List of Policies and Procedures Submitted to JCC for Approval on March 12, 2024

Status	Dept.	Policy #	Title	Notes
Revised Revised Hospital-widw Policies and Procedures				
Revised per HC comment 3-12-24	_LHHPP	24-22	Code Green Protocol	1. Added "Laguna Honda Hospital and Rehabilitation Center (LHH) ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision &/or interventions to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. 2. Added definitions for "Wandering" and "Elopement" 3. Added information regarding "delayed egress door alrms", "Resident Locator System" and "a systimatic approach to monitoring and managing" at risk residents. 4. Added information regarding "Interventions to increase staff awareness" and monitoring interventions as well as communiting changes. 5. Specified locations for searching within the neighborhoods. 6. Added specifics for the "Resident Locator Program" for redirectable and on-redirectable residents. 7. Added "If the resident is missing, any staff member has the authority to activate Code Green by calling the Nursing Office at 4-2999 to report “Code Green (Unit) " 8. Added details to provide when calling SFSO with a Code Green. 9. Added designated areas to search if a resident is missing, both on and off the neighborhood throughout the document. 10. Added more details to what information the caller is to provide to the nursing office. 11. Added "until a thorough and complete search has been performed by all neighborhoods, SFSO, and Security or when the resident has been found. " to procedures in an Ongoing Overhead Page and Text Page for Code Green 12. Added "resident attempting to elope or " to "missing" throughout the document. 13. Added "If areas were locked during the period that resident was not seen, those areas do not need to be searched. If resident had potential or suspected to enter these areas and staff do not have access to enter, contact owner/department of office or troubleshoot with nursing operations supervisor/nurse manager. " 14. Added "iv.LHH Community Ambassadors/Pavilion Lobby staff– will review identified residents who are at high risk for elopement when alerted for a Code Green. If resident is seen, they would redirect the resident or visually track the resident if possible, notify the neighborhood." 15. Added "to discard Resident Photo or return to original area per standard work after CODE GREEN terminated" 16. Added to the list of documents to be completed when a resident is missing. 17. Added "For Code Green after Code Green incident cleared or within 4 hours of the Code Green activation:" 18. Added "patient/" to resident throughout the document. 19. Added "Administrator, Assistant NHA, Medical Director, DONs, (if acute patient) " to list of those emailed in a Code Green. 20. Added "7. Reporting" section detailing when to notify the State Licensing and Certification office 21. Added "8. Procedure Post-Elopement and Resident Returns to LHH" detailing tasks the nurse, physician and Social Services are assigned. As well as next steps and documentation.

List of Policies and Procedures Submitted to JCC for Approval on March 12, 2024				
Revised Hospital-widw Policies and Procedures				
Revised	_LHHPP	23-03	Screening and Response to Suicidal Ideation	1. Replaced "Conducting" with "Trained, licensed staff and providers (nurses and social works) conducted" 2. Added "C-SSRS: Columbia Suicide Severity Rating Scale, a validated screening instrument to assess risk for suicidality to guide next steps by a clinician" 3. Added "from using the C-SSRS as performed by trained, licensed staff" 4. Replaced "assess resident's mood using" with "use" 5. Added "to assess the resident's mood" 6. Replaced "with " with "who have" 7. "Added "as" 8. Added "utilizing the Patient Safety and Ligature Identification Checklist. Items identified on the list should be noted in the electronic health record (EHR). Support the resident in creating a therapeutic environment such as desired noise level, lighting and visitors." 9. Added "that may need to be removed or for which risk may need to be mitigated" 10. Replaced "Aeroscout" with "Aeroscout (an electronic patient location tag)." 11. Added "the resident within 2 hours " 12. Added "within 2 hours" 13. Added "utilizing the Patient Safety and Ligature Identification Checklist. Items identified on the list should be noted in the electronic health record (EHR). Support the resident in creating a therapeutic environment such as desired noise level, lighting and visitors." 14. Added "that may need to be removed or for which risk may need to be mitigated." 15. Added ", including the need for and urgency of psychiatry consultation if indicated." 16. Deleted "/PATIENT " 17. Addded "utilizing the Patient Safety and Ligature Identification Checklist. Items identified on the list should be noted in the electronic health record (EHR). Support the resident in creating a therapeutic environment such as desired noise level, lighting and visitors" 18. Added "any need for and" and "C-SSRS" 19. Replaced "physician" with "clinical team" 20. Deleted "via routine referral process." 21. Added "within the next business day" and "(as described in c) " 22. Deleted and if not excluded by criteria in Policy 20-01 (Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units), Admissibility and Screening Procedures 1(c)" 23. Replaced "PROVIDER UPDATES" with "COMMUNICATION WITH RCT" 24. Added "A.Columbia-Suicide Severity Rating Scale" 25. Corrected reference "24-28" to 24-23"
Revised	_LHHPP	24-08	Off Campus Appointments or Activities	1. Deleted "to be" 2. Deleted "LHHPP 21-06 Transporting the Resident's Field Medical Records on Campus"
Revised	_LHHPP	70-01 C1	Fire Response	1. Added "in a resident's room" 2. Added "delayed egress"
Revised	_LHHPP	71-01	Fire Safety Program	1. Replaced "twice" with "once per shift"
Revised Nursing Policies and Procedures				
Revision	NPP	Acute A 02.0	Documentation of Care – Acute Unit	1. Updating policy to remove all references to come-and-go procedures, which will no longer be allowed on the Acute Unit
Revision	NPP	D6 1.1	Battery Operated Lift Transfer	1. Deleted "or designee"
Revision	NPP	J 8.0	Blood Transfusion	1. Updating policy to remove all references to come-and-go procedures, which will no longer be allowed on the Acute Unit, and workflows related to patient movement between SNF and Acute

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Revision	NPP	M 12.0	Adaptive/Assistive Devices Management	1. Added "RN will ensure the resident's care plan is updated by end of shift for appropriate interventions when it applies to meeting resident's needs for adaptive/assistive devices, and when the resident has received a physician order for use of an adaptive/assistive device. The care plan and physician order should include details regarding use (e.g., frequency, duration, positioning) as appropriate. " 2. Added "broda chair"

Revised Revised Hospital-wide Policies and Procedures

CODE GREEN PROTOCOL

POLICY:

1. ~~This facility~~Laguna Honda Hospital and Rehabilitation Center (LHH) ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision &/or interventions to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.

~~1.~~2. The Resident Care Team (RCT) shall assess all residents for risk of elopement on admission, quarterly, on relocation and as resident condition warrants.

~~2.~~3. A Code Green alert shall be utilized to communicate to staff that a resident has been declared missing from Laguna Honda Hospital and Rehabilitation Center (LHH) and search for resident according to procedures have been implemented.

~~3.~~4. It shall be documented in the EHR if the Resident is Missing Cognitively Impaired (MCI) or Absent Without Official Leave (AWOL~~-~~).

Definitions:

"Wandering" is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless.

"Elopement" occurs when a resident leaves the premises (LHH property) or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.

PURPOSE:

To minimize the risk of elopement, standardize elopement response and conduct appropriate search procedures.

To establish guidelines for LHH staff to provide an organized and prompt search for a resident who is determined to be missing.

PROCEDURE:

The facility is equipped with delayed egress door- alarms which audibly alert staff when activated.

The facility has a Resident Locator System per physician order for use with high risk for elopement individuals.

Alarms are not a replacement for necessary supervision. Staff are to respond~~ing~~ to alarms in a timely manner.

LHH shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.

1. **Initial Elopement Assessment**

   a. Upon admission, the Registered Nurse (RN), in collaboration with the RCT, shall assess each resident for elopement risk(s) and document in the EHR.

   b. For residents who are determined to be at high risk for elopement, the RCT shall implement appropriate clinical interventions (e.g. use of resident locator device, special activities, etc.) to minimize the risk of elopement.

2. **On-going Elopement Assessment**

   ~~a.~~ The RN and physician, in collaboration with the RCT, shall assess the resident for elopement risk quarterly, annually, on unit-to-unit relocation, after any change in condition that results in a significant increase in elopement risk, and following an elopement event, whether attempted or actual in the EHR.

   a. For residents who have had a change in condition, unit-to-unit relocation, or attempted elopement, the RCT shall review and revise the resident's plan of care as necessary to minimize additional risks.

   b. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.

   c. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. Any changes or new interventions will be communicated to relevant staff.

3. **Resident Elopement While On Campus**

   a. Code Green

      i. If a resident is missing the resident's neighborhood staff ~~-~~shall conduct a search within or off t~~t~~he neighborhood if needed where the resident had potential to go to, such as all neighborhood households, rooms or offices (that would be accessible to the resident), activity areas off unit such as

Serenity Park, Pavilion esplanade, farm area; or as indicated from the Resident Locator program.

-

- If resident is found, resident will be redirected back to neighborhood or staff will stay with resident at a safe distance, per care plan or have visual supervision of the resident until the resident returns safely back to unit or is considered safe (e.g., resident is with trusted family member, escorted appointment, planned supervised activity, etc.).

- If resident is found but is not redirectable with attempts to elope, proceed with activation of Code Green below.

b. Activation Of Code Green

i. If the resident is missing, a~~A~~ny staff member has the authority to activate Code Green by calling the Nursing Office at 4-2999 to report "Code Green (Unit)

~~i.~~ii. Charge nurse or designee to call x4-2319 to inform SFSO of the CODE GREEN (Unit) -" ", name of resident and description of what the resident looks like.

~~ii.~~iii. Charge nurse or designee shall print picture of resident attempting to elope or missing resident from the electronic health record (EHR).

iv. If resident is missing, the ~~C~~Charge Nurse or designee shall call for a huddle with neighborhood staff to show the picture of the missing resident and assign staff to search designated areas:

- Resident rooms and bathrooms in each household
- Living rooms in each household
- Stairwells in each household
- Medication Rooms
- Galley, Great Room/Dining Rooms, Charting and Report Room
- Offices (MDS, Nurse Manager, AT, Conference Room, Staff Lounge, Staff Bathroom). If areas were locked during the period that resident was not seen, those areas do not need to be searched. If resident

had potential or suspected to enter these areas and staff do not have access to enter, contact owner/department of office or troubleshoot with nursing operations supervisor/nurse manager.

- Spa Rooms, Linen Rooms, Storage Rooms, Biohazard Rooms, EVS Room, Laundry Room and Physician Office
- Garden and Patio (if any)

As well as off the neighborhood as follows (if accessible during business hours or off hours, SFSO):

- Barber Shop and Beauty Salon
- Library
- Vending/ATM Room
- Cafeteria
- Art Studio
- John Kanaley Center
- Chapel and Simon Auditorium
- Rehabilitation Area
- Wellness Center
- Clinic

~~iii.~~v. NURSING OFFICE staff receiving the 4-2999 shall carry out the following Code Green responses:

- Obtain the following information from the caller:

1. Location of neighborhood where the missing resident or resident attempting to elope resides.
2. Full name of the resident.
3. Full name of staff activating Code Green.

~~1.~~

5. Repeat back the information to the person activating Code Green for accuracy.

~~iv.~~vi. NURSING OFFICE Overhead Page:

- Initial Page – CODE GREEN (Unit) " " (number) (specify neighborhood) X3.

- Ongoing Page for Code Green – continue to overhead page every 30 minutes until a thorough and complete search has been performed by all neighborhoods, SFSO, and Security or when the resident has been found.

~~v.~~vii. NURSING OFFICE Send Text Page – 415-327-8124.

- Initially – CODE GREEN (Unit) " " (number), specify neighborhood, followed by first name and last name of resident attempting to elope or missing resident.

Ongoing Page for CODE GREEN - continue to text page every 30 minutes until a thorough and complete search has been performed by all neighborhoods, SFSO, and Security or when the resident has been found.

- End of day – shall send group page CODE GREEN (Unit) "~~"~~4 (specify neighborhood) remains active at 9PM if resident continues to be missing or Code Green is not cleared yet.

~~b.~~ Code Green In Progress – Once Code Green is activated the following shall be conducted:

c.

i. Other Neighborhoods – Charge Nurse shall receive a CODE GREEN ~~Stage~~ (Unit) " " (number) text page with neighborhood and full name of resident attempting to elope or missing.

For Code Green - search within the neighborhood is initiated as follows:

- Charge nurse or designee shall obtain picture of resident attempting to elope or missing (e.g. print from EHR, online, binder).

