing, side effects, and monitoring information.

7. Pharmacy: Dispensing of Monoclonal Antibody Therapy

a. Pharmacy will deliver the diluted preparation of Monoclonal antibody therapy along with the required specific infusion set/filter to the South 5 RN.

8. Nursing: Resident Assessment Prior to Infusion

a. Obtain IV access per physician order, if the resident does not have an existing patent IV access.
    i. If the resident has an existing central venous access device, it is acceptable to access it for the monoclonal antibody infusion (e.g., PICC, subcutaneous port, midline).
    ii. Due to the rapidity of the one-time infusion, if needing to gain intravenous access, choose as large of a vein as is possible.

b. RN to perform a head-to-toe physical assessment prior to the infusion; pay close attention to auscultating lung sounds, document condition of skin, listen to bowel sounds, note abdominal girth, and any peripheral edema.
   i. Rationale: observing for any signs of anaphylaxis, respiratory, and/or cardiac effects of monoclonal antibody therapy.
   ii. Document subjective and objective physical assessment data in the EHR
c. Explain procedure to resident.
   i. If the resident can retain teaching information, instruct the resident to inform you of any new symptoms they might experience during the infusion.

9. Nursing: Intravenous Administration of Monoclonal Antibody Therapy

a. Monoclonal antibody therapy is not a hazardous drug; however, nursing will utilize hazardous drug precautions when administering the therapy on South 5, due to it being a new drug per the FDA.

b. Don a gown (if not already wearing gown) along with a face shield or an eye shield. RN will already be wearing a respirator mask.

c. Perform hand hygiene

d. Don 2 pairs of gloves

e. Spike monoclonal antibody intravenous bag with IV tubing (Polyvinyl chloride (PVC) or polyethylene (PE)-lined PVC infusion set) and in-line or add-on 0.20/0.22-micron polyethersulfone (PES) filter (this is the tubing used for non-lipid TPN infusions at LHH), and prime line fully but do not allow IV solution to drip from the distal end of the IV tubing.

f. Remove gloves.

g. Perform hand hygiene

h. Don 2 pairs of gloves, then transport IV bag with primed tubing to the resident's room.

i. Hang the IV bag on the IV pole and insert the IV tubing into the IV pump.

j. Turn on the pump, and in the IV pump drug library, program the pump for the specific monoclonal antibody/antibodies.

k. Remove gloves and perform hand hygiene.

l. Record baseline vital signs immediately before infusion; blood pressure, heart rate, respiratory rate, temperature, oxygen saturation.
   i. Document vital signs in the EHR

m. Place a pad or towel under the hand/arm where the Monoclonal antibody therapy will be administered.

n. Perform hand hygiene

o. Don 2 pairs of gloves due to hazardous drug precautions

p. Two RNs deemed skilled and competent in the administration of monoclonal antibody therapy are required to have independent verification (a double check) of the 6 rights of

medication administration at the resident's bedside immediately before the infusion; right resident, right drug, right dose, right route/rate (also check drug/volume/rate on IV pump), right time, right documentation.

q. Once the 6 rights of medication administration are verified by the 2 RNs, begin administration of intravenous monoclonal antibody therapy according to the MAR instructions.
   i. Explain the procedure to the resident
   ii. After confirming blood return from the IV site (ensuring that the IV is patent), flush the IV extension set with 10 mL normal saline
   iii. Attach the primed IV tubing to the resident's IV extension set
   iv. Press start on the IV pump and administer monoclonal antibody therapy at the one-time-infusion rate.

r. Remain with the resident during the first 15 minutes of the infusion to observe for any signs or symptoms of an adverse reaction.

s. Recheck vital signs 5 minutes after the infusion has begun, at the end of the infusion, then once per shift for 48 hours after the infusion is complete, and PRN for any signs or symptoms of possible adverse reaction.
   i. Document vital signs in the EHR

t. If no adverse reaction is experienced, and the resident has tolerated the infusion, the IV medication line should be flushed with at least 30 mL of Normal Saline (NS) to ensure complete drug administration.
   i. Rationale: Due to potential overfilling of prefilled saline bags, the entire infusion solution in the bag should be administered to avoid underdosage.

u. When infusion is complete, prepare to disconnect tubing from the resident's IV site;
   i. Perform hand hygiene
   ii. Don 2 pair of gloves
   iii. Explain procedure to the resident
   iv. Disconnect the IV tubing from the IV extension set, and either saline lock IV per physician order, or continue maintenance IV fluids per physician order
      - It is recommended to leave the IV access in for at least 24 hours in case of a delayed adverse reaction
   v. Discard tubing and IV bag per the hazardous drug policy and procedure (discard in the yellow hazardous medication receptacle)
   vi. Remove gloves and perform hand hygiene

v. The RN will repeat the head-to-toe physical assessment at the end of the infusion and at any point during the infusion if an adverse reaction is suspected.
   i. Document subjective and objective assessment findings in the EHR.
   ii. Document resident's tolerance to the monoclonal antibody therapy infusion in the nursing progress note.

w. Intermittently observe the resident during the first hour after the infusion was initiated, as this is the most likely time to experience an adverse reaction.

x. On-going nursing re-assessment will include subjective and objective monitoring for the following potential adverse reactions, which may include;
   i. Fever
   ii. Chills
   iii. Nausea/Vomiting

iv. Headache
v. Bronchospasm (restricted air flow, wheezing)
vi. Hypotension or hypertension
vii. Angioedema (swelling that commonly occurs on the hands, feet, eyes, cheeks, and lips).
viii. Throat irritation
ix. Rash including urticaria (red welts on the skin)
x. Pruritis (itching of the skin)
xi. Myalgia (muscle pain)
xii. Dizziness

y. If the resident develops an adverse reaction, discontinue the infusion immediately, disconnect the tubing from the IV site, and alert the physician and pharmacist immediately.

z. For any signs or symptoms of anaphylaxis, activate a Code Blue per Laguna Honda Policy and Procedure.

10. Physician Reporting of Adverse Event

a. The prescribing health care provider and/or the provider's designee are/is responsible for mandatory reporting of all medication errors and serious adverse events* potentially related to monoclonal antibody therapy treatment within 7 calendar days from the onset of the event. The reports should include unique identifiers and the words "Monoclonal antibody therapy treatment under Emergency Use Authorization (EUA)" in the description section of the report. Consult with LHH pharmacy regarding reporting requirements.

b. Submit adverse event reports to FDA MedWatch using one of the following methods:
   i. Complete and submit the report online: www.fda.gov/medwatch/report.htm, or by using a postage-paid Form FDA 3500 (available at http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf) and returning by mail (MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787), or by fax (1-800-FDA-0178), or call 1-800-FDA-1088 to request a reporting form
   ii. Submitted reports should include in the field name, "Describe Event, Problem, or Product Use/Medication Error" the statement "Monoclonal antibody therapy treatment under Emergency Use Authorization (EUA)"
   iii. *Serious Adverse Events are defined as:
      - death;
      - a life-threatening adverse event;
      - inpatient hospitalization or prolongation of existing hospitalization;
      - a persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions;
      - a congenital anomaly/birth defect;
      - a medical or surgical intervention to prevent death, a life-threatening event, hospitalization, disability, or congenital anomaly.

c. The prescribing health care provider and/or the provider's designee are/is to provide mandatory responses to requests from FDA for information about adverse events and medication errors following receipt of monoclonal antibody therapy.

ATTACHMENTS:

ATTACHMENT 1: LHH Monoclonal Antibody Consent Form (Example)

REFERENCES:

HW Policy 25-05: Hazardous Drugs Management
HW Policy 24-16: Code Blue

Chen, P., Nirula, A., Heller, B., et.al (2020). SARS-CoV-2 Neutralizing Antibody LY-CoV555 in Outpatients with Covid-19. *NEJM, October 28, 2020.*

Oncology Nursing Society, ONS Recommendations for Administration of Monoclonal antibody therapy for COVID-19 Positive Patients, accessed at: https://www.ons.org/sites/default/files/202011/ONS_Recommendations_Administration_Monoclonal antibody therapy_COVID19.pdf

Original adoption: 21/07/21 (Year/Month/Day)

ATTACHMENT 4

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

COVID-19 MONOCLONAL ANTIBODY CONSENT FORM

SECTION A Please print clearly.

First name:_____ **Last name:**_____

Date of birth:_____ **Age:**_____ **Gender:** ☐ Female ☐ Male **Phone:**_____

SECTION B I certify that I am: (a) the resident and at least 18 years of age; (b) the legal guardian of the resident; or (c) a person authorized to consent on behalf of the resident where the resident is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Laguna Honda Hospital and Rehabilitation Center and the licensed healthcare professional administering the monoclonal antibody to administer the COVID-19 monoclonal antibody. I understand that it is not possible to predict all possible side effects or complications associated with receiving the monoclonal antibody. I understand the risks and benefits associated with the COVID-19 monoclonal antibody and have received, read and/or had explained to me the EUA Fact Sheet on the monoclonal antibody I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Print Name:_____ **Resident/Authorized Person signature:**_____ **Date:**_____

Clinician's name (print):_____ **Clinician's signature:**_____ **Title:**_____

CENTRAL PROCESSING DEPARTMENT (CPD)

POLICY:

Laguna Honda Hospital (LHH) has a policy in place for the cleaning and disinfection of resident care equipment according to standards of practice.

PURPOSE:

Contamination of resident equipment is prevented by routine cleaning and disinfection.

Materials Management processes, issues and controls reusable and disposable medical supplies and equipment, both sterile and non-sterile, for departments at LHH. Central Processing Department (CPD) shall be the primary center for cleaning and disinfection of reusable medical supplies and equipment that are not maintained by staff in residential neighborhoods and clinics. Reusable supplies and equipment maintained by CPD include but not limited to:

- Crash carts
- Isolation carts
- IV pumps
- Enteral feeding pumps

Medical supplies and equipment that require sterilization between use is managed by CPD in partnership with the outpatient medical clinic. See Policy statement.

PROCEDURE:

1. CPD staff utilize standard work for the cleaning, disinfection, and management of reusable medical supplies and equipment. Standard precautions will be practiced in procedures carried out in CPD.

2. Cleaning and disinfection of reusable supplies and equipment will be performed in the area designated as the soiled area.

3. Processing area is a clean area where supplies and equipment are managed after cleaning and disinfection.

4. Commercially prepared items without a specified expiration date, sterilized and labeled by the manufacturer as “sterile until opened or damaged” shall be considered as sterile until opened or damaged. Packages are inspected for damage by CPD staff before distribution.

ATTACHMENT:
None.

REFERENCE:
Central Processing Department Policies and Procedures
LHHPP 72-01 F13 Cleaning and Disinfection Non-Critical Resident Care Equipment

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

DENTAL SERVICES

POLICY:

Since all residents infected with transmissible agents may not be identified, Standard Precautions must be used routinely in caring for all dental residents.

PURPOSE:

To prevent the transmission of infectious agents by the proper use infection prevention strategies including handwashing, protective barriers, and the proper cleansing and disposal of used or contaminated equipment and surfaces.

PROCEDURE:

1. All procedures should be done in a way to minimize formation of droplets, spatters. or aerosols.

2. Standard Precautions are maintained at all times. If gloves are punctured during a procedure, they must be removed, hands must be washed, and a new pair of gloves put on.

3. Between residents, gloves must be removed, and hands and forearms must be washed before donning a pair of gloves for examining the next resident.

4. A lab coat or disposable gown must be worn over clothing and changed daily and when visibly soiled. Short sleeved attire is preferred.

5. All surfaces that may be exposed to blood or saliva during procedures must be cleaned and disinfected between residents. Surfaces which may become contaminated with blood or saliva and which are difficult to disinfect must be covered with impervious material (aluminum foil, plastic wrap, or impervious paper). Gloved employees must remove the impervious material after each resident and replace the material after gloves are removed.

6. All instruments must be physically cleaned by a staff member wearing heavy rubber gloves before any disinfection procedures. Instruments that penetrate soft tissue or bone must be sterilized (steam or gas) after each use. Instruments that do not penetrate tissue or bone (e.g. amalgam condensers, plastic instruments and burs) should be sterilized after each use if possible; however, high level disinfection is adequate if sterilization is not feasible. High level disinfection with chemical agents should follow manufacturer's recommendations.

7. Work surfaces must be physically cleaned at the end of each workday, then disinfected with a chemical germicide.

8. Materials used in the mouth (impression materials, appliances, etc.) must be thoroughly cleaned and disinfected before being handled, adjusted, or sent to a dental laboratory. These materials must also be cleaned and disinfected before being placed back in the resident's mouth after return from a dental laboratory.

9. If handpieces can be sterilized, this should be done. If this is not possible, the handpieces should be flushed, thoroughly scrubbed with a brush and detergent and then wiped with alcohol. This should be done between each use.

10. Check valves should be present in water retraction valves. Water cooled handpieces should be run for 20-30 seconds after use on each resident and for several minutes at the beginning of each day.

11. All disposable material, other than sharp instruments, that becomes saturated with blood must be discarded in a red biohazard bag.

12. Liquid blood or semi-liquid material can be carefully poured into a drain.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions

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

STANDARD FOR REFRIGERATION EQUIPMENT

POLICY:

1. Laguna Honda Hospital (LHH) has established and implemented standardized policies and procedures to monitor the safety of the refrigeration units for function and cleanliness according to Centers for Medicare and Medicaid Services (CMS) regulations governing long-term care.

PURPOSE:

To maintain safe processes for temperature control for food/beverages and biologicals and to reduce the risk of accidental consumption of, or the contamination of, food/beverages and biologicals. Facility standards for temperature control have been established to prevent the growth of pathogens and prevent damage to biologicals from freezing.

PROCEDURE:

1. LHH has three (3) separate refrigeration unit types to be specifically used for its intended purpose:

    a. **Nutrition/Nourishment**: Storage of resident food and beverage items

    b. **Biological**: Storage exclusively for drugs or specimens needing refrigeration

    c. **Staff**: Storage of food brought in by staff for staff consumption

2. Items are kept in their designated refrigeration units only to prevent cross contamination.

3. Refer to referenced hospital-wide and departmental-specific policies regarding the management of the different types of refrigeration unit types throughout the facility.

ATTACHMENT:

None.

REFERENCE:

EVS Policy XVI Ice Machine and Refrigerator Cleaning
Food and Nutrition Services Policy 1.73 Temperature Logs for Refrigerators/Freezers
Food and Nutrition Services Policy 1.143 Food Supply/Food Storage
Food and Nutrition Services Policy 1.144 Storeroom Content: Security, Safety & Sanitation
LHHPP 31-01 Wireless Refrigerator and Freezer Temperature Monitoring System
NPP D9-09.0 Maintaining Temperature of Medication and Nourishment Refrigerators via TempTrak & Cleanliness of Refrigerators

Revised: 16/01/12, 20/10/13 (Year/Month/Day)
Original adoption: 05/11/01

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Disinfectant Guide

CELEBRATING 150 YEARS OF DEDICATED AND COMPASSIONATE SERVICE TO SAN FRANCISCO
150
LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

How to use:

1. Unplug any electrical item from power source before cleaning to prevent electrical shock
2. Perform hand hygiene, don clean gloves
3. Wipe down surfaces ensuring that high touch surfaces are thoroughly cleaned
4. Ensure surface is visibly wet with product and allow to dry (Do not wipe dry)
5. To achieve required contact time, more than one wipe may need to be used
6. Obtain a new wipe between surfaces and if the wipe no longer has sufficient product
7. Upon task completion, discard wipe, remove gloves and perform hand hygiene
8. Do not refill containers, they should be thrown away when empty

Product

Use	Standard Product	Contact Time	Alternative Product	Contact Time
	Purell Dispenser		Purell Hand Sanitizer or 3G Hand Sanitizer Packet	
☑Hands Only		Until Hands Dry		Until Hands Dry
Use	**Standard Product**	**Contact Time**	**Alternative Product**	**Contact Time**
	PDI Sani-Cloth Prime Germicidal Disposable (Purple Top)		PDI Sani-Cloth Germicidal Bleach (Orange Top)	
☑Glucometers, Cisco phones, WOWs and Medical Equipment		☑For all residents (Except C. Diff. Residents) 1 Minute		☑For C. Diff. Residents 4 Minutes

Adopted: (06262020)
Version: 1.3 Rev 08082022

CONTACT EVS at DPH-LHHEVSLeadership@sfdph.org with questions

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Title: Single-resident Blood Pressure (BP) Cuffs

Performed By: Nurse, CNA, any staff taking a resident's BP

Revision Date:
Date First Created: 5/15/20

Owner: Nursing **Revised By:** Dauterman, Yu **Revision #: 1**

Purpose: To ensure that staff members have PPE necessary for resident care, while mitigating the risk of running out of PPE supplies.

Major Steps		Detail(s)	Diagram, Work Flow, Picture, Time Grid
1.	**PROVIDE RESIDENT WITH THEIR OWN BP CUFF**	• Each resident is provided a BP cuff that will be specifically for them 1. A new BP cuff is provided to each resident at admission or transfer to LHH and as needed to replace the BP cuff due to damage, loss, or changes to the resident's body size 2. Determine the appropriate size cuff - see table and instructions → 3. Write resident's name in permanent marker on the outside of the cuff	➢ Use information below to determine cuff size* <table><tr><th>Arm circumference</th><th>BP cuff size</th></tr><tr><td>22-26 cm</td><td>12x22 cm = SMALL</td></tr><tr><td>27-34 cm</td><td>16x30cm = ADULT</td></tr><tr><td>35-44 cm</td><td>16x36cm = LARGE</td></tr><tr><td>45-52 cm</td><td>16x42 cm = XL/THIGH</td></tr></table>*Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research. Recommendations for blood pressure measurement in humans and experimental animals. Part 1: measurement in humans. Hypertension 2005; 45:142–61.*
2.	**STORAGE OF RESIDENT-SPECIFIC BP CUFFS**	• Use a brown paper bag with the resident's name written on it in permanent marker • Store bag in resident's room • Return BP cuff to brown paper bag and storage place in resident's room after each use	➢ A brown paper bag allows the BP cuff to dry out in the event that it becomes damp with use (i.e. sweat) ➢ Replace brown paper bag if it becomes soiled, wet, contaminated, or worn out ○ Tear off portion of the bag with resident's name and discard in a designated shredding bin as the resident's name is protected health information
3.	**MANAGING RESIDENT-SPECIFIC BP CUFFS**	• The resident's designated BP cuff is stored in a brown paper bag in their room • Disinfect the BP cuff tube after each time it is used and disconnected from the tubing on the VS machine	➢ Do not use a resident's BP cuff on another resident ➢ Do not allow a resident's BP cuff to come in contact with another resident's BP cuff
4.	**WHEN TO DISCARD AND REPLACE THE RESIDENT'S BP CUFF**	• Discard and replace the resident's BP cuff when: ○ Worn out or tattered ○ Visibly soiled ○ After the resident has recovered from an active infection (i.e. flu, C. diff, Norovirus, etc)	➢ Resident's name must be marked out with a permanent marker prior to discarding the BP cuff as the resident's name is protected health information

AEROSOL TRANSMISSIBLE DISEASE (ATD) EXPOSURE CONTROL PLAN

POLICY:

The Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to maintaining a healthy work force by controlling occupational exposure of its employees to infectious diseases.

The Aerosol Transmissible Disease Exposure Control Plan (ATDP) is a program administered jointly by the Departments of Workplace Safety and Emergency Management (WSEM), Infection Control, and Employee Health. The ATDP shall require the same responsibilities for supervisors, employees and designated staff as the Illness and Injury Prevention Program (IIPP).

PURPOSE:

The purpose of the ATDP is to implement and maintain effective procedures for controlling occupational exposure to ATDs, consistent with LHH policy and pursuant to Title 8 of the California Code of Regulations, Section 5199.

PROCEDURE:

1. Definitions and Applicability of ATDP

a. Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP)

A disease or pathogen for which droplet or airborne precautions is recommended, as listed in Appendix A.

b. Airborne Infectious Disease (AirID)

Either: (1) an ATD transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which airborne infection isolation is recommended by the CDC or CDPH, as listed in Appendix A, or (2) the disease process caused by novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet.

c. Occupational Exposure

Occupational exposure is exposure from work activity that causes a higher risk of contracting disease than what would be considered ordinary for employees having direct contact with the general public outside of the healthcare setting. The ATDP applies to all LHH employees who have the potential to be occupationally exposed. Job classifications of potentially occupationally exposed employees are listed in Appendix B.

d. Ebola Virus Disease

This ATDP does not apply to Ebola Virus Disease (EVD). Laguna Honda employees will not treat patients with EVD and will, therefore, not be occupationally exposed to EVD. If any person in the facility is suspected of having EVD, they will be isolated and transported to an appropriate acute care hospital according to the Laguna Honda Ebola Response Plan.

e. High Hazard Procedures

High hazard procedures are procedures performed on a resident who is a case or suspected case of an ATD in which the potential for exposure to an aerosol transmissible pathogen is increased due to the reasonably anticipated generation of aerosolized pathogens.

2. Methods of Controlling Exposures

a. Source Control

In the event a LHH resident is suspected of having an ATD, the following procedure shall be followed prior to transfer to an isolation room:

i. Resident will be instructed to remain at bedside with curtains drawn. If available, resident can be placed temporarily in a well-ventilated private room with doors closed.

ii. If tolerated, the resident should be encouraged to wear a surgical mask.

iii. Resident will be instructed to follow respiratory hygiene and cough etiquette protocol. This includes covering mouth and nose with tissue when coughing or sneezing, and to discard tissue in non-touch receptacle provided by nursing staff.

iv. Resident shall be encouraged to practice hand hygiene. Hand washing facilities and, if appropriate, alcohol hand sanitizer shall be made available.

v. Resident should only be allowed to leave room for essential purposes. If resident needs to leave the room he/she shall wear a surgical mask.

vi. The Nurse Manager/Charge Nurse shall be responsible for notifying unit staff and other personnel of special precautions that need to be followed until re-location occurs. The nursing staff will be responsible for notifying the receiving department of suspected diagnosis and source control measures which should be implemented.

b. Procedures for Airborne Infection Isolation (AII)
LHH has seven negative pressure AII rooms. The room numbers of the AII rooms are S628, S648, S528, S548, S428, S448, and PM56. Any resident who is identified as a case or suspected case of ATD will be transferred to an AII room according to the following procedure.

i. Notify the Infection Control Nurse who will make the determination if an AII room is appropriate and work with the bed control coordinator to plan relocation. In the event that the Infection Control Nurse is not available the Nurse Manager on duty shall be notified.

ii. The Charge Nurse of the neighborhood that the resident is currently on shall contact the Charge Nurse of the receiving neighborhood to discuss transfer arrangements for the resident requiring airborne isolation.

iii. The Infection Control Nurse/Nurse Manager on duty will notify the Watch Engineer that an isolation room will be activated. The Watch Engineer or other Stationary Engineer will assess and confirm the integrity of the negative pressure system and report back to the Infection Control Nurse/Nurse Manager on duty that the room is fit or unfit for occupancy.

iv. Transfer to the AII room must take place as soon as possible but no later than 5 hours after initial identification.

v. The door to the isolation room will be labeled notifying staff to “STOP”. Check with nurse before entering and N95 required.

vi. The resident will be instructed to remain in the isolation room with the door closed.

vii. Respirators and personal protective clothing will be made available in the ante room to all staff entering the isolation room. Additional supplies are available from Central supply.

viii. Any staff member who enters an AII room occupied by a resident with known or suspected AirID must wear an N95 or PAPR in accordance with the LHH Respiratory Protection Program (LHH 73-09). Employees who have not been medically cleared, fit tested and/or trained for N95 or PAPR use will not enter the AII room.

ix. Residents will receive all medical treatment in the AII room. Movement and transport of residents out of the AII room should be for medically essential purposes only and the resident will wear a surgical type mask and be escorted by hospital staff.

c. Maintenance of AII Rooms

i. AII room ventilation systems will be maintained, inspected and monitored by facility services for exhaust or re-circulation, filter loading and leakage at least annually, whenever filters are changed, and as needed.

ii. Negative pressure will be maintained in AII rooms occupied by a resident with known or suspected AirID with a ventilation rate of 12 or more air changes per hour (ACH). Negative pressure will be monitored continuously by the built-in, alarmed electronic monitor. Facility Services is responsible for negative pressure monitoring and recording of results. These records shall be maintained for a minimum of five years by the Chief Engineer.

iii. In addition to electronic monitoring, negative pressure will be visually demonstrated daily in AII rooms occupied by known or suspected AirID cases. This will be done by the Watch Engineer and results recorded in the Watch Engineer's log.

iv. When occupied by a resident with known or suspected AirID, doors and windows to the AII room shall be kept closed at all times, except when doors are opened for entering or exiting.

v. When a case or suspected case vacates an AII room, the room shall be ventilated for 99.9% removal efficiency according to Table 1 below from the CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings before anyone enters the room without PPE.

