List of Hospital-wide/Departmental Policies and Procedures to JCC for Approval on April 9, 2024

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Notes
New Hospital-wide Policies and Procedures				
New	_LHHPP	24-17	Comfort Care	End of life care policy
Revised Hospital-wide Policies and Procedures				

Revised	_LHHPP	20-11	LHH Response to ZSFG Surge Condition	1. Replaced "hosptial" with "facility" 2. Reworded ZSFG's Definition section for "Condition Yellow" and "Condition Red" 3. Replaced Chief Nursing Officer (CNO)" with "Directors of Nursing (DON) 4. Added "information and" 5. Added "LHH Chief Quality Officer – coordination with Quality Management to ensure the facility is in compliance with all state and federal requirements. The Chief Quality Officer will manage any required notification to the California Department of Public Health." 6. Added "Review of movement should be done with the Chief Quality Officer or designee." 7. Replaced "Quality Management Director" with "Chief Quality Officer (CQO)" or CQO through out the document 8. Replaced "Chief Operating Officer" with "Assistant Nursing Home Administrator, Support Services" 9. Added "Chief Quality Officer – shall coordinate with the California Department of Public Health (CDPH) to inform of the urgent need for the facility to support a surge at ZSFG." 10. Replaced "Director of Quality Management" with "Nurse Manager, Department of Care Coordination" 11. Replaced "could be discharged immediately in addition to" with "are" 12. Deleted "arrangements" 13. Added "or high-risk medications requiring coordination with nursing and medicine leadership to ensure safe administration" 14. Replaced "Patient Flow Coordinator/Operations Nurse Manager" with "Department of Care Coordination and Nursing Operations" 15. Replaced "Patient Flow Coordinator/ Operations Nurse Manager" with "Department of Care Coordination" 16. Combined "Post Response Debrief" section with "Performance Improvement" section 17. Added "Once gaps and areas for improvement are identified, the Plans Chief is to draft and After Action Report within 180 days of demobilization, that should then be presented to LHH's Quality Council."
Revised	_LHHPP	21-04	HIPAA Compliance	1. Replaced "both" with "all" 2. Deleted "(Appendix A)" 3. Added "beyond what is consented to in the Conditions of Admission," 4. Replaced "the written authorization of the individual" with "additional written authorization by the individual" 5. Added "authorized" and "accounts" 6. Deleted "(form MR802) 7. Replaced "terminated" with "suspended" 8. Added "Physical", "certain" and "may" 9. Deleted "Appendix A: Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms" 10 Deleted Appendix A

Revised	_LHHPP	22-04	Resident Sexual Rights and Responsibilities	1. Minor spelling and punctuation change.
Revised	_LHHPP	24-13	Falls	1. Major revisons and deletion made throughout the entire document. 2. Expanded the "Policy" section to include the goal of the LHH Falls Program and metrics that will be collected and utilized by PI, QI and for the Falls Committee. 3. Converted the "Purpose" list to the following paragraph: "To describe the process for identifying residents at risk for falling, utilize evidence-based multidisciplinary individualized fall prevention strategies, and to describe the response process to falls." 4. Deleted definitions for Environment, Hazards and Supervision" 5. Added "Fall-Risk Screening" section and refernced the standard work in Appendix A. 6. Added "2. Individualized Care Planning Based on Fall-Risk: See Standard Work (Appendix A) and Appendix D (Common Fall Risk Factors and Interventions)" section. 7. Changed the "After a fall" section to "3. Visual Management Aids to Communicate Residents at High-Risk for Falls: See Standard Work (Appendix A) a. Staff will utilize visual management tools to communicate residents who are a high-fall risk and re-revaluate and regular intervals based on any change in resident's functional status." 8. Added "4. On-going Assessment/Reassessment of Fall Risk and Fall Prevention Interventions:" section. 9. Added "5. Immediate Post Fall Response: See Standard Work (Appendix B)" section 10. Simplified the "Post Fall Notification" section and added reference to Standard Work (Appendix B) 11. Changed Appendixies A, B and C to Standard Work 12. Added Appendixies D, E, F and G 13. Updated references
Revised	_LHHPP	24-14	Opioid Overdose Prevention	1. Added "Pharmacy policy 01.01.00 General Services)" 2. Added "60-04 Unusual Occurrence" 3. Minor relabeling of refernces 4. Added "FILE NO. 210304 ORDINANCE NO. 084-21" in attachment A
Revision	_LHHPP	24-18	Resident Locator System	1. Clinical informatics department conducts weekly battery checks and replaces batteries of AeroScout® devices.
Revised	_LHHPP	24-28	Behavioral Health	1. Replaced "Substance Treatment and Recovery Services" with "STARS" 2. Deleted "of Services" 3. Replaced "Therapeutic Activity Programming policies" with "Activity Therapy A02-0 Scope of Services"
Revised	_LHHPP	29-01	Provision for Acute Care Services Not Available at Laguna Honda Hospital	1. Replaced "Laguna Honda" with "LHH" 2. Added "CDPH"

Revised	_LHHPP	29-02	Resident As Photography or Interview	1. Deleted "routinely" 2. Added "clinical puposes" 3. Replaced "form MR802" with "DPH form C.14" 4. Added " resident" 5. Replaced "http://10.80.12.69/dph/files/HIPAAdocs/PrivacyPolicies/HIPAAPrivacy-AuthorizationPol02242010.pdf" with "https://www.sf.gov/sites/default/files/2023-05/C.1.0_DPH_Use_and_Disc_of_PHI_FINAL_06.08.22.pdf"
Revised	_LHHPP	29-08	Proposed Non-Emergent Medical Intervention that Requires Informed Consent for	1. Updated format 2. Deleted "local ombudsman" 3. Added "Office of Long Term Care Patient Representative (OLTCPR)"
Revised	_LHHPP	35-04	Inventory and Disposal of Hospital Property	1. Added "the" and "Department" 2. Replaced "warehouse.sfenvironment.org" with "https://www.sfenvironment.org/virtualwarehouse"
Revised	_LHHPP	50-11	Procurement Card	1. Added "The food will adhere to the DPH Healthy Food and Food Expenditure Policy." 2. Deleted "more Netflix accounts" 3. Added "no more than 4 Netflix accounts"
Revised	_LHHPP	65-02	Monitoring of Third Party Agreements and Appendix	1. Replaced "January" with "July" 2. Replaced "calendar" with "fiscal"

Revised	_LHHPP	70-01 C11	Laguna Honda Hospital MDF/IDF Support - Facilities	1. Replaced "MDF/IDF" with "MAIN/INTERMEDIATE DISTRIBUTION FRAME" 2. Spelled out MDF, BDF, and IDF since it was the first instance of use. 3. Replaced "Desk" with "Engineer" 4. Added "(24/7) 5. Added "/Nursing Operations (4-2999) " to AOD 6. Deleted "Courtesy pages are sent to key DPH IT staff and the DPH IT Service Desk by the monitoring system if a problem occurs with a facilities system. The Service Desk staff keeps a pager (415-327-1729) where these alarms are sent. If the Service Desk receives a page and is not contacted within 15 minutes by LHH the Service Desk staff must call 415-370-8259 to ensure the Watch Desk is aware of the potential issue." 7. Moved up to section 1 "The Watch EngineerDesk will contact Service Desk (ext. 6-7378) when key indicators are present:" 8. Moved up to section 1 "Temperature in the MDF reaches 80 degrees." 9. Moved up to section 1 "Temperature in the BDF/IDFs reaches 90 degrees" 10. Added "Service Desk will inform the various IT OPS team with hardware residing in the affected area via email for awareness." 11. Added "Once Service Desk receivesd an all clear from the Watch Desk, Service Desk will send out a follow up email to the potentially impacted teams so the teams can check on their hardware" 12. Added "If Service Desk was informed of any possible hardware damage, Service Desk will open a ServiceNow incident and call the On Call staff for the impacted team(s)" 13. Moved the glossary to the begining of Appendix 1 14. Updated the "Contact List" in Appendix 1
Revised	_LHHPP	80-03	Student Volunteer and Consultant Orientation	1. Added "or complete" 2. Added "training" 3. Added "Responsible departmental manager/coordinator is responbleresponsible for providing DET with annual compliance documents for students, volunteers, and consultants for inclusion in education records." 4. Added "Responsible departmental manager/coordinator is responsible for providing DET with name and dates of new students, consultants, registry/travelers, and volunteers for on-boarding and off-boarding for education record keeping."
Revised	_LHHPP	80-05	Staff Education Program	1. Replaced "approval" with "review" 2. Removed "Visioning and Strategic Planning for Learning in the New Laguna Honda" with "None"
Deleted Hospital-wide Policies and Procedures				
Deletion	_LHHPP	24-16	Code Blue Appendix 13	Request to delete
Revised Clinical Nutrition Policies and Procedures				

Revision	Clinical Nutrition	none	Diet Manual LHH 2023	1. added the "diet at a glance" reference that summarizes all of the approved diets. 2. Explanation regarding diet liberalization for holiday meals added to introduction on pg. 4 3. Diet at a glance added on pg. 5 4. Added "approximate composition" and "suggested meal pattern" sections to clear liquid diet on pg. 18 5. Corrected "suggested meal pattern" for full liquid diet on pg. 19 6. Macronutrients for consistent carbohydrate diets changed from % to grams on pg. 26 7. Clarified distinction between vegetarian and vegan diet on pg. 42
Revised Nursing Policies and Procedures				
Revision	NPP	C 3.0	Documentation of Resident Status/Care by the Licensed Nurse - SNF	1. Added "Antimicrobials prescribed for prophylaxis, including ointments for ongoing skin conditions should be monitored and documented on once per shift for 72 hours and then as needed."
Revision	NPP	K 4.0	Applications: Heat or Cold Therapy	1. Reference Elsevier for procedure 2. Removed Therapy Aides from being able to apply heat/cold therapy
Revision	NPP	L 1.0	Emergency Intervention for Choking	1. Included PCA for staff to be BLS certified 2. Revised to refer to Elsevier for procedure 3. Revised policies to align with Code Blue 24-16 4. Updated reference list & removed attachment
Deleted Nursing Policies and Procedures				
Deletion	NPP	H 2.0	Collection of Stool Specimens	1. For deletion – reference Elsevier
Deletion	NPP	H 3.0	Sputum Specimens	1. For deletion – reference Elsevier
Deletion	NPP	H 4.0	Gastric Specimens	1. For deletion – reference Elsevier
Deletion	NPP	I 7.0	Incentive Spirometry	1. For deletion – reference Elsevier 2. Or we can keep this policy, reference Elsevier for procedure but keep policy for ordering procedure. Incentive spirometry is also in Respiratory P&P A3 but has not been updated since 2006.
Deletion	NPP	M 1.0 and Attachment 1	Orthostatic Hypotension Protocol	1. For deletion – reference Elsevier
Deletion	NPP	M 11.0	Blanket Warmer Protocol	1. Remove and refer to HWPP 31-01 Blanket Warmer Protocol
Deletion	NPP	M 15.0	Installation and Checking of Portable Bed Exit Alarm	1. Delete – No longer using bed alarms
Revised Pharmacy Policies and Procedures				