- Charge Nurse or designee shall call for a huddle with neighborhood staff to show the picture of the resident attempting to elope or missing ~~resident~~ and assign staff for designated search areas:

    1. All households' resident rooms~~-~~, bathrooms, living rooms.

    2. All stairwells ~~-~~

    3. Medication Rooms.

    4. Galley, Great Room/Dining Rooms, Charting, Report Room

    5. Offices (MDS, Nurse Manager, AT, Conference Room, Staff Lounge, Staff Bathroom, Directors of Nursing). If areas were locked during the period that resident was not seen, those areas do not need to be searched. If resident had potential or suspected to enter these areas and staff do not have access to enter, contact owner/department of office or troubleshoot with nursing operations supervisor/nurse manager.

~~5.~~

    6. Spa Rooms, other neighborhood Bathrooms, Linen Rooms, Storage Rooms, Biohazard Utility Rooms, EVS Room, Laundry Room and Physician Office.

    7. Garden and Patio (if any).

- For Code Green: Charge Nurse or designee shall call Nursing Office 415-682-1500 to report that search is completed, and resident is found or not found.

    1. If resident is found, Charge nurse or designee shall also call the neighborhood of the missing resident to inform that resident is found and arrange pick up.

- Charge Nurse or designee on all neighborhoods on all 3 shifts shall include during their change of shift report the status of CODE GREEN (Unit) "___" that was last heard from the overhead announcement, a picture of the resident attempting to elope or missing resident to the incoming shift until CODE GREEN is clear.

~~vi.~~ii. SFSO – Officer on duty shall receive a call from charge nurse of missing resident or resident attempting elope to inform them of the CODE GREEN (Unit) "___" (number), name of resident missing and description.

- Code Green search shall be conducted as follows:

  1. Forest Hill Station;

  2. LHH Grounds (including offices/rooms that maybe locked John Kanaley Center, Library, Patios, Pool, Wellness Center, etc)

  3. LHH Administration building, including all stairwells.

- Officer on duty or designee shall call Nursing Office 4-1500 to report that search is completed, and resident is found or not found.

- Officer on duty or designee shall include in their change of shift report the status of CODE GREEN (Unit) " " that was last heard from the overhead announcement, a picture of the missing resident or resident attempting to elope to incoming shift until CODE GREEN is clear.

iii. Other Departments – Upon hearing overhead page, Department Manager or designee shall huddle with their staff to search their respective work areas for any resident and contact the Nursing Office at 4-1500 if a resident is found.

~~vii.~~iv. LHH Community Ambassadors/Pavilion Lobby staff– will review identified residents who are at high risk for elopement when alerted for a Code Green. If resident is seen, they would redirect the resident or visually track the resident if possible, notify the neighborhood.

~~c.~~d. Termination Of Code Green

i. Neighborhood or Department staff shall call Nursing office once the missing resident is found.

ii. Nursing Office shall Overhead Page CODE GREEN (Unit) ALL CLEAR X3

iii. Nursing Office shall send Group Page to 415-327-8124 indicating CODE GREEN (Unit) ALL CLEAR

iv. Neighborhoods and Departments to discard Resident Photo or return to original area per standard work after CODE GREEN terminated.

v. Nurse Manager or designee where missing resident resides shall call SFSO at 4-2319 to indicate that resident is found and/or redirectable back to unit or considered safe~~.~~

~~d.~~e. Notification And Documentation

i. Neighborhood where missing resident resides

- Charge Nurse or Nurse Manager shall notify the following once CODE GREEN is **activated and terminated:**

  1. Nursing Office
  2. Nurse Manager or Nursing Ops
  3. Unit Physician or On-Duty physician
  4. SFSO
  5. Directors of Nursing (DON) &/or (if acute patient) Chief Nursing Officer
  6. Risk Management Staff
  7. Appropriate Resident Care Team Members – to assist in locating/calling resident/family
  8. Family or responsible party

- Shall document events and notifications made in EHR:

  1. Notification of family, surrogate decision-makers and/or conservators
  2. Circumstances of the elopement, interventions, and the resident status until resolution of search
  3. Progress Notes.

  If the resident is not found, the census shall be updated in the EHR at midnight and the discharge will be the day and time the resident was last seen.

  4.

  5. Any new information obtained post elopement and after the medical record has been closed shall be documented in the resident's EHR as post discharge notes.

  5.

- Other documents to be completed – during the shift when resident is

determined missing.

1. Unusual Occurrence Report (even if resident is found)

2. Care Plan – Upon resident's return, ~~i~~Initiate elopement Care Plan or update if there's an existing Care Plan.

3. Upon resident's return, staff shall document the RCT meeting discussion(s) related to the resident's elopement event.

4. Upon resident's return, conduct another elopement risk assessment.

5. Upon resident's return, the follow-up plans shall be documented in the EHR for each elopement event.

6. Appropriate reporting requirements to the State Agency shall be conducted.

7. Additional document when resident is Code Green ~~Stage 3 and/or Stage 4:~~

8. **MISSING RESIDENT INCIDENT NEIGHBORHOOD CHECKLIST** and fax to Nursing Office at 415-682-1510 once search in neighborhood and off-neighborhood completed.

Additional documentation when resident is determined missing:

~~1.~~ "Emergency Notification of Missing Resident" form – description of resident and picture fax to Nursing Office at 415-682-1510 after search in neighborhood completed.

9.

ii. Other Neighborhoods and Departments:

- For Code Green: Notify Nursing Office that search is completed and whether resident is found or not found.

  And Complete the **MISSING RESIDENT INCIDENT NEIGHBORHOOD**

CHECKLIST and Fax to Nursing Office at 415-682-1510 once search is completed within their assigned area.

iii. SFSO Officers:

For Code Green:

- Notifies Nursing Office that search is completed and whether resident is found or not found

- Completes the **SFSO SEARCH CHECKLIST** and Fax to Nursing Office at 415-682-1510 once search is completed within their assigned area.

For a resident who was/-is determined as missing:

- Completes the SFSO Missing Person report form

iv. Nursing Office staff

For Code Green:

- Completes MISSING RESIDENT INCIDENT NURSING OFFICE CHECKLIST and NURSING OFFICE AT RISK MISSING RESIDENT REPORT CALL LOG

- Send completed forms to Quality Management via QM Mailbox in Nursing Office:

  1. MISSING RESIDENT INCIDENT NEIGHBORHOOD CHECKLIST from all 13 or 14 neighborhoods

  2. MISSING RESIDENT INCIDENT NURSING OFFICE CHECKLIST

  3. NURSING OFFICE AT RISK MISSING RESIDENT REPORT CALL LOG

v. Nursing Operations:

For Code Green:

- Faxes Resident's photo and "Emergency Notification of Missing Resident" completed by charge nurse to the following:

  1. Local emergency rooms.

  2. SFSO at LHH.

3. Other agencies listed on Table 1 as appropriate.

For Code Green after Code Green incident cleared or within 4 hours of the Code Green activation:

- Nursing operations, Nurse Manager of Neighborhood or designee conducts debriefing with neighborhood staff, SFSO Staff and other appropriate staff to identify what went well and what areas needed improvement.

- When Code Green is activated and any updates thereafter, Nursing Operations shall send an email to:

  Administrator, Assistant Nursing Home Administrators (NHA), Medical Director, Directors of Nursing (DONs), (if acute patient - Chief Nursing Officer), Chief Operations Officer, Chief Quality Officer

4. Resident Elopement While Off Campus

a. If the patient/resident elopement occurs off-campus and a staff member is present, the staff shall:

   i. Initiate a search of the immediate area;

   ii. Inform the nurse manager/charge nurse &/or nursing operations supervisor, who will notify SFSO and others listed above; and

   iii. If feasible, notify the local security service and/or police (call 911)

   iv. complete a UO by the end of the shift

b. If the resident is not found, Nursing Operations shall:

   i. Complete the “Emergency Notification of Missing Resident” form

   ii. Transmit the "Emergency Notification of Missing Resident” form via fax, or other means as appropriate, to the following:

   - local emergency rooms

   - SFSO at LHH

   - Other agencies listed on Table 1 as appropriate

iii. The Nursing Operations Supervisor or designee will notify by email the following people: Administrator, Assistant NHA, Medical Director, DONs, (if acute patient) CNO, COO, CQO.

5. Resident Found Off-Grounds

a. Employees or volunteers shall attempt to return the resident to the Hospital if the resident:

i. Confirms that the patient/resident is lost,

ii. Is unable to respond to questions, appears to be frightened, confused, and/or inappropriately dressed.

b. If the patient/resident is cooperative, the patient/resident may be escorted by foot, and the LHH Nursing office (415-682-1500) shall be called to notify them of the resident's location.

c. If the resident is not cooperative, proceed to call or ask someone to call LHH Nursing office (415-682-1500) and stay with the resident, if possible, while providing sufficient identifying information for locating the resident and returning the resident to LHH.

6. Downtime Procedure

a. Text paging system – if the paging system is down, nursing office staffer shall Fax Code Green Alert Sheet to all neighborhood's indicating resident's neighborhood and full name and do a Communication Tree to alert units of the fax.

b. EHR System – if neighborhoods cannot print resident photo from EHR:

i. Nursing Office Staffer shall fax the received photo to all neighborhoods

ii. SFSO shall obtain a copy of the photo from Nursing Office

7. Reporting

a. The Regulatory Affairs nurse or designee shall notify the State Licensing and Certification office:

i. Within 24 hours of the elopement event if a cognitively impaired resident is not found within 24 hours.

ii. Within 5 days of the elopement event if a resident who has decision making capacity is not located in 5 days.

b. Informational updates about the resident shall be communicated to the RCT, Administration/AOD and Regulatory Affairs

8. Procedure Post-Elopement and Resident Returns to LHH

a. A nurse will perform a physical assessment, document, and report findings to physician.

b. Physician will perform a physical assessment, document if the resident returned from being missing or if resident had change in baseline condition. Any new physician orders will be implemented and communicated appropriately. Physician will make any urgent referrals as needed.

c. Social Services will re-assess the resident and make any referrals for counseling or psychological/psychiatric consults.

~~a.~~d. The resident and family/authorized representative will be included in the plan of care.

e. Education for staff will be provided as appropriate on the reasons for elopement and possible strategies for avoiding such behavior.

f. When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility.

g. Documentation in the medical record will include: findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable.

ATTACHMENT:
Table 1: List of Emergency Room and SFPD Missing Persons Facsimile Numbers
Emergency Notification of Missing Resident
Standard Work: Notifying Central Office of Code Green Occurrences

REFERENCE:
SFSO Checklist
24-18 Resident Locator System

Revised: 16/07/12, 19/07/09, 22/06/14 (Year/Month/Day)
Original adoption: 14/11/25

Table 1: List of Emergency Room Facsimile (Fax) Numbers
Most recently confirmed on: February 28, 2022

All numbers are 24/7 except where specifically noted.

ER Telephone	Hospital	ER Facsimile
353-1037	UCSF	353-1743
668-1000	St. Mary	750-4886
353-6300	St. Francis	931-7357
600-3333	CPMC – Pacific Campus	600-3124
600-0600	CPMC – Davies Campus	436-9159
206-8111	SF General	206-4719
206-8125	SFGH – PES	206-5733
677-2300	Chinese Hospital	677-2443
833-3304	Kaiser Hospital	833-2582

Missing Persons	SF Police	Missing Persons Facsimile
553-0123	Police (0900 1700)	558-5531 / 5522
553-1071	Police (OPS Night Spvr.)	(handled only dayshift)

Telephone	Men's Shelters
749-2110	Central City Hospitality House for Men
861-8688	City TEAM Work Start Shelter
282-6209	Dolores Street Community Services
597-7960	Multi-Service Center: South of Market
487-3300	Next Door

Telephone	Women's Shelters
487-2140	A Woman's Place
597-7960	Multi-Service Center: South of Market
487-3300	Next Door
751-7110	Asian Women's Shelter (battered, address anonymous)
503-0500	La Casa de las Madres (battered, address anonymous)
255-0165	Rosalie House (battered, address anonymous)

Telephone	Other Agencies
355-7445	SF Homeless Outreach Team

EMERGENCY NOTIFICATION OF MISSING RESIDENT

DATE:_____ **TO:_____** **FROM: LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER** **375 Laguna Honda Blvd.** **San Francisco, CA 94116-1411** **RESIDENT'S CARE UNIT:_____** **RESIDENT INFORMATION:** **Last Name _____** **First Name _____** **Nickname _____**	This space is 3 1/4" X 3 1/4" Resident Photograph

Height_____ Weight_____ Hair Color_____ Eye Color _____

Race/Ethnicity _____ Date of Birth _____

Language Spoken

_____

Places frequented in the past (addresses, bars, hotels, etc.)