TABLE 1. Air changes per hour (ACH) and time required for removal efficiencies of 99% and 99.9% of airborne contaminants*

	Minutes required for removal efficiency†	
ACH	99%	99.9%
2	138	207
4	69	104
6	46	69
12	23	35
15	18	28
20	7	14
50	3	6
400	<1	1

* This table can be used to estimate the time necessary to clear the air of airborne *Mycobacterium tuberculosis* after the source patient leaves the area or when aerosol-producing procedures are complete.
† Time in minutes to reduce the airborne concentration by 99% or 99.9%.

d. Procedure When No Available AII Room

i. If no Isolation room is available, the resident will be transferred to another facility with an available isolation room as soon as possible but no later than 5 hours after identification.

ii. The exception to the policy is if the unit physician or Medical Director has contacted SFDPH and determined that there is no airborne isolation room available in the county. This will be documented in the resident medical record after the initial 5 hours has passed and every 24hrs thereafter.

iii. LHH staff will follow all environmental control measures specified by the Infection Control Nurse and SFDPH.

iv. If the physician determines that transferring the resident would be detrimental to the resident's condition, the transfer can be put on hold. Employees caring for the resident, however, must use respiratory protection and PPE. The resident's condition shall be reviewed every 24 hours and documentation made in the medical record. Once determined that the resident can be safely transferred, transfer must be carried out per the protocol above.

e. Administrative and Work Practice Controls

i. Hand hygiene guidelines must be followed at all times.

ii. Designated isolation room treatment equipment will be utilized if possible. This includes, but is not limited to, BP cuffs, thermometers etc. The items will be dedicated to the resident in the isolation room until it is vacated.

iii. Procedures for cleaning occupied isolation rooms shall be the same as the cleaning procedures used in exam rooms (see LHH 72-01 Infection Control ManualF12) except that personnel performing cleaning procedures shall follow airborne precautions.

iv. Terminal cleaning of non-disposable medical equipment will be done after each discharge according to LHH 72-01 Infection Control Manual F13. All other equipment will be discarded at discharge.

v. Terminal cleaning of AII rooms shall be done in accordance with LHH 72-01 Infection Control Manual F2 after ventilating according to section 2(c)(v) of this plan.

f. Respiratory Protection

i. The following tasks require the use of at least an N95 respirator.

Working in an airborne isolation room occupied by a resident with known or suspected ATD, including both patient care and cleaning/maintenance tasks.

- Transporting a resident with known or suspected ATD.

- Maintaining or repairing the ventilation system for isolation rooms when the room is not occupied by a resident with known or suspected ATD.

ii. A powered air purifying respirator (PAPR) must be worn for the following tasks:

- Performing or assisting a high hazard procedure (see Table 2).

- Performing maintenance or repair on the ventilation system for isolation rooms while a suspected or confirmed case of an AirID is occupying the room.

iii. All respirator use shall be in accordance with the LHH Respiratory Protection Program (LHHPP 73-09 Respiratory Protection Program (RPP)).

g. High Hazard Procedures

All high hazard procedures listed in Table 2 will be controlled as follows when performed on a case or suspected case of AirID:

i. High hazard procedures shall be conducted in the AII room.

ii. Only personnel necessary to perform the procedure shall be in the room during the procedure.

iii. Powered Air Purifying Respirators (PAPRs) must be worn by all employees who are in the room during the procedure.

Table 2. High Hazard Procedures and Job Classes Potentially Exposed

Procedure	**Job Classes**	**Job Titles**
• Sputum Induction • Respiratory Care (e.g. suctioning, trach care) • Nasal Aspirates • Aerosol Therapy (nebulizer) • Any other aerosol generating medical procedures	2536 2320 2312 2230 2232 2302 2303 2583	Respiratory Care Practitioner Registered Nurse Licensed Vocational Nurse Physician Specialist Senior Physician Specialist Nursing Assistant Patient Care Assistant Home Health Aide
Procedure	**Job Classes**	**Job Titles**
• Maintenance/repair of isolation room ventilation systems when the room is occupied by a resident with a suspected or confirmed ATD	7334 7335	Stationary Engineer Sr. Stationary Engineer

3. Medical Services

a. Vaccinations

i. All employees will have available free of charge all vaccinations listed in Appendix C.

ii. Employees shall be offered their initial vaccinations at the DPH Occupational Health Service (OHS) clinic at Zuckerberg San Francisco General Hospital (ZSFG) during their pre-employment health exam. After employees are hired they will receive subsequent vaccinations at the LHH Employee Health Clinic (LHH Clinic).

iii. Influenza vaccinations will be available to staff during the period designated by the CDC.

iv. Employees who decline vaccination must sign a declination form for the specified vaccine, which includes the statement in Appendix D. These forms once completed shall be maintained in the Laguna Honda Employee Health record.

v. If an employee initially declines a vaccine they can anytime thereafter request and receive the vaccine from the LHH Clinic.

vi. Employees who receive vaccinations which will protect them from exposures to ATD pathogens are still required to wear personal protective equipment, including respiratory protection when required by this policy.

b. Tuberculosis (TB) Surveillance Program

All employees will participate in the Tuberculosis Surveillance Program as follows.

i. All new employees will be given a two-step PPD skin test unless medical reasons exist to give no such test. The OHS or the LHH Clinic will document the PPD administration or reason for not completing it.

ii. The PPD skin test results will be maintained in the Employee Health records at the LHH Clinic.

iii. All employees shall receive annual tuberculosis screening at the LHH Clinic. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptom review for those with prior positive skin tests.

iv. Employees who convert their skin tests will receive a TB Symptom Review Survey, chest x-rays and referral to the OHS Clinic at ZSFG. The results of the evaluation from the OHS Clinic will be sent to the LHH Clinic. The OHS Medical Director or designee will review these results and provide clearance for the employee to continue work.

4. Exposure Incident Follow-Up

a. Employees who suspect an occupational exposure to an ATD in the workplace will report the exposure immediately to their supervisor.

b. The supervisor will notify the Infection Control Nurse and the Industrial Hygienist and will complete injury/incident paperwork (Forms DWC-1, SIIR, and 5020) and the Supervisor's Airborne Transmissible Disease Exposure Report (Appendix E) to be faxed to the DPH Occupational Safety and Health Section (OSH) at 415-554-2570.

c. If the Supervisor's investigation determines that there has been an exposure to an ATD as a result of uncontrolled exposure to a resident with confirmed ATD:

   i. The Infection Control Nurse and Industrial Hygienist will use the Supervisor's Airborne Transmissible Disease Exposure Report to determine whether other employees and/or residents may have been exposed to the source resident while the resident was infectious.

   ii. The Infection Control Nurse and Employee Health will conduct a contact investigation to evaluate contacts for immunity, prophylaxis, work restrictions, isolation or precautions, as indicated by specific diseases to prevent secondary infection. The Centers for Disease Control Criteria will be used to confirm the ATD diagnosis.

   iii. Post-exposure medical evaluation shall occur as soon as feasible for employees who have had a significant exposure.

   iv. Employees will be referred to the OHS clinic for post exposure treatment during normal working hours. For exposures that occur during times when the OHS clinic is closed, the employee's supervisor shall refer the employee to ZSFG Urgent Care Clinic for medical evaluation.

   v. Employees who choose not to be evaluated by the DPH OHS clinic or the ZSFG urgent care clinic may seek treatment at any of the Workers' Compensation Designated Clinics listed at http://dphnet.dph.sf.ca.us/node/626 or their pre-designated provider.

d. The medical provider will provide Laguna Honda Employee Health with a written opinion limited to the following information:

   i. Employee's TB test status or other ATD test status.

   ii. Employee's infectivity status.

   iii. A statement that the employee has been informed of the results and offered any applicable treatment.

iv. A statement that the employee has been told about any medical conditions resulting from exposure and has been informed of treatment options.

v. Any recommendations for precautionary removal from normal duties.

e. If the medical provider recommends temporary removal from work, the employee's manager shall code the employee's time away as paid administrative leave.

5. Procedures for Post-Exposure Communication of Disease Status of Exposure Source

a. The LHH Infection Control Nurse and Unit Nurse Manager shall communicate information regarding the disease status of the source resident to all affected LHH employees, students, family members, contractors and volunteers.

b. The LHH Infection Control Nurse shall be responsible for reporting the source case or suspected case to the local health officer when required.

c. The LHH Infection Control Nurse or designee will be responsible for reporting source cases or suspected cases to other employers such as paramedics, contractors, acute hospital no longer than 72 hours after the report to the local health officer.

d. The notification to other employers shall include date, time and nature of suspected exposure and any other pertinent information to help with surveillance. The identity of the source client shall not be provided to the other employer.

6. Procedures for Ensuring Adequate Supplies of PPE During Normal Operations and During a Medical Surge

a. The Materials Manager is responsible for ensuring an adequate supply of PPE, including N95 respirators in Central Supply for use during normal operations.

b. The LHH Medical Surge Plan can be found in the Emergency Response Manual (LHHPP 70-03 Emergency Preparedness Committee Appendix H5). If resources become limited during a medical surge, the Incident Commander will rely on the Logistics Section Chief in collaboration with the Safety Officer to develop a distribution plan customized for the specific product in short supply and the specific event. This may require re-use of PPE, including N95 respirators.

c. If sufficient supplies cannot be obtained from suppliers even with rationing and re-use, the Incident Commander shall request additional resources from the SFDPH DOC.

7. Education and Training

a. Training will be provided to all employees with the potential for an occupational exposure at the time of initial assignment to a job where occupational exposure may occur, at least annually thereafter, and whenever there are changes affecting exposures or control measures.

b. WSEM or OSH will develop the initial and annual ATD Training. The training will be available to all LHH employees online through the educational computer program, Health-Stream. The exception to this will be training offered to CNA's and PCA's, which will be held in a traditional classroom setting.

c. The LHH Department of Education and Training shall be responsible for making sure LHH staff complete the on-line training.

d. Training programs shall include an opportunity for interactive questions and answers with a person knowledgeable in the subject matter. Training not given in person shall include contact information for the WSEM, the LHH Infection Control Nurse, and OSH so that questions can be answered within 24 hours by a knowledgeable person.

8. Recordkeeping

a. The Facility Services Department shall keep records of inspection, testing and maintenance of the AII rooms. These records shall be maintained for a minimum of 5 years and shall include the names and affiliations of the persons performing the test, inspection or maintenance, the date and any significant findings and actions that were taken.

b. The Director of Education and Training shall maintain all ATD training records for at least three years from the date on which training occurred. The training records shall include the dates of the training session, the contents or a summary of the training session, the names and qualifications of persons conducting the training, the names and job titles of all persons attending the training sessions.

c. LHH Employee Health shall maintain an accurate medical record for each employee with occupational exposure in accordance with Title 8 Section 3204, Access to Employee Exposure and Medical Records. The records shall include:

    i. The employee's name and any other employee identifier used in the workplace.

    ii. The employee's vaccination status for all vaccines required by this standard, any vaccination record provided by the employee, and any signed declination forms. In cases where seasonal influenza vaccination is declined, the medical record need only contain a declination form for the most recent seasonal influenza vaccine.

iii. A copy of all written opinions provided by a medical provider in accordance with this standard, and the results of all TB assessments.

iv. A copy of the information regarding any exposure incident that was provided to a medical provider.

d. The employer shall ensure that all employee medical records required by this section are:

i. Kept confidential and not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

ii. The employer shall maintain the medical records required by this section for the duration of employment plus 30 years.

ATTACHMENT:
Appendix A: Aerosol Transmissible Diseases/Pathogens
(Original adoption: 15/03/10)
Appendix B: Job Classifications with Potential Occupational Exposure
(Original adoption: 15/03/10)
Appendix C: ATD Vaccinations Recommendations for Susceptible Health Care Workers
(Original adoption: 15/03/10)
Appendix D: Vaccination Declination Statements
(Original adoption: 15/03/10)
Appendix E: Supervisor’s Airborne Transmissible Disease Exposure Report
(Original adoption: 15/03/10)

REFERENCE:
LHHPP 20-08 Use of Isolation Rooms
LHHPP 70-03 Emergency Response Plan: Appendix H5 Medical Surge Emergency Quick Reference Response Guide
LHHPP 72-01 Infection Control Manual: F2 Isolation Room Disinfection
LHHPP 72-01 Infection Control Manual: G2 Classification of Reusable Medical Devices and Processing Requirements
LHHPP 72-01 Infection Control Manual: F12 Cleaning of Examination Rooms
LHHPP 72-05 Employee Influenza Vaccination Policy and Use of Surgical Masks When Vaccination Is Declined
LHHPP 73-09 Respiratory Protection Program (RPP)
LHHPP 73-12 Annual Employee PPD Testing
Cal/OSHA, Title 8, §3204, Access to Employee Exposure and Medical Records
CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005

Revised: 15/03/10, 16/11/08 (Year/Month/Day)
Original adoption: 12/09/25

Appendix A: Aerosol Transmissible Diseases/Pathogens

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

Diseases/Pathogens Requiring Airborne Infection Isolation

Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g.
Anthrax/*Bacillus anthracis*
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient.
Localized disease in immunocompromised patient until disseminated infection ruled out
Measles (rubeola)/Measles virus
Monkeypox/Monkeypox virus
Novel or unknown pathogens
Severe acute respiratory syndrome (SARS)
Smallpox (variola)/Varioloa virus
Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
Any other disease for which public health guidelines recommend airborne infection isolation
residents diagnosed with these diseases/pathogens will require a negative pressure isolation room

Diseases/Pathogens Requiring Droplet Precautions

Diphtheria pharyngeal
Epiglottitis, due to *Haemophilus influenzae* type b
Haemophilus influenzae Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children
Influenza, human (typical seasonal variations)/influenza viruses
Meningitis
Haemophilus influenzae, type b known or suspected
Neisseria meningitidis (meningococcal) known or suspected
Meningococcal disease sepsis, pneumonia (see also meningitis)
Mumps (infectious parotitis)/Mumps virus
Mycoplasmal pneumonia
Parvovirus B19 infection (erythema infectiosum)
Pertussis (whooping cough)
Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
Pneumonia
Adenovirus
Haemophilus influenzae Serotype b, infants and children
Meningococcal
Mycoplasma, primary atypical
Streptococcus Group A
Pneumonic plague/*Yersinia pestis*
Rubella virus infection (German measles)/Rubella virus
Streptococcal disease (group A streptococcus)
Skin, wound or burn, Major
Pharyngitis in infants and young children
Pneumonia
Scarlet fever in infants and young children
Serious invasive disease
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures).Any other disease for which public health guidelines recommend droplet precautions
residents with these diseases/pathogens do not require negative pressure in the isolation room

Appendix B: Job Classifications with Potential Occupational Exposure

Class	Title	Class	Title
2230	Physician Specialist	2556	Physical Therapist
2232	Senior Physician Specialist	2558	Senior Physical Therapist
2302	Nursing Assistant	2574	Clinical Psychologist
2303	Patient Care Assistant	2576	Sprv Clincal Psychologist
2312	Licensed Vocational Nurse	2583	Home Health Aide
2320	Registered Nurse	2587	Health Worker 3
2322	Nurse Manager	2588	Health Worker 4
2323	Clinical Nurse Specialist	2736	Porter
2324	Nursing Supervisor	2920	Medical Social Worker
2326	Nursing Supervisor Psychiatric	2922	Senior Medical Social Worker
2424	X-Ray Laboratory Aide	2924	Medical Social Work Supervisor
2430	Medical Evaluations Assistant	2930	Psychiatric Social Worker
2454	Clinical Pharmacist	2931	Marriage, Family & Child Cnslr
2536	Respiratory Care Practitioner	6138	Industrial Hygienist
2542	Speech Pathologist	6139	Senior Industrial Hygienist
2548	Occupational Therapist	7334	Stationary Engineer
2550	Senior Occupational Therapist	7335	Senior Stationary Engineer
2554	Therapy Aide	P103	Special Nurse
2555	Physical Therapist Assistant		

Appendix C: ATD Vaccination Recommendations for Susceptible Health Care Workers

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	One dose
Tetanus, Diptheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses

Source: California Department of Public Health, Immunization Branch

Appendix D: Vaccination Declination Statements

General Vaccination Declination Statement

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with _____ (name of disease or pathogen). I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring _____, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

_____ _____

Employee Signature Date

Seasonal Influenza Vaccination Declination Statement

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

_____ _____

Employee Signature Date

Appendix E: Supervisor's Airborne Transmissible Disease Exposure Report

The Supervisor/Nurse Manager must complete this form when there is an alleged or suspected worker exposure to an airborne transmissible disease. The supervisor should give a copy to the potentially exposed employees to take with them when they seek medical services. The form must be immediately faxed to the OSH Section at 554-2570.

1. DPH/Division:

☐ San Francisco General Hospital ☐ Community Health Programs ☐ Jail Health Services ☐ Central Administration
☐ Laguna Honda Hospital ☐ Community Health & Safety ☐ Primary Care ☐ Other _____

2. Source Patient Diagnosis

☐ Aerosolizable spore-containing powder
☐ Avian Influenza
☐ Diphtheria pharyngeal
☐ Haemophilus influenzae
☐ Measles (rubeola)/Measles virus
☐ Meningitis
☐ Meningococcal disease sepsis
☐ Monkepox
☐ Mumps
☐ Novel or Unknown Pathogens
☐ Pertussis (whooping cough)
☐ Pneumonic plague
☐ Rubella virus infection
☐ Severe acute respiratory syndrome (SARS)
☐ Smallpox (variola) Variola virus
☐ Tuberculosis (TB)
☐ Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses
☐ Other disease for which public health guidelines recommend airborne infection isolation. Please Specify:

3. Exposure source patient (First, Last, MI)	**4. Location of Contact**	**5. Incident Date and Time** AM/PM
6. Date Source Pt. presented	**7. Laboratory Confirmed Diagnosis** ☐ Yes ☐ No	**8. Date of Diagnosis**
9. Were Isolation Procedures Employed? Please Describe	**10. If isolation procedures were not employed, please explain:**	
11. Was patient masked? ☐ Yes ☐ No	**12. Describe nature of unprotected contact**	**13. Duration of unprotected contact**

14. Were aerosol generating procedures (e.g., sputum, induction, aerosolized administration of medications, etc.) performed during the exposure incident? If yes please explain:

15. Was all appropriate Personal Protective Equipment (PPE) used? If not, explain why:

16. Were employees of any other employer involved? If so, list employer and potentially exposed employees:

17. In your opinion, what could have been done to prevent this exposure incident? Please explain:

18.Supervisor's signature: **19. Supervisor's phone number:** **Date:**

21. Potentially exposed employees:

Name (Last, First, MI)	Job Class #	Emp Phone #	Exposure Description	PPE Used
				☐ N95 ☐ Gloves ☐ Eye Protection ☐ Mask ☐ Gown ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye Protection ☐ Mask ☐ Gown ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye Protection ☐ Mask ☐ Gown ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye Protection ☐ Mask ☐ Gown ☐ Other ____________
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				☐ N95 ☐ Gloves ☐ Eye Protection ☐ Mask ☐ Gown ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye Protection ☐ Mask ☐ Gown ☐ Other ____________

22. Supervisor's signature:	23. Supervisor's phone number:	24. Date:

Warfarin Collaborative Practice Agreement

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

Warfarin Collaborative Practice Agreement

DATE OF IMPLEMENTATION: March 2012
DATES OF ANNUAL REVIEW COMPLETED: April 2023
LAGUNA HONDA HOSPITAL & REHABILITATION CENTER

SCOPE:

- Clinical pharmacists who are credentialed by the Medical Staff at Laguna Honda Hospital
- Clinical pharmacists will manage daily warfarin therapy according to the guidelines detailed in this practice agreement.

COLLABORATIVE PRACTICE AGREEMENT

Under this collaborative practice agreement, clinical pharmacists may adjust warfarin therapy and order relevant labs upon receipt of a “pharmacy to dose warfarin” order from the licensed physician.

PURPOSE:

To maximize the therapeutic efficacy of oral warfarin therapy and to minimize the potential for adverse effects and complications

POLICY:

Physicians can request for clinical pharmacists to dose and manage warfarin therapy by entering a “pharmacy to dose warfarin” order. Clinical pharmacist will manage warfarin anticoagulation using evidence-based guidelines and best practice standards.

ORGANIZATION:

The clinical pharmacist will coordinate the warfarin anticoagulation service and will determine patient-specific intervals for INR draws, evaluate patient’s warfarin therapy, and make dosage adjustments per protocol if necessary. The pharmacist will be available to evaluate all INR values returning between the hours of 8am-4:30pm on Monday - Friday. The clinical pharmacist will notify the primary or covering physician if INR values are anticipated outside of the designated window. All INRs which return outside this designated window must be evaluated and acted upon by the primary or covering physician, with care taken to provide information regarding interventions and blood draw intervals to the clinical pharmacist when they are next available.

When outlined by the protocol, or at any time an unusual or unexpected situation arises,

the clinical pharmacist will consult the primary or covering provider for medical guidance. If the patient has a critically high INR and vitamin K administration is indicated by the protocol, then vitamin K administration will be initiated after discussion with the physician. If serious bleeding is noted, the primary or covering physician and the clinical pharmacist will be notified and the corresponding physician will evaluate the patient for appropriate management.

PROCEDURES:

Anticoagulation treatment will be initiated and discontinued by the physician only. The protocol outlines procedures for the clinical pharmacist to monitor and adjust warfarin doses. Slight deviations from the protocol per clinical judgment may be warranted. Management of warfarin regimen will continue for the duration of therapy. If the duration of anticoagulation therapy is complete, discontinuation of warfarin may be discussed with the primary physician.

A. Physician Responsibility:

1. Epic order for "pharmacy to dose warfarin"
    a. Indication for warfarin
    b. INR Goal
    c. Expected duration of therapy
    d. Any pertinent information that may affect warfarin therapy (e.g. drug-drug interactions, upcoming procedures)
2. Review pharmacist notes for details regarding warfarin therapy
3. Assess the patient for changes in clinical status, e.g. bleeding
4. Contact clinical pharmacist for
    a. Change in patient's clinical status that may impact warfarin management
    b. Any scheduled invasive procedures, e.g. colonoscopy, teeth extractions
    c. Initiation of interacting drug therapy that would impact the INR, e.g. antibiotics or anti-epileptic medications
    d. Critical INR values and managements
    e. Discontinuation of warfarin therapy

B. Pharmacist Responsibility:

1. Epic order for "Anticoagulation Monitoring" by nursing
    a. Indication for warfarin
    b. Expected duration of therapy
    c. Adverse effects for monitoring
    d. Any pertinent information that may affect therapy or monitoring (e.g. drug-drug interactions, incoming procedures)

2. Warfarin dosing and lab monitoring
    a. During the initial patient chart review, the clinical pharmacist will review:
        i. Indication of therapy
        ii. Concomitant disease states
        iii. Duration of therapy

iv. Dietary information
v. Potential drug-drug interactions and drug-food interactions
vi. Dosage history (e.g. recently held/refused/missed doses)
vii. Any reports of adverse effects (e.g. bruising/bleeding)

b. Under this protocol, the clinical pharmacist is authorized to perform the following without prior physician consultation as long as the dosage adjustment follows the protocol. Slight alterations to the protocol may be warranted as seen fit by clinical judgment
   i. Write new orders for warfarin
   ii. Make warfarin dosage adjustments, including holding doses if appropriate
   iii. Order STAT and routine INR lab tests
      1. Frequency of INR Monitoring

Every 2-3 days	Until INR is within therapeutic range on 2 consecutive INR checks
Then every week	Until INR is within therapeutic range on 4 consecutive INR checks
Then every 2 weeks	Until INR is within therapeutic range on 2 consecutive INR checks
Then every 4 weeks	When INR is stable

3. Bridging therapy
   c. For patients on bridging therapy (e.g. enoxaparin), the clinical pharmacist will discontinue the bridging therapy when
      i. After at least 5 days of overlap with warfarin, and
      ii. Two consecutive therapeutic INRs are achieved

4. Scheduled invasive procedures
   d. After discussing with the primary physician, the clinical pharmacist is authorized to:
      i. Order bridging therapy (e.g. heparin or enoxaparin) if necessary
      ii. Hold warfarin as appropriate
      iii. Restart warfarin after discussing with the primary physician

5. Out of range lab values
   e. For INR values that are out of goal range, the clinical pharmacist will
      i. Perform a thorough assessment of the patient chart
      ii. Adjust the warfarin dose as necessary
      iii. Adjust INR monitoring frequency as necessary
      iv. Document the therapy plan in a consult note, which shall include the following:
         1. Indication
         2. Anticoagulation therapy start date
         3. Length of therapy
         4. Goal INR

5. Current warfarin dose
6. Held/refused/missed doses within the last 7 days
7. Drug-drug interactions
8. Warfarin dosage and INR history
9. Assessment and plan

v. For INR values slightly below or above goal, the clinical pharmacist may choose to continue current dose pending repeat INR per clinical judgement

f. For critical INR values (INR > or = 5)
   i. If vitamin K is clinically indicated, the clinical pharmacist will discuss with the primary or covering physician, and order vitamin K

C. Nursing Responsibility:

1. Anticoagulation Therapy Monitoring
   a. During therapy, nursing will monitor patients for any signs and symptoms of:
      i. Bleeding (e.g. bruising or bleeding that is abnormal, changes in menstrual periods such as increased bleeding, spotting, or bleeding between cycles, nosebleeds that won't stop, bowel movements that are red or black like tar, throwing up blood or liquid that looks like coffee grounds)
      ii. Neurological impairment (e.g. midline back pain, sensory defects, motor defects, bowel dysfunction, and bladder dysfunction)
   b. Document any findings in the EMR with a frequency specified by the nursing order
   c. Alert both physician and pharmacist if the patient displays symptoms of bleeding or neurological impairment.