Revision	Pharmacy	11. USP 797	Sterile compounding policy and attachments	COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg. 14 Page 2-3 Updated definitions PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg. 30-33 Page 4 • Replaced should with shall. •Updated Risk based to category-based terms PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg. 24 •Added "designated person" per USP 797 update requirement. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg. 3 •Fixed spelling error Page 5 Updated the pressure differential requirements for positive pressure room. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg. 11 Page 7 Updated cleanroom temp requirement and relative humidity monitoring. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.8 Page 8 • Referral to attachment 3. 3.c •Updated the volume of air to 1000L per new requirement D.ii. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.14 •Added word "Sterile" 1. b Page 14 Beyond use date for single vial change to 12 hours per USP 797 PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.26 Page 15 •Modified annually to every 6 months. Section 1. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg. 3 •G.i.ii change to exceed the action level. •G.i.v update the temp range for Gloved fingertip samples incubation time PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.4 Page 16 • I.V update media fill testing new temp range requirement. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.5 •VI description of the visual observation PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.4 •Added Surface sampling temp range requirement description, and the action CFU limit. PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.15 •Removed hazardous compounding assessment, this policy is not for hazardous compounding. Page 17 • 4. Added Separate instances. USP 797 Q&A •Added the designated person responsibilities per USP 797 updates and CA BOP meeting points PHARMACEUTICAL COMPOUNDING—STERILE PREPARATIONS. USP, 2022 pg.5

New Hospital-wide Policies and Procedures

COMFORT CARE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing the needed care and services to residents towards the end of life in accordance with their preferences and goals, and the professional standards of practice to promote their highest practicable physical, mental, and psychosocial well-being.

DEFINITIONS:

1. **"Comfort care"** is defined by the National Institutes of Health as: Care given to people who are near the end of life and have stopped treatment to cure or control their disease. Comfort care includes physical, emotional, social, and spiritual support for patients and their families. The goal of comfort care is to control pain and other symptoms so the patient can be as comfortable as possible. Comfort care may include palliative care, supportive care, and hospice care. Also called end-of-life care[i].

2. **"Palliative care**" is specialized medical care for a resident who is living with a serious illness (e.g., heart failure, COPD, dementia, cancer). Care can include curative treatment but focuses on care that optimizes quality of life by anticipating, preventing, and treating suffering in patients who have serious or life-threatening disease. Physical, psychosocial, spiritual, and emotional suffering are assessed and addressed in this process.

3. **"Terminally ill"** also referred to as end-stage-disease is a when an illness/disease cannot be cured or adequately treated and is expected to result in death of the resident. Specifically, for Medicare beneficiaries, terminally ill refers to a medical prognosis that the resident's life expectancy is 6 months or less if the illness runs its normal course (and is used when determining if a person is eligible for their hospice benefit).[1]

4. **"Hospice care"** means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient/resident and/or family member(s). Only patients with less than 6 months of expected life span.

PROCEDURE:

LHH utilizes a systematic approach for recognition, assessment, treatment, and monitoring of end-of-life care.

[1] Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, (Rev. 12385, Issued: 11-30-23)

1. Recognition:

a. Residents will be evaluated for end-of-life care concerns upon admission, during scheduled assessments, and upon change of condition or status.

b. The physician will document the resident's prognosis of a life expectancy of less than 6 months, or a terminal illness.

c. The Resident Care Team (RCT), in collaboration with the resident's primary care physician, will inform and educate the resident and or the resident's family about decisions for comfort care.

d. Preferences for palliative care, hospice care, and advance directives will be identified and documented in the electronic health record (EHR). This includes preferences regarding treatment including pain management and symptom control, treatment of acute illness, and choices regarding hospitalization.

2. Assessment:

a. The RCT will complete a comprehensive assessment to provide direction for the development of the resident's care plan to address choices and preferences of the resident.

b. Assessment and evaluation may be documented by multiple members of the RCT (e.g., nurses, physician, social worker, dietitian, etc.).

c. The assessment will include areas of concern, such as:

i. Spiritual needs

ii. Environmental preferences

iii. Nutrition and hydration concerns

iv. Oral health status

v. Bowel and bladder concerns

vi. Symptom management

vii. Level of activities desired and psychosocial needs

viii. Functional/ADL status

ix. Medications

x. Skin integrity/ Wound Care Management

3. Treatment:

a. End of life and palliative care preferences expressed by the resident or, if resident lacks capacity to make or express preferences, the resident's surrogate decision maker (SDM) will be honored as possible by LHH.

b. LHH will update and coordinate care plan with the resident and or surrogate decision maker. The interventions will be implemented in accordance with the comprehensive assessment, and the resident's needs, goals, and preferences.

c. The care plan will identify the care and services that each discipline will provide.

d. If the resident chooses hospice services, the procedures as outlined in LHHPP 20-02 Hospice Care Assessment and Transfer/Discharge Process will be followed.

e. Factors influencing the choice of treatments may include:

i. The resident's underlying diagnoses and conditions

ii. The causes, location, nature and severity of the diagnosis or conditions

iii. The resident's preferences expressed either directly or in an advance directive

iv. Possible adverse effects

v. Pain management

vi. Other symptoms such as shortness of breath, uncontrolled nausea, constipation, or vomiting

vii. Psychosocial and emotional needs of the resident and/or representative

viii. Spiritual needs

ix. LHH rules and regulations

f. LHH will provide an environment which strives to support and enhance the resident's well-being and quality of life. Interventions to promote a comforting environment include, but are not limited to:

i. Adjusting room temperature and lighting

ii. Smoothing linens

iii. Turning and repositioning to a comfortable position

iv. Loosening any constrictive bandage or device

v. Splinting where appropriate

vi. Physical modalities

vii. Exercises to address stiffness

viii. Cognitive/behavioral interventions such as music or diversions

ix. Visits with loved ones

x. Spiritual Services

4. Monitoring:

a. Medical conditions will be monitored and managed according to resident/SDM goals of care and preferences, as possible.

b. The primary care physician will assume responsibility for the overall care and treatment of the resident's medical conditions. LHH will provide opportunities for the primary care physician to consult with a palliative care specialist as needed.

c. Care will be supervised to ensure that interventions are implemented as written.

d. The RCT will monitor and evaluate the resident's response to the established care plan.

e. Resident or, if resident lacks capacity, the SDM may revoke or modify goals of care. Assessment(s), treatment(s), and monitoring steps delineated above will be applied to any changes.

ATTACHMENT:
None.

REFERENCE:
20-02 Hospice Care Assessment and Transfer/Discharge Process
Centers for Medicare & Medicaid Services. *State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities* (February 2023). F684: Quality of Care.

Original adoption: 24/03/12 (Year/Month/Day)

[i] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/comfort-care

Revised Hospital-wide Policies and Procedures

LAGUNA HONDA HOSPITAL'S RESPONSE TO ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER (ZSFG) SURGE CONDITION

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing quality and timely care and services that are consistent with community and professional standards, and to admit residents that can be safely cared for at the facility~~hospital~~.

PURPOSE:

To serve as a guide for rapid, effective, and coordinated emergency response to ZSFG's condition yellow and red alerts.

To identify essential communication and coordination to ensure resident safety.

ZSFG's DEFINITION:

~~"Condition Yellow" – activated by ZSFG when ten (10) or more patients are waiting for beds.~~

~~"Condition Red" – activated by ZSFG when only one bed is available in Critical Care with no pending transfers, Post Anesthesia Care Unit (PACU) is at capacity, and more than ten (10) or more patients are waiting for beds at ZSFG.~~

Hospital status "Condition Yellow" is instituted when ten (10) or more patients are waiting for an admission bed.

Hospital status "Condition Red" is instituted when only one bed is available in Critical Care with no pending transfers, the Post Anesthesia Care Unit (PACU) is at capacity (The PACU's capacity is relative to the number and acuity of patients at a specific time.), and more than ten (10) patients are waiting for beds; OR the AOD/HS determines that SFGH has marginal capacity to accept incoming patients.

PROCEDURE:

1. Notification:

a. ZSFG's Chief Executive Officer (CEO) or designee shall notify LHH's CEO or designee when conditions exist that require expeditious transfer of patients from ZSFG to LHH.

b. LHH CEO or designee shall confer with Executive leaders and activate LHH ~~Hospital~~ Nursing Home Incident Command System (NHICS) if appropriate.

2. LHH Internal Communication and Planning

a. Communication – the designated Incident Commander or designee will contact the following:

i. LHH ~~Chief Nursing Officer~~ Directors of Nursing (~~CNO~~DON) or designee~~—~~ to ascertain/provide current bed vacancies and bed hold situation.

ii. LHH Patient Flow Coordinator – to provide the current list of ZSFG accepted patients/referrals, and to appropriately identify priority of patients to be admitted as well as anticipate/plan for their care needs.

iii. LHH Chief Medical Officer/Medical Director or designee – to confer with the Patient Flow Coordinator the appropriate neighborhood assignment and coordinate with Chief of Medicine or designee to plan for the admitting physician assignment.

iv. LHH Patient Flow Coordinator – Once patients are identified and assigned to neighborhoods, Patient Flow Coordinator is responsible for sending a notification to each Resident Care Team (RCT) to inform them of planned admission, including patient's profile. The Coordinator shall obtain from ZFGH the most current medical information and send referral packet(s) to the neighborhood Nurse Manager or designee.