_____

_____

_____

Description/Clothing (include ribbons/Medi-alert or Laguna Honda ID band)

_____

Identifying Characteristics (include moles, hair style, scars, tattoos, etc.)

_____

_____

_____

Please immediately contact the Nursing Department at Laguna Honda Hospital and Rehabilitation Center, (415) 682-1500 or (415) 759-2300 if our resident enters your facility.

Thank you for assisting us.

Revised Hospital-wide Policies and Procedures

SCREENING AND RESPONSE TO SUICIDAL IDEATION

POLICY:

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

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

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

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

    a. ~~Conducting~~Trained, licensed staff and providers (nurses and social workers) conduct a suicide risk screen using a validated stratified risk screen tool.

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

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

PURPOSE:

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

DEFINITION:

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

C-SSRS: Columbia Suicide Severity Rating Scale, a validated screening instrument to assess risk for suicidality to guide next steps by a clinician

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

Passive suicidal ideation: An individual no longer has the motivation to live but does not have a plan to take their life. Passive suicidal thoughts sound like "I just wish I could go

to sleep and not wake up," or "I wish I could just wander into a fog and just disappear," or "I wish that the world just ended tomorrow."

PROCEDURE:

1. If the resident or patient expresses active or passive suicidal ideation, LHH shall initiate an evidenced-based assessment and interventions based on the level of suicide risk from using the C-SSRS as performed by trained, licensed staff.

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

3. When a resident or patient is relocated to another unit, the MDS Coordinator shall ~~assess resident's mood using~~use the MDS Assessment under section ~~D0200~~D-0200 and/or D-0500 (PHQ-9) to assess the resident's mood within 2 weeks from the time of relocation. If a score of 7 or higher or a YES answer to either Section D0200-I or D0500-I, the MDS Coordinator shall immediately relay the information to the Physician, Social Worker~~,~~ and Licensed Nurse for evaluation.

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

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

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

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

      i. Create a safe and therapeutic environment ~~.~~ ~~such as desired noise level, lighting and visitors.~~

         - Staff shall assess the environment for potentially dangerous items for self-harm ~~.~~that may need to be removed or for which risk may need to be mitigated.

         - Consider ~~AeroScout™.~~Aeroscout (an electronic patient location tag).

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

      iii. Immediately notify the provider for evaluation by call or page (numeric page).

Attending physician or on-call physician evaluates the resident within 2 hours and determines the appropriate next step as described in section 8.

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

v. Notify the Nursing Operations Supervisor within 2 hours.

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

i. Create a safe and therapeutic environment such as desired noise level, lighting and visitors.

~~i.~~ii. ~~Create a safe environment.~~.

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

~~ii.~~iii. Immediately notify the physician for evaluation by call or page (numeric page). Attending physician or on-call physician evaluates and determines the appropriate next step as described in section 8, including the need for and urgency of psychiatry consultation if indicated.

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

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

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

7. IF THE RESDIENT~~/PATIENT~~ DECLINES C-SSRS SCREENING

a. Create a safe and therapeutic environment such as desired noise level, lighting and visitors.

~~a.~~b. ~~Create a safe environment.~~:

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

ii. Consider ~~AeroScout™.~~Aeroscout.

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

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

8. ATTENDING PHYSICIAN OR ON CALL PHYSICIAN EVALUATION

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

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

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

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

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

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

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

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

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

a. The physicians assessing the resident will within the shift review with the

Licensed Nurse the existing care plan and orders to confirm documentation and implementation of any previous or newly recommended interventions, with Psychiatry input (if consult was called).

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

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

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

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

d. The RCT will develop a comprehensive care plan within the next business day (as described in c) to address safety related to suicidal ideation risk.

10. ~~IF PSYCHIATRIC EMERGENCY SERVICE CALLS THE UNIT ABOUT RESIDENT/PATIENT RETURNING TO LHH, REFER TO PHYSICIAN, WHO DECIDES IN COLLABORATION WITH PSYCHIATRY.~~ Returning from Psychiatric Emergency

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

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

c. The attending physician or on-call physician will determine if the resident/patient may return, and if so, will provide the order. (The physician ~~would~~shall only accept the resident for return after ~~the~~ clearance by the psychiatry clinician or on-call psychiatrist~~, and if not excluded by criteria in Policy 20-01 (Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units), Admissibility and Screening Procedures 1(c).~~.

11. IF RESIDENT IS CLEARED TO RETURN TO LHH

a. Maintain a safe environment;

i. Staff shall assess the environment for potential dangerous items for self-harm that may need to be removed or for which risk may need to be mitigated.

- Refer to the Patient Safety and Ligature Identification Checklist.

ii. Consider ~~AeroScout™.~~Aeroscout.

b. Ensure section 9 is completed.

c. Notify the Nursing Operations Supervisor.

d. Inform the RCT members.

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

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

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

12. PSYCHIATRY ~~PROVIDER UPDATES~~COMMUNICATION WITH RCT

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

13. DOCUMENTATION REQUIREMENTS

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

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

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

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

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

LHHPP 22-09 Psychiatric Emergencies
LHHPP 22-12 Clinical/Safety Search Protocol
LHHPP 24-10 Coach Use for Close Observation
LHHPP 24-~~28~~23 Behavioral Health Service Care and Services
NPP C04.0 Notification and Documentation of Change in Resident Status
MSPP (Medical Staff Policies and Procedures) D08-03 Access to LHH Psychiatry Services

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

OFF CAMPUS APPOINTMENTS OR ACTIVITIES

POLICY:

1. Escorts shall be provided with the necessary training and or information for resident safety.

2. Staff, volunteers, peer mentors, resident family members/surrogate decision-makers and their approved friends may escort a resident to an off campus appointment or activity, if deemed appropriate through an assessment by the Resident Care Team (RCT).

PURPOSE:

To provide resident safety and supervision during off campus appointments or activities.

PROCEDURE:

1. Assessment and Documentation

a. The Resident Care Team (RCT); comprising at a minimum, a physician and the licensed nurse; shall determine

   i. if a resident needs to be accompanied by an escort, and

   ii. the escort must be deemed appropriate to accompany the resident.

b. A physician's order shall be written for resident activities.

c. A physician shall be responsible for completing referrals for off-campus medical appointments.

2. Transportation

a. The Transportation Prescription Form shall be completed for any off-site appointments needing transportation. A physician shall review and sign the form and certify that the information is correct. The details of the appointment and patient information on the form shall be completed by a Licensed Nurse or Unit Clerk.

b. The Unit Clerk or designee shall:

   i. fax the Transportation Prescription Form to EVS to arrange transportation with a contracted transportation service.

   ii. write the appointment on the Neighborhood's calendar.

iii. complete the Transportation and Appointment Ticket and attach it to the specially designated envelope for off-site appointments.

c. Nursing and non-nursing staff may escort the resident using a hospital vehicle or contracted transportation service.

d. If the contracted transportation service is unable to fulfill the transportation arrangement, the Nurse Manager or designee may arrange alternative transportation, including use of hospital vehicle or taxi service, to transport the resident to the appointment and or back from the appointment.

e. For patients who are eligible for Veterans Affairs (VA) transportation services, the arrangements are made by the VA. The unit clerk or designee notifies the transportation coordinator at the VA about the resident's dialysis and other medical appointment times and locations. The transportation coordinator at the VA schedules the rides with the VA's contracted vendor. The Unit Clerk or designee and the transportation coordinator at the VA shall communicate changes in the appointment schedule or VA transportation vendor.

f. Use of Taxi Service:

i. Taxi service is used when the contracted transportation is unable to pick up or drop off resident to appointments. When the resident ends up ~~to be~~being admitted to the acute hospital and the escort needs to return to Laguna Honda, the escort should~~hospital~~ use public transportation unless ~~considered~~it results in ~~as~~ over time.

ii. The Nursing Office Supervisor is the designated safe keeper of the taxi voucher, and shall provide oversight of the process, including the reconciliation of the used of vouchers to ensure accurate accounting of the funds used.

iii. Taxi Vouchers are available in the Nursing Office. (A receipt is submitted to Nursing Office whenever a Taxi Voucher is used, including completion of the log to reflect date, amount used and staff who voucher was issued to.)

iv. Vouchers are in triplicate form: the original copy shall be given to the taxi driver; the second copy (yellow) for Finance Department; and the third copy (pink) shall be filed in the Nursing Office.

v. Nursing Office submits the receipt and log to Accounting on a monthly basis for invoice payments to replenish the Taxi Vouchers when the remaining amount number of voucher is less than $5.00.

vi. In the absence of an approved taxi voucher, a staff member may provide personal funds as necessary in the event of a transportation need for patients/residents. The staff member shall be entitled to be reimbursed of all funds used by completing properly the "Employee Expense Authorization and Reimbursement Form", which is being kept in the Nursing Office.

3. Request for Nursing Staff Escort

a. When a nursing staff escort is needed to accompany the resident to an off-site appointment or activity, the nursing staff shall carry out the following steps according to the timeline established below:

i. The Day the Transportation Prescription is signed by the Physician:

- Fax the completed Transportation Prescription form to Nursing Office.
- Write a reminder on the calendar to call nursing office the day before the scheduled appointment to confirm an escort.

ii. The Weekend prior to the appointment:

- In order to assign an escort, Nursing Office Staff will call the neighborhood the weekend prior to the appointment. Once confirmed, they shall assign an escort for the scheduled date.

iii. The Day before the appointment:

- The Neighborhood will call the Nursing Office to confirm the escort requested.

iv. The Day of the appointment:

The Charge Nurse or designee will:

- give hand off report to the escort, and
- provide the escort with the completed Transportation and Appointment Ticket enclosed in a specifically designated envelope for off-site appointment.

The Escort shall:

- obtain hand off report from the Charge Nurse or designee.
- upon return to Laguna Honda:

- hand the Transportation and Appointment Ticket back and give a verbal report to the charge nurse.

- report back to the Nursing Office once resident has been returned to the neighborhood.

4. Medical Record Information Needed for Off Campus Appointment

a. Information shared for off campus appointments shall be the minimum necessary for treatment or billing purposes during the appointment.

b. Whenever possible, the staff at the appointment destination shall access the needed information through an electronic health record.

c. When needed information is not in an electronic health record or the clinic does not have access to the SFDPH electronic health records, the medical record information may be processed through the medical records department or faxed securely to the clinic according to the facility's facsimile transmission process (as described in LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile).

5. Non-staff Escort

a. Family or Surrogate Decision-Makers and Approved Friends as Escorts

i. The RCT designee shall contact and make arrangements for the resident's family or surrogate decision-makers or approved friend to accompany the resident to an off campus appointment or activity.

ii. Resident families or surrogate decision-makers or their approved friend shall be trained by the Charge Nurse or designee.

iii. Resident families or surrogate decision-makers and their approved friends may transport the resident using their personal vehicles or contracted transportation service.

b. Volunteer Escorts (when available)

i. When the RCT determines that a volunteer escort is appropriate to accompany the resident to an off campus activity, the RCT designee shall submit a request to the Volunteer Services Department for a volunteer to escort the resident.

ii. The Volunteer Services Department shall recruit for a volunteer to escort the resident and notify the Charge Nurse or designee.

iii. The Charge Nurse or designee shall introduce the volunteer to the resident and provide pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Volunteers shall escort the resident using contracted transportation service or public transportation.

c. Peer Mentor Escorts (when available)

i. When the RCT determines that a peer mentor is appropriate to accompany the resident to an off campus activity, Social Services shall submit a referral request to the Peer Mentor coordinator.

ii. The Peer Mentor Program Coordinator shall recruit a peer mentor to match with the resident and notify the Social Worker.

iii. The social worker shall introduce the peer mentor to the resident and the peer mentor shall check in with the Charge Nurse or designee prior to outings for any pertinent information related to the activity, and the facility contact number in case of questions or unexpected emergency.

iv. Peer mentors shall escort the resident using contracted transportation service or public transportation.