TERMINATION OF CARE

1. Patients will be discontinued from the anticoagulation service if they are no longer receiving warfarin
2. If the primary physicians wish to manage the anticoagulation themselves, he/she should document explicitly in a progress note
   a. Warfarin will be managed by the primary physician
   b. If follow up is needed, the primary physician will sign out to the covering physician
3. Pharmacy will also document the above in the monthly medication regimen review note, stating the following:
   a. Date of the physician progress note that stated physician has opted out of the "warfarin per pharmacy" practice agreement (e.g. Refer to progress note from XX/XX/XX by Dr. XXX who opted out of warfarin per pharmacy practice agreement, therefore the physician will monitor INR and order warfarin per practice guidelines.)

QUALITY IMPROVEMENT

This protocol will be reviewed annually by the clinical pharmacy team, physician providers on the Pharmacy & Therapeutics Committee and will be revised as necessary.

Appendix I

Recommended Therapeutic INR Ranges

Indication	INR Range
Pulmonary arterial hypertension	1.5-2.5
Treatment of VTE and/or PE Nonvalvular atrial fibrillation Mechanical cardiac valves in the aortic position Antiphospholipid antibody syndrome Intracardiac thrombus	2 - 3
Mechanical cardiac valves in the mitral position or ball and cage valves in any position Mechanical cardiac valves in the aortic position with arrhythmia	2.5 - 3.5
Other hypercoagulable disorders	In consultation with primary physician or consultant

Appendix II

Warfarin Dosing Guidelines

A. Target INR Range: 2.0-3.0

INR	Dosage Adjustments Guidelines
1.0 – 1.4	10-20% INCREASE in weekly dose
1.5 – 1.9	5-10% INCREASE in weekly dose
2.0 – 3.0	**NO CHANGE**
3.1 – 3.3	5-10% DECREASE in weekly dose
3.4 – 4.0	HOLD for 1 day and/or 10-15% DECREASE in weekly dose
4.1 – 5.0	HOLD for 1-2 days and/or 15-20% DECREASE in weekly dose
>5.1 – 9.0	HOLD for 1-3 days.

*Notify MD if INR > 4.0, and assess for signs and symptoms of bleeding

B. Target INR Range: 2.5-3.5

INR	Dosage Adjustments
< 1.9	10-20% INCREASE in weekly dose
1.9 – 2.4	5-10% INCREASE in weekly dose
2.5 – 3.5	**NO CHANGE**
3.6 – 3.9	5-10% DECREASE in weekly dose
4.0 – 4.5	HOLD for 1 day and/or 10-20% DECREASE in weekly dose
4.6 – 5.4	HOLD for 1-2 days and/or 15-25% DECREASE in weekly dose

> 5.5 – 9.0	HOLD for x1-3 days

*Notify MD if INR > 4.5, and assess for signs and symptoms of bleeding

1. Table serves as a dosing guideline. Clinical judgment must be exercised before making any dosage adjustments.
2. Table assumes the patient has been on warfarin for at least 4 days. INR values do not reflect the true state of anticoagulation during the first 3-4 days of therapy.
3. Patients may receive a 5-10% dosage adjustment to approach the middle of the therapeutic range, as deemed appropriate by the clinical pharmacist.
4. Patient with risk factors for bleeding (e.g. varying alcohol intake, CHF, liver disease, changes in diet) will be maintained at a dose to keep the INR at the low end of the therapeutic range.
5. During the start of anticoagulation therapy, the goal is to achieve therapeutic range over a period of 3-5 days while avoiding the problems of over-anticoagulation.

APPENDIX III

Managing Prolonged Supratherapeutic INR

INR	Recommendation
INR above therapeutic range, but < 5 and no significant bleeding	• Decrease dose (if INR is slightly above range, dose decrease may not be necessary) • If INR rising rapidly or at the high end of range, consider holding 1 dose
INR ≥ 5 and < 9 and no significant bleeding	• Hold warfarin • Resume therapy at lower dose when INR falls within therapeutic range • Patient with high bleeding risk: hold warfarin AND give vitamin K 2.5mg PO x1 (check INR in 24 hours to assure response to therapy)
INR ≥ 9 and no significant bleeding	• Hold warfarin • Give vitamin K 5mg PO x1, may repeat if necessary • Resume therapy at lower dose when INR is within therapeutic range
Serious bleeding at any elevation of INR	• Discontinue warfarin • Give vitamin K 10mg by slow IV infusion for warfarin reversal

1. Vitamin K can lead to a brief period of relative warfarin resistance and difficulty reestablishing a therapeutic range; higher doses of warfarin may be needed but frequent monitoring of INR is imperative.
2. Due to the potential for hypersensitivity reactions or anaphylaxis to IV vitamin K, it should be given slowly (not to exceed 1 mg/min); alternatively, it can be given by subcutaneous or oral route, although response may be delayed if absorption

is impaired. Avoid intramuscular administration due to risk of hematoma formation.

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Revised Central Processing Department Policies and Procedures

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER
Policy and Procedures

TABLE OF CONTENTS

Materials Management

~~Central Supply~~CPD – Central Processsing Department

1. Mission Statement

Laguna Honda Hospital Materials Management and ~~Central Supply~~CPD - Mission Statement

To combine efforts of Purchasing, Receiving, Storeroom, Central ~~Process~~ Processing Department/~~Sterile Processing Department~~, and Inventory Control to provide goods and services in the most-cost effective, expeditious and compliant manner, maintaining internal supplies for immediate access for Laguna Honda Hospital.

- Coordinate~~,~~ with the Office of Contract Administration (OCA), ~~maximum~~ maximize utilization of City Purchasing Contracts, where appropriate.

- Maximize the use of Vizient contracts in the procurement process.

- Coordinate and monitor all vendor activities within Laguna Honda Hospital.

- Utilize Value Analysis Committee (VAC) for coordination and approval of new patientcare (non-drug related) products and to ensure consensus to deliver the highest value in products and service.

- Abide by City & County of San Francisco approved policies and procedures and Group Purchasing Organization (GPO) with consideration of the highest ethical purchasing standard.

- Communicate with internal and external departments for needed information to allow an efficient procurement process.

- Collaborate with the DPH Contracts Department on the development of service agreements.

~~- Manage biomedical support functions for Laguna Honda.~~

- Distribute supplies efficiently to all nursing and administrative units.

- Coordinate the disposal of equipment, supplies, and furniture through Virtual Warehouse.

2. Definitions

Capital Equipment – equipment with a value over $5000, useful life of 3 years, and a stand-alone item.

Contract Office of DPH – Department of Public Health responsible for contracting professional services and processing other contracts as deemed necessary. DPH Contracts office is in a constant collaboration with the City & County of San Francisco Boards, Health Commissions, Contract Monitoring Division (CMD), Office of Contract Administration and Civil Service Commission.

CPD – Central Processing Department

Executive Administrator – Chief Executive Officer (CEO) for Laguna Honda Hospital

Associate Administrator – Chief Operating Officer (COO) for Laguna Honda Hospital

MM – Materials Management

Materials and Supplies – expendable and durable supplies.

Materials Management – Purchasing, inventory, receiving, Warehouse and Central ~~Process~~ Processing Department~~/Sterile Processing~~

Materials Manager – Department Head for Materials Management

General Services – services that are not professional services in natures (MD, Ph.D., Consulting Services). Examples ~~are~~of general services: repair of kitchen equipment, security service, valet parking attendants, Courier etc.

Vizient – Group Purchasing Organization

OCA – Office of Contract Administration, the Central Procurement Agency for the City & County of San Francisco ~~Office of Contract Administration, Purchasing Department~~.

Prop Q – Is the delegated authority to each city department to purchasing goods and services under $10,000 per purchase order.

Purchase Order –Legal document that authorizes the expenditure of funds for purchase of supplies or services.

Purchaser – Approval authority in Purchasing Department

Purchasing Authority – Authority granted by the City & County of San Francisco to purchase materials and supplies and other services. Some examples are Group Purchasing Organization (GPO), Prop Q, Prop 6, etc.

Peoplesoft-Software system to manage inventory, create Purchase Orders, & requestors to create online requisition for stocked supplies and special-order goods and services.

3. Policies & Procedures

3.1 Availability of Funds

Policy: Product or Services May Only be Ordered Utilizing Properly Authorized Purchase Orders

Purpose: **City Policy -** The Controller's office (requires the City and County to use) the City Charter requirement to encumber funds for all purchases and contracts. The City & County of San Francisco Charter, Section 3.105, states that the Controller must authorize all disbursements of funds in the custody of the Treasurer. Said authorization of Funds by the Controller is accomplished through the certification process which verifies that sufficient unencumbered balances are available, in the proper fund, to meet payments. The Certification of the Funds is only executed through the posting of an encumbrance, such as a Purchase Order.

Procedure: Prior to ordering services or any products an approved purchase order must be submitted. A purchase order may be requested through the following processes using these procedures:

1. Request for Purchase Order
2. Request for Blanket Purchase Order – OCA – Purchasing
3. Request for Blanket Purchase Order -Vizient
4. Request of Release of a Purchase Order Against a Term Agreement or City Contract

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.2 Request for Purchase Order for Non-Catalog Items

Policy: An ePro requisition must be created in Peoplesoft and submitted to Materials Management department for processing.

Purpose: All services and products requested should be accompanied by a Purchase Order. Create a special requisition in PeopleSoft for non-catalog items and submit for approval. Non-catalog items are materials or supplies you order not on the formulary catalog (these items do not have an H item number associated with it). Materials Management department will process the requisition and create a purchase order.

Procedure:

1. Log into CCSF portal
2. Go into Procurement > Requisitions > Specials requisitions (for non-catalog items)
3. Fill out the following:
    - Item Description
    - Price
    - Quantity
    - Category
    - Unit of Measure
    - Supplier ID/Supplier Name
4. Add to cart. Once all items are added to the cart, select Check ~~out~~out.
5. Click on the Requisition Settings ~~link~~link.
6. Select override
7. Assign a buyer by DSW#
8. Insert Chart-fields
    - Location
    - GL Unit
    - Account
    - Fund
    - Dept
    - Authority
    - PC Bus Unit
    - Activity
9. Enter Comments/Notes: such as location or department or requestor ~~information~~information.
10. Attach a valid Quote. It is recommended to provide at least three quotes from approved suppliers.
11. Check Budget, once verified it should turn green "~~Valid"~~Valid."
12. Save and Submit
13. Department Head will go into Peoplesoft and review and approve ~~request~~request.
14. Once approved, requisition will be routed to Materials Management and Purchaser will create a Purchase Order. Please allow 3-7 days for processing. If urgent, please notify Buyer assigned to the requisition or Director of Materials Management.

15. Buyer will forward a copy of a Purchase Order to Supplier for processing. A copy of Purchase order will be sent to the requestor.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.3 Request for Purchase Order for Catalog Items

Policy: An ePro requisition must be created in Peoplesoft and submitted to Materials Management department for processing.

Purpose: All services and products requested should be accompanied by a Purchase Order. Create a requisition in PeopleSoft for catalog items and submit for approval. Catalog items are materials or supplies you order in the formulary catalog (these items have an H item number associated with it). Materials Management department will process the requisition and create a purchase order.

Procedure:

1. Log into CCSF portal
2. Go into Procurement > Requisitions > ePro requisitions
3. Search the catalog number. If you don't know the hospital number (H + 7 or 4 digits), search using the description of the item.
4. Filter your results by the Preferred items. To do this, click Yes link under the preferred supplier towards the left side of the page.
5. Once the preferred vendors are listed - please prioritize Medline 0000003192 (bulk account) or 0000029887 (JIT account) and Medline is our primary vendor. Do not change the UOM designated for the product as this can/will cause issues.
6. Once you've selected the correct items and unit of measure (UOM), insert the quantity, and add them to your shopping cart and click check out
7. Click on the Requisition Settings link. Select override and make sure that you enter Buyer by DSW#
8. Enter the chart fields:
    - Location
    - GL Unit
    - Account
    - Fund
    - Dept
    - Authority
    - PC Bus Unit
    - Activity
9. Enter Comments/Notes in "Requisition Comments and Attachments" section: such as location or department or requestor information. If you enter comments, select "show at receipt" and "shown on voucher"
10. Attach any necessary attachments such as quote.
11. Check Budget, once verified it should turn green "Valid"
12. Save and Submit
13. Department Head will go into Peoplesoft and review and approve request
14. Once approved, requisition will be routed to Materials Management and Buyer will create a Purchase Order. Please allow 3-7 days for processing. If urgent, please notify Buyer assigned to the requisition or Director of Materials Management.
15. Buyer will forward a copy of a Purchase Order to Supplier for processing. A copy of Purchase order will be sent to the requestor.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.4 Processing Purchase Order Using Prop-Q

Policy: A Prop Q purchase would be any purchase made through a non-Vizient vendor. Prop Q purchases cannot be reoccurring and must NOT exceed $10K in total spend. A Prop Q purchase order will require the completion and submission of the new OCA Prop Q Checklist (CL-600_Prop_Q_Checklist) which must be attached to each purchase order and uploaded into PeopleSoft.

Purpose: To ensure all Prop Q purchases comply with the City's legal requirements, the checklist contains eleven comprehensive subject areas which require validation and checklist completion before each Prop Q purchase order can be executed.

Procedure:

1. Create an online requisition in ePro (follow directions from 3.2).
2. Once a requisition is approved, buyer in Materials Management will create a Purchase order.
3. In Purchase order page, change purchasing authority to "PROPQ-NO BID"
4. Click "Supplier Details" > "Supplier Information" > "Compliance Summary" and make sure supplier is compliant. If supplier is not compliant, they will need to go through necessary steps to become compliant
    - 12B Equal Benefits Ordinance
    - ~~12X Banned States~~
    - Business Tax Registration
    - Insurance Certificate
5. Attach the following documents in "Edit Comments"
    - Completed CL-600 Prop Q Check List
    - Certificate of Liability Insurance
    - Any necessary supporting documents
6. Submit for approval, please allow 3-7 days for processing. If urgent, please notify Buyer assigned to the requisition or Director of Materials Management.
7. Buyer will forward a copy of a Purchase Order to Supplier for processing. A copy of Purchase order will be sent to the requestor.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.5 Processing a Purchase Order using a City Term Contract

Policy: To release against a term contract or city contract, a valid purchase order must be created.

Purpose: City Contracts may be utilized if they are current and to purchase commonly purchased goods and services.

Procedure:

1. Create an online requisition in ePro (follow directions from 3.2).
2. Once a requisition is approved, buyer in Materials Management will create a Purchase order.
3. In purchase order contracts tab, input the “Contract ID” and appropriate “Contract” and “Category” numbers. Refer to the actual contract for appropriate “Contract Line” and “Category Line”
4. Fill out and update all necessary information.
5. Submit for approval, please allow 3-7 days for processing. If urgent, please notify Buyer assigned to the requisition or Director of Materials Management.
6. Buyer will forward a copy of a Purchase Order to Supplier for processing. A copy of Purchase order will be sent to the requestor.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.6 Processing a Purchase Order using Vizient Contract

Policy: Vizient Agreements are the foundation for purchasing services within the Department of Public Health and Laguna Honda Hospital.

Purpose: Vizient agreements are to be made available to all customers within LHH as these contracts relate to commodities needed for those operating units. Vizient agreements and suppliers are to be given first choice in provision of goods and services to this hospital. Where product standardization exists, only compelling reasons for deviation from the use of Vizient contracts will be considered.

Procedure:

1. Create an online requisition in ePro (follow directions from 3.2).
2. Once a requisition is approved, buyer in Materials Management will create a Purchase order.
3. In Purchase order page, select Header Details > PO type > input “VZ” (for Vizient) > OK
4. Change purchasing authority to “UCHS-BID”
5. Fill out and update all necessary information.
6. Submit for approval, please allow 3-7 days for processing. If urgent, please notify Buyer assigned to the requisition or Director of Materials Management.
7. Buyer will forward a copy of a Purchase Order to Supplier for processing. A copy of Purchase order will be sent to the requestor.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.7 Processing Office Depot Non-Catalog Order

Procedure:

1. Access the form on LHH Internal Web Site: Laguna Honda Materials Management > Forms > LHH ~~Materials Management On-Line Requisitioning User Info~~Office Depot Order Form.
2. Complete the form and obtain approval by department supervisor.
3. Email the form ~~or send through interoffice mail~~ to Materials Management.
4. Materials Management staff will place the order and forward requestor a copy of order confirmation.
5. Items will be delivered to end user by storekeeper upon arrival.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.7 Processing Office Depot Non-Catalog Order

Procedure:

6. Access the form on LHH Internal Web Site: Laguna Honda Materials Management > Forms > LHH Materials Management On-Line Requisitioning User Info Form.
7. Complete the form and obtain approval by department supervisor.
8. Email the form or send through interoffice mail to Materials Management.
9. Materials Management staff will place the order and forward requestor a copy of order confirmation.
10. Items will be delivered to end user by storekeeper upon arrival.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.8 Processing Office Depot Business Card Orders

Policy: Those requesting Business Cards use the following procedure.

Procedure:

1. Access from the LH Forms URL on the LHH Internal Web Site: Laguna Honda Materials Management > Forms > select Business Card Order Form Laguna Honda Hospital.
2. Complete the form and obtain approval by department supervisor.
3. Email the form or send through interoffice mail to Materials Management.
4. Materials Management staff will place the order and forward requestor a copy of order confirmation.
5. Materials Management staff will complete the data entry on the Office Depot website to create a mockup of your card. The font, layout, color, and backside are standardized per San Francisco Health Network.
6. Materials Management will scan a copy of the business card for the requestor to approve the proof prior to ordering the card.
7. The requestor must approve the proof.
8. Upon receiving proof approval, Materials Management will submit the order electronically to Office Depot.
9. Items will be delivered to requestor by storekeeper upon arrival.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.9 Processing Invoices

Procedure:

1. Date stamp invoice once received by Materials Management.
2. If invoice is not for Materials Management or ~~Central Supply~~CPD, forward invoice to appropriate department.
3. Verify the purchase order number on the invoice; if there is no purchase order number, find correct one and write it in.
4. Confirm in PeopleSoft if all items referenced in the Purchase Order are received
5. If freight is added in the invoice but not in the Purchase, do a change order and add “freight”.
6. Notify Accounting about the freight added so they can reapprove the Purchase Order.
7. Once reapproved, have storekeeper create receipt and provide receipt number to accounting.
8. If the invoice is okay to pay, stamp invoice with "OK To Pay" stamp with current date and sign.
9. Deliver original document to accounting department via by email or interoffice same day that invoice is approved.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.10 Purchasing of Goods and Services - Contracts

POLICY: Vizient Agreements shall be utilized in procurement of the majority of goods and services for Laguna Honda Hospital.

PURPOSE:
To ensure that materials and services ordered by the facility are consistent with LHH's policy for use of only approved contracts for services and material. To ensure staff time is utilized for purchasing of products and only creating contracts in areas not covered by Vizient. Support Administrative Code §15.105.

PROCEDURE

1. Vizient Agreements are the foundation for purchasing services within the Department of Public Health and Laguna Honda Hospital.

2. City Contracts may be utilized when they are 1) current, 2) offer goods and services that are not supported by the above agreements or 3) already exist and show more value than UHCS authority.

3. If an approved Vizient contractor does not qualify as approved city and county vendor, the vendor will be advised on compliance. If the vendor does not become compliant, other Vizient vendors for this service or commodity are to be utilized. If no vendor can qualify as an approved city vendor a contract with City and County Purchasing may be initiated if dollar volumes are suitable for contracting. Associate Administrator is to be informed prior to a contract request being initiated.

4. Vizient agreements are to be made available to all customers within LHH as these contracts relate to commodities needed for those operating units. Vizient agreements and suppliers are to be given first choice in provision of goods and services to this hospital. Where product standardization exists, only compelling reasons for deviation from the use of Vizient contracts will be considered.

5. Vizient contract numbers are to appear in the note pad section of the BPO or PO and in the detail section of the BPO or PO. Access to Vizient (www. www.vizientinc.com) web sites are to be utilized in confirmation of these agreement numbers and inclusive dates.

6. Materials Manager is to remain informed on duration of contracts and vendor compliance with City & County of San Francisco purchasing policies as well as vendor performance.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.11 Equipment Lease

Policy: An ePro requisition for equipment Lease must be submitted to Materials Management department in advance of service needs.

Purpose: All services requested should be accompanied by a Purchase Order. Create a requisition in PeopleSoft for catalog equipment lease and submit for approval and Materials Management department will process.

1. Equipment leases include the rental of fixed or mobile equipment used in Laguna Honda Hospital (No motor vehicles.)

2. Submit an ePro request for a ~~supplier blanket~~blanket ~~-~~purchase order with the following:

   - Letter on company letterhead describing the scope of lease to be performed and estimated cost.
   - Company lease agreement
   - City & County of San Francisco contract addendum (**Model Equipment Lease Attachment** P-520 (8-05))
   - Certificate of Insurance as required by OCA – purchasing, Risk Management, and City & County of San Francisco Insurance Department.
     (~~for~~For installation or service).

3. Submit four (4) original signed packages as described above.

4. Once received by materials management this package will be sent to the executive administrator for approval and the city attorney (as to form).

5. Once approvals are in place, materials management will send the forms to OCA – purchasing for verification of insurance and signature by the Director of Purchasing for the City & County of San Francisco.

6. OCA – Purchasing will issue a supplier purchase order. Department must request a release against supplier purchase order. Once department may contact the supplier to place equipment order.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.12 Conflict of Interest

Policy: As employees of the City & County of San Francisco we are required to work under the provisions of the *San Francisco Campaign and Governmental Code, Section 3.214.*

1. Any manager, who in the proper functioning of her or her job will be required to read and sign acceptance of these provisions, annually.

2. Any manager, who in the proper functioning of her or her job will be required to read and sign *State of California Form 700*, annually.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.13 MANDATORY TRAINING SESSIONS FOR MANAGERS

Policy: Annually MM will provide Purchasing Workshops as required. Newly hired managers will receive an overview of the purchasing process.

Topics

Introduction to Purchasing – including use of Vizient, ethnical purchasing practices, controller's office recommendations.

Understanding the Purchasing Process

Understanding Service Contracts

Understanding Certificates of Insurance

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.14 Selection of a Vendor When Multiple Vizient Awards Exist

Policy:

All factors affecting the purchasing decision will be considered when more than one contract exists for selection in the Vizient contract catalog.

1. Selection criteria will be developed for each contract process which will include consideration the lowest price, availability of the product, quality of the product, clinical consideration of specific use at Laguna Honda, and the least expensive distributor.