~~iv.~~v. LHH Chief Quality Officer – coordination with Quality Management to ensure the facility is in compliance with all state and federal requirements. The Chief Quality Officer will manage any required notification to the California Department of Public Health.

b. Planning

i. Bed Allocation

- Current Bed Holds may be moved to North Mezzanine vacant beds, if available, to accommodate incoming admissions. Review of movement should be done with the Chief Quality Officer or designee.

- Three (3) General SNF Isolation Rooms shall be kept available for the clinical needs of in-house residents during the flu season.

- Three (3) acute care beds (one medical acute, one acute isolation, and one acute rehab) shall be kept available for the clinical needs of in-house residents and a community acute rehab patient.

- If acute care bed(s) will be used for SNF level of care admission, the ~~Quality Management Director~~Chief Quality Officer (CQO) or designee shall notify the ~~San Francisco~~ California Department of Public Health ~~Licensing~~ (CDPH) office and obtain approval prior to occupancy.

- A minimum of 3 follow-up calls to CDPH may be necessary to obtain approval for placing SNF level of care residents on the acute care unit.

- Subsequent approval from CDPH is required every 72 hours when a SNF level of care resident remains on the acute care unit past 3 days. The ~~Quality Management Director~~ CQO or designee shall contact CDPH to obtain subsequent approvals every 72 hours as necessary.

- Priority shall be given to transferring SNF level of care residents who are placed on the acute care unit to relocate to the SNF unit.

ii. LHH CEO or designee – shall activate the NHICS if appropriate *see LHH HW 70-03 Emergency Response Plan.*

iii. Nurse Managers and Directors – shall coordinate with the CNO and Patient Flow Coordinator in carrying out any bed relocation(s) needed, preparing for staffing to implement admissions, and prepare any needed special supplies/equipment, and/or staff education.

iv. LHH ~~Chief Operating Officer~~Assistant Nursing Home Administrator, Support Services – shall coordinate with EVS Supervisor terminal cleaning of any resident rooms; Facilities and or Materials Management for any special supplies/equipment needed.

v. Chief Quality Officer – shall coordinate with the California Department of Public Health (CDPH) to inform of the urgent need for the facility to support a surge at ZSFG.

~~v.~~vi. ~~Director of Quality Management~~Nurse Manager, Department of Care Coordination – shall coordinate completion of Utilization Management reviews of residents to be admitted.

~~vi.~~vii. Director of Admissions and Eligibility – shall plan to register identified resident(s) for admissions for timely processes of face sheets and blue cards.

~~vii.~~viii. Director of Social Services – shall provide a list of residents who ~~could be discharged immediately in addition to~~are planned community discharges for the day and following day to better account LHH bed availability.

~~viii.~~ix. Chief Finance Officer – shall assist in resource allocation or funding, to safely implement admissions.

~~ix.~~x. Director of Pharmacy Services – shall be informed of any pharmaceutical products that require pre-planning ~~arrangements~~ to ensure timely availability or high-risk medications requiring coordination with nursing and medicine leadership to ensure safe administration, such as TPN.

3. External Communication and Coordination

a. Communication

~~v.~~vi. LHH CEO or designee shall communicate with ZSFG CEO or designee to confirm number of residents LHH will admit.

b. Coordination

~~vi.~~vii. LHH Patient Flow Coordinator will coordinate with:

- ZSFG Utilization Management Nurse Manager (UM NM) or designee – to provide names of patients for admission including assigned neighborhood, admitting physician pager number and admitting neighborhood charge nurse phone number.

- ZSFG Case Manager – confirm time of ambulance pick up

~~vii.~~viii. ZSFG Attending Physician – shall contact LHH Admitting MD for hand off

~~viii.~~ix. ZSFG RN – shall contact LHH Charge Nurse for hand off report

~~ix.~~x. LHH Admission and Eligibility Department – shall coordinate with ZSFG UM Nurses for any documentation or insurance plan information for the identified patients to be admitted.

4. Documentation

a. The Health Information Services (HIS) Department shall be notified of SNF level of care patients that are admitted to the acute care unit (admit type, full name, and bed/room assignment) by the Patient Flow Coordinator.

b. When SNF level of care patients are admitted to the acute care unit, an exception shall be made to HIS policy number 7.05 permitting the use of SNF documentation protocols for the SNF patient(s) that are physically placed on the acute care unit. SNF documentation may be continued and follow the patient to the SNF unit when the patient/resident is transferred from the acute care unit to the SNF unit and a new medical record does not have to initiated.

5. Utilization Management (UM) and Billing

a. UM Nurses shall conduct utilization reviews and processes based on the level of care determination and payer requirements.

b. When SNF level of care admissions are placed in an acute care bed, the following processes shall be followed:

~~x.~~xi. If the resident's primary coverage is a Medi-Cal Managed Care, or other private insurance, notify the managed care organization that the resident is admitted to an acute care bed and that the facility shall submit a claim based on the authorization for a SNF stay that was pre-approved by the health plan.

~~xi.~~xii. If the resident's primary coverage is Medicare, the resident shall be issued a Medicare acute care denial and informed that the resident will not be able to access his/her Medicare SNF benefits while s/he is on the acute care unit. The Billing Department shall not submit Medicare SNF claim(s) for payment of a resident who meets SNF level of care on admission while occupying an acute care bed.

~~xii.~~xiii. If the resident's primary coverage is Medi-Cal, Hudman calls shall be initiated by staff from the UM Department. The Billing Department shall submit a claim to Medi-Cal for administrative days.

~~xiii.~~xiv. A SNF level of care resident who is admitted to an acute care bed is not eligible for bed hold when theys~~/he~~ are discharge~~d~~s to a community acute care hospital.

6. Change of Condition from SNF Level of Care to Acute Care

a. In the event that the SNF level of care resident becomes acutely ill and meets acute care criteria; this shall be considered a change of condition and an event that triggers a new admission, and a new medical record shall be initiated per acute care regulations.

b. The attending physician of record or designee shall make the determination of need for acute care services and notify the ~~Patient Flow Coordinator/Operations Nurse Manager~~Department of Care Coordination and Nursing Operations or designee.

a. The following departments shall be notified by the ~~Patient Flow Coordinator/ Operations Nurse Manager~~ Department of Care Coordination or designee as soon as practicable after the physician determines that the resident/patient meets acute level of care:

i. Nursing staff on the acute care unit

ii. Admissions and Eligibility

iii. Health Information Services

iv. Utilization Management

v. Pharmacy Services

vi. Billing Department

7. Post Response Debrief & Performance Improvement

a. ~~Incident Commander (I~~if NHICS was activated, Plans Chief with help from the Emergency Manager, is to ~~) shall~~ arrange for post activation~~HICS~~ debrief/hotwash with LHH and ZSFG~~H~~ staff involved in the incident response~~.~~.

~~a.~~b. Once gaps and areas for improvement are identified, the Plans Chief is to draft and After Action Report within 180 days of demobilization, that should then be presented to LHH's Quality Council.

~~b. LHH Patient Flow Coordinator shall arrange for a debrief with ZSFG UM NM or designee.~~

~~**8. Performance Improvement**~~

~~a. Incident Commander (when HICS is activated) shall identify identified gaps and opportunities, including action plan(s), and report to LHH's Quality Council.~~

~~b. LHH Patient Flow Coordinator shall identify gaps and opportunities, including action plan(s), and report to LHH's Quality Council.~~

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 17/11/14, 19/03/12 (Year/Month/Day)
Original adoption: 16/07/12

HIPAA COMPLIANCE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) implements procedures that comply with the San Francisco Department of Public Health's (DPH) "HIPAA Compliance: Privacy Policy", which adopts the Privacy Rules set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related federal and state confidentiality laws.

~~LHH staff are responsible for complying with both LHH and DPH Privacy and Data Security policies (Appendix A).~~ LHH staff are responsible for complying with ~~both~~ all LHH and DPH Privacy and Data Security policies~~ (Appendix A).~~.

PURPOSE:

The purpose of this policy is to provide guidance to LHH providers, staff, approved affiliated students, contractors, and volunteers ("staff") by clarifying how the basic requirements for protecting the confidentiality of medical information apply to LHH work processes as required by the HIPAA Privacy Rule.

~~The basic tenet of the Privacy Rule is that providers may use and disclose PHI without the individual's authorization only for treatment, payment, and health care operations, as well as certain public interest related purposes such as public health reporting. Other uses and disclosures of PHI generally require the written authorization of the individual.~~
The basic tenet of the Privacy Rule is that providers may use and disclose PHI without the individual's authorization only for treatment, payment, and health care operations beyond what is consented to in the Conditions of Admission, as well as certain public interest related purposes such as public health reporting. Other uses and disclosures of PHI generally require ~~the~~ additional written authorization by~~of~~ the individual.

The Privacy Rule also introduces the concept of "minimum necessary". This requirement mandates that when using or disclosing PHI, or when requesting PHI from external providers or entities, providers shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose. The Privacy Rule does recognize that providers may need to use all of an individual's health information in the provision of patient care. However, access to PHI by the workforce must be limited based on job scope and the need for the information.

The Privacy Rule also includes a set of rights for consumers of health care services. These include the right to obtain a written notice explaining how DPH shall use and disclose their information, to access their health information (including requesting copies, requesting amendments, and receiving an accounting of specified disclosures), to request that certain information be restricted from use or disclosure for purposes of treatment, payment and health care operations (this request need not be granted if it is unreasonable

or overly burdensome), to request that information be communicated in particular ways to ensure confidentiality, and to refuse to authorize the release of information for most purposes not related to treatment, payment or health care operations.

This policy provides an overview of the requirements of the Privacy Rule.