6. Escorts for discharging resident out of the City and County of San Francisco (CCSF).

a. Generally, transportation for discharging patients within the Bay Area involving a City vehicle will be handled by the Social Services Department. A Nursing staff member may accompany the Social Worker, but it is the responsibility of the Social Worker to reserve and drive a City vehicle to the discharge location.

b. If travel outside of the Bay Area is required, the Nursing office is contacted to solicit a Patient Care Assistant (PCA) to voluntarily escort the resident out of CCSF. Such an escort arrangement would involve transportation via airline or bus. If no PCA staff is willing to escort the resident, plans for the trip as arranged by Laguna Honda will be abandoned.

c. The need for escort shall be based on supervision only. No treatments or other medical intervention shall be administered by the PCA during escort.

d. Travel airline or bus tickets for the resident and the staff person shall be made in advance though City-approved travel agencies.

e. If accommodation is required during the trip, The Accounting Department shall attempt to book lodging for the staff and resident using a P-Card. If attempts to book the lodging are unsuccessful, the staff person shall be asked to pay for the lodging and be reimbursed though the Business Travel Reimbursement process.

   i. Separate accommodations shall be provided for the resident and the staff member.

   ii. Social Services and/or Accounting shall assist the employee in completing forms and other requirements for travel reimbursement. The applicable form is Travel/Training Authorization Form.

f. Staff members shall be paid the applicable premium rates during the duration of the trip. Preapproval is required by the Chief Nursing Officer.

g. Expenses related to employee travel will be charged to the Nursing operating fund. Expenses related to resident travel will be charged to the Gift Fund.

ATTACHMENT:
Attachment A: Transportation and Appointment Ticket

REFERENCE:
LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile
~~LHHPP 21-06 Transporting the Resident's Filed Medical Records on Campus~~
LHHPP 24-10 Coach Use for Close Observation
MR908 Transportation Prescription

Revised: 99/01/12, 12/07/31, 13/05/28, 13/09/24, 15/09/08, 19/03/12, 19/07/09, 20/01/14 (Year/Month/Day)
Original adoption: 96/07/15

FIRE RESPONSE PLAN

POLICY:

The care and safety of our residents is the primary mission of Laguna Honda Hospital and Rehabilitation Center (LHH).

PURPOSE:

The purpose of this policy is to set forth procedures for responding to a fire with the primary objectives of life safety, continuity of operations, and preservation of property.

PROCEDURE:

1. When You See Smoke or Fire

a. Follow the R.A.C.E. acronym below for basic fire response steps:

i. **R**escue persons in immediate danger while announcing "Code Red" to nearby staff.

- If a person is on fire, the best immediate response is to have them stop, drop and roll. However, if someone cannot drop and roll, you may wrap the person in bedding or clothing to smother the fire or use a fire extinguisher if it is safe to do so.

ii. **A**larm by continuing to shout "Code Red" to nearby staff and by activating the alarm using the nearest manual pull station.

- Any person may activate the Fire Plan by pulling a manual pull station. In addition, the fire detection system may be automatically activated via heat sensors and particle (smoke) detectors.

- When the fire alarm goes off due to activation of a smoke detector in a resident's room, the annunciator panel at the nurse's station will display the source of the fire and the light outside the resident's room will flash red. Check the panel at the nurse's station to find the fire quickly.

- When the alarm activates, chimes will ring and strobes will flash in the building.

- Once activated, the fire alarm automatically alerts the San Francisco Fire Department, which will respond immediately.

    - Dial 4-2999. Provide the following information:

- Location of fire
- What is burning
- Your name

Do not hang up until the operator repeats back the information and asks you any clarifying questions they may have.

Report as above even if the fire appears to have been put out. Fire can appear under control and then flare up unexpectedly and therefore must be cleared by the fire department.

Nursing Office shall announce “Attention, Attention. Code Red (location) on the overhead paging system,” and will call 911.

iii. **C**ontain the smoke and/or fire by closing all windows and doors.

- Move residents needing oxygen to a safe area to administer it.
- Licensed staff turns off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.
- Turn off electrical equipment in the area.

iv. **E**xtinguish the fire only when it is safe to do so*. Otherwise Evacuate. Extinguishers are located in corridors and units throughout the facility. Extinguishers are used according to the P.A.S.S. acronym:

- **P**ull the pin
- **A**im at the base of the fire
- **S**queeze the handle
- **S**weep side to side

*ABC Dry Chemical Fire Extinguishers contain monoammonium phosphate and ammonium sulfate. Exposure to these chemicals can cause irritation to the eyes, skin and respiratory pathways. Additionally, inhalation of the chemicals can aggravate existing respiratory conditions such as asthma, emphysema or bronchitis. For more information, refer to the safety data sheet available on the WSEM webpage.

Note: If a fire extinguisher is used, restrict access to the area and notify EVS. EVS shall then clean up the residue following standard procedures listed in Appendix D: EVS Fire Extinguishant Discharge Clean-Up Procedures.

b. If evacuation of residents is necessary, follow the procedures in LHHPP 70-01-B3 Resident Evacuation Plan

2. Fire Response in the Hospital Buildings

a. Resident Safety

When a fire occurs in any of the new hospital buildings (North Residence, South Residence, or Pavilion), the following steps shall be taken to protect resident safety:

i. Move residents needing oxygen to a safe area to administer it.

ii. Turn off wall gases (oxygen, compressed air, suction) at the emergency shut off in the affected household after those using medical gases have been relocated safely.

iii. Turn off electrical equipment in the area.

b. Fire Door Closure

Upon alarm activation, all fire/smoke doors held open by electromagnets will immediately close. Staff shall ensure that automatic doors have closed.

i. Passage through activated fire doors is acceptable after visual check through window and/ or light touch to assure the area is free of smoke, flames, or excessive heat.

ii. Fire alarm activation in the Pavilion Building triggers four automatic accordion fire doors on the Esplanade to close. Any staff member on the Esplanade during accordion door activation is expected to assist residents or visitors who are unsure of what to do. Accordion doors retract if an obstacle is encountered and then re-close automatically. The doors can be opened by pressing a clearly marked green bar after safety on the other side of the door is verified by visual check through the accordion door window.

iii. The Rehabilitation Department (Pavilion ground floor), Art Studio (Pavilion 1st floor, and Pharmacy (Pavilion 2nd floor) have roll down fire screens in addition to fire doors. The roll down doors must be kept clear of obstructions.

c. Stairwell Doors

i. Activation of the fire alarm by a smoke detector will cause delayed egress exit doors in the neighborhoods of the affected building to automatically unlock to allow for evacuation.

ii. The doors will not automatically unlock during a drill or if the fire alarm is activated using a manual pull station; a heat or smoke sensor must also be activated.

iii. Stairwell doors can also be unlocked from the master lock outside of the medication room on each neighborhood.

iv. In case of fire activity in the North Mezzanine secure neighborhood, North 1, 2, 3 and 4 will send one staff member to North Mezzanine to monitor the fire stairwell doors to assure resident safety as follows:

- **N1**: send staff to monitor NM **Cypress** household door
- **N2**: send staff to monitor NM **Redwood** household door
- **N3**: send staff to monitor NM **Cedar** household door
- **N4**: send staff to monitor NM **Juniper** household door

v. Relock each of the stairwell doors after the "all clear" is announced over the public-address system.

d. Elevators

i. Never use elevators during a fire.

ii. Elevators are equipped with fire screens and systems to bring the elevator to the lowest safe floor automatically in case of fire in the building.

If you are in an elevator, exit the elevator once it reaches the lowest safe floor. If the fire screen is down, press the clearly marked button in the center to open the screen.

iii. Elevators will be placed back in service by the Fire Department or the Watch Engineer once “all clear” has been declared.

e. Evacuation of Hazardous Area

i. An evacuation of a unit or department area shall take place if the fire cannot be safely extinguished or if smoke or other damage renders the area unsafe for residents.

ii. Residents shall be moved to a safe area 1-2 fire doors away from the fire on the same floor if possible (horizontal evacuation).

iii. Initiate horizontal evacuation in the following order:

- Ambulatory residents
- Semi-ambulatory residents and those in wheelchairs
- Residents who are more dependent/in bed.

iv. During horizontal evacuation, the Nurse Manager or designee shall:

- Coordinate the movement of residents.
- Perform a check of the unit to verify that all persons have been moved out of the hazardous area.
- Remove medical records from the hazardous area if safe to do so.
- Account for residents, staff, and visitors and take steps to locate anyone missing.

v. When vertical evacuation is necessary for the safety of residents, follow the procedures in LHHPP 70-01 B3 Resident Evacuation Plan.

f. In areas of the hospital where there are no resident care activities, including the production kitchen, pharmacy, and service area of the first floor of the south tower, staff shall evacuate according to their department plans.

g. Post Fire Procedures

i. Ventilate the area to clear any smoke by opening windows or using a fan if needed; do not block any fire doors.

ii. If a fire extinguisher was used, any electrical equipment or wiring that is contaminated must be shut off and immediately cleaned up following procedures listed in Appendix D.,

iii. Call EVS to clean up the discharge residue as soon as possible.

3. Fire Response in the Administration Building

a. When the fire alarm sounds in the administration building, the basic R.A.C.E. procedure shall be followed, but then all occupants in staff work areas must evacuate the building according to the following procedures:

i. When the alarm sounds, building occupants will calmly secure work areas and exit the building via the nearest fire exit. If you are not on ground level, use stairs to reach the nearest exit. Elevators must not be used in a fire.

ii. Once you have exited the building, proceed to the front of the building near the flagpole. If the fire prevents access to this area, the 5th floor parking lot will be the alternate meeting area.

iii. At least three staff members from each of the wings/building areas that are normally occupied are pre-assigned to participate on an Evacuation Team and will keep a red vest and clipboard with a list of staff in their work area.

iv. The Evacuation Team members will put on their red vests, collect their clipboard with attendance sheets, and sweep their assigned areas, knocking on all doors to make sure that all occupants have evacuated.

v. Evacuation Team members will proceed to the meeting area in front of the building where they will take attendance using the lists of staff for each area.

vi. Evacuation Team members will also compile a list of people present at the meeting location whose names are not on the list of building occupants. Attendance sheets will be turned over to the Incident Commander.

vii. If a determination is made by SFFD, SFSD, Engineering, or WSEM that there is no fire in the administration building either because the alarm was triggered in error or only in the Pavilion building, “All Clear” will be announced and occupants may re-enter the building.

viii. If there is an actual fire in the administration building, occupants will not return to the building until the SFFD and/or the Incident Commander declare “All Clear.”

b. If residents are present in Simon Auditorium or the Chapel when the fire alarm sounds in the Administration Building, the following procedures shall be followed:

i. If smoke or fire are detectable in the immediate vicinity of the auditorium or chapel, residents shall evacuate through the exit doors leading to the front of the Administration building.

ii. If additional staff are needed to assist with evacuating residents, Spiritual Care or Activity Therapy staff shall notify the Nursing Office at 4-2999 or the HICS command center at 4-4636 once HICS has been activated.

iii. If there is no fire in the immediate vicinity (i.e. there is no evidence of smoke or fire), residents shall be directed to shelter in place and Spiritual Care or Activity Therapy staff shall distribute ear muffs to residents in order to mitigate their noise exposure until the alarm is silenced. Ear muffs are available in boxes in the chapel.

iv. SFFD may order evacuation of residents at any time.

4. HICS Activation in Response to a Fire

a. Designation of an Incident Commander

i. As soon as possible after alarm activation, the Nursing Office will notify the Executive Administrator or the Administrator on Duty (AOD) of the Code Red.

ii. The AOD and the Nursing Officer will:

- Determine the extent of the fire
- Activate HICS if a fire leads to a disruption in normal operations in any area
- Designate the Incident Commander

b. Incident Commander Responsibilities:

i. Learn from the Nursing Office staff/telecommunications operator the LOCATION and NATURE of the fire. Verify that Nursing Office staff/ telecommunications operator telephoned SFFD to confirm the automated alarm.

ii. Ascertain the following from the Fireground Officer (watch engineer initially, then senior fire fighter once SFFD arrives)

- Immediate danger to residents or staff
- Arrival of SFFD at scene
- Any need to consider additional evacuation
- Resources required

iii. Coordinate the hospital's response to the fire emergency, including activation of other HICS roles as necessary.

iv. Upon receiving clearance from the Fire Department or watch engineer, authorize the announcement of "CODE RED ALL CLEAR (location)" by Nursing Office staff/ telecommunications operator.

v. Authorize initialization of clean up and restoration of the affected area as required. This work should include removal of fire debris and immediate restoration of the rooms (unless arson is suspected, in which case crime scene must be preserved).

vi. Manage the post fire clean-up operation by providing specific direction and resources. Assure the incident is completely documented for required reporting.

vii. Schedule a post-fire debriefing as necessary.

viii. Contact the Nursing Directors and Nurse Managers as needed to arrange for alternate accommodations for residents who may be temporarily displaced due to fire.