2. Appropriate Managers or Committees will be included in the process.

3. Evaluation and selection documentation will be maintained for the length of the contract.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.15 Storeroom Supplies

Policy:

Supplies may be obtained from the CPD Storeroom.

Procedure:

1. ~~Send an electronic Peoplesoft eReq online PMM requisition to MM.~~ Access the CPD Requisition Form on LHH Internal Website: Laguna Honda Materials Management > PeopleSoft ePro Requisitioning > LHH CPD Requisitioner General Order Template

2. ~~The following business day or same day the product will be delivered to your department by MM staff~~ Download the Requisition Template.

3. Complete the Requisition Form
4. Email the completed for to CPD
~~2.~~5. CPD staff will process the order and deliver to the requesting department by the next business day or within the same day.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.17 Communications

POLICY:

The Associate Administrator – MM services shall have final review and approval authority for all communications within the ~~or~~ exterior to Laguna Honda Hospital. This authority may be authorized to the Director of Materials Management.

PURPOSE:
To ensure that material representing the Hospital is accurate and consistent with the Hospital's mission.

PROCEDURE:

1. Communication includes telephone, faxes, emails, ~~memos~~memos, and other written communication.

2. Originators shall forward all materials intended for **distribution to the public** to the division head for prior approval. Division head responsible for the program or service being described must approve. Prior to any distribution, the division head shall provide a copy of such material to the CEO for approval. (See related Hospital Wide Policy 01-05)

3. This policy is not intended to hinder communication of a nature involving normal business practices, but to clarify issues of positions or policy that may cause LHH to be seen in a light that is not consistent with our mission.

4. This policy is not to hinder the rights of employees as it relates to any “whistle blower” ordinance as enacted by the Board of Supervisors, right of free speech as a private citizen.

5. Line of authority is essential to operations at LHH; the immediate supervisor is to be included in any communication to those in the line above the immediate supervisor.

6. Any communication to other departments is to be copied to the immediate supervisor.

7. Any communications directed outside LHH or to other departments are to be copied to the immediate supervisor.

8. The immediate supervisor, prior to sending communication, must approve any communication of an accusatory nature, issues involving change in policy of the department or section, nonperformance of individuals in their positions, in advance.

Usual business communication of an ongoing and business-related nature is exempt from this policy.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.18 Vizient Group Purchasing Organization Access

POLICY:

MANAGERS WILL HAVE ACCESS TO VIZIENT WEBSITE AND INFORMATION

1. Access to the ~~websites~~websites above ~~contains~~contain information needed for purchasing and program information. Much of this information is detailed and relevant.

2. Access is granted by a combination of approvals by Materials Management and Vizient. Please email ~~Ellen Pon,~~the Director of Materials Management for access to these sites.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.20 Peoplesoft Inventory PAR Replenishment

Policy: Creating Purchase Orders via the Peoplesoft software system.

1. Director of Materials Management or the Assistant Materials Coordinator(s) will check PAR Request in Peoplesoft daily to process all Peoplesoft Inventory system electronic requisitions.

2. All requisitions will be processed into a Purchase Order daily.

3. The requisition will be reviewed for appropriate quantity and funding. Any questionable requisitions will be reviewed with the requesting department requestor or department manager.

4. The Purchase Order will be submitted via GHX Exchange electronic order, fax, or phone-in order based on existing vendor agreements.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.21 Biomedical Technical Assistance

Policy:

As of March 2023, LHH has contracted with ~~Agiliti Healthcare Services~~Cure Biomedical to provide biomedical services for our medical equipment including beds. Please refer to Biomed Policies and Procedure for full details. ~~This agreement will cover approximately 500 pieces of medical equipment in the hospital with the remaining equipment maintained by Plant Services. The agreement calls for **annual** (non-life safety equipment) **or semiannual** (life safety equipment) preventative maintenance (PM) inspections/checks and repairs as needed throughout the year. Some equipment will be PM only with repairs made by the manufacturer or other arrangements. Agiliti has established a repair shop in the H2 Materials Management.~~

~~1. Locate the Equipment Control number on the piece of equipment that needs service during the 30 days prior to due date.~~

~~2. Any equipment that is unable to be located (MIA), UHS tech will utilize the Aero Scout system to attempt to locate the missing equipment.~~

~~3. When MIA equipment is unable to be located, UHS tech will notify Materials Management and we will send an email to the Nurse Managers to search their units for MIA equipment.~~

~~4. UHS will continue to maintain the MIA equipment on the contract for 90 days and continue to search. After 90 days, the equipment will be removed from our contract.~~

~~5. UHS will conduct a semi-annual house-wide search and inventory all equipment.~~

~~6. New equipment is provided an electrical safety check and functional check. Equipment is tagged with an equipment control # label, Aero Scout tag affixed, and equipment information provided to Facilities to enter into the Aero Scout system.~~

~~7. Any broken, malfunctioning, or equipment overdue for PM will be tagged with problem noted and placed in the Nursing soiled utility room. CPD techs will pick up equipment and bring to Agiliti Tech.~~

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

3.22 Bulk Oxygen

Policy: LHH has contracted with Airgas Northern California & Nevada, Inc. for bulk tank rental and medical oxygen replenishment of bulk tanks, 3,000-gallon primary tank and 525-gallon reserve tank. Materials Management and Plant Services will coordinate with Airgas for the delivery time and refill of the bulk tanks on a regularly scheduled basis.

Airgas (866) 323-4391

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-01 ANNUAL PHYSICAL INVENTORY COUNT

POLICY:

Materials Management and ~~Central Supply~~CPD to maintain accountable and accurate on-hand inventory.

PURPOSE:

To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported, and reconciled prior to on hand inventory adjustments.

PROCEDURE:

MM/~~CSR~~CPD- Annual Physical Inventory Count – objective is to get a snapshot of all items in inventory at one time. There will be one person designated as the "leader" or go-to person for questions regarding bin location, units of measure, and other inventory questions as well as handling any incoming phone calls and handling the count sheets. Another person will be designated as the "data entry person". The rest of the staff will be designated as "counters" and will be the ones physically counting products and logging it on the count sheets.

By end of day 3:00 pm Friday, Before Inventory Day.

1) Label with note "Do Not Count, Not in Inventory" for items not in inventory
2) Receive in all delivery documents for products that have arrived and put into inventory.
3) Confirm “pick plan”.
4) Credit all returns and make sure product has been put back in the accurate locations.

For CPD Saturday, Inventory Day

1) Ensure disable item “express issue” process
2) Pick any remaining express issue items and set aside for delivery.
3) Any urgent express issues will be maintained on a manual log sheet and will need to be requested by phone.
4) Leader will run the “Inventory value history report”, “Current Inventory Value report” and “Inventory detail report” in CVS/Excel format, save and named FY____ ~~CSR~~CPD Pre Physical Inventory Count Stock Status or FY_____ MM Pre-Physical Inventory Count Stock Status.
5) Leader will create a “counting event” by storage location **(LHH CPD, PND-$ LCPD & MM).**
6) Leader will create count sheets sorted by bin location **(LHH CPD, PND-$ LCPD & MM).**
7) The leader will print Count Sheets and divide the number of count sheets by groups so everyone will be spread out while counting.
8) Leader will assign count sheets to the group of counters.
9) Each counter will only have one count sheet at any given time. They will also be given a clipboard, yellow post-it notes, and a pen.
10) Counters will count inventory and write in the count in the spaces provided; count the correct unit of measure of the item. Convert the item unit of measure if necessary. For every blank, there should be a number even if that number is zero.

11) Counters to identify items with "2nd location (see item label with **green dots** & refer to the 2nd bin location sheet hanging on each rack); combined the counted on-hand total on the 1st location of item counted.
12) As counters finish counting each item, they will put a yellow post-it notes on the bin tag to indicate that the item has been counted.
13) There will need to be a log sheet for urgent inventory requests that the leader will need to track. The sheet will be divided between "already counted" items and "not counted yet" items. When necessary, the leader will log the item being requested, the qty requested, and the unit it will need to be charged to later. If that item already has a yellow post-it notes on the item, that same designee will log that item on the "already counted" portion of their log sheet. If there is NOT a yellow post-it notes on that item, the designee will indicate how much product was taken out on a green post-it notes and place it under the item and log this under the "not counted yet" items.
14) If a counter sees a green post-it notes on an item that they need to count, they will need to ADD the qty on that note to how much product they physically count on that item.
15) Once a counter is finished counting a sheet, they will legibly sign (or sign and print name) at the bottom and they will submit it to the leader who in turn will provide them with another count sheet.
16) Count sheets will be placed in an inbox for the data entry person.
17) The data entry person will review/enter the data from the count sheet into the system, save the data after each sheet is entered, and place the count sheets in the outbox.
18) After all count sheets have been submitted and entered into the system, the leader and data entry person will generate Physical accounting reconciliation report and highlight items with discrepancy for recount.
19) Leader will assign recount sheets to group of counters.
20) Data entry person will update and validate the legitimacy of the item discrepancy and placed into the inbox.
21) Data entry person to run a stock inventory update.
22) Inventory Value history, Current value and inventory detail reports are running and saved under 20xx CPD Post Physical Inventory Count Stock Status and 20xx MM Post Physical Inventory Count Stock Status.
23) Print a hard copy of the stock status report.

CPD Bin location total to count:

LHH CPD – All Locations
LHH MM – All Locations

Counting event total: 2 (CPD/MM)

Data entry: (1) Assigned by Dept. Director

Data entry: (2) Assigned by Dept. Director

Leader: (1) Assigned by Dept. Director

Counters: As Assigned by Dept. Director

Most recent review: 03/11/2022

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F-02 ~~Central Supply~~CPD Inventory Cycle Count

POLICY:

Materials Management to maintain accountable and accurate on-hand inventory.

PURPOSE:

To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported and reconciled prior to on hand inventory adjustments.

PROCEDURE:

1. ABC Analysis Report
    a. The ABC report (A=20% / B=20% / C=60%) based on usage will be used to determine the frequency of items are cycle counted per month.
    b. A list items are counted weekly, B list items are counted two times a month and C list items are counted monthly.

2. ABC Analysis Report Review
    a. Management will review the ABC Analysis Report periodically to review if the items are properly categorized.
    b. The ~~1944 Materials Coordinator~~Director of Materials Management will approve all changes to inventory cycle count segments. The ~~1944 Materials Coordinator~~Director of Materials Management may delegate this responsibility to the ~~1942 Assistant Materials Coordinator~~1942 Assistant Materials Manager ~~or~~ 2392 Senior Central Processing and Distribution Technician.

3. Cycle Counts
    a. Staff will conduct cycle counts only and cannot adjust on-hand inventory unless approved by the 1942 Assistant Materials ~~Manager~~Manager.
    b. The Supervisor or Lead will review and investigate all inventory cycle count discrepancies prior to on hand adjustments.

4. Cycle Count Tracking and Record Retention
    a. A manual cycle count tracking logbook will be maintained to record cycle count dates, staff counters, and which individual cycle counts was performed.
    b. All cycle counts will be stored for 1 fiscal year plus current fiscal year.

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F-03 INVENTORY DISCREPANCY REPORTING

POLICY:

A formal inventory discrepancy ~~reporting~~reporting, and adjustment process shall be followed by materials management and ~~central supply~~CPD staff prior to a manual inventory adjustment.

PURPOSE:

Provide management oversight on manual inventory adjustments and to guide staff on the correct inventory discrepancy reporting procedure.

PROCEDURE:

1. When Materials Management or ~~Central Supply~~CPD staff becomes aware of an inventory discrepancy, the supervisor (or lead tech if no supervisor) is notified.

2. The supervisor will utilize ~~Pathways Materials Management (PMM)~~PeopleSoft reports to run a Balancing Inventory Transaction Detail report for the item.

3. Using the report, the supervisor will review pick tickets, ~~materials~~materials, and equipment log sheet, packing slips, cycle count sheets, and online delivery documents to identify and verify the actual on-hand quantity.

4. If there is an adjustment to be made, the supervisor will complete an Inventory Adjustment Form (Attachment 4.2)

5. The Inventory Adjustment Form will be submitted to the 1942 Assistant Materials ~~Manager~~ Manager or ~~1944 Materials Manager~~Director of Materials for approval.

6. Once signature approval is obtained by the 1942 Assistant Materials Manager or the ~~1944 Materials Manager~~Director of Materials Management, the supervisor will adjust the on-hand inventory.

7. The Inventory Adjustment Form will be stored in the filing cabinet and maintained for 3 years.

ATTACHMENT: 4.2 Inventory Adjustment Form

Most recent review: 03/11/2022

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F-04 REPORTING AND DISPOSING OF OBSOLETE AND EXPIRED PRODUCTS

POLICY:

Materials Management and ~~Central Supply~~CPD staff will report and dispose of obsolete and expired products in a standardized format.

PURPOSE:

To provide definitions of obsolete and expired products and to provide a guideline for Materials Management and ~~Central Supply~~CPD staff to follow.

PROCEDURE:

1. Definitions:

    a. Obsolete: defined as no longer used by Clinical authority

    b. Expired: defined as 3 months prior to manufacturer's stated "End Use Date" or "expiration date" unless product is in short supply.

2. If Materials Management or ~~Central Supply~~CPD staff identify items in ~~Central Supply~~CPD, ~~-~~Materials Management, or Nursing Supply Carts as expired, they will remove the item and report the finding to their supervisor.

3. The supervisor will determine the best course of action, submit form 4.5: obsolete and expired items and obtain written approval from the 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management for the appropriate disposition.

4. If there is an adjustment to be made to inventory, the supervisor will also complete an Inventory Adjustment Form (Attachment 4.2)

5. Obsolete or Expired items will be stored in a separate bulk location pending the appropriate disposition.

ATTACHMENT: 4.2 Inventory Adjustment Form, 4.5 Obsolete and Expired Items

Most recent review: 03/11/2022

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F-06 RECORD RETENTION FOR FILES

POLICY:

Materials Management and ~~Central Supply~~CPD will retain records for tracking and auditing purposes.

PURPOSE:

To provide guidelines to staff for storage and retention of purchasing, inventory management, and receiving records.

PROCEDURE:

Retain records in Materials Management warehouse or electronically as follows:

1. Annual Physical Inventory – 5 years
2. Cycle Counts – 1 fiscal year plus current fiscal year
3. Inventory Discrepancy Form – 3 years
4. Materials Management Delivery logbook – 3 years
5. Pick tickets – 3 months
6. Purchase Orders – 7 years
7. Packing Slips
   a. Just-in-time packing slips – 3 months
   b. Bulk packing slips – 7 years
   c. Peoplesoft PO's packing slips – 7 years
8. Materials and Equipment Log sheet – 1 year

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A2. HOURS OF OPERATION AND STAFF

POLICY:

1. ~~Central Supply~~CPD ~~Room (CSR)~~ hours of operation are scheduled to accommodate needs of the Nursing Units and to be responsive to peak demand periods.

PURPOSE:

1. Ready availability of medical supplies and equipment on Nursing Units facilitates efficient nursing services for residents.

PROCEDURE:

I. HOURS OF OPERATION

A. The ~~Central Supply~~CPD ~~Room (CSR)~~ will be open and staffed 7 days/week from 6:30 am to 8:30 pm.

B. When ~~CSR~~CPD is not open and staffed, medical supplies and equipment can be obtained by contacting the Nursing supervisor who has access to ~~the CSR~~CPD.

C. The Supervisor of ~~CSR~~CPD is available by pager 415-327- 1725 and the Materials Manager pager is 415-327-1924.

II. ~~CSR~~CPD STAFF

A. ~~CSR~~CPD Technicians are qualified by education and training for the functions they perform.

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A3. TRAFFIC FLOW IN ~~CENTRAL SUPPLY~~CPD ROOM

POLICY:

1. Separate entrances into the ~~Central Supply~~CPD ~~Room (CSR)~~ and separate areas within ~~the CSR~~CPD are established for soiled and clean materials.
2. Soiled areas are visually identified by signage.
3. Traffic flows one-way in ~~the CSR~~CPD from soiled to clean areas.

PURPOSE:

1. One-way traffic flow from soiled areas to clean areas minimizes potential contamination of clean materials and prevents staff from reusing patient care equipment before it has been cleaned and disinfected.

PROCEDURE:

I. SEGREGATED ENTRANCES AND AREAS
   A. There are separate entrances into ~~the Central Supply~~CPD ~~Room~~:
      - Clean Entrance for entry of clean, unused or new equipment and supplies, and
      - Soiled Entrance for entry of soiled or used resident care equipment that is being returned to ~~the CSR~~CPD for cleaning.

   B. There are segregated areas ~~in the Central Supply~~CPD ~~Room~~:
      - Soiled Area for cleaning and disinfecting of equipment,
      - Clean Area for assembly and routine maintenance of cleaned and disinfected equipment, and
      - Clean Storage Areas for storage of clean unused supplies and new or refurbished equipment ready for distribution.
      -

II. TRAFFIC FLOW OF USED EQUIPMENT
   A. Soiled or used patient care equipment is brought into ~~the CSR~~CPD through the Soiled Entrance and into the Soiled Area for cleaning and disinfection.
   B. After cleaning and disinfection, the equipment is moved into the Clean Area for assembly and/or repair.
   C. Following refurbishing, clean equipment is stored in Clean Storage Areas.
   D. Clean equipment is taken out of ~~the CSR~~CPD through the Clean Entrance.

III. TRAFFIC FLOW OF NEW SUPPLIES
   A. New unused supplies and equipment is brought into ~~the CSR~~CPD through the Clean Entrance.
   B. Stored in clean Storage Areas, and
   C. Taken out of ~~the CSR~~CPD through the Clean Entrance.

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B1. PEOPLESOFT INVENTORY MANAGEMENT SYSTEM

POLICY:

1. The Peoplesoft Inventory Management System is the principal system utilized by ~~the Central Supply~~CPD ~~Department~~ to monitor inventory levels of medical supplies on the Nursing Units and to order medical supplies from the contracted vendor.
2. The inventory of medical supplies on Nursing Units will be maintained at established PAR levels (maximum inventory levels).
3. LHH utilizes Periodic Automatic Replacement (PAR) levels and "Just In Time" stocking to manage inventory of medical supplies on Nursing Units

PURPOSE:

1. ~~The Central Supply~~CPD ~~Departmen~~t utilizes Peoplesoft Inventory Management System to monitor inventory levels on Nursing Units and to order medical supplies from the contracted vendor when levels fall below the PAR level (maximum inventory level). The Peoplesoft Inventory Management System is utilized to place bulk order supplies for stocking ~~Central Supply~~CPD ~~Room (CSR)~~ inventory.

2. Utilizing Peoplesoft Inventory Management System levels and "Just In Time" stocking minimizes storage inventory in the ~~Central Supply~~CPD ~~Room~~ and on Nursing Units thereby conserving space, reducing expense and minimizing loss due to exceeding the manufacturer's expiration date.

DEFINITIONS:

Peoplesoft Inventory Management System is a software system administered by the Materials Management Department for hospital wide ordering of medical supplies.

PROCEDURE:

I. AUTHORIZATION
   A. Authorizations and passwords for the Peoplesoft Inventory Management System are obtained from the System Administrator in the Materials Management Department.

II. STOCKING NURSING UNITS
   A. Establishment of Periodic Automatic Replacement (PAR) levels
   In collaboration with the Nursing Department PAR levels of medical supplies are established for each Nursing Unit and entered the Peoplesoft Inventory Management System. PAR levels are established to provide 3-4 days of medical supplies.

   B. Monitoring inventory levels

      1. In collaboration with the Nursing Department an inventory counting schedule (Monday through Sunday) is established to maintain PAR levels in each Nursing Unit.

2. Inventory counting is performed at the beginning of the DAY shift by ~~the Central Supply~~CPD ~~(CS)~~ Technician according to the inventory counting schedule.
3. In ~~the Central Supply~~CPD ~~Room (CSR~~CPD~~)~~ the PAR levels are electronically downloaded by the CST from a computer terminal running the Peoplesoft Inventory Management System program to a hard wire connected handheld device (HHD).
4. At the Nursing Unit the ~~CS~~ CPD technician and Storekeeper physically inventories the Unit's inventory and enters numerical piece counts into the hand-held device (HHD).
5. On returning to ~~the CSR~~CPD, the technician and storekeepers electronically downloads the inventory from the HHD to the computer terminal. The Peoplesoft Inventory Management System software automatically calculates the difference between the Unit's PAR level and current inventory.
6. For items in the "Just In Time" system, the Peoplesoft Inventory Management System software, through its connectivity feature, automatically places an electronic order with the contracted vendor.
7. For items not in the "Just In Time" system, the Peoplesoft Inventory Management System automatically generates and prints a PICK ticket on ~~the CSR~~CPD printer. PICK Ticket items are supplied by ~~Central Supply~~CPD.

C. Delivering supplies
1. The vendor delivers the filled orders for "Just In Time" items the following day in Unit specific labeled bulk (case) packages or Unit specific labeled blue totes (for boxes and pieces). Orders are delivered by the supplier in pallets to the Receiving section of Materials Management where pallets are broken down by units.
2. Blue Totes and bulk packages are placed on flat bed and electric trolley carts by ~~Central Supply~~CPD technicians and storekeepers who add any Pick Ticket items from ~~Central Supply~~CPD technician and Storekeepers deliver the order to the Nursing Unit. The ~~Central Supply~~CPD technician and Storekeepers restocks the supply shelves and electric trolley carts with the ordered items in accordance with Infection Control Policy and Procedure G10, "Storage of Supplies (Clean/Sterile)."

D. Back-up Procedures
1. Preferred procedure for unanticipated needs is for Unit Nurses to log onto Peoplesoft Inventory Management System, the web based PMM site, and order the needed supplies online. The order will be automatically routed to ~~Central Supply~~CPD and Materials Managements printers. ~~Central Supply~~CPD technicians will then fill the order from ~~CS~~CPD inventory.
2. Procedure when Peoplesoft Inventory Management System communicator is not operational is for a ~~Central Supply~~CPD technician to perform the Nursing Unit inventory count as usual, download the inventory to Peoplesoft Inventory Management System and generate a printed order. ~~Central Supply~~CPD Technicians will then fill the order from ~~Central Supply~~CPD inventory.
3. Procedure when computer systems are not operational is for Nursing Unit to complete a paper Requisition and either ~~faxed~~ fax or hand deliver to the ~~Central Supply~~CPD window. Orders will be filled and provided to the requestor immediately, delivered to Unit the

same day or delivered to the Unit the next day depending on the requestor's need. ~~Central Supply~~CPD Requisitions are available at the ~~CS~~CPD window. A representative example is attached as Appendix A.

When the Peoplesoft Inventory Management System computer system becomes operational ~~the Central Supply~~CPD staff will issue and then process an order for each paper ~~Central Supply~~CPD Requisition filled at the window.

During the time the Peoplesoft Inventory Management System is not operational, inventory counting on each Unit will be performed manually by ~~Central Supply~~CPD staff and requisition orders will be faxed to the supplier for filling and delivery.

4. To request Help with Peoplesoft Inventory Management System
During the hours of 8 am to 4 pm (08:00-16:00), contact ZSFGH MMIS Help Desk for assistance ~~or Rommel Sarangelo at Laguna Honda Hospital for assistance~~.

~~Tuesday – Saturday~~Monday - Friday	628-206-4600 or 628-206-~~206-5314~~,
~~Sunday – Thursday~~	~~206-4600~~
~~Monday – Friday~~	~~206-4717~~

If SFGH is unavailable or unable to assist, contact the Director of Materials Management:

Monday-Friday 415-759-3337.

III. STOCKING ~~CENTRAL SUPPLY~~CPD

A. ~~Central Supply~~CPD Technicians are responsible for physically reviewing ~~Central Supply~~CPD Room inventory on a regular schedule and ordering supplies using Peoplesoft Inventory Management System bulk to maintain inventory adequate to meet requests from Nursing Units.

B. The Peoplesoft Inventory Management System software, through its connectivity feature, places an order electronically with the contracted supplier. The filled order is delivered from the vendor the next day.

C. Orders are delivered by the supplier in pallets to the Receiving section of Materials Management where pallets are broken down and bulk containers transferred to the ~~Central Supply~~CPD storage area.

D. ~~Central Supply~~CPD Technicians transfer supplies from the ~~Central Supply~~CPD storage area to the ~~Central Supply~~CPD Room as needed.