DEFINITION:

Protected Health Information (PHI) covers information relating to an individual's health, the care received, and/or payment for services, including demographic data. It includes all information in any form related to the individual's health care that can be individually identified as belonging to a particular person.

Patient Identifiable Information (PII) is individually identifiable information regarding patient/resident name, address, Social Security number, account number, security code, driver's license number, financial or credit account numbers, phone numbers, and Internet domain addresses, and other personal identifiers.

PROCEDURE:

1. Resident notification of HIPAA Privacy Practices at Time of Admission

    a. All LHH residents shall be provided with the "DPH Notice of HIPAA Privacy Practices" upon admission.

    b. Staff shall request the resident/decision maker to sign the acknowledgment of receipt, however the resident has the right to refuse to sign under privacy laws.

    c. The signed acknowledgement shall be kept in the resident's medical record.

    d. The date the notice was provided shall be entered in the electronic health record.

    e. A copy of the notice shall be offered to the resident/ decision maker.

    f. Exception: The notice does not need to be provided or signed again if the electronic health record indicates a date and user identification verifying that the HIPAA notice was previously provided (i.e. for most residents who were admitted from Zuckerberg San Francisco General Hospital).

2. Posting of the DPH Notice of Privacy Practices Notices

    a. LHH shall post the DPH Notice of Privacy Practices in a clear and prominent location where it is reasonable to expect residents to be able to read the notice.

    b. LHH posts notice summaries in the main lobby of the Pavilion building outside Admissions and Eligibility, Outpatient Clinic entry area, and the entry area of each

neighborhood and includes the full notice in the survey binders available to residents.

c. Notices are available in English, Chinese, Russian, Spanish, Tagalog and Vietnamese.

d. ALL neighborhoods shall have a notice posted in English, except for N4 and N5 which shall have posted notices in Spanish and Chinese, respectively, as these are the most commonly used languages by the residents.

3. LHH staff~~s~~ may use and disclose PHI for treatment, payment, and healthcare operations. Use of information applies to internal sharing or utilization of PHI. Disclosure applies to the release of PHI.

   a. Treatment, payment, and health care operations are defined as follows:

      i. Treatment means providing, coordinating or managing a patient's care, including patient education and training, and consultations between providers and referrals.

      ii. Payment means activities related to being paid for services rendered. These activities include eligibility determinations, billing, claims management, utilization review, and debt collection.

      iii. Health care operations means a broad range of activities such as quality assessment, student training, contracting for health care services, medical review, legal services, auditing functions, business planning and development, licensing and accreditation, business management, and general administrative activities.

   b. Minimum Necessary Uses and Disclosures

      i. Whenever using or disclosing PHI, LHH staff shall limit the PHI requested, used, or disclosed to the minimum necessary to accomplish the resident's care or business purpose.

   c. Disclosures to Family, Other Relatives, Close Personal Friends, and Personal Representatives

      i. PHI shall only be disclosed to a resident's family members, other relatives, close personal friends, or any other individual when:

         - The resident has verbally agreed;
         - The resident was provided with the opportunity to object to the disclosure and did not object; and
         - The verbal authorization was documented in the resident's medical record.

ii. Any such disclosure shall be limited to information directly relevant to that person's involvement with the resident's care of payment for care.

iii. PHI shall be disclosed to a resident's personal representative (i.e. those granted legal authority to make health care decisions on behalf of another) in the same manner as they would for the resident.

iv. Disclosures related to mental health, substance abuse, or sexually transmitted disease, or HIV/AIDS services shall be disclosed as provided for in this policy.

4. Social Media

Social media includes items such as blogs, podcasts, websites, discussion forums, and social networks (e.g., Facebook, Instagram, Snapchat, YouTube, Twitter, LinkedIn or hyperlinks from email).

a. Images of residents shall not be disclosed through authorized social media accounts of any kind without permission of the resident, guardian or conservator as described in LHHPP 29-02 Resident aAs Photography Or Interview Subject ~~(form MR802)~~.

b. Unauthorized disclosure of protected health information is a violation of the HIPAA Privacy Rule, DPH policy, and LHH policy. No resident PHI or PII shall be disclosed through any form of social media, which includes:

i. Posting or hyperlinking photos, images, video, recordings, text, or other information that could reasonably lead to the identification of a patient/resident.

c. DPH issued email addresses may not be used for personal access to social networking sites. DPH issued email addresses shall not be used for personal use on social networking sites.

d. Staff members shall consult with their supervisor or the Privacy Officer if they are unsure whether any DPH or LHH-related information or patient information is confidential.

e. Transparency: If staff members identify their affiliation with DPH or LHH in any online social medium or network or if their affiliation with DPH or LHH could be presumed, they must make it clear that they are not speaking for DPH or LHH by using this statement: ***"The views expressed here are my own and not those of my employer."***

f. Any social media conversation, whether public or private, may be subject to public disclosure.

5. Training of Staff Regarding PHI

   a. All LHH staff ~~rs~~ shall receive initial HIPAA training utilizing the DPH curriculum prior to commencing work. In addition, annual re-training is provided to all staff through the Department of Education and Training. Managers are responsible for assuring compliance. LHH staff shall not be permitted to access the electronic health record if they have not completed the initial HIPAA training, and their access to the electronic health record shall be ~~terminated~~ suspended if they do not complete the annual HIPAA training by the required deadline.

      i. All volunteers receive orientation to HIPAA Privacy Practices with essential points from the DPH curriculum.

   b. All LHH staff, volunteers, and affiliated students must comply with the DPH confidentiality agreement and sign the DPH User Confidentiality, Security and Electronic Signature Agreement Form (available on the LHH Intranet under “LHH Forms”, section “I”).

   c. Signed confidentiality agreement forms are filed in the employee's personnel record in Human Resources, in the Volunteer Coordinators office, or in the affiliating departments' student placement coordinators office. Staff electronic signatures on this document are also acceptable and records are available through the Department of Education and Training.

   d. Volunteers shall not access resident medical records and shall not chart in the medical record.

   e. Similar requirements for business associates (BA’s) are described in each BA agreement.

6. Handling of PHI

   a. Physical c~~C~~opies of PHI are to be discarded directly into the confidential shredding bins when no longer needed.

   b. PHI (electronic or hard copy) shall not to be left in open view.

   c. PHI discussed at resident care conferences and other team meetings is for the sole purpose of providing care and shall be kept confidential.

   d. PHI shared as part of internal quality improvement efforts, such as performance improvement committees, is used for informational purposes to continuously improve practice and outcomes.

e. Reports containing PHI shall only be shared with staff on a "need to know" basis, secured from privacy breaches and discarded in the confidential shredding bins, when no longer needed.

7. Special Requirements for Mental Health and Developmental Disability Information, Substance Abuse Information, Sexually Transmitted Disease Information, and Health Information of Minors

   a. Mental health Information

      i. California state law provides for special protections for certain mental health information. Mental health information may be shared among DPH providers and contractors for the purposes of treatment. All other uses and disclosures require the specific authorization of the patient to disclose mental health information.

      ii. Mental health information includes psychotherapy notes, medication prescription and monitoring, counseling session start and stop times, modalities/frequencies of treatment, results of clinical tests, or summaries of diagnosis, functional status, treatment plans, symptoms, prognosis, or progress recorded by mental health professionals.

      iii. Disclosures of mental health information may require the specific authorization from the resident for release as required by California Welfare and Institutions Code, section 5328 et seq. (also known as the Lanterman-Petris-Short Act).

   b. Substance Abuse Information

      i. California state law provides for statutory restrictions for the release of information developed or acquired in the course of providing substance abuse treatment in a federally-funded substance abuse program. Substance abuse treatment provided in the course of general medical treatment is not subject to these provisions.

      ii. Federal and state statutes require written authorization for disclosure of substance abuse information in certain circumstances and other special protections for substance abuse information. In these situations, the state law must be followed. Questions regarding the use or disclosure of substance abuse information shall be referred to the Privacy Officer.

   c. Sexually Transmitted Diseases and HIV/AIDS Information

      i. Except for the purpose of diagnosis, care, or treatment by DPH providers, no HIV test results shall be disclosed unless the resident has given specific written authorization.

8. Reporting Privacy Breaches

   a. An Unusual Occurrence report shall be completed for any suspected privacy breach.

   b. Suspected privacy breaches shall be reported to the LHH Privacy Officer for follow up.

ATTACHMENT:
~~Appendix A: Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms~~

REFERENCE:
LHHPP 21-01 Medical Records Information: Confidentiality and Release
LHHPP 21-02 Transmission of Confidential Medical Information Via Facsimile
LHHPP 21-05 Medical Record Documentation
LHHPP 21-06 Transporting the Resident's Filed Medical Records
LHHPP 24-08 Off Campus Appointments Or Activities
LHHPP 29-02 Resident as Photography or Interview Subject
LHHPP 29-07 Human Subject Research
LHHPP 60-01 Performance Improvement Program
User Agreement for Confidentiality, Data Security and Electronic Signature

Revised: 13/01/29, 13/09/24, 15/09/08, 19/03/12, 22/06/14 (Year/Month/Day)
Original adoption: 11/09/27

~~Appendix A - Listing of DPH Privacy Policies, DPH Data Security Policies and Privacy Forms~~

~~DPH Privacy Policies~~

1. ~~DPH Privacy Policy~~
2. ~~Authorization for Use and Disclosure of PHI~~
3. ~~Privacy and the Conduct of Research~~
4. ~~Patient / Client / Resident Rights Regarding PHI~~
5. ~~Administrative Requirements~~
6. ~~User confidentiality and Security Agreement~~
7. ~~Use of PHI in Disciplinary Investigations and Proceedings~~
8. ~~Secured Delivery of PHI Interoffice, Mail, Fax~~
9. ~~Reporting of Unlawful or Unauthorized Access of PHI~~
10. ~~Reporting Individuals with Lapse of Consciousness to DMV~~