ATTACHMENT:
Appendix A: Nursing Operations Procedure
Appendix B: Watch Engineer Procedure
Appendix C: Sheriff's Department Procedure
Appendix D: EVS Clean-up Procedure

REFERENCE:
LHHPP 70-01 B3 Resident Evacuation Plan
Safety Data Sheet Amerex ABC Dry Chemical Fire Extinguisher

Revised: 09/08/24, 11/09/27, 13/05/28, 14/07/29, 14/09/09, 18/03/13, 19/03/12, 19/09/10 (Year/Month/Day)
(Previously numbered as LHHPP 71-02)

Appendix A: Nursing Operations Fire Response Procedures

1. Upon Notification of a Code Red on the Emergency Phone Line:

    a. NOTIFY the fire department of the fire and location by telephone call to 911.

    b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: “Attention, Attention, May I have your Attention Please.” “CODE RED (location)”

    c. Page the Emergency Response Group (Stationary Engineers, SFSD, Emergency Management Coordinator, Nursing Program Directors, Nursing Operations Managers).

    d. If a live fire is discovered, notify the following:

        i. Executive Administrator
        ii. AOD (Administrator on Duty).
        iii. Chief Operation Officer
        iv. Chief Medical Officer
        v. Chief Nursing Officer
        vi. Emergency Management Coordinator

    e. Keep telephone lines open to the incident.

    f. Log all activity relative to the alarm for review by supervisor.

    g. When instructed by senior SFFD firefighter and approved by Incident Commander, announce three times over paging system: “CODE RED (location) IS ALL CLEAR.”

2. Upon alarm activation without a phone call from the affected area:

    a. Expect to receive a call from SFSD regarding the location of the alarm activation. If you do not receive a call, call SFSD at 4-2319 to confirm location of the alarm.

    b. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: “Attention, Attention, May I have your Attention Please.” “CODE RED (location)”

3. Upon Notification of a Code Red Drill:

    a. Initiate an overhead page by dialing #39. After two beeps, dial 00 and ANNOUNCE THREE TIMES: “Attention, Attention, May I have your Attention Please.” “CODE RED DRILL (location)”

b. Page the Emergency Response Group (Stationary Engineers, SFSD, Emergency Management Coordinator, Nursing Program Directors, Nursing Operations Managers).

c. When notified that the drill is all clear by the unit being drilled, or by Engineering staff, announce three times over the paging system: “CODE RED DRILL (location) IS ALL CLEAR.”

Appendix B: Watch Engineer Fire Response Procedures

1. Upon activation of the fire alarm system, the Watch Engineer on duty shall:

    a. Immediately respond to the location of the alarm and become the Fireground Officer if there is an actual fire.

    b. Initial response to fire shall include the following:

        i. Activate nearest fire alarm pull station if not already done.
        ii. Tell others to close doors and windows.
        iii. Tell others to turn off Oxygen cylinders and wall gases.
        iv. Extinguish fire, if small.
        v. Direct firefighting until SFFD arrives.
        vi. If false alarm, locate source detector and possible causes.

    c. If hazardous materials are involved, inform the SFSD to notify 911 responders.

    d. If necessary, go directly to the location of the emergency shut-off breaker of the intake/exhaust fan(s) and shut them off. Immediately return to the fireground.

    e. If HICS has been activated, carry out the Incident Command directives.

    f. Determine whether adjacent areas are at risk and advise Incident Commander. When SFFD arrives, relinquish authority to the senior firefighter and inform Incident Commander of that person's name.

    g. When the SFFD authorizes a "Code red (location) all clear".

        i. Notify the Incident Command Center and Nursing Operations of all clear authorization.
        ii. Reset the alarm system.
        iii. Reset the elevators if not damaged by fire.
        iv. Report completion of re-setting to the Command Center.

    h. Secure fire sprinkler valves, if fire sprinklers activated and once fire is extinguished. All watch engineers are responsible for knowing where shut-off valves are located. Make immediate arrangements to have sprinkler heads replaced and system recharged.

    i. Initiate clean up and restoration of the affected area as required.

Appendix C: San Francisco Sherriff Department Fire Response Procedures

1. Upon fire alarm activation of notification of fire:

    a. SFSD staff shall gather information on the fire alarm panel including what caused the alarm and the location.

    b. SFSD staff shall call the Nursing Office at 4-2999 and provide information gathered and broadcast this information over the radio to all SFSD units.

    c. A Deputy shall respond to the location of the alarm.

    d. Another Deputy shall respond to the Pavilion lobby to stand by to direct or escort responding SFFD personnel.

    e. SFSD supervisor, in conjunction with the LHH AOD or Incident Commander, will determine if any evacuation procedures or other duties are required until the arrival of SFFD.

2. Documentation:

    a. In the event of an actual fire emergency, SFSD deputy will complete an incident report. It will include the name of the SFFD Officer who authorized the Code Red all clear announcement. This report will be completed before the end of the shift. A request for a copy of this report may be made to SFSD Public Information Officer at City Hall by the hospital's Chief Operating Officer and/or Fire Safety Officer.

Appendix D: EVS Fire Extinguisher Discharge Clean-Up Procedures

1. Upon notification of the use of a fire extinguisher requiring clean up, the following steps must be followed immediately:

    a. Ask individuals not associated with clean up to leave the area.

    b. Wear the following personal protective equipment during clean up:
        i. Gloves
        ii. Safety googles
        iii. Disposable boot covers
        iv. Coveralls/Gown
        v. Use of either an N95 or reusable respirator is optional.

    c. Use a HEPA vacuum to collect loose debris fire extinguisher discharge.

    d. For cleaning surfaces with stuck-on residue, prepare a 1:1 mixture of water and baking soda and clean the affected areas using a wet rag if necessary.

    e. If electrical equipment has traces of residue, clean external surfaces using a HEPA vacuum. However, if equipment is severely damaged, discard the equipment appropriately.

    f. All waste generated during the clean-up process shall be disposed in regular trash.

    g. After cleaning, wash your hands thoroughly.

    h. Return the HEPA vacuum to EVS after use.
    Note: This vacuum is solely for cleaning fire extinguisher residue and must not be used for any other purpose.

FIRE SAFETY PROGRAM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall maintain a Fire Safety Program with standards for prevention of fire and for the protection of life and property.

PURPOSE:

To assure that high standards of fire prevention are maintained at LHH and that staff is familiar with LHH fire procedures.

PROCEDURE:

1. LHH shall maintain a current copy of its Emergency Preparedness Plan, which shall include its Fire Plan.

2. The Fire Plan shall be reviewed annually and revised as needed by the LHH Emergency Preparedness Committee.

3. Facility Services will post area evacuation plans throughout the facility.

4. Fire Safety Engineer shall implement parts of the Fire Safety Program through monthly Environment of Care rounds throughout the Hospital.

5. Fire Precautions for All Employees

    a. General precautions:

        i. Each employee must accept personal responsibility to prevent fires.

        ii. Each employee is obligated to report the existence of fire hazards, or the contravention of fire regulations immediately upon occurrence or observation to the Fire Safety Officer or watch engineer.

        iii. Each employee shall be alert to recognize common fire hazards, whether they are direct or indirect hazards. Examples are smoke, accumulated refuse or trash; strange fumes or gases; broken plugs, frayed cords, careless resident smoking; defective electromagnetic doors; defective exit lights; flammables in inappropriate places; use of space heaters, rice cookers, or other unapproved electrical devices.

    b. Fire Response Training:

        i. Department heads are responsible and accountable for annual training of employees in their departments to fire training standards.

ii. Annual and new employee training will be provided under the auspices of the Department of Education and Training.

c. Fire Drills and Exercises

i. Facility Services will conduct fire drills in the hospital buildings during each shift at least quarterly, and will maintain documentation of the evaluation of each drill.

ii. Facility Services will conduct fire drills in the administration building once per shift ~~twice~~ per year and will maintain a record of these drills.

iii. During drills, staff will simulate certain actions they would take, but will not disturb residents nor interrupt essential patient care procedures occurring at the time.

iv. Drills are reviewed by the Performance Improvement and Patient Safety (PIPS) Committee.

ATTACHMENT:
None

REFERENCE:
California Health and Safety Code; Section 12376
California Health and Safety Code, Sections 208(a) and 1276
LHHPP 71-06 Holiday Decorations
LHH Fire Plan, a component of the LHH Emergency Preparedness Plan

Revised: 96/07/15, 00/03/02, 09/08/24, 14/05/27, 18/11/13 (Year/Month/Day)
Original adoption: 92/05/20

Revised Nursing Policies and Procedures

DOCUMENTATION OF CARE – ACUTE UNIT

POLICY:

1. The Laguna Honda Hospital (LHH) Acute Unit are defined as the Acute Medical and Acute Rehab units. The Acute Rehab unit is also known as the Inpatient Rehabilitation Facility (IRF).
2. The responsible Physician, Nurse Manager (NM), Charge Nurse, and the Nursing Director (ND) will be notified of any new admissions.
3. The Registered Nurse (RN) implements and documents the nursing process in the delivery of care to the patient in the electronic health record (EHR): assessments, nursing diagnoses, outcomes and planning, implementation and evaluation.
4. Each nursing role (e.g., RN, Licensed Vocational Nurse [LVN], Patient Care Assistant [PCA], or Home Health Aide [HHA]) will perform and document care delivered that is within the scope of their practice.
5. If no PCA is available, the RN will perform PCA tasks and documentation.
6. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse.
7. Float LVN or RN assigned to the Acute Unit will receive a unit-specific orientation to the environment of care and unit routine from a trained acute staff or Nursing Supervisor prior to providing care. They may perform and document tasks within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g., medication administration, wound dressing changes, etc.). They may not perform Acute specific tasks which require training or competencies, such as blood transfusions. Refer to *Nursing Policy & Procedure Acute-01.0 Nursing Staff Education – Acute Unit.*

PURPOSE:

To outline nursing documentation standards and requirements related to patient in the Acute Units.

PROCEDURE:

A. Principles of Nursing Documentation

1. Documentation of Nursing Care:
    a. is recorded in the medical record and is reflective of the care provided.
    b. will be factual, accurate, complete, sequential, and legible.
    c. is subject to legal review and must be without ambiguity in interpretation (e.g., only use standardized/approved abbreviations)
    d. will contain a date, time, and the author's signature and credentials (legibly written or electronic) for each entry.
    e.
    f. is recorded and signed immediately after the care event or the observation has taken place. When this cannot occur, the author changes the time in the EHR to reflect the time that the action and observation occurred.
    g. will not be recorded in advance of care being provided.
    h. is entered with any changes in condition and is documented with enough detail to ensure continuity of care and level of care.

2. Documentation identifies late entries (when documentation is completed outside the shift performed) with the date and time of the observation and clearly indicates the added documentation is a late entry. The delay reason must also be included. This information is attached to the component of documentation that is being added as a late entry.
3. Incorrect documentation cannot be deleted or erased as the medical record is a legal documentation. Errors in the EHR require a "correction" comment to be entered with pertinent details for the reason for the correction if applicable.
4. Paper Documentation:
   a. will be completed using a blue or black ink pen.
   b. will be crossed out with a single line and reason written next to it for any errors. This correction must be signed or initialed, dated, and timed. White-out is prohibited.
5. Documenting Nursing Care and Assessments
   a. The LHH Acute Unit uses a combination of documentation methods:
      i. Charting by exception for assessment only (e.g., Within Defined Limits [WDL])
      ii. Documenting changes
      iii. Set, periodic documentation
      ~~iv. Documentation specific to the acute admission or come-and-go procedure~~
   b. WDLs can be utilized to document assessments when the definition is available in the EHR for the documenting clinician and the clinician has assessed all elements within the definition.
   c. Fields that do not pertain to the patient's care or condition may be left blank.

B. Nursing Documentation

1. Shift documentation: Document as warranted by patient condition with a minimum of once per shift or as ordered. Documentation includes assessment data, newly identified or changes to nursing diagnosis (care plan problems), interventions implemented, and evaluation of patient's response to interventions.
   a. Head-to-toe assessment is completed at least once per shift, at the beginning of the shift or when first admitted.
   b. Vital Signs are documented at a minimum every shift on Acute Rehab at the beginning of the shift and every 4 hours on Acute Medical.
   c. Pain should also be assessed prior to administering routine pain medication, before and after as needed pain medication, and when clinically indicated. Refer to 25-06 Pain Assessment and Management.
   d. Intake and output will be documented each shift for all patients.
   e. Weights are documented at a minimum weekly on Acute Rehab and daily on Acute Medical.
   f. Complete additional assessments as clinically indicated every shift and as needed (e.g., lines, drains, airways, and wounds [LDA], restraint, coach).
   g. Initiate, revise, continue or resolve care plans and write a care plan note reflecting the patient's progress toward goals at a minimum every shift.
   h. Document a progress note every shift to provide a narrative of any supplemental information including, but not limited to:
      i. shift events
      ii. physician notification
      iii. interventions and evaluation of patient's response to interventions

iv. injuries, falls, or accidents
v. critical labs and abnormal test results (e.g., x-ray)
vi. medication errors
vii. any pertinent, relevant information necessary for continuity of care

i. Patient acuity will be documented before the end of every shift and reported to the nursing office.