Most recent review: 03/11/2022

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B2. OMNICELL DISPENSING CABINETS (Omni Supplier)

POLICY:

1. The ~~Central Supply~~CPD Department is responsible for stocking medical supplies in Omnicell Dispensing Cabinets (Omni Supplier).

2. Omni Suppliers will be stocked with medical supplies from ~~Central Supply~~CPD inventory using the inventory principles of "Just In Time" and "first in, first out."

PURPOSE:

1. Reliable restocking is needed for effective use of the Omnicell Dispensing Cabinets.

DEFINITIONS:

The Omnicell System combines software and controlled access dispensing cabinets in a system to provide password protected access to medications and medical supplies, automated electronic billing to identified patient accounts, and automated electronic notification for restocking. The Omnicell system is administered by the Pharmacy Department.

The Omni Supplier is the controlled access dispensing supply cabinet.

PROCEDURE:

I. AUTHORIZATION

Authorizations and passwords for the Omnicell system are obtained from the System Administrator in the Pharmacy Department.

II. STOCKING OMNISUPPLIER

A. Establishment of Periodic Automatic Replacement (PAR) levels (maximum inventory levels) and Critically Low Levels (CLL).

In collaboration with the Nursing Department, PAR levels and Critically Low Levels (CLL) of medical supplies are established for each Omni Supplier and entered into the Omnicell system.

B. Notification of Reorder or Critically Low Level

1. When medical supply items are removed from Omni Supplier cabinets, the ~~Central Supply~~CPD ~~(CS) Department~~ is notified via a Reorder or Critically Low-Level (CLL) Notification automatically printed from the ~~Central Supply~~CPD ~~Room (CSR~~CPD~~)~~ printer.

C. Stocking

1. Scheduled Stocking of Omni Suppliers is performed by ~~CS~~CPD Technicians according to a regular established schedule. Supplies are obtained from ~~CSR~~CPD~~-~~ inventory.

2. Unscheduled Stocking of Omnicell's is performed by ~~Central Supply~~CPD Technicians and Storekeeper on an "as needed basis" in response to a Critically Low-Level Notification or a request from the Nursing Unit for stocking.
3. Cycle Counts are performed monthly by ~~Central Supply~~CPD Technicians. A physical count of each item in an Omni Supplier is compared to that Omni Supplier's computer record for that item. Discrepancies are noted, and corrected by the ~~CS~~CPD Technician. A report of discrepancies is provided to the ~~Central Supply~~CPD Manager. In addition, expired items are removed from the system.
4. Using the principle of "first in, first out," new stock is placed at the back of the bin and older stock moved forward in the bin to avoid expiration.

D. Manual Override Access

1. Every Omni Supplier has a manual lock override system, which allows it to be manually unlocked with a key during emergency situations such as system failure or power outage. Keys are available on the Units, in the Pharmacy Department and in ~~the Central Supply~~CPD ~~Room (CSR)~~.

E. System Down Time and Disasters

1. If an Omnicell is in a Manual Override Mode or if the Omnicell computer is not operational, ~~the CSR~~CPD staff is not receiving replenishment orders. In these situations, ~~Central Supply~~CPD technicians will manually count the inventory in the affected Omni Supplier cabinet and compare the observed count to the PAR level. The ~~CS~~CPD technician will then fill the order and restock the cabinet. Depending on usage levels, Omnicell will be counted 1-2 times per day.

2. In the event of Omnicell malfunction such that staff is unable to open the cabinet, Nursing Unit staff will request supplies, usually provided through the Omnicell system, by ordering through the Peoplesoft Inventory Management system [See ~~Central Supply~~CPD Policy & Procedure B1, "Peoplesoft Inventory Management system].

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B3. OXYGEN

POLICY:

1. Oxygen and cylinders are handled and stored consistent with LHH Policy and Procedure 70-05, "Gases: Handling and Storage of Medical Gases."

PURPOSE:

1. To ensure a safe environment for residents, visitors and staff.

PROCEDURE:

I. Oxygen Concentrators

A. Oxygen concentrators for resident use are provided on a rental basis from a contract vendor.
B. On receipt of a telephone request from either the Unit Nurse or Respiratory Therapy, a ~~Central Supply~~CPD ~~(CS)~~ Technician contacts the vendor by phone and places the order:
   i. Concentration required: 5L or 10 L,
   ii. Resident's Unit, Bed # and Name.
C. Delivery by the vendor is directly to the resident's Unit and Bed.
D. When the concentrator is no longer needed, a ~~Central Supply~~CPD Technician notifies the vendor who picks up the equipment.

II. Storage

A. Storage

1. Oxygen cylinders are green and are labeled "No smoking, Oxygen." Full cylinders are differentiated from empty cylinders by a green tag or blue wrap covering the valve.

2. Full cylinders are stored secured in designated, labeled, and locked Oxygen storage rooms.
3. **Storage is planned so cylinders are used in order of which they are received from the supplier. Cylinders will be rotated.**
4. Storage rooms contain fire extinguishers and smoke alarms.
5. Unit staff obtains full cylinders from ~~Central Supply~~CPD ~~Room~~ staff or Nursing Staff with Key Access to equipment room.
6. **Empty cylinders are segregated from full cylinders.**
7. Empty cylinders are returned to hallway outside of Oxygen storage rooms by Unit staff. ~~Central Supply~~CPD ~~Room~~ staff returns empty cylinders to Oxygen Receiving room.
8. **Cylinders stored in the open are protected from weather.**

B. Stocking

1. Both EE size cylinders are stocked.
2. ~~Central Supply~~CPD Technicians stock designated Oxygen storage rooms with full cylinders and remove empty cylinders 2 times per day 7 days per week from Monday-Saturday (Morning and Afternoon), and Sunday (only afternoon delivery). As per agreement with Nursing.

B. Transport of Cylinders

1. Full and empty cylinders are transported in a secure electric cart carrier throughout the hospital. All cylinders, empty or full, shall be properly fastened at all times during site delivery and storage.
2. Persons transporting full or empty gas cylinders must ensure that the safety cap is secured at all times when transported in the care units.
3. Valve protection devices shall not be used for lifting cylinders.

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B4. E-CYLINDER "OXYGEN" STORAGE CABINET REPLENISHMENT.

PURPOSE: To accurately account for delivered E-cylinder tanks to the neighborhoods with oxygen storage cabinets (PMSNF, S2, S4, S5, S6, N1, N3, N5, N6).

PROCESS:

1. ~~CS~~CPD~~R~~ staff to replenish E-cylinder storage cabinets twice a day M-F, 6:30am & 3:00pm and Sunday at 1:00pm.

2. The E-cylinder oxygen storage cabinet/slots are to be segregated for "Full/Ready to use" oxygen cylinders and "empty" oxygen cylinders.

3. The Oxygen par level is "**6"** Full tanks per cabinet. The first 2 "left side slots" will be designated for "Full/Ready to Use" oxygen cylinder and the 2 right side slots of the oxygen storage will be designated for "Empty" oxygen cylinders.

4. Full oxygen cylinder will be delivered and tagged with "Full/Ready to use signage by ~~CSR~~CPD ~~-~~staff.

5. Empty oxygen cylinders with "empty tags" to be taken out from the O2 cabinets.

6. Remove oxygen cylinder "Empty tags" from an Empty cylinder (to consider E-cylinder, E-cylinder gauge needle must reach the "red line" indicator).

7. Empty tags will be kept hanging on the oxygen cabinet doors.

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B5. CRASH CART MAINTAINACE AND STOCKING

POLICY:

1. Crash Carts will be maintained in operational condition with appropriate equipment and supplies consistent with LHH Policy and Procedure 70-32, "Code Blue."

PURPOSE:

1. To ensure that Medical and Nursing Staff who respond to Code Blue medical emergencies have the equipment and supplies they need.

PROCEDURE:

I. MAINTAINANCE

A. Daily Maintenance

1. The defibrillator and portable suction machine on top of the crash cart are checked daily for operational readiness. Batteries are replaced as needed.

B. Quarterly Maintenance

1. Expiration dating of medical supplies, such as IV bags, are evaluating monthly intervals as per Code Blue committee's request. Supplies which are anticipated to expire in the ensuing 3 months are replaced.

II. STOCKING

A. Back-up Crash Cart

1. A complete Back-up Crash Cart is maintained in operational condition in the ~~Central Supply~~CPD ~~Room (CSR).~~

2. The Back-Up Crash Cart is stocked as specified in LHH Policy and Procedure 70-32, "Code Blue."

B. Stocking

1. Following use of a Crash Cart during a Code Blue or a Code Blue Drill, the used Crash Cart is brought to ~~the CSR~~CPD by Unit staff for cleaning and stocking. The Back-up Crash Cart is taken back to the Unit so that all floors have a Crash Cart available for use at all times.

2. A ~~CS~~CPD Technician removes used supplies, cleans the Cart and stocks the cart as specified in LHH Policy and Procedure 70-32, "Code Blue."

3. The defibrillator and portable suction machine are checked for operational readiness. Batteries are replaced as needed.

4. A yellow tag lock is placed on the Cart indicating that SCR stocking and cleaning is complete.

5. Pharmacy is notified by facsimile that the Cart is ready for medication stocking.

6. A red tag lock is placed on the Cart following medication stocking by Pharmacy and the Cart is retained in ~~the CSR~~CPD as the Back-up Cart until needed.

Reference: LHH Policy and Procedure 70-32, "Code Blue"

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B6. EQUIPMENT MAINTAINACE

POLICY:

1. ~~Bio-medical~~Biomedical equipment will be maintained in operational condition.

2. Contracts for repair and for regular maintenance of ~~bio-medical~~biomedical equipment will be established with appropriate vendors.

PURPOSE:

1. Properly functioning ~~bio-medical~~biomedical equipment is necessary for

resident care. PROCEDURE:

I. REGULAR MAINTAINANCE

A. A regular maintenance schedule is established by ~~the Central Supply~~CPD ~~Room (CSR~~CPD~~)~~ for the ~~bio-medical~~biomedical equipment including but not limited to:
   1. Tympanic thermometer
   2. Blood pressure machines
   3. IV pumps
   4. Enteral feeding pumps
   5. Suction pumps
   6. Defibrillators
   7. Bladder scanners
   8. Nebulizers

B. Regular maintenance is performed by a contract vendor under the supervision of the Facility Services.

II. REPAIR

A. Malfunctioning equipment is brought to ~~the CSR~~CPD by Unit staff.

B. ~~Central Supply~~CPD ~~(CS)~~ Technicians evaluate the extent of repair needed.
   1. Battery charging or battery replacement is performed by CS Technicians and the equipment is then cleaned, disinfected and returned to inventory for use.
   2. More extensive repair is conducted by the contract vendor. Equipment is then cleaned, disinfected and returned to inventory for use.

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B7. CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE EQUIPMENT

POLICY:

1. Soiled resident care equipment returned to ~~the Clinical Supply Room (CSR)~~CPD will be cleaned and disinfected consistent with Infection Control Policy and Procedures G2, "Classification of Reusable Medical Devices and Processing Requirements," and G5, "Cleaning and Disinfection of Non-Critical Resident Care Equipment."

PURPOSE:

1. Cleaning and disinfection of resident care equipment prevents disease transmission.

PROCEDURE:

I. DEFINITIONS

A. Non-critical resident care equipment includes items that come in contact with intact skin but not mucous membranes. Intact skin is an effective barrier and sterility is not critical

A. Noncritical resident care equipment that is stocked, cleaned and maintained by the ~~Central Supply~~CPD Department includes but is not limited to:
   1. IV Infusion pumps
   2. Enteral feeding pumps
   3. Blood pressure machines
   4. Tympanic thermometers
   5. Bladder scanners
   6. Gomco Suction machines
   7. Oxygen concentrators

II. CLEANING

~~A.~~ Equipment is cleaned in the Soiled Area of ~~the Central Supply~~CPD ~~Room (CSR)~~

A.

B. Equipment is hand cleaned with hospital approved neutral ph, high sudsing detergent.

C. Soaking, brushes, and scrubbing cloths are used as appropriate to remove all dried blood, secretions, enteral ~~formula~~formula, or other soil.

D. Equipment is rinsed 3 times with tap water to remove detergent residue.

E. Following rinsing, the equipment is allowed to air dry or dried with a clean cloth.

III. DISINFECTION

A. Equipment is disinfected in the Soiled Area of ~~the CSR~~CPD

B. Hospital approved ~~quaternary ammonium~~ germicidal disinfectants are used for disinfection.

C. Non-critical devices require low-level disinfection with an exposure time of ≤ 10 minutes

D. The germicidal disinfectant is liberally applied to all exposed surfaces of clean and dry equipment with a clean applicator.

E. The disinfectant is allowed to air dry.

Reference:

Infection Control Policy and Procedure G2, "Classification of Reusable Medical Devices and Processing Requirements"

Infection Control Policy and Procedure G5, "Cleaning and Disinfection of Non-Critical Resident Care Equipment"

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

B12. Shelf Life of Sterile Packages

POLICY:

1. All sterile supplies including those supplies that are purchased sterile are included in the sterile shelf life program.

2. The loss of sterility of any sterilized item is "event" related and not "time" related. Sterilized supplies are considered sterile and may be used as long as the integrity of the package is not compromised by becoming torn, wet, damaged or otherwise suspected of being contaminated.

3. Commercially sterilized packages that contain materials that will become outdated (medication) or will decompose (latex) over time are time dated by the manufacturer of the product.

4. Sterile Packages are stored in accordance with LHH Infection Control Policy G10, "Storage of Supplies (Clean/Sterile)."

PURPOSE:

1. Sterility must be maintained until the product is used.

PROCEDURE:

I. COMMERICALLY STERILIZED PACKAGES

The shelf life of commercially sterilized packages (supplies) is indicated by the manufacturer's expiration date (time dated) unless the integrity of the package is compromised by becoming torn, wet, damaged or otherwise suspected of being contaminated.

II. HOSPITAL STERILIZED PACKAGES

A. The shelf life of hospital sterilized packages (supplies) is event dated.

B. All items processed for sterilization are properly wrapped and processed in such a manner so as to provide an effective barrier to microbial contamination.

C. All hospital sterilized supplies are wrapped in either two layers of disposable, synthetic non-woven material or in peel pouches. *Indicator tape* will be applied to all wrapped packages as a visual indicator that item was processed.

D. The outside wrapper of hospital sterilized packages is externally labeled with
   1. Date of sterilization,
   2. Load control identifier (may be the date of sterilization if only one lad/day is processed),
   3. Initials of the technician processing the package, and
   4. Label stating "Package is sterile unless opened or damaged. Check before use."

III. INSPECTION OF STERILE SUPPLIES PRIOR TO USE

All sterile packages (time or event dated) should be inspected by the user before use.

Any package that is stained (water marked), wet or damp, torn or punctured should be considered contaminated and either discarded or reprocessed.

IV. STORAGE OF STERILE SUPPLIES IN ~~CENTRAL SUPPLY~~CPD

Sterile supplies are stocked and rotated on the principle of "first in, first out." The oldest dated sterile supply is used first.

Packages that exceed 12 months of inactivity are evaluated for necessity with the Manager of ~~Central Supply~~CPD.

Sterile supplies should be stored:

- In a clean environment,
- On racks that are 8 to 10 inches from the floor and at least 18 inches from the ceiling and at least 2 inches from the wall,
- In a position to avoid cursing, bending or compression, and
- In closed shelving to maintain dust-free conditions.

Sterile supplies should not be stored under sinks, under exposed water.

Sterile supplies with turnaround times of greater than three months should have a protective plastic wrap or double peal pouch protection. Supplies that have a short turnaround time do not require a dust cover.

V. PERIOTIC INSPECTION OF STERILE SUPPLIES IN ~~CENTRAL SUPPLY~~CPD

Because sterile supplies are stocked and rotated on the principle of "first in, first out" and because supplies are ordered on the principle of "Just In Time'" few if any sterile supplies are stored in ~~Central Supply~~CPD for 3 months or longer.

For sterile supplies that are stored for 3 months or longer, a ~~Central Supply~~CPD Technician will conduct inspection at 3 month intervals for:

- Evidence of tampering,
- Wrapping material decomposition,
- Punctures,
- Moisture, or
- Other signs of compromised packaging.

The inspection should be documented and the documentation forwarded to the Manager or Charge Nurse. Packages that are pulled from the stock during the inspection should be noted on the inspection form. A summary of the inspection should be reported to the Infection Control Committee annually.

VI. TRAINING

~~Central Supply~~CPD Technicians are trained in the following:

- Time-related vs. event-related sterile shelf life,
- Inspecting the condition of sterile packages,
- Handling, transportation and storage of sterile supplies,
- Consequences of using non-sterile supplies such as infection,
- Possible consequences of dust and dirt build up on the outside wrapping of the sterile packages such as infection, and
- Rotation of supplies (first in, first out).

Documentation of training is maintained by the Manager/Supervisor of ~~Central Supply~~CPD.

Reference: LHH Infection Control Policy G10, "Storage of Supplies (Clean/Sterile)"

Most recent review: 03/11/2022

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C1. Code of Ethics

POLICY:

~~Central Supply~~CPD staff will perform responsibilities professionally and competently without discrimination and in the best interests of LHH.

PURPOSE:

To ensure staff follow the code of ethics of the department.

PROCEDURE:

A. ~~Central Supply~~CPD Staff function efficiently and effectively, demonstrating professional conduct and attitude:
   1. Responds to need of Nursing Staff,
   2. Performs tasks competently, and
   3. Works collaboratively with Nursing Staff, Pharmacy Staff and Staff of Materials Management Department.

B. ~~Central Supply~~CPD Staff provide service to requesters without discrimination:
   1. Exhibits no prejudice for sex, race, creed, or religion,
   2. Provides service without regard to social status, economic status or personal attribute.

C. ~~Central Supply~~CPD Staff practices technology founded on scientific basis:
   1. Applies theoretical knowledge and concepts in the performance of tasks,
   2. Utilizes equipment and accessories consistent with the purpose for which it has been designed, and
   3. Employs procedures and techniques appropriately, efficiently ad effectively.

D. ~~Central Supply~~CPD Staff exercise discretion and judgment:
   1. Assumes responsibility for decisions, and
   2. Seeks guidance, help or Departmental management approval when appropriate.

E. Clinic Staff respect confidences entrusted in the course of professional practice:
   1. Protects the patient's right to privacy,
   2. Keeps confidential, information relating to patients, colleagues and associates, and
   3. Reveals confidential information only as required by law or to protect the welfare of the individual or the community.

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C2. SHIFT HOURS, BREAKS, & OVERTIME

POLICY:

Standard shift hours will be defined for purposes of shift differential pay, when overtime accrues and the amount of break time employees are authorized.

PROCEDURE

I. ~~CENTRAL SUPPLY~~CPD OPERATES 7 DAYS A WEEK (including Holidays) DAY Shift: 6:30am - 3:00pm

8:30am – 5:00pm

9:30am - 6:00pm

EVENING Shift: 12:00pm – 8:30pm

II. SIGN-IN SHEET

It is the employee's responsibility to record start time, break and mealtimes, and departure times on the sign-in sheets as arrivals and departures ~~actually happen~~happen (i.e., don't sign in and out at same time). Start times and return from break/mealtimes must reflect the time the employee is in uniform and ready for assignment. Times are recorded according to the departmental clock only. If arriving earlier than the scheduled shift, the start time is written as the time you are scheduled to begin unless asked to start early. Failure to completely and accurately record time may result in delayed pay for the day not recorded. Inaccuracy may also be construed as dishonesty.

III. BREAKS AND LUNCH

Break times are provided in 15-minute units for each block of 4 hours worked. Employees on shifts between 4 and less than 8 hours long are entitled to one, 15-minute break. For those working shifts less than 8 hours, the supervisor may extend the shift's ending time to allow additional time for a mid-shift break or mealtime. Employees on shift ranging from 8 to 12 hours long receive two, 15-minute breaks and the unpaid 30-minute meal break.

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C3. ATTENDANCE STANDARDS

POLICY:

Employees will maintain regular attendance and prompt arrival times.

PURPOSE:

Each staff member is responsible for managing work time effectively and within the standards described in this policy. The ability of the department to provide safe and adequate patient care services is compromised when there is a high rate of unscheduled absences.

PROCEDURE:

I. NOTIFYING THE DEPARTMTNE OF AN UNSCHEDULED ABSENCE

Employees who are unable to work as scheduled must notify the Supervisor (or Department Manager). If unable to speak to the appropriate person, the employee must call again until they reach this person. Speaking with anyone but the Supervisor or Manager does not constitute notification. The person calling in will ask and make note of the Supervisor or manager to whom they are speaking.

During the initial call, the employee may notify the department that the absence will continue any number of days up to the end of their scheduled workweek. The employees must state clearly the number of days of absence anticipated, and if the absence continues beyond that number of days or continues into the employee's following workweek, another call is required. The employee's supervisor may contact the employee to request a physician's certification of illness.

The Supervisor or Manager will record the call on the appropriate sign-in sheet, date and initial the message.

Sick leave used for medical appointments must be approved at least 24-hours in advance. Verification of the visit may be requested.

II. NOTIFYING THE DEPARTMENT OF A LATE ARRIVAL

An employee who can anticipate a late arrival must notify the Supervisor (or Manager) of their expected tardiness, stating the expected arrival time. This will be written on the appropriate sign-in sheet by the Supervisor or Manager.

III. ABSENTEEISM

A. Excessive Absenteeism is defined to be at or above 104 hours (or 13 shifts) of sick leave or other unscheduled absences per year.

B. Abusive Pattern is defined by sick days consistently associated with off days, holidays, other scheduled days off, or on the same day of the week. To establish this pattern, it is not necessary to be excessive in hours of sick leave or unscheduled absences.

C. Absences which fall under the guidelines for ADA, FCL, FMLA or Worker's Compensation shall not be considered in performance evaluations or disciplinary actions for determination of "Excessive Absenteeism" or "Abusive Patterns". The designation of time under these provisions must be approved prior to the leave or within a reasonable time thereafter, as provided for by the governing rules.

D. Medical verification of sick leave does not protect one from being charged with excessive absenteeism or abusive pattern.

E. Unscheduled early departure from work cannot be coded as comp time, vacation, legal holiday, etc.

F. Sick leave is subject to the approval of the supervisor. It is not an automatic benefit. Supervisors will not unduly deny approval for sick leave, since it is in the department's best interests to have an employee who is ill recover as soon as possible. However, the supervisor has the authority to deny sick leave, or request some evidence of illness whenever they have cause to believe an employee is abusing the sick leave privilege. Failure to provide some evidence, which includes but is not limited to a physician's certification of illness, may result in having the leave recorded as AWOL. Employees calling in sick on a holiday they are scheduled to work, or on a day they have previously been denied off, are two occasions where the supervisor should carefully consider requesting evidence of illness.

IV. TARDINESS

Tardiness is any occasion that an employee is not on-duty, in uniform (as applicable) and ready to work at the start of scheduled shift, and following any breaks or mealtime. Employee will be responsible for accurately signing in at their arrival time, as indicated by the designated department clock.

A. Excessive Tardiness is defined as more than three per month.

B. A five (5) minute grace period will be allowed at the beginning of the shift before an employee is considered tardy. However, the employee must make up the five (5) minutes by the end of the shift or at the end of the shift, at the charge tech's discretion. The grace period is a privilege provided for the occasional delay in an employee's arrival. Employees who consistently arrive late but within the grace are subject to losing this privilege.

C. "Tardy" in excess of the grace period will be recorded with a 'T', to represent 'Tardy', on the sign-in sheet. Approval must be given by supervisor to make time up over five (5) minutes. Time not made up will be deducted from pay (coded as Personal Leave).

D. A scheduled assignment of the tardy employee may be given to another employee to meet service needs.

E. Unless the department has been notified of late arrival, employees arriving after 60 minutes from their scheduled start time may be refused work for the day and consequently recorded as AWOL

V. ATTENDANCE REVIEW

A. A review of unscheduled absences and tardiness will be conducted at least once annually and as often as necessary to encourage good attendance. The reviewed time frame will not be used twice for disciplinary purposes.
B. For those individuals who are borderline or already excessive in absenteeism or abusive pattern, supervisors may require medical verification of future illnesses by written notification, prior to the next illness. A specific time frame will be given for the effective dates (e.g. 3 months, 6 months). Employees who continue to be excessively absent or tardy may be subject to further corrective actions, including disciplinary recommendations up to and including dismissal
C. For purposes of a Performance Appraisal, attendance will be considered in light of all time management factors (tardiness, accounting for time). If an employee is marked development needed for time management on year one and shows no improvement for year two, the second year will be cause for the overall ranking to be marked development needed even though all other areas are not marked development needed.