~~DPH Data Security Policies~~

1. ~~DPH Electronic Data Security Policies – User Brief~~
2. ~~Access Control Policy~~
3. ~~Confidentiality, Security, and Electronic Signature Agreement~~
4. ~~Disaster, Contingency and Business Continuity Planning~~
5. ~~Data Backup~~
6. ~~Policy for Classification of Data~~
7. ~~Data Network Security~~
8. ~~Security Documentation and Accountability~~
9. ~~Malicious Software Prevention and Surveillance~~
10. ~~Policy for Secure Disposal or Reuse of Media Containing Critical Data~~
11. ~~Network Operating System Architecture and Administration~~
12. ~~SFDPH Password Policy~~
13. ~~Portable Computer and PDA Security~~
14. ~~Remote Network Access Policy~~
15. ~~Risk Analysis and Risk Management~~
16. ~~Policy for Secure Storage, Disposal or Reuse of Media Containing Critical Data~~
17. ~~Secure Transmission of Protected Health Information~~
18. ~~Security Activity Logging, Tracking and Reporting~~
19. ~~Security Policy Violation Discipline and Sanctions~~
20. ~~Security in the System and Software Development Process~~
21. ~~Security Awareness, Orientation and Training~~
22. ~~Wireless Network and Information Transmission Security~~
23. ~~Workstation, Data Display and Printout Security Policy~~

~~DPH Privacy Forms~~

1. ~~DPH Authorization to Disclose PHI~~
2. ~~CBHS Authorization for Use or Disclosure of PHI~~
3. ~~DPH Research Proposal Approval Form~~
4. ~~Health Information Data Use Agreement and Form~~
5. ~~Summary DPH Notice of HIPAA Privacy Practices~~
6. ~~Detail DPH Notice of HIPAA Privacy Practices~~
7. ~~User Confidentiality and Security Agreement Form~~
8. ~~PHI Cover Sheet Required for Fax, Interoffice, Mail~~
9. ~~Summary of Unauthorized Access of PHI~~
10. ~~HIPAA Business Associate Addendum~~

RESIDENT SEXUAL RIGHTS AND RESPONSIBILITIES

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to support the overall well-being of all LHH residents with recognition that sexuality is an important component. Toward this end, LHH has established the following policies and procedures regarding resident sexual rights and responsibilities.

PURPOSES:

1. To ensure the rights of residents to participate in consensual sexual acts and to support the overall well-being of facility residents.

2. To provide the appropriate sex education while maintaining the public health and safety of residents.

3. To preserve and protect the privacy rights of all residents in the facility.

RESIDENT SEXUAL RIGHTS:

1. LHH and its staff recognize that residents have the right to a consensual sexual life free from persecution, condemnation, discrimination, or staff/societal intervention into their private sexual behavior.

2. Residents have the right to seek out and engage in sexual acts or activities, providing they do not involve non-consensual acts, violence, and sexual behavior with persons under 18 years of age, constraint, coercion, or fraud. Residents are prohibited from providing or receiving goods, services or money in return for sexual services.

3. Residents have the right to obtain and utilize legal sexual entertainment that is freely available in the marketplace.

4. Residents have the right not to be exposed to sexually explicit material or behavior.

5. LHH and its staff recognize the need for residents to have access to professional health care and counseling in the areas of sexuality, sexual functioning, sexually transmitted disease and contraception.

6. LHH and its staff recognize that mechanisms and physical assistance may be needed and must be provided to residents when necessary to facilitate sexual activity. Residents have the right to request such assistance.

7. LHH and its staff further note that no staff member will be required to directly facilitate sexual activity for hospital resident(s) if that staff member expresses the desire to be removed from such duties.

8. Some residents, due to mental and/or intellectual impairments, may not have the capacity to make reasonable judgments about their sexual behaviors. In those cases, in which the resident's ability to make reasonable judgments is in question, the Resident Care Team (RCT) will determine to what extent, if any, the above Resident Sexual Rights applies to that individual.

9. Residents have the right to report the violation of their privacy by staff or other residents to members of the RCT.

RESIDENT SEXUAL RESPONSIBILITIES:

1. Residents have the responsibility to communicate to the staff their desire for privacy.

2. Residents have the responsibility not to engage in sexual acts that involve persons who are under 18 years of age or who lack the ability to make reasonable judgments about their sexuality.

3. Residents have the responsibility not to engage in sexual acts that involve violence, constraint, coercion or fraud.

4. Residents have the responsibility not to expose other non-consenting residents, hospital guests, visitors, or staff to explicit sexual material or behavior.

5. Residents have the responsibility not to persecute, condemn, or discriminate against other residents' or staff's sexual attitudes or feelings.

6. Residents have the responsibility, when they feel their sexual rights, or the sexual rights of other residents have been violated, to report incidents to a member of the RCT, hospital administration, or the Ombudsman.

7. Residents have the responsibility to report possible infections that may be transmitted by sexual activity, including HIV (the AIDS virus) to their partner and health care provider prior to engaging in sexual activity, and to act in ways that reduce the potential of the transmission of these infections to others.

8. Residents have the responsibility to use effective methods of birth control when pregnancy is either undesirable or contraindicated due to the resident's medical condition. Condoms are in stock in the Pharmacy and available through physician order. If the physician writes a prescription for oral contraceptives, Pharmacy will order after verifying insurance coverage. Community standard is to use ~~long~~ long-acting reversible contraceptive methods which would need to be placed in a GYN clinic.

SEXUAL ACTIVITY ASSESSMENT:

1. As part of its general role, the social worker or other qualified member of the RCT completes a sexual screening when resident indicates a need for private space.

2. When clinically appropriate, based on the request, the RCT will:

   a. assess resident for ability to engage in consensual sexual relations, using Sexuality Assessment Tool, and document on the form any counseling ~~given;~~given.

   b. provide resident with appropriate education and counseling.

EDUCATION PROCEDURE:

1. LHH staff will provide residents with education on the following topics, as appropriate:

   a. how to communicate to staff the desire for privacy/sexual activity

   b. safe sex practices

   c. information about sexually transmitted diseases

   d. contraception and pregnancy

   e. resources for further information evaluation

   f. protection of residents with mental or intellectual impairments

   g. reporting violations of right to privacy

2. The Sexuality Assessment Tool documenting counseling received will be placed in the front of the medical record.

3. If intended partner is known to be a LHH resident, consult with the intended partner's attending physician or nurse regarding the initiation of a sexuality assessment for that resident.

BIOETHICS CONSULTATION:

1. Bioethics consultation may be sought if the RCT is unable to reach a conclusion regarding sexual activity.

ATTACHMENT:
None.

REFERENCE:

None.

Revised: 94/08/13; 99/12/20, 10/12/03, 19/05/14 (Year/Month/Day)
Original adoption: 94/08/15

FALLS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall employ fall prevention strategies designed to identify fall risk factors, minimize fallfalls risk by ameliorating or eliminating risk factors when appropriate,contributing to falls while at the same time, maintaining or improving the resident's mobility and quality of life in accordance with their advance care planning wishes.[1]

2. The goal of the LHH Falls Program will be to reduce fall-related-injury while honoring our residents' autonomy and wishes to retain as much independence for as long as possible, and in accordance with their advanced health care planning choices.

3. LHH will collect and analyze fall-related metrics to plan and implement performance improvement (PI)/quality improvement (QI) activities aimed at reducing total falls and falls with major injury. These PI/QI improvement activities will occur on a hospital-wide basis via the Falls Committee and on a unit-based level via the Quality Assurance and Performance Improvement (QAPI) structure (e.g., Falls/Restraints QAPI).

PURPOSE:

1. To describe the processProvide a safe environment for identifying residents at .

2. Minimize fall risk and overall number of falls.

3. Mitigate injuries from falls.

1. Standardize practice guidelines for falling, utilizinge evidenceutilizing evidence-based and multidisciplinary individualized fall fall prevention strategies.

2. , and to dDescribe the response process to fallspost fall.and interventions.

DEFINITION:

Fall: A fall is any event whereby a resident unintentionally comes to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force, whether resulting in injury or no injury.

Major Injury: Injuryindicate to injuries that t resultsresulted in bone fractures, joint dislocations, closed head injuries with altered consciousness, and/or subdural hematoma (intracranial hemorrhage).

[1] Tideiksaar, R. Falls in Older People. 3rd edition. Baltimore, MD:Health Professions Press.
[2] Centers for Medicare and Medical services (2010). *Long Term Care Facility Resident Assessment Instrument User's Manual , Version 3.0 Baltimore, MD. Need to be updated*

~~**Environment**: refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the resident's rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas.~~

~~**Hazards**: elements of the resident environment that have the potential to cause injury or illness.~~

~~**Supervision/Adequate Supervision**: an intervention and means of mitigating the risk of an accident. Adequacy is determined by assessing the appropriate level of and number of staff required, the competency and training of the staff, and the frequency of supervision needed. The determination is based on the individual resident's assessed needs and identified hazards in the resident's environment.~~

PROCEDURE:

1. **Fall-Risk Screening:** See Standard Work (Appendix A)

~~1. Screening for fall risk upon admission or significant change of condition:~~

a. The Licensed Nurse (LN)~~RN~~ completes the 'Schmid Fall Risk Assessment' screening tool~~Assessment"~~ in the electronic health record (EHR) at the following intervals: See Standard Work (Appendix A)

i. Admission/Re-Admission,

ii. Transfer to a new unit (the receiving unit will complete the assessment),

iii. With ~~on admission, quarterly, post fall, and with~~ a change in resident condition,

iv. Post fall (after a fall),

v. Quarterly with MDS assessment completion,

~~i.~~vi. Anytime the L~~R~~N deems it appropriate based on resident condition.

2. **Individualized Care Planning Based on Fall-Risk:** See Standard Work (Appendix A) and Appendix D (Common Fall Risk Factors and Interventions)

~~ii.~~ Residents/Patients determined to be at~~a~~ high risk for falls shall have a multidisciplinary individualized Safety/Fall Care Plan ~~completed by the RN~~

a. ~~Ancillary consults may be~~ initiated by the RN.

3. **Visual Management Aids to Communicate Residents at High-Risk for Falls:** See Standard Work (Appendix A)

   a. Staff will utilize visual management tools to communicate residents who are a high-fall risk and re-revaluate and regular intervals based on any change in resident's functional status.