2. Additional pertinent information about the patient will also be collected and documented as deemed appropriate by the RN, such as critical lab values and physician communication.
3. Allergies: observe for allergic reactions and adverse drug reactions during the patient's stay. For any new reactions, notify the physician. The physician adds new allergies and/or adverse drug reactions to the EHR allergy section.
4. Weekly assessments are determined by the patient's clinical condition and can include wound and behavior. Refer to K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury, K 2.0 Wound Assessment and Management, and G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning.
5. Psychotropic drugs require a consent and may use consents from a previous encounter (i.e., SNF admission). Monitor behavior every shift. Refer to policy 25-10 Use of Psychotropic Medications and J 2.5 Monitoring Behavior and The Effects of Psychotropic Medications.
6. Document the use of interpreters. Refer to policy 29-05 Interpreter Services and Language Assistance.

C. **PCA or HHA shift documentation**:

1. Vital signs, pain, height and weight, consistent with unit frequency and as needed as directed by the RN.
2. Intake and output, except for nephrostomy output and enteral input/output, which is documented by the RN.
3. Activities of daily living
4. Daily Cares
5. Additional documentation as needed per patient condition or assignment (e.g., coach, restraint, etc.)
6. Notes: document any supplement data not noted in other areas as needed (e.g., nurse notifications, changes in condition, etc.)
7. When no PCA or HHA is available, the RN will perform the tasks and documentation.

D. RN and LVN:

1. LVNs will be assigned to the Acute Unit only when attempts to staff with an RN or PCA has been exhausted. The LVN will never be assigned alone to the Acute Unit or as the Charge Nurse.
2. If an LVN or RN has not been oriented and is assigned to the Acute Unit, they may perform and document tasks within their scope of practice and consistent with tasks they can perform on a SNF unit (e.g, medication administration, wound dressing changes, etc.). They may not perform Acute specific tasks which require training or competencies, such as blood transfusions. Trained acute staff may provide a brief unit orientation to ensure safe practice.

E. Plan of Care

1. **Assessment**: the RN will use a systematic approach to collecting and analyzing data about the patient. RN assessment and data gathered include sources such as physician notes, orders, nursing notes, allied health notes and information obtained from the patient/family.

2. **Diagnosis**: the RN's clinical judgment about the patient's response to actual or potential health conditions or needs, including for discharge.
3. **Outcomes/Planning**: based on the assessment and diagnosis, the RN sets measurable and achievable short- and long-range goals for the patient.
    a. The plan of care will include evidence-based care plans that are the most relevant to the patient/family and their clinical condition.
    b. The anticipated end date for those evidence-based care plans will be appropriate for the patient/family and their clinical scenario.
    c. Care plans are multidisciplinary (i.e., Social Services input in the Discharge planning care plan)
4. **Implementation**: nursing care is implemented according to the care plan.
5. **Evaluation**: the patient's status and effectiveness of the nursing care must be continuously evaluated, and the care plan modified as needed.
    a. Care plans will be resolved when they are no longer applicable to the patient.
    b. The progress to the patient's plan of care should be documented every shift in a care plan note and as needed per the patient's condition and status.

F. Patient/Family Education

Nurses will document patient/family education in the medical record. Documentation will include patient/family response and retention of information provided.

G. Leave of Absence

1. When a patient leaves the hospital for a temporary period of time on a physician's written order, the patient's status is assessed and documented.
2. On return, a focused assessment of status, including the patient's reported adherence to medication or other therapeutic plan will be documented.

H. Admissions

1. Notifications:
    a. Notify the physician and patient care team at the time the patient arrives.
    b. Notify Nursing Operations for off hours admissions.
    c. Notify Admissions & Eligibility when the patient information is incorrect.
    d. Notify Food Services to order the first meal tray after the physician provides the diet order.
    e. For any patients admitted from SNF, request SNF Unit send multi-dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials, bottles, eye drops, fridge items) with the patient to the Acute Unit. Refer to policy Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing.
2. Procedures:
    a. Apply new identification band to wrist.
        i. If resident is allergic or refuses, note on the electronic health record and use alternative method of identification.
        ii. Cut/remove any identification bands that came from LHH SNF or another facility.
        iii. Refer to NPP J 1.0 Medication Administration.
    b. Review allergies.

c. Itemize clothing, property and valuables on the Inventory Property Sheet and obtain patient signature. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
d. Obtain MRSA surveillance specimen within 24 hours of admission per order. Check for results within 72 hours. Document any positive MRSA results, and notifications and education provided to the patient, surrogate decision maker (SDM) or receiving unit or facility. Refer to 72-01 Infection Control Manual C21 MRSA Testing.
e. Admissions to the Acute Unit are new encounters with new a Contact Serial Number (CSN) and orders.

3. Assessment:
   a. Obtain vital signs and pain score. Screen Acute Rehab patients for orthostatic hypotension.
   b. Obtain height and weight. Refer to NPP G 4.0 Measuring Resident's Height and NPP G 7.0 Obtaining, Recording and Evaluating Resident's Weight.
   c. Complete a head-to-toe and admission assessments (e.g., allergies, fall risk).
   d. Complete additional assessments at admission (e.g., fall, smoking, elopement, pain) as well as other assessments or repeat assessments when clinically indicated (e.g., lift sling, restraint).
   e. Examine skin for any lines, drains, airways and wounds (LDA) and document in the EHR. Complete an Unusual Occurrence for any pressure injuries, suspicious bruises or markings. Report any suspect lice or scabies infestation to Nurse Manager, Infection Control Nurse and Physician. For any wounds, complete a wound assessment and schedule weekly wound monitoring in the EHR. Refer to 24-15 Prevention and Management of Pressure Ulcers/Pressure Injuries and K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury.
   f. Initiate care plan within 4 hours of admission.
   g. Inventory belongings.
   h. If the admitting nurse is unable to complete the entire admission assessment, the following shift's nurse is to continue and the complete the remainder of the assessment as endorsed.

~~**I. Come-and-Go Procedures**~~

~~1. Come-and-Go procedures, such as blood transfusions and medication infusions, are not admissions and do not require admission documentation.~~
~~2. Documentation will occur on the Skilled Nursing Facility (SNF) medical record.~~
~~3. Documentation will follow the procedure as outlined in Procedure section B Nursing Documentation, as ordered and as specified in other policies, such as the NPP J 8.0 Blood Product Administration.~~

~~J.~~ I. Discharges

1. Any transfer to an outside acute hospital for emergency services is a discharge.
2. The physician or nurse will inform the patient, family or surrogate decision maker of any acute medical problem and the reason for transfer to the outside acute facility. Notification and time must be documented in the EHR.
3. The physician must complete a discharge order and medication reconciliation, unless the patient is deceased.
4. The nurse will document the resident's condition at the time of discharge, including skin.

5. The nurse will provide transfer documents from the EHR to send with the patient that contain the interfacility transfer records, resident's profile and diagnosis, hospital course, medications, treatments, dietary requirement, allergies, treatment plan, and advance directive documents.
6. Education at discharge
7. The nurse will arrange transportation/ambulance based on medical urgency. For life-threatening situations requiring immediate response of a paramedic team, the nurse may activate a 911 call per physician order.
8. Reconcile and itemize clothing, property and valuables on the Inventory Property Sheet. Indicate discharge disposition of property. Label and secure the remaining property. Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss.
9. Discharge the patient from the unit in the EHR.
10. For Psychiatric Emergency Services discharges, refer to the Psychiatric Emergency Policy.
11. For expirations:
    a. Complete the expiration documentation.
    b. Verify the physician has notified Donor Network West (DNW) organ donation network (1-800-55-DONOR or 1-800-553-6667) within 1 hour of death. The caller will document the date, time and referral number. Refer to C01-03 Organ/Tissue Transplant Donation Program.
12. Notifications:
    a. Nursing operations, food services and social services when a patient is discharged to an outside acute hospital.
    b. For any patients being discharged back to SNF, send multi-dose (bulk) medications (i.e., creams/topicals, patches, inhalers, vials, bottles, eye drops, fridge items) to the SNF unit. Refer to policy Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing.

~~K.~~J. Significant Changes

1. For any significant changes, notify the physician and Nurse Manager or Nurse Supervisor of significant change. The physician or nurse will notify patient, family or surrogate decision maker of the significant change. Document any notification and attempts to notify, with the date, time and individual's name.

~~L.~~K. Acute Rehabilitation (IRF)

1. Interdisciplinary Team Meetings shall occur and be documented weekly, beginning with the date of admission, to discuss the plan of care, provide evidence that the patient is benefiting from the program and that acute rehabilitation continues to be the most appropriate level of care.
2. Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) must be completed for all acute rehabilitation patients.
    a. Complete the assessments required for the IRF-PAI by the 3rd calendar day of the rehabilitation stay for the admissions and on the date of discharge for the discharges.
    b. Complete the admission IRF-PAI by day 4. Complete discharge IRF-PAI by day 4 after discharge.
3. Refer to 27-06 Guidelines for Inpatient Rehabilitation Facility Documentation

CROSS REFERENCES

20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
20-04 Discharge Planning
21-05 Medical Record Documentation
22-05 Handling Resident's Property and Prevention of Theft and Loss
22-07_A02 Physical Restraints - Acute Units
24-15 Prevention and Management of Pressure Ulcers/Pressure Injuries
25-06 Pain Assessment and Management.
25-10 Use of Psychotropic Medications
27-06 Guidelines for Inpatient Rehabilitation Facility Documentation
29-05 Interpreter Services and Language Assistance
72-01 Infection Control Manual C21 MRSA Testing
Acute-01.0 Nursing Staff Education – Acute Unit.
C 1.0 Admission and Readmission Procedure
C 1.3 Discharge to Acute
C 3.0 Documentation of Resident Status/Care by the License Nurse
C 3.2 Documentation of Resident Care by Nurse Assistants
C 4.0 Notification and Documentation of a Change in Resident Status
G 1.0 Vital Signs
G 3.0 Intake and Output
G 6.0 Behavioral Risk Assessment and Guidelines for Care Planning
G 4.0 Measuring Resident's Height
G 7.0 Obtaining, Recording and Evaluating Resident's Weight
J 1.0 Medication Administration
J 2.5 Monitoring Behavior and The Effects of Psychotropic Medications
K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury,
K 2.0 Wound Assessment and Management
Pharmacy 02.01.00b Skilled Nursing Distribution of Medications and Order Processing
Medicine C01-03 Organ/Tissue Transplant Donation Program

REFERENCES

California Code of Regulations, Title 22, Division 5, Chapter 1 – General Acute Care Hospitals. Retrieved from https://www.law.cornell.edu/regulations/california/title-22/division-5/chapter-1 on August 31, 2022

§70749 – Patient Health Record Content
§70753 – Transfer Summary
§70217 – Nursing Service Staff

Nursing Practice Act, Business & Professions Code, Chapter 6, Nursing Section 2725

Standards of Competent Performance, California Code of Regulations, Title 16, Section 1443.5

California Code of Regulations, Title 22, Section 70215

Department of Health and Human Services 42 CFR Part 482-Conditions of Participation for Hospitals,
California Assembly Bill 631, Section 7184
Public Law 99509, Section 9318

NEW: 2023/03/14

Reviewed: 2023/03/14

BATTERY OPERATED LIFT TRANSFER

POLICY:

1. The licensed nurse ~~or designee~~ will assess each resident to be transferred by the EZ Lift to determine the most appropriate material, style and size of sling. The results of their assessment will be entered on electronic health record (EHR).

2. Two nursing staff members are always required for operation of the EZ Lift.

3. Residents will be reassessed for appropriate slings after a change of condition including but not limited to ability to control the head, an amputation, leg sores, significant weight change, difficulty or refusal to follow directions.

4. For residents with aggressive behavior, lacking the ability to follow directions, or whenever otherwise clinically indicated, additional nursing staff will assist with lift transfer (see also #2).