VI. REQUIRED SICK LEAVE

A. To prevent one employee from spreading illness to others, a supervisor may request an employee who appears to be ill to leave work on sick leave.

VII. SICK LEAVE IN EXCESS OF FIVE DAYS

A Request for Leave form, or as appropriate a Request for FMLA form, must be submitted and approved for leave in excess of 5 days, including sick leave. The employee is responsible for contacting the Manager to discuss the leave. If an employee exceeds the 5 days without proper authorization, they are coded Absent Without Leave (AWOL). This is grounds for a recommendation for dismissal. In the event a formal leave of absence is approved in writing, the employee is not required to keep in touch with the department for the period of the approved leave.

VIII. FUNERAL LEAVE

A request for funeral leave must have prior approval of the Manager. This may be done by telephone. The number of days to be granted will be decided on a case-by-case basis, but generally will be up to five days for child, parent, brother or sister, up to three days for other relatives, plus two additional days if the funeral is out of state. Although funeral leave is paid from the employee's accrued sick pay, it is not generally considered during an attendance review.

IX. ABSENCE WITHOUT LEAVE (AWOL)

An employee who does not notify the department of their absence is considered absent without leave. Unauthorized absence, a serious offense, may result in appropriate disciplinary procedures.

X. ABANDONMENT OF POST

Abandonment of post is any occurrence where an employee is not in their assigned work area as scheduled, without permission from the person in charge of that area. This can include an unauthorized break. Abandonment of post is a serious infraction, which may result in disciplinary recommendations.

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C4. DRESS CODE

POLICY:

Employees are to comply with Standard of Dress while on duty. All employee in Classification 2390 Sterile Processing and Distribution Technician and Classification 1934 Storekeeper shall report to Laguna Honda Hospital ~~Central Supply~~CPD Department in mandatory scrubs during their shifts and will maintain a professional appearance consistent with their duties, responsibilities, and their level of interaction with LHH staff, vendor, or other customers.

PURPOSE:

To establish and maintain a high level of professionalism and to assert highly visible, readily identifiable service department.

PROCEDURE:

~~Central Supply~~CPD Staff will always exercise appropriate personal hygiene in order to project a well-groomed appearance.

~~Central Supply~~CPD Staff will wear clean scrubs daily.

Work clothes must be neat and presentable.

UNIFORM ALLOWANCE:

Classification 2390 Sterile Processing and Distribution Technician see SEIU Local 1021 MOU Article II Section T UNIFORM ALLOWANCE FOR DEPARTMENT OF PUBLIC HEALTH EMPLOYEES 218. Employees who are required to wear and supply their own uniform or lab coat or smock in the course of their duties and who are employed on September 1 of any year covered by this Agreement, shall be paid an annual uniform allowance of two hundred fifty dollars ($250), or, in the case of lab coats or smocks, two hundred dollars ($200) no later than December 1 of each year.

Classification 1934 Storekeepers working in ~~Central Supply~~CPD Department scrubs will be provided by Materials Management Department each year.

Most recent review: 03/11/2022

Revised: 03/11/2021

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D1. CONTINUING EDUCATION

POLICY:

All ~~Central Supply~~CPD employees will have the opportunity to further their education by attending organized courses in subjects relating to assigned responsibilities.

PROCEDURE:

I. In-service training provided by other departments of the hospital shall be available to the employee and scheduled by the department.

II. Information on curriculums, seminars, workshops, classes, and community activities for all employees shall be provided.

III. A record of continuing education for all employees shall be kept.

Most recent review: 03/11/2022

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E1. EMERGENCY PREPAREDNESS

POLICY:

Please refer to the Hospital-Wide Health & Safety Program Disaster Plan (Code Yellow)

Most recent review: 03/11/2022

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E2. FIRE PLAN

POLICY:

Please refer to the Hospital-Wide Health & Safety Program – Fire Plan (Code Red)

Most recent review: 03/11/2022

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F-01 ANNUAL PHYSICAL INVENTORY COUNT

POLICY:

Materials Management and ~~Central Supply~~CPD to maintain accountable and accurate on-hand inventory.

PURPOSE:

To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported and reconciled prior to on hand inventory adjustments.

PROCEDURE:

MM/~~CSR~~CPD ~~-~~Annual Physical Inventory Count – objective is to get a snapshot of all items in inventory at one time. There will be one person designated as the "leader" or go-to person for questions regarding bin location, units of measure, and other inventory questions as well as handling any incoming phone calls and handling the count sheets. Another person will be designated as the "data entry person". The rest of the staff will be designated as "counters" and will be the ones physically counting products and logging it on the count sheets.

By end of day 3:00 pm Friday, Before Inventory Day.

5) Label with note "Do Not Count, Not in Inventory" for items not in inventory
6) Receive in all delivery documents for products that have arrived and put into inventory.
7) Confirm “pick plan”.
8) Credit all returns and make sure product has been put back in the accurate locations.

For CPD Saturday, Inventory Day

24) Ensure disable item “express issue” process
25) Pick any remaining express issue items and set aside for delivery.
26) Any urgent express issues will be maintained on a manual log sheet and will need to be requested by phone.
27) Leader will run the “Inventory value history report”, “Current Inventory Value report” and “Inventory detail report” in CVS/Excel format, save and named FY____ ~~CSR~~CPD ~~-~~Pre Physical Inventory Count Stock Status or FY_____ MM Pre-Physical Inventory Count Stock Status.
28) Leader will create a “counting event” by storage location **(LHH CPD, PND-$ LCPD & MM).**
29) Leader will create count sheets sorted by bin location **(LHH CPD, PND-$ LCPD & MM).**
30) The leader will print Count Sheets and divide the number of count sheets by groups so everyone will be spread out while counting.
31) Leader will assign count sheets to the group of counters.
32) Each counter will only have one count sheet at any given time. They will also be given a clipboard, yellow post-it notes, and a pen.
33) Counters will count inventory and write in the count in the spaces provided; count the correct unit of measure of the item. Convert the item unit of measure if necessary. For every blank, there should be a number even if that number is zero.

34) Counters to identify items with "2nd location (see item label with **green dots** & refer to the 2nd bin location sheet hanging on each rack); combined the counted on-hand total on the 1st location of item counted.
35) As counters finish counting each item, they will put a yellow post-it notes on the bin tag to indicate that the item has been counted.
36) There will need to be a log sheet for urgent inventory requests that the leader will need to track. The sheet will be divided between "already counted" items and "not counted yet" items. When necessary, the leader will log the item being requested, the qty requested, and the unit it will need to be charged to later. If that item already has a yellow post-it notes on the item, that same designee will log that item on the "already counted" portion of their log sheet. If there is NOT a yellow post-it notes on that item, the designee will indicate how much product was taken out on a green post-it notes and place it under the item and log this under the "not counted yet" items.
37) If a counter sees a green post-it notes on an item that they need to count, they will need to ADD the qty on that note to how much product they physically count on that item.
38) Once a counter is finished counting a sheet, they will legibly sign (or sign and print name) at the bottom and they will submit it to the leader who in turn will provide them with another count sheet.
39) Count sheets will be placed in an inbox for the data entry person.
40) The data entry person will review/enter the data from the count sheet into the system, save the data after each sheet is entered, and place the count sheets in the outbox.
41) After all count sheets have been submitted and entered into the system, the leader and data entry person will generate Physical accounting reconciliation report and highlight items with discrepancy for recount.
42) Leader will assign recount sheets to group of counters.
43) Data entry person will update and validate the legitimacy of the item discrepancy and placed into the inbox.
44) Data entry person to run a stock inventory update.
45) Inventory Value history, Current value and inventory detail reports are ran and saved under 2020 CPD Post Physical Inventory Count Stock Status and 2020 MM Post Physical Inventory Count Stock Status.
46) Print a hard copy of the stock status report.

CPD Bin location total to count:

LHH CPD – All Locations
LHH MM – All Locations

Counting event total: 2 (CPD/MM)

Data entry: (1) Assigned by Dept. Director

Data entry: (2) Assigned by Dept. Director

Leader: (1) Assigned by Dept. Director

Counters: As Assigned by Dept. Director

Most recent review: 03/11/2022

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F-02 INVENTORY CYCLE COUNT

POLICY:

~~Central Supply~~CPD to maintain accountable and accurate on-hand inventory.

PURPOSE:

To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported and reconciled prior to on hand inventory adjustments.

PROCEDURE:

1. ABC Analysis Report
    a. The ABC report (A=20% / B=20% / C=60%) based on usage will be used to determine the frequency of items are cycle counted per month.
    b. A list items are counted weekly, B list items are counted bi-weekly and C list items are counted monthly.

2. ABC Analysis Report Review
    a. Management will review the ABC Analysis Report periodically to review if the items are properly categorized.

3. The 1944 Materials Coordinator will approve all changes to inventory cycle count segments. The 1944 Materials Coordinator may delegate this responsibility to the ~~1942 Assistant Materials Coordinator~~1942 Assistant Materials Manager 1942 Assistant Materials Manager or 2392 Senior Central Processing and Distribution Technician.

4. Cycle Counts
    a. Staff will conduct cycle counts only and cannot adjust on-hand inventory unless approved by the 1942 Assistant Materials Manager.
    b. The Supervisor or Lead will review and investigate all inventory cycle count discrepancies prior to on hand adjustments.

5. Cycle Count Tracking and Record Retention
    a. A manual cycle count tracking log book will be maintained to record cycle count dates, staff counters, and which individual cycle counts was performed.
    b. All cycle counts will be stored for 1 fiscal year plus current fiscal year.

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F-03 INVENTORY DISCREPANCY REPORTING

POLICY:

A formal inventory discrepancy reporting and adjustment process shall be followed by materials management and ~~central supply~~CPD staff prior to a manual inventory adjustment.

PURPOSE:

Provide management oversight on manual inventory adjustments and to guide staff on

the correct inventory discrepancy reporting procedure.

PROCEDURE:

1. When Materials Management or ~~Central Supply~~CPD staff becomes aware of an inventory discrepancy, the supervisor (or lead tech if no supervisor) is notified.

2. The supervisor will utilize Peoplesoft Inventory Systems report to run a Balancing Inventory Transaction Detail report for the item.

3. Using the report, the supervisor will review pick tickets, materials, and equipment log sheet, packing slips, cycle count sheets, and online delivery documents to identify and verify the actual on-hand quantity.

4. Storekeepers to do the adjustment after confirming receiving discrepancy.

5. If there is an adjustment to be made, the supervisor will complete an Inventory Adjustment Form (Attachment 4.2)

6. The Inventory Adjustment Form will be submitted to the 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management for approval.

7. Once signature approval is obtained by the 1942 Assistant Materials Manager or the ~~1944 Materials Manager~~Director of Materials Management, the supervisor will adjust the on-hand inventory.

8. The Inventory Adjustment Form will be stored in the filing cabinet and maintained for 3 years.

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F-04 REPORTING AND DISPOSING OF OBSOLETE AND EXPIRED PRODUCTS

POLICY:

Materials Management and ~~Central Supply~~CPD staff will report and dispose of obsolete and expired products in a standardized format.

PURPOSE:

To provide definitions of obsolete and expired products and to provide a guideline for Materials Management and ~~Central Supply~~CPD staff to follow.

PROCEDURE:

1. Definitions:
    a. Obsolete: defined as no longer used by Clinical authority
    b. Expired: defined as 3 months prior to manufacturer's stated "End Use Date" or "expiration date" unless product is in short supply.
2. If Materials Management or ~~Central Supply~~CPD staff identify items in ~~Central Supply~~CPD, Materials Management, or Nursing Supply Carts as expired, they will remove the item and report the finding to their supervisor.
3. The supervisor will determine the best course of action, submit form 4.5: obsolete and expired items and obtain written approval from the 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management for the appropriate disposition.
4. If there is an adjustment to be made to inventory, the supervisor will also complete an Inventory Adjustment Form (Attachment 4.2)
5. Obsolete or Expired items will be stored in a separate bulk location pending the appropriate disposition.

ATTACHMENT: 4.2 Inventory Adjustment Form

4.5 Obsolete and Expired Items

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F-05 ~~CENTRAL SUPPLY~~CPD STOREROOM SECURITY AND INVENTORY CONTROL

POLICY:

1. Non-~~Central Supply~~CPD employees accessing ~~Central Supply~~CPD ~~(CSR)~~ storeroom will document items taken from ~~CSR~~CPD on Materials and Equipment Log sheet (attachment 4.3)

2. ~~CSR~~CPD staff will review log sheet and stock issue items to appropriate department.

3. Electronic identification badge access requires approval from Director of Materials Management; all non-~~CSR~~CPD staff will need to sign ~~the CSR~~CPD Inventory Security Form (attachment 4.4) before access will be allowed.

4. Materials Management will track the issuance of grand master keys to DPH personnel; all grand master key recipients will sign ~~CSR~~CPD Inventory Security Agreement (attachment 4.4)

PURPOSE:

1. To reduce the risk of unauthorized loss of supplies.

2. To provide non-~~CSR~~CPD staff access to urgently required medical supplies and equipment during the hours that ~~CSR~~CPD is closed.

3. To provide non-~~CSR~~CPD staff a formal process to document items taken from ~~CSR~~CPD.

4. To provide Materials Management with the ability to monitor off-hour access via master key access or electronic identification badge access.

5. To ensure all staff with ~~CSR~~CPD access understand the Materials and Equipment log sheet and how to complete it accurately.

PROCEDURE:

1. When Non-~~CSR~~CPD staff require medical supplies or equipment and ~~CSR~~CPD staff are not available to assist, that employee will:

    a. Use electronic identification badge or master key to gain access to ~~CSR~~CPD storeroom.
    b. Pick up clipboard with Materials and Equipment log sheet located on Will Call shelf located immediately on the left wall upon entering ~~CSR~~CPD.
    c. Locate needed materials and/or equipment
    d. Complete log sheet
    e. Replace clipboard with log sheet back to original location.

f. Ensure ~~CSR~~CPD doors are properly closed and locked.

2. ~~CSR~~CPD staff will check log sheet daily; if items were taken, ~~CSR~~CPD staff will charge out items to appropriate department and notify materials management whenever this occurs.

3. The Materials and Equipment log sheets will be filed in ~~CSR~~CPD filing cabinet and retained for 2 years.

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F-06 RECORD RETENTION FOR FILES

POLICY:

Materials Management and ~~Central Supply~~CPD will retain records for tracking and auditing purposes.

PURPOSE:

To provide guidelines to staff for storage and retention of purchasing, inventory management, and receiving records.

PROCEDURE:

Retain records in Materials Management warehouse as follows:

1. Annual Physical Inventory – 5 years
2. Cycle Counts – 1 fiscal year plus current fiscal year
3. Inventory Discrepancy Form – 3 years
4. Materials Management Delivery logbook – 3 years
5. Pick tickets – 3 months
6. Purchase Orders – 7 years
7. Packing Slips
    a. Just-in-time packing slips – 3 months
    b. Bulk PMM packing slips – 7 years
    c. FAMIS PO's packing slips – 7 years
8. Materials and Equipment Log sheet – 1 year

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Attachment 4.4: ~~CSR~~CPD Inventory Security Agreement

~~CSR~~CPD Inventory Security Agreement

I, _____, hereby acknowledge that I will be receiving electronic badge access to the ~~Central Supply~~CPD ~~(CSR)~~ storeroom or a master key that accesses ~~Central Supply~~CPD. I have been advised, and I fully understand, that these are to be used solely for those functions I have been authorized to perform as part of my department's work responsibility, and that the access authorization is for my exclusive use only. I hereby accept full responsibility for any and all activity that I conduct within the ~~CSR~~CPD storeroom

Furthermore, in accordance with this policy, and all previous policies regarding security, I agree not to transfer, loan, or share, my electronic identification badge to any other person or persons, or to otherwise allow access by anyone else using my badge or key in any other manner or under any other circumstances. If I ever have reason to believe that my badge or key has been compromised, I will report such information to the office of DPH Materials Management at Laguna Honda Hospital, 415-759-2326.

In addition, I understand that any violation of the terms of this agreement by me may be considered a misuse of my badge and/or key, and that any event of misuse may result in cancellation of my access to the system, and any other disciplinary action deemed appropriate by my department head.

I also agree that I have received and reviewed the ~~Central Supply~~CPD Storeroom Inventory Security Policy and Procedure and understand and agree to my part in the process, including, but not limited to, writing down all item #'s, descriptions, and quantities of items taken and ensuring that the door is secure when I exit from ~~CSR~~CPD.

User Print Name: _____

User Signature: _____

Department: _____

Date: _____

Attachment 4.5: Obsolete and Expired Items

Obsolete and Expired Items	
Directions: Fill out one form for every supply or equipment that is obsolete or expired and get signature approval from 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management before making any adjustments.	
Date:	**Reported by:**
~~PMM~~DPH Item no: (if no ~~PMM~~DPH #, describe item or equipment)	
Quantity on hand:	
Description of why supply or equipment is obsolete or expired	
Plan of Resolution:	
Submit document with any applicable documentation.	
Authorized Signature: 1942 Assistant Materials Manager or ~~1944~~ Director of Materials Management ~~Manager~~	
Printed Name:	

	Date Processed		Processed By:

Deletion Central Processing Department Policies and Procedures

B8. CLEANING OF MEDICAL INSTRUMENTS PRIOR TO DISINFECTION OR STERILIZATION~~CLEANING OF MEDICAL INSTRUMENTS PRIOR TO DISINFECTION OR STERIIZATION~~

POLICY:

~~Reusable medical instruments are cleaned prior to disinfection or sterilization consistent with LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments."~~Policy has been deleted. Refer to Clinic Standard of Work for Handling of Surgical Instruments in the General and Dental Clinic

~~PURPOSE:~~

~~Reusable instruments may serve as a vehicle in the transmission of infections if they are not properly processed. To ensure the final microbial process (i.e., sterilization, high level disinfection, etc.) is effective, prior disassembly and cleaning is required.~~

~~PROCEDURE:~~

~~I. Use of Personal Protective Equipment and Attire~~

~~A. Gloves:~~

~~Vinyl or latex gloves are worn when hand-washing delicate microsurgical instruments.~~

~~Thicker, more durable gloves are worn for handling full trays of instruments, other heavy items, or sharps.~~

~~The cuff of the gloves shall be long enough to prevent water from coming over the wrist and into the glove.~~

~~B. Gowns:~~

~~Long sleeved, fluid-resistant cover gowns are worn. Gloves are pulled up over the gown cuff.~~

~~C. Masks and Eye Protection:~~

~~To prevent mucous membranes from potential splashes, sprays, or aerosols created during the processing, a fluid resistant mask and eye protection must be worn.~~

~~D. Feet and Leg Protection:~~

~~Rubber or plastic boots or disposable shoe cover/legging combinations are worn when processing items where large amounts of fluid will be involved.~~

~~E. Hair:~~

~~Hair must be covered with a cap.~~

~~II. Soaking (Pre-Cleaning)~~

A. Immediately after use, medical instruments are immersed in enzymatic detergent and soaked until cleaning. Soaking of instruments is required to prevent drying of blood, body fluids or other organic materials on instruments

B. Soaking is done using the facility approved enzymatic detergent prepared according to the manufacturer's recommendations. Tepid water is used to prevent coagulation of protein materials.

C. When soaked items are transferred from one location to another, all liquid is removed prior to transfer. Containers must be either a plastic or rubber bin with a lid or a solid bottomed rigid sterilization container system with the lid in place.

III. Cleaning

Cleaning is the single most important step in making a medical instrument ready for reuse. Without adequate cleaning, disinfection and sterilization processes are ineffective.

Cleaning can be done **manually or mechanically** (by machines). Whenever possible, cleaning is done mechanically.

Instruments that require disassembly must be disassembled prior to cleaning to ensure exposure of all surfaces to the cleaning process.

Cleaning is done using the facility approved enzymatic detergent prepared according to the manufacturer's recommendations.

A. Manual Cleaning:

The sink used for cleaning instruments is separate from those used for hand-washing or surgical scrub.

Instruments are not cleaned under *running* water, as this will create aerosols. Immersible instruments are cleaned under water. Items that cannot be immersed are cleaned in a manner that does not produce aerosols.

Brushes and other cleaning implements are used to facilitate the cleaning process. Brushes and other cleaning implements are disinfected or sterilized daily.

B. Mechanical Cleaning:

Follow the manufacturer's instructions.

C. Rinsing and Drying

After cleaning, instruments are thoroughly rinsed with tap water and manually dried with a clean cloth or allowed to air dry.

References: LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments."

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

B9. HIGH-LEVEL CHEMICAL DISINFECTION

POLICY:

~~High-level chemical disinfection is performed by trained and qualified Central Supply Technicians according to accepted standards of practice and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."~~Policy has been deleted. CPD no longer performs Hig-Level Chemical Disinfection

~~**PURPOSE:**~~

~~High-level chemical disinfection is a process used for the disinfection of semi-critical patient care devices (devices that touch mucous membranes or non-intact skin). This level of disinfection is effective in destroying most types of harmful microorganisms, but not necessarily bacterial spores.~~

~~**PROCEDURE:**~~

~~I. Prior to the disinfection process, all devices are cleaned according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments."~~

~~II. Fluid resistant gowns, gloves, face masks, and eye protection are worn during the cleaning and disinfection procedures.~~

~~III. Hospital approved high-level disinfectants must be used.~~

~~Chemicals are mixed, stored and used in accordance with manufacturer's recommendations and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."~~

~~IV. Refer to Appendix A for Specific instructions on the use of Cidexplus® Solution (glutaraldehyde 3.4%) for high-level disinfection.~~

~~V. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and *Legionella*.~~

Appendix A: Use of Cidexplus® Solution (glutaraldehyde 3.4%) for High-Level Chemical Disinfection

For complete information on use refer to Cidexplus Product information

I. Material Compatibility For compatibility of device materials with Cidexplus refer to device manufacture's recommendations and Cidexplus Product Information

II. Cleaning Agent Compatibility
Detergents that are either highly acidic or alkaline are contraindicated as cleaning agents since improper rinsing could affect the efficacy of the Cidexplus Solution by altering its pH. Rinse devices completely prior to immersion in Cidexplus Solution

III. Safety
Caution: Contains Glutaraldehyde

- Harmful by inhalation and if swallowed.
- Irritating to respiratory system and skin.
- Risk of serious damage to eyes
- May cause sensitization by inhalation and skin contact.

Precautions

- Wear suitable protective clothing, gloves, and eye/face protection.
- Use only in well-ventilated areas.
- Avoid contamination of food
- Avoid release to the environment

First-Aid Measures

- Refer to Cidexplus Product Information

IV. Directions for Use
Activation

A. Activate the Cidexplus Solution by adding the entire contents of the Activator Vial, which is attached to the Cidexplus Solution container. Shake well. Activated solution immediately changes color to green indicating that the activator has been added to the solution.

B. Record the date of activation (mixing date) and expiration date on the container label in the space provided add the initials of the individual who performed the mixing.

C. Test the activated solution with Cidexplus Solution Test Strips prior to each use. The minimum effective concentration (MEC) of glutaraldehyde is 2.1%.

Cidexplus Solution Test strips monitor the MEC of 2.1%.

V. Cleaning

Feces, mucous, tissues, blood and other body fluids must be thoroughly cleansed from surfaces and lumens of devices before processing in Cidexplus Solution.

Thoroughly clean, rinse and rough dry devices before immersing in Cidexplus Solution.

Clean and rinse lumens of hollow instruments before filling with Cidexplus Solution

VI. Usage

A. Test the activated solution with Cidexplus Solution Test Strips prior to each use.

B. Immerse cleaned and rough dried medical devices completely in the Cidexplus Solution, filling all lumens.

C. Leave medical devices completely immersed for at least 20 minutes at 25°C for High-Level Disinfection

D. Rinsing
Rinse with sterile water.

E. Disposal
Used gluteraldehyde solution is placed in a sealed container provided by Industrial Hygienist and will be picked up by Facility Services for disposal.