4. **On-going Assessment/Reassessment** of Fall Risk and Fall Prevention Interventions:

~~for clarification~~

   ~~iii.~~ An ongoing assessment and reassessment of ~~identified risk factors (e.g., drug regimen review from Pharmacy, or mobility assessment from the Rehabilitation Services Department).~~

~~2. Interventions shall be developed and implemented for each resident individually, based on the resident's fall risk screening and potential hazards in the environment. The interventions shall include adequate supervision of residents whom are at risk for falling.~~

   a. ~~An ongoing~~ fall prevention~~evaluation of~~ interventions shall be documented to ensure their proper implementation and effectiveness~~efficacy,~~ and modified or replaced as necessary within the resident's plan of care. This will be completed at the following frequency:~~.~~

      i. Annually

      ii. Quarterly with MDS/RCC Reviews

      iii. Upon~~After~~ a change in condition

      ~~i.~~iv. Post-fall~~:~~

5. **Immediate Post Fall Response:** See Standard Work (Appendix B)

~~The RN assesses the~~

   a. When a resident experiences a fall, the initial resident interventions post-fall will include:

   ~~b.~~ Refer to Standard Work for the Resident Care Team (RCT) role in post-fall response~~signs of injury~~ and resident assessment, and nursing huddle.~~for changes in condition:~~

      i.

      ii. If a serious injury is suspected, do not attempt to move the resident. Notify the physician whether an injury is suspected or not. The physician will evaluate the resident and determine interventions based on the resident's wishes as expressed in their advanced care plan and/or as determined via

discussion with their Surrogate Decision Maker (SDM) or Public Guardian.~~immediately~~

~~iii. If a fracture or joint dislocation is suspected, immobilize the affected area before moving the resident. If the area cannot be immobilized, stay with the resident and provide comfort until either the physician or EMS arrives.~~

~~c. After the initial assessment, if it is safe to do so, assist the resident to bed or chair. Do not lift the resident by the arms or legs. Do not attempt to transfer a resident off the floor alone, always use a minimum of 2 person assist. Whenever necessary, use a mechanical lifting device (e.g., EZ Lift, ceiling lift).~~

~~i. Begin neuro checks if the resident hit their head or if the fall was unwitnessed.~~

~~ii. Check vital signs.~~

~~iii. Check for bruises, scrapes, lacerations, or any other injuries.~~

~~iv. If a fracture is suspected, monitor the pulses in the extremity distal to the suspected fracture to ensure that blood flow is not occluded.~~

~~d.~~ **~~Notification:~~Post Fall Notification:**

6. ~~Notify the~~ See Standard Work (Appendix B)

~~i.~~ The physician will be notified as referenced in the Immediate Post Fall Response in the .~~The attending physician:~~

~~ii. When has already been notified as specifiedappropriate, the physician evaluates the resident for injury and documents accordingly in the EHR.~~

~~iii. The~~ above section (5,~~attending physician shall evaluate the resident under the following circumstances:~~

- ~~Loss of consciousness.~~
- ~~Head injury.~~
- ~~Lacerations.~~
- ~~Deep bruising.~~
- ~~Pain in the hip or in the groin.~~

~~e.~~a.~~Pain or swelling, or if~~ a~~, iii),~~ ~~bone has an unusual shape (e.g., shortening and/or unusual rotation of the body part).~~

- ~~Difficulty or pain when standing or trying to walk.~~
- ~~Limping, or other unsteadiness in gait (not present prior to the fall).~~
- ~~Any other circumstances where the evaluating nurse feels the resident has sustained injuries requiring evaluation by the physician.~~

~~f.~~b. Notify the Supervisor/Nurse Manager~~,~~.

~~g.~~c. Notify the Medical Social Worker~~, of the fall.~~

~~h.~~d. Notify the resident's family or legal representative~~,~~.

e. Notify the Fall Responder (Appendix F: Fall Responder).

f. Refer to Appendix G 'Fall Occurrence Case Reviews' for a description on the different forums for post fall reviews and notification.

7. **Post Fall RCT Huddle:** See Standard Work (Appendix B)

a. The post fall huddle will be a brief review of what occurred and will be led by the Charge RN along with those who were present at the time of the fall (witnessed fall), or those who discovered the resident after the fall (unwitnessed fall).

~~3.~~8. **Documentation:** See Standard Work (Appendix C)

a. **Post-Fall Assessment Flowsheet in the EHR**: The RN will document the initial~~Initiate and complete a~~ Post Fall Assessment in the EHR within the 'Post Fall Assessment Flowsheet.' See Standard Work~~subsequent to resident falls~~.

b. **Nursing Note:** See Standard Work for content/instructions

c. **Post Fall Monitoring (Reassessment) Flowsheet in EHR:** See Standard Work

~~• **Nursing Note:** Each shift shall document the Post-Fall Assessment every 4 hours for 24 hours.~~

~~b.~~d. Nursing documentation of the fall incident and resident monitoring and evaluation will also~~every shift for 24 hours shall~~ be documented in a Nursing Note every shift for 72 hours, and as often as clinically indicated depending on the nature of the change in condition of the resident. ~~the EHR.~~

~~c.~~e. **Weekly Summaries:** Nursing will include~~Include~~ the outcome of the~~a~~ fall in subsequent weekly~~/monthly~~ summaries in the EHR until injuries or consequences are resolved.

f. **Resident Care Plan Review, Care Plan Update, and Review:** See Appendix D (Common Fall Risk Factors and Interventions)

~~d. If the resident does not have a Fall Risk Care Plan in the EHR prior to the fall, then initiate a new care plan, otherwise review the current problem description of the fall risk in the Care Plan. If new risk factors or interventions are identified, update~~

the resident's Care Plan. Use the "Common Fall Risk Factors and Interventions" matrix in Appendix B to determine the associated fall risks relevant to the resident:

i. Any identified risk factors shall be addressed in the Care Plan (e.g., Falls related to: history of frequent falls, multiple medications, lower extremity weakness, etc.)

ii. The goal of an "At Risk for Falls" care plan is to minimize the risk for falls, minimize the risk for injuries from falling and to maximize the resident's functional mobility.

iii. Ancillary staff may be consulted as necessary to clarify risks and interventions (e.g., a drug regimen review by Pharmacy or a mobility assessment by the Rehabilitation Services Department).

iv. Once the falls risk factors have been identified, the Nursing staff and/or Resident Care Team (RCT) shall identify and implement interventions that can be used to address the resident's risk factors.

- Use the "Common Fall Risk Factors and Interventions" matrix in Appendix B for intervention ideas.

- Interventions chosen for the resident shall be entered under the "Intervention" column in the Care Plan.

9. Complete an **Unusual Occurrence (UO) Report:** See Standard Work (Appendix C)

a. Licensed NurseStaff who witnessed the fall, or staff who discovered the resident had experienced an unwitnessed fall, will complete a UO report. Refer to LHHPP 60-04 Unusual Occurrences. This will be completed for each fall occurrence. for UO form F-821A "Confidential Report of Unusual Occurrence."

e. **Special considerations for a**A special meeting of the RCT may be required. The RCT shall finalize Care Plan revisions in their review.

4.10. When **fall withresults in major injury:** Refer to Standard Work (Appendix G)

a. The Nurse Manager (NM) or designee will consult with RM to determine when ashall initiate root cause analysis (RCA) should be completed (e.g., Departmental within the shift of when a suspected/confirmed major injury is identified.

b. The Nurse Manager or designee shall document root cause analysis (RCA versus Organizational) using Fishbone Diagram, including analysis, gaps identified, action plan and sent to Quality Management and Designated Clinical Nurse Specialist for data aggregation and hospital-wide analysis.

~~The Nurse Manager shall conduct a special meeting with the RCT to discuss the identified gaps and document the interventions from the~~ RCA~~).~~ ~~in the resident care plan.~~

~~c. Results of RCA shall be reported by the Nurse Manager quarterly to Nursing Quality and Improvement Council (NQIC).~~

ATTACHMENT:

Appendix A: Standard Work - Screening for Fall Risk, Visual Management Tools, and Individualized Fall Prevention Care Planning
Appendix B: Standard Work - Post Fall Response
Appendix C: Standard Work - Post Fall ~~Risk Assessment and~~ Documentation ~~Guidelines~~
Appendix D: ~~B:~~ Common Fall Risk Factors and Interventions
Appendix E: Physical Rehabilitation Guidelines
Appendix F: Physical Rehabilitation Therapy~~C: Post~~ Fall Responder Role~~Assessment Form MR 524~~
Appendix G: Fall Occurrence Reviews Table

REFERENCE:

LHHPP 60-04 Unusual Occurrences~~, including F-821A "Confidential Report of Unusual Occurrence"~~
NPP C3~~C 3~~.0 Documentation of Resident Care/Status by the Licensed Nurse - SNF
LHHPP 27-02 Referrals for Rehabilitation Services

Centers for Disease Control and Prevention (CDC). STEADI – Older Adult Fall Prevention. Retrieved on
July 23, 2023, from: Institute for Healthcare Improvement (IHI). *How to Guide: Reducing Patient Injuries*
from Falls. (December 2012).
Centers for Medicare and Medicaid Services~~Medical services~~ (October 2018). *Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.16 Baltimore, MD*
Joint Commission (JC). Sentinel Alert Event. Retrieved on July 23, 2023, from: Veteran Health Affairs
(VHA). National Center for Patient Safety: Falls Notebook.

Revised: 08/01/08, 11/03/14, 17/01/10, 19/07/09, 24/2/23 (Year/Month/Day)
Original Adoption: 00/01/27

Appendix D: Common Fall Risk Factors and Common Interventions That May be Used.