5. Each resident will have his/her own sling(s) which will be identified with his/her name.

6. All nursing staff will receive training and demonstrate competency in the safe use of the equipment prior to transferring a resident at a minimum during new employee orientation and annually thereafter.

7. EZ Lift slings should only be used for the EZ Lift.

PURPOSE:

To provide safe transfers.

PROCEDURE:

A. The licensed nurse or designee will assess each resident prior to the first transfer and reassess as needed to determine the most appropriate sling for the battery operated lift.

1. Resident factors to be considered regarding type of sling:

    a. Resident's weight
    b. Resident's measurements:
        i. Length of Trunk: maximum distance 2 inches from resident's tailbone to base of neck.
        ii. Resident's girth / width of shoulders – resident's body should not overlap the sides of the sling
    c. The resident's ability to support and control his/her head
    d. If the resident has an amputation(s) above the knee or contractures
    e. If the resident has large fleshy thighs or delicate skin or sores on the legs
    f. Difficulty or refusal to follow directions

2. Determining type of sling

    a. Regular
        i. Without padded legs
        ii. Made of canvas or mesh for bathing and quick drying

b. Deluxe (standard)
    i. Have padded legs for comfort and support
    ii. Made of canvas
c. Multi-purpose
    i. Made of canvas with padded legs or mesh
    ii. Use for persons with –
        - Lower body contractures
        - With amputation
        - Large fleshy thighs
        - Delicate skin
    iii. Special Head Support slings are available on special order for residents with weak head control

d. Determining the sling size (Refer to Attachment 1a & b: EZ Way Sling Sizing Chart):

B. Documentation

1. Care Plan

    a. Document the type of transfer technique used.

C. Prior to transfer

1. Check the resident's care plan.

2. Inspect the lift for damage and the sling for fraying or other signs of wear.

3. Identify the resident's sling by name and check style and size using the information in the resident's care plan.

4. Prepare the surface the resident is being transferred to and lock all the wheelchair gurney brakes.

5. Positioning the sling:

    a. Position sling under the resident with the handles facing outward from the resident's skin.
    b. Check that the resident is centered on the sling:
        i. The sling wraps around the shoulders like a shawl.
        ii. Is not more than 3 inches below the coccyx.
        iii. The resident will not be sitting on the sling.
        iv. The resident's body and arms fit and remain in the sling during transfer.
    c. Lift the resident's left thigh; and pull the left wing of the sling under the thigh. Then place it on top of the left thigh. Repeat for the other leg. You may choose to do the right leg first, using the right wing and placing it over the right thigh.

6. Positioning the lift:

    a. Wheel must be unlocked during the transfer.
    b. Position the green nosecone 2 inches above the abdomen.

7. Attaching the Regular and Deluxe Sling to the lift:

a. First attach the two shortest loops at the shoulders. (The other loops are used to move from a reclining position to a reclining position).
b. Take the wing lying on the left thigh and using the middle loop attaches it to the right lift hook. Repeat for the other leg. You may choose to do the right leg first attaching the loop to the left lift hook.

8. Attaching the Multipurpose Sling to the lift:

a. Check that the center of the commode hole is one inch below the tailbone.
b. The wings of the sling are threaded through each other.
c. The middle or longest loop may be used depending upon the resident's comfort and sense of comfort.

9. Moving the resident to the chair:

a. Ensure that the resident's arms are in the sling.
b. Push the "Up button" on the hand control.
c. Once there is tension and the resident is 1 inch off the mattress:
    i. Check that loops are secure in the hooks
    ii. The sling is smooth under the resident
d. Move the lift to the chair and standing behind the chair use the handles to guide the resident.
e. Push the "down" button.

10. Emergency Lowering:

a. If the hand held controls or the controls on the lift fail:
    i. Pull up on the emergency button 1-3 times
    ii. Pull up on the emergency lowering handle until the resident is placed on the desired surface.

REFERENCES:

EZ Lift Operating Instructions [Manufacturers Manual]. (2005). Clarinda, IA: EZ Way, Inc.

Sorrentino, S., Remmert, L.N., (2012). *Mosby's textbook for nursing assistants*, (8th ed), St. Louis,

~~MO: Elsevier~~
MO: Elsevier

CROSS REFERENCES:

Nursing P&P D6 2.0 Transfer Techniques
Nursing P&P D6 4.0 Positioning and Alignment in Bed and Chair

ATTACHMENTS/APPENDICES:

Attachment 1a: EZ Lift Sling Assessment Form
Attachment 1b: EZ Way Sling Sizing Chart
Attachment 2: EZ Lift Operating Instructions

Revised: 2008/01, 2010/04, 2010/06, 2010/08, 2011/02/14; 2014/07/22; 2016/09/23; 2019/09/10; 2023/09/12

Reviewed: 2023/09/12

Approved: 2023/09/12

BLOOD PRODUCT ADMINISTRATION

POLICY:

1. The transfusion of blood products is restricted to Pavilion Mezzanine Acute (PMA).

2. Packed Red blood cells (RBCs) are the only blood component transfused at Laguna Honda Hospital (LHH).

3. Administration sets are changed with each unit.

4. Physician obtains consent prior to blood transfusion. Signed consent forms remain in effect for 12 months from the date and time that they are signed, provided that specific transfusion risks do not change and the patient or surrogate decision maker (SDM) does not later withdraw the consent.

5. ABO/Rh Confirmation: if a 2nd registered nurse (RN) or phlebotomist is unavailable, the same phlebotomist or RN may draw the 2nd specimen at a different time (at least 5 minutes apart).

PURPOSE:

1. To describe the procedure for ordering and receiving of blood products from the Zuckerberg San Francisco General Hospital (ZSFG) Blood Bank/Transfusion Service.

2. To describe the procedure for safe administration of blood products, including pre-transfusion checks, setting-up and starting transfusion, monitoring patients during the procedure, documenting transfusions, and initiating assessment, treatment and laboratory investigation in case of suspected transfusion reactions.

3. This policy supplements the Department of Public Health (DPH) policy 18.05 Blood Product Administration with Laguna Honda Hospital (LHH) specific procedures.

PROCEDURE:

A. Physician Orders/Consent

~~1. If the patient is from the acute unit, the acute physician will enter the orders entirely.~~
~~2. If the patient is from a Skilled Nursing Facility (SNF), either the SNF or acute physician may enter the orders pending handoff discussion.~~
~~3.~~1. ~~Order must be placed to approve administration of SNF medications while in the acute unit for the come-and-go blood transfusion.~~The physician will place blood transfusion orders and obtain consent.

B. ZSFG Blood Bank - Blood Issue and Return

1. The PMA RN will notify the blood bank when the patient is ready for the transfusion by phone.
2. The blood bank will arrange a courier (cab driver) to deliver the blood to PMA, and who must sign the Blood Bank Delivery Receipt for Blood or Blood Products form to document timely delivery.
3. The cooler keeps the temperature safe for administration for 12 hours, or for the duration specified on the cooler. For example, if the blood was placed in the cooler at 8 am, all the blood must be removed from the cooler for administration before 8 pm.
4. PMA RN attaches the delivery receipt and a patient label to a sheet of paper for scanning.
5. If the blood will not be transfused within the time frame due to late delivery, patient refusal or any other reason, notify the ZSFG Blood Bank for potential return of unused/unopened blood return via courier.

~~**C. Resident Preparation**~~

~~1. The SNF neighborhood LN will:~~
~~a. Provide a hand off to the PMA RN prior to sending the patient to PMA.~~
~~b. Verify that the patient has a legible identification band.~~
~~c. Verify that the patient has a valid, signed consent. Send a copy of the consent with the patient to PMA if the consent has not been scanned.~~
~~d. Send the medication cassette with the patient.~~
~~2. In preparation for the transfusion, the PMA RN will complete the following:~~
~~A. Notify the kitchen if the blood transfusion will occur during a meal time.~~
~~B. Perform and document resident physical assessment, including vital signs (temperature, blood pressure, pulse, respiratory rate, and oxygen saturation) and other baseline body system assessments as appropriate (e.g., cardiovascular, respiratory, genitourinary, skin, intake and output)~~
~~C. Administer any pre-medication as ordered.~~

~~D.~~A. Blood Administration

1. Complete required pre-transfusion verification
2. Obtain vitals (e.g., blood pressure, pulse, respiration and temperature):
    a. baseline (within 1 hour) prior to initiating the blood transfusion to serve as a reference point in case of suspected transfusion reaction
    b. 15 minutes after the start of the transfusion
    c. 1 hour after the start of the transfusion
    d. At transfusion completion
    e. 20 minutes post-transfusion
3. The RN will remain at the resident's bedside for the first 15 minutes of the transfusion for each unit to monitor the resident's response and for the signs and symptoms of a transfusion reaction.

~~**E. Post transfusion Observations**~~

~~1. Acute:~~
~~a. The resident shall remain on PMA for 1 hour after transfusion has been completed. The resident may stay longer for resident centered care.~~
~~b. If vital signs are stable, the resident may return to SNF neighborhood.~~
~~c. The PMA RN will provide a hand off report to the SNF LN prior to sending the resident back to the SNF neighborhood.~~

~~2. SNF:~~
~~a. Vital signs on the SNF neighborhood will be performed once per shift for a minimum of 48 hours. Monitoring may be more frequent or extended if indicated.~~

~~F.~~B. Downtime Documentation

Record vital signs and other required information for the blood transfusion (Appendix C) Attach a blood bag unit sticker from each unit transfused to the documentation form. The completed paperwork will be scanned into the patient's medical record per standard unit procedure.

APPENDICES:

Appendix A: Blood Bank Cooler and Unit Tags
Appendix B: A Patient's Guide to Blood Transfusion (English & Spanish)
Appendix C: Downtime paperwork (blood bank requisition, blood transfusion administration record)

Appendix D: Blood Bank Consent

REFERENCES:

Elsevier Clinical Skills: Blood Product Administration: Red Blood Cells and Whole Blood https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco

Department of Public Health Administrative Policies 18.05 Blood Product Administration (2019)

Paul Gann Blood Safety Act, California Health and Safety Code Section 1645

Revised: 2000/08; 2008/09; 2015/02; 2015/10/23; 2016/07; 2020/03/17; 2022/10/11; 2023/08/08

Reviewed: 2023/08/08

Approved: 2023/08/08

ADAPTIVE/ASSISTIVE DEVICES MANAGEMENT POLICY

POLICY:

To ensure that residents are provided with adaptive/assistive devices that facilitates their engagement in activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs) and maintain overall quality of life (QOL).

DEFINITION:

Adaptive/Assistive Device: aids, controls, supplies, or appliances which enable an individual to increase the ability to perform ADLs/IADLs, increase independence in their environment and/or to improve the ability to communicate.

PROCEDURE:

1. Registered Nurse (RN) will assess and communicate with other disciplines regarding the resident's needs for adaptive/assistive devices that include, but are not limited to: call light, wheelchairs, mobility device, adaptive eating device, mobility loop and other related equipment to complete ADL/IADL with increased independence at the following intervals:

    a. Upon admission/readmission, RN will assess whether resident may benefit from an adaptive/assistive device and notify physician for further evaluation, if needed.

    b. Daily rounding to include confirmation of the appropriate placement of adaptive/assistive device as per care plan, and verification that device is working correctly.

    c. During resident reviews (quarterly or as needed), in collaboration with the Resident Care Team (RCT), Resident Care Conference (RCC), and/or interdisciplinary team. The resident's individualized care plan, and the effectiveness of the adaptive/assistive device should be discussed to ensure resident's goals are met. If a functional change is noted in resident's ability to engage in ADLs, it should be considered whether an alternative adaptive/assistive device is indicated, and an assessment should be conducted by appropriate disciplines to ensure the appropriate device is ordered to meet the resident's needs.

    d. As per resident and/or resident's family request. The RCT should collaborate with resident and family to discuss the goals of adaptive/assistive device use to meet resident's functional needs. An assessment should be conducted by appropriate disciplines to ensure the appropriate device is ordered to meet the resident's needs.

e. If a new device, replacement of device, or repair of device is required, follow standard of work to meet resident's needs (see Appendix B).

f. RN will ensure the resident's care plan is updated by end of shift for appropriate interventions when it applies to meeting resident's needs for adaptive/assistive devices, and when the resident has received a physician order for use of an adaptive/assistive device. The care plan and physician order should include details regarding use (e.g., frequency, duration, positioning) as appropriate.

g. For Custom wheelchair repairs RN will perform the following but not limited to:
   - Resident/Surrogate consent.
   - Vendor identified and appointment setup for pick up, replacement/repair/new equipment.
   - Provide resident with alternative setup (e.g., facility wheelchair until custom wheelchair repaired and returned to resident).
   - Keep record of resident's custom wheelchair, accessories, repaired portions, vendor receipts, etc.
   - Coordinate with occupational therapy department if skilled rehabilitation services required to determine the appropriateness of the equipment (current/alternative).
   - Coordinate with Materials Management if assistance required for replacement of equipment/parts, repair of equipment, and new equipment.