Reference: LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments"

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

B10. CHEMICAL STERILIZATION

POLICY:

~~Chemical Sterilization is performed by trained and qualified Central supply Technicians according to accepted standards of practice and LHH Infection Control Policy F9, "Chemical Sterilization Standards."~~Policy has been deleted. CPD no longer performs Chemical Sterilization

~~PURPOSE:~~

~~Chemical sterilization is a process for the sterilization of critical patient care devices (devices that enter sterile tissue or access to the vascular system) that cannot undergo steam sterilization.~~

~~DEFINITIONS:~~

~~Sterilization is a validated process used to render a product free of all forms of viable microorganisms including spores.~~

~~PROCEDURE:~~

~~I. Prior to the sterilization process, all devices are to be thoroughly cleaned to remove organic material and reduce bioburden according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments."~~

~~II. Fluid resistant gowns, gloves, face masks, and eye protection must be worn during the cleaning and sterilization process.~~

~~III. Hospital approved chemical sterilants must be used.~~

~~IV. Chemicals are mixed, stored and used in accordance with manufacturer's recommendations and LHH Infection Control Policy F9, "Chemical Sterilization."~~

~~V. Refer to Appendix A for Specific instructions on the use of Cidexplus® Solution (glutaraldehyde 3.4%) for chemical sterilization.~~

~~VI. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and *Legionella*.~~

~~VII. If an item's sterility must be maintained, rinse with sterile water and use sterile gloves when removing and handling the device after completion of the chemical sterilization process. Item must be placed in a sterile transport tray.~~

~~**Reference:** LHH Infection Control Policy F9, "Chemical Sterilization Standards"~~

~~LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments"~~

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

B11. STEAM STERILIZATION

POLICY:

~~Reusable medical instruments and other items are steam sterilized whenever possible. Moist heat in the form of saturated steam under pressure is the most widely used and the most dependable method of sterilization.~~ Policy has been deleted. CPD no longer performs Steam Sterilization.

~~Steam sterilization is conducted in accordance with LHH Infection Control Policy G9, "Steam Sterilization Standards."~~

~~PURPOSE:~~

~~Steam under pressure completely eliminates or kills all microorganisms.~~

~~DEFINITIONS:~~

~~Sterilization is a validated process used to render a product free of all forms of viable microorganisms including spores.~~

~~Steam sterilization is a sterilization process that uses saturated steam under pressure for a specified exposure time and at a specified temperature, as the sterilizing agent.~~

~~PROCEDURE:~~

~~I. STERILIZATION USING A GRAVITY DISPLACEMENT TO PRE-VACUUM STERILIZER~~

~~The minimum exposure period for steam sterilization of wrapped supplies is 30 minutes at 4 minute exposure time at 270° F (121°C) and 20 lb/sq in (P.S.I.) and 20 minutes drying time.~~

~~II. WRAPPING AND PACKAGING~~

~~The following types of sterile packaging are currently approved:~~

~~1. Rigid sterilization containers,~~
~~2. Paper-plastic peel pouches,~~
~~3. Non-woven wrappers (polypropylene). Two layers of wrap (double wrap) are used.~~

~~III. STERILIZATION MONITORS~~

~~The steam cycle is monitored by Mechanical, Chemical and Biological Monitors..~~

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

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

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

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

1. *Indicator Tape* is used to secure packages. Black bars appear on the surface of the *Indicator Tape* when it is exposed to sterilization conditions.

2. *Chemical Strips* are placed inside each sterilization package. The *Chemical Strip* changes color from rose to brown and validates that the inside of each sterilization package has been exposed to sterilization conditions.

3. At the end of the sterilization cycle, when the autoclave is being unloaded, the *Indicator Tape* securing wrapped packages is interpreted and the results are recorded in the "Steam Sterilization Log," which is kept adjacent to the autoclave.

4. NEVER USE AN ITEM IF THE *INDICATOR TAPE* OR *CHEMICAL STRIPS* HAVE NOT CHANGED COLOR.

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

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

At the end of the cycle, the *Chemical Indicator* is interpreted and the results recorded in the "Steam Sterilization Log."

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

Both test and control *Biological Indicators* are either

1. Sent to Clinical Laboratory for testing, or

a. Incubated in an incubator recommended by the manufacturer.

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

IV. LOADING THE STERILIZER

1. Label each package with:
   a. Load identifier,
   b. Sterilization date, and
   c. Technician's initials.

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

3. Instrument sets cannot be stacked; steam must be able to circulate freely around each item.

4. Items capable of holding water (i.e. basins) should be positioned in a fashion that would allow water to drain out of them.

5. Metal items cannot be placed above textile items.

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

V. STERILIZATION

1. Record the unique load identifier and all items to be sterilized in the "Steam Sterilization Log," which is kept adjacent to the autoclave.

2. Visually verify that all settings are correct.

3. Initiate sterilization cycle following specific instructions for each autoclave that are provided in Appendices to this document.

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

VI. UNLOADING THE STERILIZER

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

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

3. If printout/graph is used, visually inspect the printout/graph and verify that the sterilization parameters of 250°F. 20 lb/sq in for 30 minutes have been met. Initial and date the print/graph and retain in *Sterilization Load Records*.

4. Open the sterilizer door only a few inches for about one hour, after which the load may be removed. The sterilized items must remain on the sterilization carriage until they have cooled to room temperature. Do not place the carriage under cool-air vents and if possible, place it in a low traffic area and label it with a "Caution Hot" sign.

VII. RELEASE OF STERILIZATION LOAD FOR USE

A designated Central Supply Technician is responsible for:

1. Assembling all testing information into the *Sterilization Load Record,*
2. Verifying completeness of the *Sterilization Load Record* detailed below,
3. Reviewing all test results for each load,
4. Releasing the load for use based on acceptable test results (See Appendix B: Release of Sterilized Load), and
   a. Notifying Manager or Charge Nurse if testing results are not acceptable for release of the load.

VIII. STERILIZATION LOAD RECORDS

Sterilization Load Records for each steam sterilized load include:

1. "Steam Sterilization Log" in which are recorded:
   - Unique identifier for each load. If only one load is run per day, this identifier can be the sterilization date.
   - Date and time cycle was run,
   - Printed name and initials of operator,
   - Identification of sterilizer,
   - *Chemical Tape* results, and
   - *Chemical Strip* (from *Challenge Pack*) results.
2. Temperature, chamber pressure and time of exposure. This can be either the temperature printout/graph or manual documentation of time, temperature and pressure demonstrating 250°F, 20 lb/sq in for 30 minutes

3. Biological Monitor results including :
   - Date of testing,
   - Lot number of Biological Indicator,
   - Test Biological Indicator results, and
   - Control Biological Indicator results.
4. Signed **Release of Sterilization Load** including printed name and signature of Central Supply Technician releasing the load for use.

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

Reference: LHH Infection Control Policy G9, "Steam Sterilization Standards"

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

B12. Shelf Life of Sterile Packages

POLICY:

1. All sterile supplies including those supplies that are purchased sterile are included in the sterile shelf life program.

2. The loss of sterility of any sterilized item is "event" related and not "time" related. Sterilized supplies are considered sterile and may be used as long as the integrity of the package is not compromised by becoming torn, wet, damaged or otherwise suspected of being contaminated.

3. Commercially sterilized packages that contain materials that will become outdated (medication) or will decompose (latex) over time are time dated by the manufacturer of the product.

4. Sterile Packages are stored in accordance with LHH Infection Control Policy G10, "Storage of Supplies (Clean/Sterile)."

PURPOSE:

1. Sterility must be maintained until the product is used.

PROCEDURE:

I. COMMERICALLY STERILIZED PACKAGES

The shelf life of commercially sterilized packages (supplies) is indicated by the manufacturer's expiration date (time dated) unless the integrity of the package is compromised by becoming torn, wet, damaged or otherwise suspected of being contaminated.

II. HOSPITAL STERILIZED PACKAGES

A. The shelf life of hospital sterilized packages (supplies) is event dated.

B. All items processed for sterilization are properly wrapped and processed in such a manner so as to provide an effective barrier to microbial contamination.

C. All hospital sterilized supplies are wrapped in either two layers of disposable, synthetic non-woven material or in peel pouches. *Indicator tape* will be applied to all wrapped packages as a visual indicator that item was processed.

D. The outside wrapper of hospital sterilized packages is externally labeled with
   1. Date of sterilization,
   2. Load control identifier (may be the date of sterilization if only one lad/day is processed),
   3. Initials of the technician processing the package, and
   4. Label stating "Package is sterile unless opened or damaged. Check before use."

III. INSPECTION OF STERILE SUPPLIES PRIOR TO USE

All sterile packages (time or event dated) should be inspected by the user before use.

Any package that is stained (water marked), wet or damp, torn or punctured should be considered contaminated and either discarded or reprocessed.

IV. STORAGE OF STERILE SUPPLIES IN ~~CENTRAL SUPPLY~~CPD

Sterile supplies are stocked and rotated on the principle of "first in, first out." The oldest dated sterile supply is used first.

Packages that exceed 12 months of inactivity are evaluated for necessity with the Manager of ~~Central Supply~~CPD.

Sterile supplies should be stored:

- In a clean environment,
- On racks that are 8 to 10 inches from the floor and at least 18 inches from the ceiling and at least 2 inches from the wall,
- In a position to avoid cursing, bending or compression, and
- In closed shelving to maintain dust-free conditions.

Sterile supplies should not be stored under sinks, under exposed water.

Sterile supplies with turnaround times of greater than three months should have a protective plastic wrap or double peal pouch protection. Supplies that have a short turnaround time do not require a dust cover.

V. PERIOTIC INSPECTION OF STERILE SUPPLIES IN ~~CENTRAL SUPPLY~~CPD

Because sterile supplies are stocked and rotated on the principle of "first in, first out" and because supplies are ordered on the principle of "Just In Time'" few if any sterile supplies are stored in ~~Central Supply~~CPD for 3 months or longer.

For sterile supplies that are stored for 3 months or longer, a ~~Central Supply~~CPD Technician will conduct inspection at 3 month intervals for:

- Evidence of tampering,
- Wrapping material decomposition,
- Punctures,
- Moisture, or
- Other signs of compromised packaging.

The inspection should be documented and the documentation forwarded to the Manager or Charge Nurse. Packages that are pulled from the stock during the inspection should be noted on the inspection form. A summary of the inspection should be reported to the Infection Control Committee annually.

VI. TRAINING

~~Central Supply~~CPD Technicians are trained in the following:

- Time-related vs. event-related sterile shelf life,
- Inspecting the condition of sterile packages,
- Handling, transportation and storage of sterile supplies,
- Consequences of using non-sterile supplies such as infection,
- Possible consequences of dust and dirt build up on the outside wrapping of the sterile packages such as infection, and
- Rotation of supplies (first in, first out).

Documentation of training is maintained by the Manager/Supervisor of ~~Central Supply~~CPD.

Reference: LHH Infection Control Policy G10, "Storage of Supplies (Clean/Sterile)"

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

C1. Code of Ethics

POLICY:

~~Central Supply~~CPD staff will perform responsibilities professionally and competently without discrimination and in the best interests of LHH.

PURPOSE:

To ensure staff follow the code of ethics of the department.

PROCEDURE:

A. ~~Central Supply~~CPD Staff function efficiently and effectively, demonstrating professional conduct and attitude:
   1. Responds to need of Nursing Staff,
   2. Performs tasks competently, and
   3. Works collaboratively with Nursing Staff, Pharmacy Staff and Staff of Materials Management Department.

B. ~~Central Supply~~CPD Staff provide service to requesters without discrimination:
   1. Exhibits no prejudice for sex, race, creed, or religion,
   2. Provides service without regard to social status, economic status or personal attribute.

C. ~~Central Supply~~CPD Staff practices technology founded on scientific basis:
   1. Applies theoretical knowledge and concepts in the performance of tasks,
   2. Utilizes equipment and accessories consistent with the purpose for which it has been designed, and
   3. Employs procedures and techniques appropriately, efficiently ad effectively.

D. ~~Central Supply~~CPD Staff exercise discretion and judgment:
   1. Assumes responsibility for decisions, and
   2. Seeks guidance, help or Departmental management approval when appropriate.

E. Clinic Staff respect confidences entrusted in the course of professional practice:
   1. Protects the patient's right to privacy,
   2. Keeps confidential, information relating to patients, colleagues and associates, and
   3. Reveals confidential information only as required by law or to protect the welfare of the individual or the community.

Most recent review: 03/11/2022
Revised: 03/11/2021
Original adoption: 04/14/2021

C2. SHIFT HOURS, BREAKS, & OVERTIME

POLICY:

Standard shift hours will be defined for purposes of shift differential pay, when overtime accrues and the amount of break time employees are authorized.

PROCEDURE

I. ~~CENTRAL SUPPLY~~CPD OPERATES 7 DAYS A WEEK (including Holidays) DAY Shift: 6:30am - 3:00pm

8:30am – 5:00pm

9:30am - 6:00pm

EVENING Shift: 12:00pm – 8:30pm

II. SIGN-IN SHEET

It is the employee's responsibility to record start time, break and mealtimes, and departure times on the sign-in sheets as arrivals and departures ~~actually happen~~happen (i.e., don't sign in and out at same time). Start times and return from break/mealtimes must reflect the time the employee is in uniform and ready for assignment. Times are recorded according to the departmental clock only. If arriving earlier than the scheduled shift, the start time is written as the time you are scheduled to begin unless asked to start early. Failure to completely and accurately record time may result in delayed pay for the day not recorded. Inaccuracy may also be construed as dishonesty.

III. BREAKS AND LUNCH

Break times are provided in 15-minute units for each block of 4 hours worked. Employees on shifts between 4 and less than 8 hours long are entitled to one, 15-minute break. For those working shifts less than 8 hours, the supervisor may extend the shift's ending time to allow additional time for a mid-shift break or mealtime. Employees on shift ranging from 8 to 12 hours long receive two, 15-minute breaks and the unpaid 30-minute meal break.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

C3. ATTENDANCE STANDARDS

POLICY:

Employees will maintain regular attendance and prompt arrival times.

PURPOSE:

Each staff member is responsible for managing work time effectively and within the standards described in this policy. The ability of the department to provide safe and adequate patient care services is compromised when there is a high rate of unscheduled absences.

PROCEDURE:

I. NOTIFYING THE DEPARTMTNE OF AN UNSCHEDULED ABSENCE

Employees who are unable to work as scheduled must notify the Supervisor (or Department Manager). If unable to speak to the appropriate person, the employee must call again until they reach this person. Speaking with anyone but the Supervisor or Manager does not constitute notification. The person calling in will ask and make note of the Supervisor or manager to whom they are speaking.

During the initial call, the employee may notify the department that the absence will continue any number of days up to the end of their scheduled workweek. The employees must state clearly the number of days of absence anticipated, and if the absence continues beyond that number of days or continues into the employee's following workweek, another call is required. The employee's supervisor may contact the employee to request a physician's certification of illness.

The Supervisor or Manager will record the call on the appropriate sign-in sheet, date and initial the message.

Sick leave used for medical appointments must be approved at least 24-hours in advance. Verification of the visit may be requested.

II. NOTIFYING THE DEPARTMENT OF A LATE ARRIVAL

An employee who can anticipate a late arrival must notify the Supervisor (or Manager) of their expected tardiness, stating the expected arrival time. This will be written on the appropriate sign-in sheet by the Supervisor or Manager.

III. ABSENTEEISM

A. Excessive Absenteeism is defined to be at or above 104 hours (or 13 shifts) of sick leave or other unscheduled absences per year.

B. Abusive Pattern is defined by sick days consistently associated with off days, holidays, other scheduled days off, or on the same day of the week. To establish this pattern, it is not necessary to be excessive in hours of sick leave or unscheduled absences.

C. Absences which fall under the guidelines for ADA, FCL, FMLA or Worker's Compensation shall not be considered in performance evaluations or disciplinary actions for determination of "Excessive Absenteeism" or "Abusive Patterns". The designation of time under these provisions must be approved prior to the leave or within a reasonable time thereafter, as provided for by the governing rules.

D. Medical verification of sick leave does not protect one from being charged with excessive absenteeism or abusive pattern.

E. Unscheduled early departure from work cannot be coded as comp time, vacation, legal holiday, etc.

F. Sick leave is subject to the approval of the supervisor. It is not an automatic benefit. Supervisors will not unduly deny approval for sick leave, since it is in the department's best interests to have an employee who is ill recover as soon as possible. However, the supervisor has the authority to deny sick leave, or request some evidence of illness whenever they have cause to believe an employee is abusing the sick leave privilege. Failure to provide some evidence, which includes but is not limited to a physician's certification of illness, may result in having the leave recorded as AWOL. Employees calling in sick on a holiday they are scheduled to work, or on a day they have previously been denied off, are two occasions where the supervisor should carefully consider requesting evidence of illness.

IV. TARDINESS

Tardiness is any occasion that an employee is not on-duty, in uniform (as applicable) and ready to work at the start of scheduled shift, and following any breaks or mealtime. Employee will be responsible for accurately signing in at their arrival time, as indicated by the designated department clock.

A. Excessive Tardiness is defined as more than three per month.

B. A five (5) minute grace period will be allowed at the beginning of the shift before an employee is considered tardy. However, the employee must make up the five (5) minutes by the end of the shift or at the end of the shift, at the charge tech's discretion. The grace period is a privilege provided for the occasional delay in an employee's arrival. Employees who consistently arrive late but within the grace are subject to losing this privilege.

C. "Tardy" in excess of the grace period will be recorded with a 'T', to represent 'Tardy', on the sign-in sheet. Approval must be given by supervisor to make time up over five (5) minutes. Time not made up will be deducted from pay (coded as Personal Leave).

D. A scheduled assignment of the tardy employee may be given to another employee to meet service needs.

E. Unless the department has been notified of late arrival, employees arriving after 60 minutes from their scheduled start time may be refused work for the day and consequently recorded as AWOL

V. ATTENDANCE REVIEW

A. A review of unscheduled absences and tardiness will be conducted at least once annually and as often as necessary to encourage good attendance. The reviewed time frame will not be used twice for disciplinary purposes.
B. For those individuals who are borderline or already excessive in absenteeism or abusive pattern, supervisors may require medical verification of future illnesses by written notification, prior to the next illness. A specific time frame will be given for the effective dates (e.g. 3 months, 6 months). Employees who continue to be excessively absent or tardy may be subject to further corrective actions, including disciplinary recommendations up to and including dismissal
C. For purposes of a Performance Appraisal, attendance will be considered in light of all time management factors (tardiness, accounting for time). If an employee is marked development needed for time management on year one and shows no improvement for year two, the second year will be cause for the overall ranking to be marked development needed even though all other areas are not marked development needed.

VI. REQUIRED SICK LEAVE

A. To prevent one employee from spreading illness to others, a supervisor may request an employee who appears to be ill to leave work on sick leave.

VII. SICK LEAVE IN EXCESS OF FIVE DAYS

A Request for Leave form, or as appropriate a Request for FMLA form, must be submitted and approved for leave in excess of 5 days, including sick leave. The employee is responsible for contacting the Manager to discuss the leave. If an employee exceeds the 5 days without proper authorization, they are coded Absent Without Leave (AWOL). This is grounds for a recommendation for dismissal. In the event a formal leave of absence is approved in writing, the employee is not required to keep in touch with the department for the period of the approved leave.

VIII. FUNERAL LEAVE

A request for funeral leave must have prior approval of the Manager. This may be done by telephone. The number of days to be granted will be decided on a case-by-case basis, but generally will be up to five days for child, parent, brother or sister, up to three days for other relatives, plus two additional days if the funeral is out of state. Although funeral leave is paid from the employee's accrued sick pay, it is not generally considered during an attendance review.

IX. ABSENCE WITHOUT LEAVE (AWOL)

An employee who does not notify the department of their absence is considered absent without leave. Unauthorized absence, a serious offense, may result in appropriate disciplinary procedures.

X. ABANDONMENT OF POST

Abandonment of post is any occurrence where an employee is not in their assigned work area as scheduled, without permission from the person in charge of that area. This can include an unauthorized break. Abandonment of post is a serious infraction, which may result in disciplinary recommendations.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

C4. DRESS CODE

POLICY:

Employees are to comply with Standard of Dress while on duty. All employee in Classification 2390 Sterile Processing and Distribution Technician and Classification 1934 Storekeeper shall report to Laguna Honda Hospital ~~Central Supply~~CPD Department in mandatory scrubs during their shifts and will maintain a professional appearance consistent with their duties, responsibilities, and their level of interaction with LHH staff, vendor, or other customers.

PURPOSE:

To establish and maintain a high level of professionalism and to assert highly visible, readily identifiable service department.

PROCEDURE:

~~Central Supply~~CPD Staff will always exercise appropriate personal hygiene in order to project a well-groomed appearance.

~~Central Supply~~CPD Staff will wear clean scrubs daily.

Work clothes must be neat and presentable.

UNIFORM ALLOWANCE:

Classification 2390 Sterile Processing and Distribution Technician see SEIU Local 1021 MOU Article II Section T UNIFORM ALLOWANCE FOR DEPARTMENT OF PUBLIC HEALTH EMPLOYEES 218. Employees who are required to wear and supply their own uniform or lab coat or smock in the course of their duties and who are employed on September 1 of any year covered by this Agreement, shall be paid an annual uniform allowance of two hundred fifty dollars ($250), or, in the case of lab coats or smocks, two hundred dollars ($200) no later than December 1 of each year.

Classification 1934 Storekeepers working in ~~Central Supply~~CPD Department scrubs will be provided by Materials Management Department each year.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

D1. CONTINUING EDUCATION

POLICY:

All ~~Central Supply~~CPD employees will have the opportunity to further their education by attending organized courses in subjects relating to assigned responsibilities.

PROCEDURE:

I. In-service training provided by other departments of the hospital shall be available to the employee and scheduled by the department.

II. Information on curriculums, seminars, workshops, classes, and community activities for all employees shall be provided.

III. A record of continuing education for all employees shall be kept.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

E1. EMERGENCY PREPAREDNESS

POLICY:

Please refer to the Hospital-Wide Health & Safety Program Disaster Plan (Code Yellow)

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

E2. FIRE PLAN

POLICY:

Please refer to the Hospital-Wide Health & Safety Program – Fire Plan (Code Red)

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-01 ANNUAL PHYSICAL INVENTORY COUNT

POLICY:

Materials Management and ~~Central Supply~~CPD to maintain accountable and accurate on-hand inventory.

PURPOSE:

To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported and reconciled prior to on hand inventory adjustments.

PROCEDURE:

MM/~~CSR~~CPD ~~-~~Annual Physical Inventory Count – objective is to get a snapshot of all items in inventory at one time. There will be one person designated as the "leader" or go-to person for questions regarding bin location, units of measure, and other inventory questions as well as handling any incoming phone calls and handling the count sheets. Another person will be designated as the "data entry person". The rest of the staff will be designated as "counters" and will be the ones physically counting products and logging it on the count sheets.

By end of day 3:00 pm Friday, Before Inventory Day.

5) Label with note "Do Not Count, Not in Inventory" for items not in inventory
6) Receive in all delivery documents for products that have arrived and put into inventory.
7) Confirm “pick plan”.
8) Credit all returns and make sure product has been put back in the accurate locations.

For CPD Saturday, Inventory Day

24) Ensure disable item “express issue” process
25) Pick any remaining express issue items and set aside for delivery.
26) Any urgent express issues will be maintained on a manual log sheet and will need to be requested by phone.
27) Leader will run the “Inventory value history report”, “Current Inventory Value report” and “Inventory detail report” in CVS/Excel format, save and named FY____ ~~CSR~~CPD ~~-~~Pre Physical Inventory Count Stock Status or FY_____ MM Pre-Physical Inventory Count Stock Status.
28) Leader will create a “counting event” by storage location **(LHH CPD, PND-$ LCPD & MM).**
29) Leader will create count sheets sorted by bin location **(LHH CPD, PND-$ LCPD & MM).**
30) The leader will print Count Sheets and divide the number of count sheets by groups so everyone will be spread out while counting.
31) Leader will assign count sheets to the group of counters.
32) Each counter will only have one count sheet at any given time. They will also be given a clipboard, yellow post-it notes, and a pen.
33) Counters will count inventory and write in the count in the spaces provided; count the correct unit of measure of the item. Convert the item unit of measure if necessary. For every blank, there should be a number even if that number is zero.