Risk Factor	Common Issues/Problems	Interventions
Recent Medical History • Review of medical record • Nursing interview • MD interview	• Infection • Dehydration or electrolyte imbalance • Anemia • Hypo/Hyperglycemia • Vestibular dysfunction • Acute hypoxia • Cardiac arrhythmia • Pain	• Monitor for signs and symptoms of infection • Assess for dehydration • Obtain lab values for possible electrolyte imbalances or anemia (monitor for signs and symptoms) • Check blood sugars • Check pulse oximetry • Assure adequate pain control
Polypharmacy • Adverse Effects of Medication • Review of medical record • Nursing interview • MD interview • PharmD review	• Resident is on medication that may contribute to falling (Antipsychotic, antidepressant, antihypertensive, antianxiolytic, antihistamine, sedative/ hypnotic, anticonvulsant) • Resident is on more than four medications • Possible toxic or supratherapeutic drug levels • Recent change in medications • ETOH or substance abuse	• Check orthostatic blood pressure and pulse • Notify physician of oversedation or change of condition • Instruct cognitively intact residents of appropriate ways to minimize drug side effects (e.g., rising slowly, flexing lower extremities before rising from sitting position, etc.) • Consult for focused review of medications to identify alternative pharmacologic agents with less sedation and/or orthostatic hypotension. • Obtain baseline levels of anticonvulsants to establish resident is not in supratherapeutic range
Social/Behavioral History • Review of medical record • Nursing interview • Activity Therapy review	• Unit or bed change • Care giver or staff change (other than shift change) • New admission • Difficulty coping with changes • History or signs of depression • History of increased agitation • History of wandering	• Provide increased company and conversation • Move high risk resident close to nursing station • Charting near resident • Periodically reassess residents, especially following new episodes of illness or change in medication • Increase nurse-to-resident ratio • Change of scene • Try to eliminate the cause of restlessness, agitation, and/or discomfort that may result in resident attempting to get up unattended • Visual barriers to unsafe areas • Calm music or relaxation tapes • Focused review of prior areas of interest, personal coping strategies, etc. Identify specific activities that reduce restlessness or agitation • Psychology/Psychiatry consult

Care Planning: Use the Risk Factors and Common Issues/Problems columns to develop the care plan problem statement. The intervention column will help you with the Care Plan interventions. A common care plan goal is "minimize risk of falls and injury from falls while maximizing mobility and quality life".

[4] Scott V., Donaldson, M., Gallagher, E., Gallagher, E., Donaldson, M. (2003, September, 1-29). "A Review of the Literature on Best Practices in Falls Prevention for Residents of Long-term Care Facilities," *Long Term Care Falls Review*.

[5] Rubenstein, L., Josephson, K., Robbins, A. (1994, September) "Falls in the Nursing Home," *Annals of Internal Medicine*, 121: 6, 442-451.

Appendix D: Common Fall Risk Factors and Interventions (continued)

Risk Factor	Common Issues/Problems	Interventions
Postural Hypotension • Positional BP's • HR rest and activity • Review of medical record	• Drop in systolic BP >20 mm Hg between lying and after standing 1 minute • Complaint of dizziness when first standing	• Raise head of bed to minimize sudden drop in blood pressure on rising • Consider elastic stockings to minimize venous pooling in the legs • Rise slowly or sit on the side of the bed for several minutes before standing up • Assess for dehydration • Focused medication review to identify possible ADR of medications (antipsychotics, antihypertensives, antidepressants, gabapentin)
Mobility Impairments • Review of medical record • Nursing interview • Resident observation	• Lower-extremity weakness • Poor balance or sliding in chair • Balance problem while standing or walking • Unilateral weakness • Contractures • Use of assistive device • Use of prosthesis • Foot problems (especially painful feet) • No shoes or poorly-fitting shoes • Incontinence	• Provide fall prevention education for residents, families, visitors and staff • Restorative walking program • Provide assistance with transfers and ambulation • Focused review of medications potentially contributing to unsteady gait • PT consult for: – Gait training – Strength training – Balance Assessment – Assistive Devices • OT consult for wheelchair positioning assessment • Provide well-fitting shoes • Toileting program
Environmental Factors • Nursing interview • Resident observation	• Loose wheelchair brakes • Loose bed brakes • Poor lighting • Cluttered space • Need for grab bars • Bed too high • Wet floors • Unstable wheelchair	• Keep smooth floors dry and clean • Minimize obstacles • Furniture should be arranged to provide support for patient when walking • Conveniently placed grab bars • Call button within easy reach • Provide low bed • Calm environment • Lock bed wheels • Wheelchair shop consult: – Adjust brakes – Install anti-tip bars – Install weights
Sensory Deficits • Review of medical record • Nursing interview • Resident observation	• Decreased hearing • Hearing aid not working or ill-fitted • Decreased vision • Glasses dirty or ill-fitted • Peripheral neuropathy	• Audiology consult • Optometry consult • Check glasses and/or hearing aids for proper fit and operation • Check for impacted cerumen • Occupational Therapy Low Vision Consult

Appendix E: Falls – Physical Rehabilitation Guidelines

Goal

To ensure a multifactorial approach is taken to prevent and/or reduce residents' risk of falls, and/or reduce risk or severity of injuries related to falls.

Purpose

To streamline rehabilitation services process and procedure for addressing residents' needs as follows, but not limited to: status post fall, history of falls, prevent falls, and prevent or reduce risk of injury from falls.

Procedure

- Physical and Occupational Therapists will respond to physician orders received for any falls occurring within 24 hours, as follows, but not limited to:
    - Conduct resident assessments of rehabilitation needs and falls risks (Refer to Policy 27-02)
    - Evaluate resident mobility and safety in the resident's environment to ensure safe transfers, mobility, and activities of daily living.
    - Develop, implement, and evaluate an intervention program for residents to reduce their fall-risk and injury risk. Update resident falls care plan accordingly.
    - Contribute to interdisciplinary care planning and participate in resident care team (RCT)/resident care conference (RCC) meetings for residents on rehabilitation services caseload.
    - Participate in clinical education of staff and program evaluation at the unit-service level, as indicated.
    - Consult with multidisciplinary team including the following but not limited to: speech language pathologist to collaborate on cognitive strategies for falls prevention; neuropsychologist for special approaches to behavioral management and falls prevention, biomedical services to trial environmental modification strategies and approaches for falls prevention, etc.
    - Conduct clinical cross-training with nursing staff for mobility and training.
    - Examine and enhance tools and products at the unit for fall and injury prevention (rolling seated walkers, w/c brake extenders, non-skid seating, etc.)
    - Rehab representative as a Therapy Fall Responder will perform as follows but not limited:
        - fully engage in all aspects of fall prevention,
        - care planning

Appendix E: Falls – Physical Rehabilitation Guidelines (continued)

- treatment decisions as residents are discussed in ,special review falls RCC meetings for residents, who've had a fall related to mobility and/or ADLs,

Occupational Therapists (examples)

a. Use purposeful activity to maximize independence, prevent disability, and maintain health.
b. Enhance cognitive, perceptual, motor, sensory, and psychomotor functioning.
c. Teach patients alternative methods to prevent falls and complete activities of daily living and instrumental activities of daily living skills, and
d. Adapt environments for optimal independence and safety to prevent patient falls.

Physical Therapists (examples)

a. Prevent the onset and progression of impairment, functional limitation, disability or changes in physical function and health status resulting from fall and/or injury.
b. Assess and instruct safe ambulation with and without assistive devices.
c. Intervene to restore, maintain, and promote overall fitness and optimal quality of life as related to movement and health, thereby preventing falls and related complications.

Appendix F – Physical Rehabilitation Therapy Fall Responder Role

Therapy Fall Responder Role:

- Designated OT/PT staff will act as a falls responder for falls related to mobility and/or ADLs.
- Falls responder will attend special review falls RCC when the fall is related to mobility and/or ADLs.
- Special review falls RCC will be scheduled by MDS within 5 business days during business hours, M-F, excluding holidays.
- Rehabilitation RCC representation may be scheduled using the rehabilitation group email list and/or rehabilitation's main phone line.

OPIOID OVERDOSE PREVENTION

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) protects and promotes the health of all residents. Residents who use substances may be at risk for overdose. This policy outlines LHH overdose prevention process which includes resource posting, staff overdose prevention training, and sets procedures to follow in the event of an overdose.

PURPOSE:

The purpose of this policy is to support the Department of Public Health's (DPH) compliance with local legislation, Ordinance 084-21 (Appendix A). This legislation requires DPH to annually submit to the Board of Supervisors a departmental policy describing how the department and its grantees that provide direct services to clients who use drugs will promote strategies to reduce drug overdoses ("Overdose Prevention Policy"). This LHH policy is in compliance with DPH Overdose Prevention Policy.

PROCEDURE:

1. Drug Treatment and Harm Reduction Programs and Services

Residents served by LHH include people who use drugs who may be at risk for overdose. LHH provides direct treatment services and supports harm reduction as an effective strategy for overdose prevention. See policies MSPP D08-07 LHH Psychiatry Substance Treatment and Recovery Services and HWPP 24-25 Harm Reduction. LHH will continue to support effective strategies to prevent overdose death such as increasing the provision and use of naloxone to reverse overdose; expanding the use of Medications for Opioid Use Disorder (MOUD) to prevent overdose.

2. Resource Posting:

LHH staff will post the schedules for harm reduction resources available in the community on the LHH intranet per standing communication procedure and in physical locations that meet LHH posting requirements. The updated schedules are available to print and save at the Overdose Prevention Resources SF.Gov webpage (https://sf.gov/information/overdose-prevention-resources). LHH staff will make these schedules available to residents as needed (e.g. printing it for a resident being discharged to the community).

3. Training

In collaboration with DPH Population Behavioral Health, LHH will implement Overdose Recognition and Response training for all relevant staff (who engage with

residents who use substances) in accordance with DPH policy. Implementation of the training and tracking of completion will be through standing procedures of LHH DET (Department of Education and Training).