2. Physician will address resident's needs for adaptive/assistive devices through:
   a. Collaboration with nursing or other RCT/IDT members at team meetings, and/or

   b. Individualized resident assessment. If the use of adaptive/assistive device is appropriate, the physician will refer the resident to the appropriate disciplines for evaluation and treatment to meet resident's needs.

3. Rehabilitation Services will address the resident's needs for adaptive/assistive devices as follows, but not limited to:

   a. Responding to physician orders as per Rehabilitation P & P 27-02.

   b. Performing quarterly reviews via screen completion.

   c. Requesting physician order for resident evaluation if indicated as per IDT/RCT team meetings.

   d. Communicate new order or replacement of parts order with Materials Management for adaptive/assistive device including but not limited to providing

specificity of the item, expedited need for the item, unit/department the requisition must be submitted to, vendor details, part details, quote, etc.

4. Facilities department will respond to work orders submitted for the resident's adaptive/assistive (facility device only), in a timely fashion. These work order requests may include, but are not limited to:

    a. Adaptive Call light installation

    b. Facility wheelchair replacement/repair (e.g., manual wheelchair, high back recliner chair, broda chair, geri chair, etc.)

    c. Providing transport wheelchair for resident's appointments

    d. Adaptive shower chairs/bathing setup

    e. Custom wheelchair basic repairs (i.e., tightening of screw or inflating the tire) if it does not impact the integrity of the custom wheelchair

5. Biomed department will respond to work orders after physician orders, rehabilitation services evaluation and treatment (only for applicable items), and bed committee approval has been received for the release of adaptive/assistive devices to appropriate unit/department as follows, but are not limited to:

    a. Adaptive beds

    b. Adaptive bed devices/assistive devices (e.g., mobility bar, quarter rail, trapeze for bed/chair setup as applicable)

6. Interdisciplinary Team (IDT): Any resident care team member may submit work order to appropriate discipline to address resident's needs for adaptive/assistive devices that must be met in a timely fashion. Refer to Appendix B.

7. Adaptive/Assistive devices that may be considered a restraint must be reviewed and approved by the bed committee team before the device is assigned to the resident and resident's care plan is updated.

ADAPTIVE/ASSISTIVE DEVICES

1. Examples of adaptive/assistive devices that may be recommended to enhance a resident's ability to participate in ADLs/IADLs in their environment include but are not limited to:

    a. Transfer devices, e.g., sliding board

    b. Mobility devices, e.g., cane, walker

    c. Prosthetic devices

    d. Locomotion devices, e.g., power wheelchair, manual wheelchair, high back recliner wheelchair, custom wheelchair

    e. Speech Language Pathology (SLP) recommended communication devices and software

    f. Adapted writing utensils

    g. Dressing aids (button hooks, zipper pulls, elastic shoelaces, sock aids, dressing sticks, reach extenders/reachers etc.)

    h. Eating aids (adaptive utensils, non-skid bowls, long straws, straw holders, plate guards, etc.)
    Mobility bar or quarter rail for bed setup

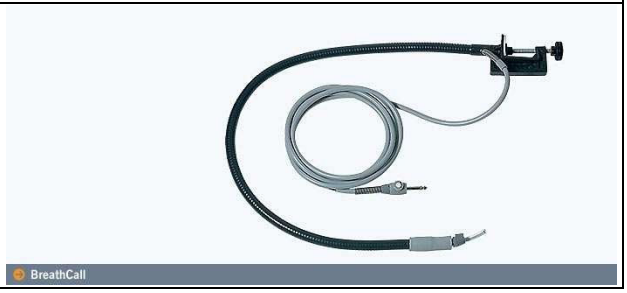
    i. Positioning devices (chair/bed)

    j. Adaptive Call light devices (see Appendix A for details)

APPENDIX A: ADAPTIVE CALL LIGHT DEVICES

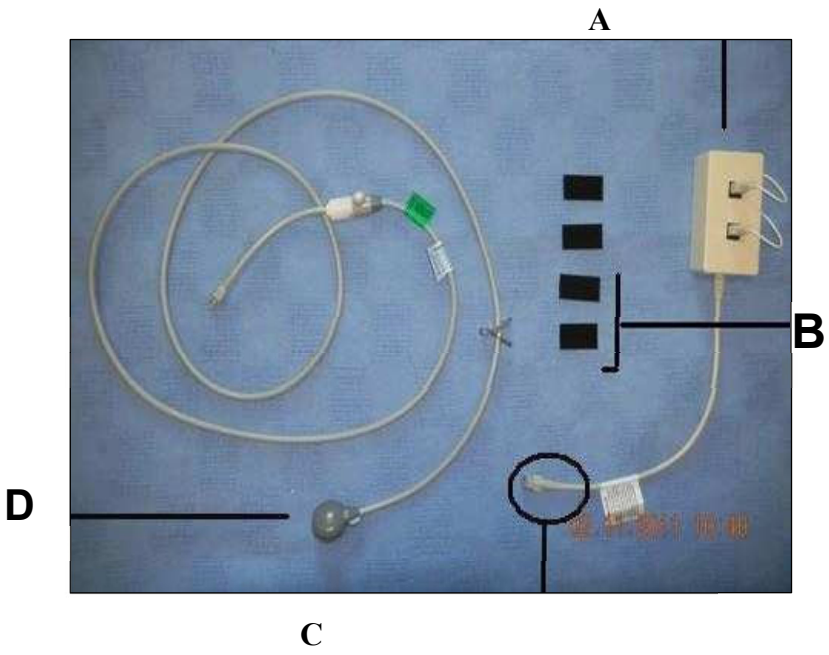
For residents who have limited or loss of hand function, please see the chart below and follow the instructions to match the resident with the appropriate device. For complex resident issues, please contact physician and request a physician order to be sent to rehabilitation services to address resident's needs for adaptive/assistive devices (See examples below: "Type of Adaptive Call Light Devices").

1. TYPES OF ADAPTIVE CALL LIGHT DEVICES

Indications	Name	Adaptive Device
Raise and lower their hand to/from their chest or other hard surface	Mechanical Pad	
Slightly moves fingers	EZ Call	
Has a weak pinch or grasp	Press Call	
No ability to move arms/completely plegic	Breath Call	

2. **NURSE CALL ADAPTOR INSTALLATION AND SET UP:**

a. The following should be present in the kit received.



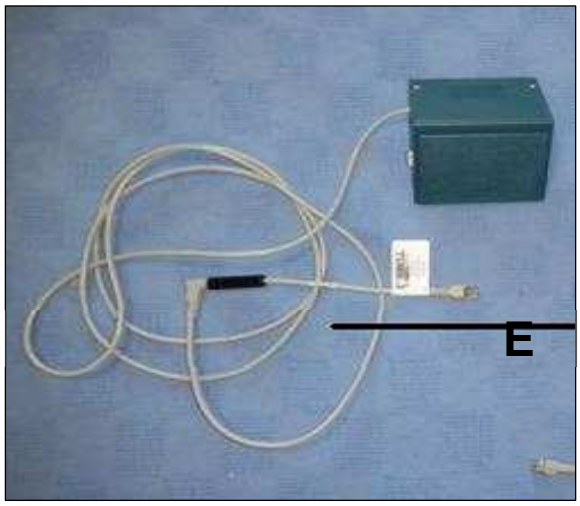
Legend:

A Nurse Call Adaptor

B Velcro Straps

C Receptacle of the Call Adaptor
Note: Pillow speakers and assistive call light devices have also receptacle used to attached to the corresponding sockets

D Assistive Call Light Device - A



Legend:

E Assistive Call Light Device

b. Insert the receptacle of the adaptor to the socket of the nurse call panel.

ARROW POINTING TO THE RECEPTACLE

CIRCLED AREA SHOWS THE SOCKET FROM CONNECTING CORD ATTACHED TO THE NURSE CALL PANEL.

c. Use the black Velcro straps provided to secure the adaptor in the wall.

d. Insert the pillow speaker and the assistive call light device into the socket of the adaptor.

ASSISTIVE CALL LIGHT DEVICE

PILLOW SPEAKER

e. Choose any of the two options for placement of the adaptor.

OPTION A:

ADAPTOR ON TOP OF THE PANEL

OPTION B:

ADAPTOR ON SIDE OF PANEL

APPENDIX B: STANDARD OF WORK

	Major Steps	Details (if applicable)	Owner
1	New/Replacement: Nursing/IDT identifies resident's need for equipment (new or replacement of a part). Engineering Equipment Repair: Nursing/IDT identifies resident's need for equipment repair and submits facilities' work order for a facility-equipment repair. Personal Equipment Repair: Nursing/IDT identifies resident's need for personal equipment repair, and contacts vendor and submits order for resident's personal equipment repair (ensures resident/surrogate provide consent). Follow custom wheelchair policy 70-06.	Rehab and/or IDT ensures all documentation needs are met including collaborating with nursing so care plan and Kardex are updated, and physician order in place for devices (frequency, duration, start/end time), as indicated in electronic health record.	• Nursing/IDT • Engineering • Rehab
2	Physician order sent to rehab to address resident's equipment needs; rehab responds within 24-48 hours as per policy P&P 27-02	Rehab ensures resident's functional needs are met and/or maintained, while the resident is awaiting the arrival of the item.	• Physician • Rehab
3	Engineering addresses work order for repair in a timely fashion. This applies to LHH owned equipment only.	Engineering reaches out to nursing/IDT immediately if unable to repair.	• Engineering
4	Rehab evaluates the resident and provides recommendation for equipment specificity to Materials Management and Restraint committee/Bed committee. **	**If the equipment is considered a restraint (e.g., broda chair, mobility bar, quarter rail, leg strap, geri chair), this must be approved by Restraint committee/Bed committee prior to Materials Management and/or Biomed contacting the vendor to initiate the ordering process as per item list (see below). Biomed items list: Mobility bar, quarter rail, bed, mattress, trapeze. Materials Management: All other items	• Rehab • Material Management • Biomed & Bed committee**
5	Materials Management reaches out to the vendor, receives a quote.		• Material Management

	Major Steps	Details (if applicable)	Owner
6	Materials Management sends quote to Rehab for final approval of specifications and ensure accuracy of item being ordered. . Once quote is approved Rehab will inform MM of the appropriate business owner (department). MM will advise the department to enter a requisition in Peoplesoft.	Rehab to advise MM if the item is to remain in Rehab, going to a specific unit/neighborhood for the resident, or if it is "facility" equipment that is maintained by Facilities. This information will determine the department entering a requisition.	• Material Management • Rehab
7	Materials Management issues the Purchase Order and submits a CC copy to Rehab, as well as Engineering, the department responsible for inventorying, tagging, storage, and maintaining/repairing the item		• Material Management • Rehab • Engineering
8	Material Management contacts Engineering once the items arrives for it to be tagged and inventoried, with a CC to rehab, once item arrives.	MM places Facilities work order to inventory the LHH owned equipment.	• Material Management
9	Item is delivered to Rehab and/or appropriate unit/department, after it is inventoried, or Rehab retrieves the item from Materials Management, based on the most efficient delivery method MM places Facilities work order to inventory the LHH owned equipment.		• Nursing • Rehab • Engineering • Biomed • Material Management
1	Rehab applies the item to the resident and ensures it meets resident needs. Nursing applies the item to the resident, as applicable. Engineering stores a LHH facility item. Biomed stores items (assigned to biomed department)		• Rehab • Nursing • Engineering • Biomed

REFERENCE:

Curbell Electronics, Inc. www.curbellelectronics.com
Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) Manual System. 100-07 State Operations Provider Certification.
DHS. The ODDS Guide to Assistive Devices and Assistive Technology. Retrieved on August 11, 2023 from http://www.dhs.state.or.us/spd/tools/dd/cm/Assistive%20Devices%20and%20Technology%20Worker%20Guide.pdf

https://udservices.org/adaptive-devices-people-disabilities/

CROSS-REFERENCES:
NPP D1 2.1 Nurse and Resident Call System
LHDP Occupational Therapy P&P 50-02 OT Service Equipment and Supplies
LHH D6 5.0, Ambulation
LHH 70-09 Occupational Therapy Service Equipment and Supplies

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