34) Counters to identify items with "2nd location (see item label with **green dots** & refer to the 2nd bin location sheet hanging on each rack); combined the counted on-hand total on the 1st location of item counted.
35) As counters finish counting each item, they will put a yellow post-it notes on the bin tag to indicate that the item has been counted.
36) There will need to be a log sheet for urgent inventory requests that the leader will need to track. The sheet will be divided between "already counted" items and "not counted yet" items. When necessary, the leader will log the item being requested, the qty requested, and the unit it will need to be charged to later. If that item already has a yellow post-it notes on the item, that same designee will log that item on the "already counted" portion of their log sheet. If there is NOT a yellow post-it notes on that item, the designee will indicate how much product was taken out on a green post-it notes and place it under the item and log this under the "not counted yet" items.
37) If a counter sees a green post-it notes on an item that they need to count, they will need to ADD the qty on that note to how much product they physically count on that item.
38) Once a counter is finished counting a sheet, they will legibly sign (or sign and print name) at the bottom and they will submit it to the leader who in turn will provide them with another count sheet.
39) Count sheets will be placed in an inbox for the data entry person.
40) The data entry person will review/enter the data from the count sheet into the system, save the data after each sheet is entered, and place the count sheets in the outbox.
41) After all count sheets have been submitted and entered into the system, the leader and data entry person will generate Physical accounting reconciliation report and highlight items with discrepancy for recount.
42) Leader will assign recount sheets to group of counters.
43) Data entry person will update and validate the legitimacy of the item discrepancy and placed into the inbox.
44) Data entry person to run a stock inventory update.
45) Inventory Value history, Current value and inventory detail reports are ran and saved under 2020 CPD Post Physical Inventory Count Stock Status and 2020 MM Post Physical Inventory Count Stock Status.
46) Print a hard copy of the stock status report.

CPD Bin location total to count:

LHH CPD – All Locations
LHH MM – All Locations

Counting event total: 2 (CPD/MM)

Data entry: (1) Assigned by Dept. Director

Data entry: (2) Assigned by Dept. Director

Leader: (1) Assigned by Dept. Director

Counters: As Assigned by Dept. Director

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-02 INVENTORY CYCLE COUNT

POLICY:

~~Central Supply~~CPD to maintain accountable and accurate on-hand inventory.

PURPOSE:

To ensure the cycle counts are regularly scheduled, tracked, discrepancies are properly researched, reported and reconciled prior to on hand inventory adjustments.

PROCEDURE:

1. ABC Analysis Report
    a. The ABC report (A=20% / B=20% / C=60%) based on usage will be used to determine the frequency of items are cycle counted per month.
    b. A list items are counted weekly, B list items are counted bi-weekly and C list items are counted monthly.

2. ABC Analysis Report Review
    a. Management will review the ABC Analysis Report periodically to review if the items are properly categorized.

3. The 1944 Materials Coordinator will approve all changes to inventory cycle count segments. The 1944 Materials Coordinator may delegate this responsibility to the ~~1942 Assistant Materials Coordinator~~1942 Assistant Materials Manager 1942 Assistant Materials Manager or 2392 Senior Central Processing and Distribution Technician.

4. Cycle Counts
    a. Staff will conduct cycle counts only and cannot adjust on-hand inventory unless approved by the 1942 Assistant Materials Manager.
    b. The Supervisor or Lead will review and investigate all inventory cycle count discrepancies prior to on hand adjustments.

5. Cycle Count Tracking and Record Retention
    a. A manual cycle count tracking log book will be maintained to record cycle count dates, staff counters, and which individual cycle counts was performed.
    b. All cycle counts will be stored for 1 fiscal year plus current fiscal year.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-03 INVENTORY DISCREPANCY REPORTING

POLICY:

A formal inventory discrepancy reporting and adjustment process shall be followed by materials management and ~~central supply~~CPD staff prior to a manual inventory adjustment.

PURPOSE:

Provide management oversight on manual inventory adjustments and to guide staff on

the correct inventory discrepancy reporting procedure.

PROCEDURE:

1. When Materials Management or ~~Central Supply~~CPD staff becomes aware of an inventory discrepancy, the supervisor (or lead tech if no supervisor) is notified.

2. The supervisor will utilize Peoplesoft Inventory Systems report to run a Balancing Inventory Transaction Detail report for the item.

3. Using the report, the supervisor will review pick tickets, materials, and equipment log sheet, packing slips, cycle count sheets, and online delivery documents to identify and verify the actual on-hand quantity.

4. Storekeepers to do the adjustment after confirming receiving discrepancy.

5. If there is an adjustment to be made, the supervisor will complete an Inventory Adjustment Form (Attachment 4.2)

6. The Inventory Adjustment Form will be submitted to the 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management for approval.

7. Once signature approval is obtained by the 1942 Assistant Materials Manager or the ~~1944 Materials Manager~~Director of Materials Management, the supervisor will adjust the on-hand inventory.

8. The Inventory Adjustment Form will be stored in the filing cabinet and maintained for 3 years.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-04 REPORTING AND DISPOSING OF OBSOLETE AND EXPIRED PRODUCTS

POLICY:

Materials Management and ~~Central Supply~~CPD staff will report and dispose of obsolete and expired products in a standardized format.

PURPOSE:

To provide definitions of obsolete and expired products and to provide a guideline for Materials Management and ~~Central Supply~~CPD staff to follow.

PROCEDURE:

1. Definitions:
    a. Obsolete: defined as no longer used by Clinical authority
    b. Expired: defined as 3 months prior to manufacturer's stated "End Use Date" or "expiration date" unless product is in short supply.
2. If Materials Management or ~~Central Supply~~CPD staff identify items in ~~Central Supply~~CPD, Materials Management, or Nursing Supply Carts as expired, they will remove the item and report the finding to their supervisor.
3. The supervisor will determine the best course of action, submit form 4.5: obsolete and expired items and obtain written approval from the 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management for the appropriate disposition.
4. If there is an adjustment to be made to inventory, the supervisor will also complete an Inventory Adjustment Form (Attachment 4.2)
5. Obsolete or Expired items will be stored in a separate bulk location pending the appropriate disposition.

ATTACHMENT: 4.2 Inventory Adjustment Form

4.5 Obsolete and Expired Items

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-05 ~~CENTRAL SUPPLY~~CPD STOREROOM SECURITY AND INVENTORY CONTROL

POLICY:

1. Non-~~Central Supply~~CPD employees accessing ~~Central Supply~~CPD ~~(CSR)~~ storeroom will document items taken from ~~CSR~~CPD on Materials and Equipment Log sheet (attachment 4.3)

2. ~~CSR~~CPD staff will review log sheet and stock issue items to appropriate department.

3. Electronic identification badge access requires approval from Director of Materials Management; all non-~~CSR~~CPD staff will need to sign ~~the CSR~~CPD Inventory Security Form (attachment 4.4) before access will be allowed.

4. Materials Management will track the issuance of grand master keys to DPH personnel; all grand master key recipients will sign ~~CSR~~CPD Inventory Security Agreement (attachment 4.4)

PURPOSE:

1. To reduce the risk of unauthorized loss of supplies.

2. To provide non-~~CSR~~CPD staff access to urgently required medical supplies and equipment during the hours that ~~CSR~~CPD is closed.

3. To provide non-~~CSR~~CPD staff a formal process to document items taken from ~~CSR~~CPD.

4. To provide Materials Management with the ability to monitor off-hour access via master key access or electronic identification badge access.

5. To ensure all staff with ~~CSR~~CPD access understand the Materials and Equipment log sheet and how to complete it accurately.

PROCEDURE:

1. When Non-~~CSR~~CPD staff require medical supplies or equipment and ~~CSR~~CPD staff are not available to assist, that employee will:

    a. Use electronic identification badge or master key to gain access to ~~CSR~~CPD storeroom.
    b. Pick up clipboard with Materials and Equipment log sheet located on Will Call shelf located immediately on the left wall upon entering ~~CSR~~CPD.
    c. Locate needed materials and/or equipment
    d. Complete log sheet
    e. Replace clipboard with log sheet back to original location.

f. Ensure ~~CSR~~CPD doors are properly closed and locked.

2. ~~CSR~~CPD staff will check log sheet daily; if items were taken, ~~CSR~~CPD staff will charge out items to appropriate department and notify materials management whenever this occurs.

3. The Materials and Equipment log sheets will be filed in ~~CSR~~CPD filing cabinet and retained for 2 years.

Most recent review: 03/11/2022

Revised: 03/11/2021

Original adoption: 04/14/2021

F-06 RECORD RETENTION FOR FILES

POLICY:

Materials Management and ~~Central Supply~~CPD will retain records for tracking and auditing purposes.

PURPOSE:

To provide guidelines to staff for storage and retention of purchasing, inventory management, and receiving records.

PROCEDURE:

Retain records in Materials Management warehouse as follows:

1. Annual Physical Inventory – 5 years
2. Cycle Counts – 1 fiscal year plus current fiscal year
3. Inventory Discrepancy Form – 3 years
4. Materials Management Delivery logbook – 3 years
5. Pick tickets – 3 months
6. Purchase Orders – 7 years
7. Packing Slips
    a. Just-in-time packing slips – 3 months
    b. Bulk PMM packing slips – 7 years
    c. FAMIS PO's packing slips – 7 years
8. Materials and Equipment Log sheet – 1 year

Most recent review: 03/11/2022

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Original adoption: 04/14/2021

Attachment 4.4: ~~CSR~~CPD Inventory Security Agreement

~~CSR~~CPD Inventory Security Agreement

I, _____, hereby acknowledge that I will be receiving electronic badge access to the ~~Central Supply~~CPD ~~(CSR)~~ storeroom or a master key that accesses ~~Central Supply~~CPD. I have been advised, and I fully understand, that these are to be used solely for those functions I have been authorized to perform as part of my department's work responsibility, and that the access authorization is for my exclusive use only. I hereby accept full responsibility for any and all activity that I conduct within the ~~CSR~~CPD storeroom

Furthermore, in accordance with this policy, and all previous policies regarding security, I agree not to transfer, loan, or share, my electronic identification badge to any other person or persons, or to otherwise allow access by anyone else using my badge or key in any other manner or under any other circumstances. If I ever have reason to believe that my badge or key has been compromised, I will report such information to the office of DPH Materials Management at Laguna Honda Hospital, 415-759-2326.

In addition, I understand that any violation of the terms of this agreement by me may be considered a misuse of my badge and/or key, and that any event of misuse may result in cancellation of my access to the system, and any other disciplinary action deemed appropriate by my department head.

I also agree that I have received and reviewed the ~~Central Supply~~CPD Storeroom Inventory Security Policy and Procedure and understand and agree to my part in the process, including, but not limited to, writing down all item #'s, descriptions, and quantities of items taken and ensuring that the door is secure when I exit from ~~CSR~~CPD.

User Print Name: _____

User Signature: _____

Department: _____

Date: _____

Attachment 4.5: Obsolete and Expired Items

Obsolete and Expired Items	
Directions: Fill out one form for every supply or equipment that is obsolete or expired and get signature approval from 1942 Assistant Materials Manager or ~~1944 Materials Manager~~Director of Materials Management before making any adjustments.	
Date:	**Reported by:**
~~PMM~~DPH Item no: (if no ~~PMM~~DPH #, describe item or equipment)	
Quantity on hand:	
Description of why supply or equipment is obsolete or expired	
Plan of Resolution:	
Submit document with any applicable documentation.	
Authorized Signature: 1942 Assistant Materials Manager or ~~1944~~ Director of Materials Management ~~Manager~~	
Printed Name:	

	Date Processed		Processed By:

Revised Food Services Policies and Procedures

1.139 Pot machine Temperature Checks

Established and Revised: ~~3/87, 1/89, 1/92, 5/97, 9/2006, 7/2009~~ 1/24
Reviewed: ~~8/13, 8/14~~ 1/24

Policy: To assure the proper ware washing and sanitation, the pot machine and ~~cafeteria~~ dish machine will be checked for proper wash and rinse temperatures.

Procedure:

1. Supervisor or team leader~~Chefs~~ will check the temperatures on the dish machine and Chef or designee will check pot machine~~s~~ daily.
2. The Chef~~s~~ or designee will record temperatures in ~~log book~~logbook.
3. The Pot washer will inspect the machines for proper functioning.
4. Any substandard temperatures and/or improper operation of the ~~dishmachine~~dish machine or pot machine will be ~~noted~~noted, and action will be taken to correct the problem by the Chef or designee to contact~~ing~~ Facility Services or Ecolab ~~onomic Labs~~.
5. Follow-up on all corrective action taken.
6. Chef~~s~~ will initial the checklist forms and keep on file for review by Food Service Management ~~the Assistant Food Service Director~~.

1.64 Preventive Maintenance

Established and Revised: ~~3/81, 1/89, 5/97, 9/06, 7/09, 8/14~~ 1/24
Reviewed: ~~8/13, 8/14~~ 1/24

Policy: A regular preventive check will be performed on equipment in the Nutrition Service Department.

Purpose:

- To minimize occurrence of breakdowns.
- To maximize life span of equipment.

Procedure:

1. Inspections will be made by Chef~~s~~ and Food Service Management ~~Assistant Food Service Director~~.

2. Inspections are made on a regular basis by Facility Service and/or city approved vendors ~~contracted vendors~~. Below is equipment that are regularly inspected and/or serviced per manufacturer recommendation.

   - ~~Hobart Service: s~~Slicers, choppers, ~~etc.~~
   - ~~ACME Pacific Service: o~~Ovens and r~~R~~anges, steamers, steam wells, toasters, steam tables, walk-in refrigerators, walk-in freezers, ~~Dishmachines~~dish machines, ~~P~~pot machine, pot washing sink, tray-line and tray service equipment, ~~G~~galley service equipment, mixers, filtering system, Fire Extinguishers System, liquid coffee dispenser, juice dispenser, soda dispenser, and any other equipment operating in the department ~~etc.~~
   - ~~Economic Laboratories: Dishmachine and Potmachine~~
   - ~~Facility Services: Filter System~~
   - ~~International Fire Equipment: Fire Extinguishers System~~
   - ~~Kraft: Liquid Coffee Dispensers~~
   - ~~Dispenser Juice Co: Juice Dispensers~~
   - ~~Coca Cola: Soda Dispenser~~

Plant Services makes routine inspections and follow up corrective actions.

1.67 Dish machine Q.C. Checklist

Established and Revised: ~~3/87, 1/89, 1/92, 5/97, 9/06, 7/09, 6/11~~ 1/24
Reviewed: ~~8/13, 8/14~~ 1/24

Policy: To assure its adequate functions of the dish machine for proper ware washing and sanitation, at each meal, the dish machine will be checked for its proper functions.

Procedure:

1. Supervisor or team leader will check the dish machine at each ware washing process.
2. Using a department approved test strip ~~165 F test strip~~ or an approved holding thermometer, the supervisor will take the temperature of the dish machine at each ware washing process. They will record temperatures and condition of dish machine according to checklist.
3. Final Rinse Temperature will be at 180¶F. Please contact Facility Services if this falls below standards.
4. If dish machine does not reach correct temperatures, we will utilize the pot machine to properly sanitize the wares and vice versa when the pot machine doesn't reach proper temperature.
5. If both ~~dishmachine~~dish machine and pot machine does not reach proper temperature, then the supervisor or chef will call Ecolab Service Rep to turn on Ultra San. The Service Rep or a Supervisor/Chef will take a chlorine litmus strip and test the final rinse by dabbing the strip onto a pool of water on a tray or plate as it exits the dish machine. It must reach the color ~~for~~ of 50 ppm.
6. Any substandard of temperatures and/or conditions of dish machine will be noted and follow through on any necessary corrective action. This will be done through Facility Services for emergency repairs, steam line, drains and water line. ~~Economics Laboratory or Acme Pacific~~ Facility Services or city approved vendor will conduct any mechanical repairs of the dish machine after the estimated price has been approved through the proper purchasing channel.
7. Follow up on all corrective action taken.
8. Supervisor will initial the checklist forms and keep on file until reviewed by the Food Service Manager.
9. For staff safety, Supervisor and/or ~~Teamleader~~Team leader and dishwashers will follow the lock out, tag out procedure on the ~~dishmachine~~dish machine at all times.

Noted Standards: Power Scrapper: 1~~2~~10-140¶F; Power Wash: 150-16~~0~~5¶F; Rinse: 160-190¶F; Final Rinse 180-~~200~~195¶F; Pressure Gauge: 15-~~25~~ 40 psi.

Deletion Nursing
Policies and Procedures

ORAL AND NASOPHARYNGEAL SUCTIONING

POLICY:

1. Licensed Nurses may perform oral and nasopharyngeal suctioning when indicated, without a physician's order.

2. For residents who are imminently dying, do not suction upper airway unless congestion causing resident/patient distress.

PURPOSE:

To maintain an open airway by removing oral and nasopharyngeal secretions which inhibit normal respiration.

PROCEDURE:

A. Equipment:

Disposable suction kit (Frequently use French 10, 12, or 14)
Suction machine
Water soluble lubricant
Connecting tube
Mask
Normal Saline
Catheter plug

B. To suction nasopharynx via nose (if necessary) before suctioning mouth:

1. Position resident slightly on side in a high Fowler's or semi-Fowler's position when possible.

2. Attach the suction catheter to the suction machine.

3. Wash hands.

4. Apply sterile glove.

5. Open the sterile saline bottle. Open kit on a clean surface. Connect resident's individual connecting tube and suction catheter.

6. Dip the tip of catheter into sterile saline to moisten the inside of the catheter, then lightly coat end of catheter with lubricant. Gently guide catheter into nostril, using a downward motion. Do not force. If one nostril is blocked, use the other.

7. Determine the appropriate depth of catheter insertion by measuring a distance equivalent to that between the tip of the nose and the earlobe.

8. Slowly advance the catheter tip into the resident's pharynx while instructing him/her to inhale without swallowing.

9. Slowly withdraw catheter while gently rotating. Release suction intermittently every 1-2 seconds for approximately 10 seconds only.

10. Clear catheter by suctioning saline through it.

11. Repeat this procedure until the excess secretions are removed and resident is breathing comfortably.

12. Discard disposable catheter by wrapping catheter around your gloved hand and pulling the glove off around the catheter.

13. Plug the connecting tube with the sterile catheter plug.

14. Discard disposable suction canister, connecting tube, and catheter plug every 24 hours or PRN.

15. Each resident is to have his/her own suction kit, which is discarded after each suctioning episode.

C. To suction mouth and oral pharynx:

Guide catheter into throat and create suction intermittently for approximately 15 seconds only. Discard after each use.

D. Documentation:

1. Progress Notes: Document in the electronic health record (EHR) if any change from baseline, document assessment and evaluation of the intervention's effectiveness. Describe the color, quality and approximate quantity of secretions removed and the condition of the resident.

2. Treatment Record: Document suctioning in the EHR and describe effectiveness on the back side for prn.

ATTACHMENTS/APPENDICES:

None

REFERENCES

EBSCO – Nursing Reference Center - Nasopharyngeal Suctioning: Performing. September 18, 2015

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Revised: 2000/08, 2008/08, 2016/03, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

TRACHEOBRONCHIAL SUCTIONING

POLICY:

1. Procedure is to be performed by a Licensed Nurse using sterile technique.

2. Suctioning should be done only when needed to reduce substantial secretions as indicated by increased respiratory difficulty, easily audible "gurgling" breathing sounds or post assessment of lung sounds.

3. For imminently terminal residents with audible airway congestion, do not suction unless congestion is causing resident/patient distress.

PURPOSE:

To clean air passages of accumulated secretions which prevent the resident from getting adequate ventilation by means of a suction catheter inserted through a tracheostomy.

PROCEDURE:

A. Equipment

Suction machine, if no wall suction, and unsterile emesis basin
Sterile suction kit (single-use) which contains: suction catheter, sterile gloves
Water soluble lubricant
Sterile connecting tubes
Sterile catheter plug
Mask and/or plastic apron; goggles, face mask, if needed
Sterile normal saline
Sterile gauze 4" x 4"
Resuscitation bag and oxygen tank or wall oxygen, if needed

B. Preparation of resident

1. Explain to resident (even if s/he is unresponsive) that suctioning may cause coughing and gagging which also helps to remove secretions. Continue to assure throughout the procedure to minimize anxiety and promote relaxation.

2. Provide for privacy.

3. Suggested positioning: Semi-Fowler's position with chin up to promote lung expansion and productive coughing.

4. If the resident is able to cooperate, have him/her cough and breathe slowly and deeply.

5. If the resident has an artificial airway, or easily becomes hypoxic, hyperoxygenate his lungs, using the resuscitation bag for one or two breaths just before and after suctioning

C. Assessment

Auscultate lungs bilaterally and take vital signs, if resident's condition warrants.

D. Equipment preparation

1. Mask, plastic apron and/or goggles, face mask are to be worn by the nurse when the resident has copious secretions.

2. Wash hands thoroughly before and after performing this procedure. Put on mask.

3. Test the wall suction or plug in and test the suction machine and connect the tubing.

4. Label the sterile normal saline solution bottle with the date, time, and nurse's initial. Discard after 24 hours. Remove the cap from the normal saline bottle.

5. Open the suction kit on a clean surface. Place the sterile barrier under the resident's chin by handling only by the edges.

6. Put on the sterile gloves. Use one hand to do sterile suctioning. Use the other hand to handle non-sterile items.

7. Attach the sterile suction catheter to the connecting tubing by holding the catheter in your sterile gloved hand and the connecting tubing in your clean-gloved hand.

8. Remove resident oxygen mask if using.

9. Turn on the wall suction or suction machine.

10. Dip the catheter tip in the sterile saline solution to lubricate outside of the catheter.

11. With the catheter tip in the sterile saline solution, cover the control valve with the thumb of the sterile gloved hand and suction a small amount of the solution through the catheter to test the suction equipment and lubricate the inside of the catheter to facilitate passage of secretions through it.

E. Suctioning

1. With the catheter's control valve uncovered, gently insert the catheter deep into the trachea (and into a bronchus, if indicated), through the resident's tracheostomy tube. Do not apply suction during insertion to avoid tissue trauma and oxygen loss.

2. Apply suction for five to ten seconds during the withdrawal of the catheter by intermittently covering the control vent with the clean-gloved hand, while simultaneously rotating the catheter with the sterile-gloved hand.

3. If applicable, resume oxygen delivery after suctioning.

4. Observe the resident and allow him to rest before the next suctioning.

5. Repeat the suctioning until airway is cleared of excess secretions.

6. If secretions are thick, clear the catheter periodically by suctioning a small amount of sterile saline solution through it.

7. Clear the connecting tubing by suctioning saline solution to rinse it.

8. Turn off the suction and disconnect the catheter from the connecting tubing. Cover the connecting tube with the plastic bag.

9. To discard the catheter, coil it around your gloved hand and pull off the glove from the wrist over the coiled catheter. Put the catheter and the suction bowl into the infectious waste receptacle.

10. Auscultate lungs bilaterally and take vital signs, if the resident's condition warrants, to assess the procedure's effectiveness.

11. Perform tracheostomy care as needed.

F. Cuffed tracheostomy tube suctioning

Note: Cuff deflation /re-inflation to prevent necrosis, always done by Respiratory Therapist. (See Cross -Reference HWPP 27-05.)

G. Care of Equipment

1. Connecting tubing and catheter plug are to be changed every 24 hours or PRN.

2. Opened solutions are to be labeled with the date, time, nurse's initials, and discarded after 24 hours.

3. Disposable suction canister is to be changed every 24 hours or PRN.

H. Documentation

1. Pavilion Mezzanine Acute

   Document the date, time of the procedure, and the reason for suctioning. Note the amount, color, consistency, and odor of the secretions and the frequency of suctioning. Record vital signs, including pain assessment; and auscultation findings before and after suctioning; hyper oxygenation measures if given; and pertinent data regarding the resident's subjective response to the procedure

2. Skilled Nursing Neighborhood

   a. When resident requires suctioning because of an unexpected change in his condition, document date, time, frequency of suctioning at least once each shift or more often as condition warrants, and include amount, color, consistency, and odor of secretions.

   b. When resident requires suctioning routinely to clear secretions, document onto electronic health record. If resident requires as needed suctioning, describe the frequency of suctioning, character of the secretions, and outcome or effectiveness of procedure.

ATTACHMENTS/APPENDICES

None

REFERENCES:

EBSCO – Nursing Reference Center - Tracheostomy Care: Providing. February 20, 2015

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Hospitalwide Policies and Procedures
27-05 Tracheostomy Management

Nursing Policies and Procedures
I 1.0 Oral and Nasopharangeal Suctioning
I 3.0 Tracheostomy Care

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