4. Overdose Reversal and Response:

The following list describes steps that staff can take to respond to an overdose at LHH or if accompanying a resident in the community.

a. If a resident is unresponsive and/or unconscious, LHH staff shall follow Code Blue policy and their CPR/ACLS training. Call for help as soon as possible.

b. Any staff member who has received training in overdose recognition, response and naloxone administration can attend to an individual with suspected overdose (Attachment B). Staff will administer naloxone from the prn supply for the resident or from the crash cart, or from any other available source (e.g., if the person has naloxone nasal spray on them).

c. After the first dose of naloxone has been administered, if the person has a pulse, perform rescue breathing. For individuals without a pulse, perform CPR (rescue breathing + chest compressions). If available, an Ambu Bag (artificial breathing) or breathing shield can be used instead.

d. If there is no response to the naloxone from the person after 2-3 minutes, administer a second dose of naloxone and continue with CPR/rescue breathing while awaiting support.

e. If on LHH campus, Code Blue team will assess the resident and manage accordingly.

f. The Code Blue Committee shall review overdose reversals and report to [who] through the Unusual Occurrence system.

g. The LHH Pharmacy shall monitor naloxone ~~supplies, and~~supplies and replace when naloxone supply expires through existing policies and procedures described in LHH policy # (~~'s[insert those here]~~Pharmacy policy 01.01.00 General Services).

h. The Quality Management Department shall track data for overdose and reversal incidents through existing policies and procedures described in LHH policy 60-04 Unusual Occurrence~~#'s [insert those here]~~s.

5. Overdose Prevention Champion and Process Monitoring

a. LHH will identify Overdose Prevention Champion(s), who will develop a process to monitor and evaluate the compliance with established overdose prevention procedures (sections 2-5 above) per DPH policy.

b. The Overdose Prevention Champion(s) will report LHH's implementation of the overdose prevention policy during DPH Overdose Prevention Champion meetings.

ATTACHMENT:

Attachment A: Administrative Code - Departmental Overdose Prevention Policies FILE NO. 210304 ORDINANCE NO. 084-21

Appendix B: Legal References - California Civil Code Section 1714.22

REFERENCES:

1. DPH Overdose Prevention Policy
2. San Francisco Ordinance 084-21
3. LHH 24-25 Harm Reduction ~~Policy HWPP 24-25~~
4. MSPP D08-07 ~~LHH Psychiatry Substance Treatment and Recovery Services Policy~~ LHH Psychiatry Substance Treatment and Recovery Services (STARS) ~~Starts~~ ~~MSPP D08-07~~
5. LHH 24-16 Code Blue Policy ~~HWPP 24-16~~
6. LHH 60-04 Unusual Occurrences Policy ~~HWPP 60-04~~

Most recent review: (Year/Month/Day)
Revised: (Year/Month/Day)
Original adoption: 22/12/13

ATTACHMENT A - ADMINISTRATIVE CODE - DEPARTMENTAL OVERDOSE PREVENTION POLICIES

FILE NO. 210304
ORDINANCE NO. 084-21
ENACTMENT DATE: 06/25/2021

[Administrative Code - Departmental Overdose Prevention Policies]
Ordinance amending the Administrative Code to require the Department of Public Health, Department of Homelessness and Supportive Housing, Human Services Agency, and Department of Emergency Management to develop and submit to the Board of Supervisors departmental overdose prevention policies.

Be it ordained by the People of the City and County of San Francisco:

Section 1. Findings.

(a) According to data from the Office of the Medical Examiner, the number of people who have died from drug overdoses in San Francisco has been rising at a staggering rate. In 2017, 222 people in San Francisco died from a drug overdose. In 2020, 697 people in San Francisco died from a drug overdose. This represents more than a tripling of the death rate in only three years, such that deaths from drug overdoses now average nearly two a day, and nearly 60 a month.

(b) Fentanyl, which is estimated to be 50 to 100 times more potent than morphine, entered the San Francisco market around 2015, causing eleven deaths that year. In 2016, the number of fentanyl overdose deaths in San Francisco doubled, reaching a total of 22. In 2020, 502 people were reported to have died in San Francisco as a result of overdose from use of fentanyl. Thus, in five years, fentanyl overdose deaths in San Francisco increased by 4500%.

(c) This is a public health crisis of major proportions that is out of control. The number of people who died from a drug overdose in San Francisco in 2020 was more than three times the number of people who died in San Francisco from COVID-19 that same year.

(d) Based on data showing the addresses of fatal drug overdoses in San Francisco over the first eight months of 2020, 111 people died on sidewalks or alleys, or in parks or cars; 296 people were found dead in homes or hotels, many in supportive housing in the Tenderloin; and 60 people were pronounced dead at hospitals.

(e) Consuming drugs alone while sheltering-in-place during the COVID-19 pandemic almost certainly amplified the overdose death risk of strong drugs; more than half of the 561 deaths from accidental overdoses during the period January - October 2020 occurred indoors.

(f) A 2019 study published in Drug and Alcohol Dependence surveyed overdose mortality among residents of single room occupancy (SRO) buildings in San Francisco during the period 2010 – 2017, and found that overdose mortality was substantially higher among SRO residents as compared to non-SRO residents, and that SRO residents were also more likely to die from overdosing at home than elsewhere.

(g) A 2019 study published in the Journal of Urban Health examined the acceptability, feasibility, and implementation of the Tenant Overdose Response Organizers (TORO) program facilitated in ten SROs in Canada. That study concluded that the overdose response interventions used by the TORO program, including peer-led overdose prevention and response trainings, wall-mounted naloxone for emergency response, and peer-led support groups, are effective tools in addressing overdose risk in SROs. The study also concluded that tenants who had participated in the program and were taught about opioid overdoses were better able to respond to overdoses and contribute to wider community responses. This study helped inform the DOPE (Drug Overdose Prevention and Education) Project's SRO initiative in San Francisco.

Section 2. Chapter 15 of the Administrative Code is hereby amended by adding Section 15.17, to read as follows:

SEC. 15.17. DEPARTMENTAL OVERDOSE PREVENTION POLICIES.

By no later than December 31, 2021, and every year thereafter, the Department of Public Health, the Department of Homelessness and Supportive Housing, the Healthy Streets Operation Center through the Department of Emergency Management, and the Human Services Agency shall each submit to the Board of Supervisors a departmental policy describing how the department and its grantees that provide direct services to clients who use drugs will promote strategies to reduce drug overdoses ("Overdose Prevention Policy"), along with a resolution to accept transmission of the policy. Each departmental Overdose Prevention Policy shall, to the extent applicable to the department's activities:

(a) Address how departmental programs will provide drug treatment and harm reduction programs and services;

(b) Describe where the department will post the following materials to ensure that they are available and accessible to all clients:

(1) Up-to-date information about the location and schedule of syringe access and disposal services; and

(2) Up-to-date referral information about naloxone access and the schedule of overdose prevention and naloxone distribution services;

(c) Include an onsite overdose response policy that describes the steps the department will take in the event that an individual overdoses on property managed by the department or in the presence of department personnel;

(d) Ensure that department staff who work with people who use drugs receive training in overdose prevention strategies; and

(e) Describe the process by which the department will ensure that grantees that manage property on behalf of the department and/or provide direct services to people who use drugs implement overdose prevention policies that contain the information required in subsections (a)-(d) of this Section 15.17 as applied to the grantee.

Section 3. Effective Date.

This ordinance shall become effective 30 days after enactment. Enactment occurs when the Mayor signs the ordinance, the Mayor returns the ordinance unsigned or does not sign the ordinance within ten days of receiving it, or the Board of Supervisors overrides the Mayor's veto of the ordinance.

ATTACHMENT B - LEGAL REFERENCES - CALIFORNIA CIVIL CODE SECTION 1714.22

Legal/Liability:

Under California Law, staff who have received opioid overdose prevention and treatment training (meaning any training operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose) are legally allowed to administer naloxone to a person who may be experiencing an opioid overdose. A person who is trained in overdose prevention strategies and administers naloxone shall not be held liable for civil action or be subject to criminal prosecution for possession or administration.

A prescriber may issue a standing order authorizing the administration of naloxone by any trained layperson to someone who may be experiencing an opioid overdose. If the program does not have an authorized prescriber (anyone who has prescribing privileges in the state of California), then they may work with a program that provides training and naloxone distribution to come provide training to staff.

Pursuant to Section 1714.22 of the California Civil Code:

For purposes of this section, the following definitions shall apply:

“Opioid antagonist” means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.

“Opioid overdose prevention and treatment training program” means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:
(A) The causes of an opiate overdose.
(B) Mouth to mouth resuscitation.
(C) How to contact appropriate emergency medical services.
(D) How to administer an opioid antagonist.

(2) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the administration of an opioid antagonist to a person at risk of an opioid-related overdose by a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.

(d) (1) A person who is prescribed or possesses an opioid antagonist pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.

(f) Notwithstanding any other law, a person who possesses or distributes an opioid antagonist pursuant to a prescription or standing order shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this possession or distribution. Notwithstanding any other law, a person not otherwise licensed to administer an opioid antagonist, but trained as required under paragraph (1) of subdivision (d), who acts with reasonable care in administering an opioid antagonist, in good faith and not for compensation, to a person who is experiencing or is suspected of experiencing an overdose shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for this administration.

RESIDENT LOCATOR SYSTEM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) Resident Care Teams (RCT) may use a tracking system (also called locator system) to minimize the risk of adverse resident outcomes for residents who may be attempting to elope or those who may wander.~~reduce risk of loss, injury, and other adverse outcomes for residents.~~

PURPOSE:

LHH's goal is to provide care in the least restrictive setting. The use of the resident locator system is intended to ensure safety and maximize resident's freedom.

BACKGROUND:

LHH has installed ~~in its new building~~ a Wi-Fi based tracking system (brand named AeroScout®) in the hospital building. A tag worn by a resident regularly signals its presence. Standard Wi-Fi access points detect the signal, which system software uses to determine the tag's location and to associate it with the resident's name, MR#, and primary language. Special detectors, called exciters, are installed in critical locations (including exits from the LHH neighborhoods, fire doors, main hospital exits, entrance to swimming pool). These cause a nearby tag to signal its presence. For any resident wearing a tag, the authorized area for wandering is determined and pre-programmed. If the resident attempts to go into an unauthorized location (e.g., an elopement risk resident exits a fire door), the system transmits alerts to predetermined recipients via their wireless devices, so that staff can intervene.

PROCEDURE:

1. Resident Assessment:

a. At every assessment (admission, re-admission, quarterly, annual, significant change of condition, or other as needed), the RCT will assess each resident for wandering/elopement risk.

b. If the RCT determines the resident is cognitively impaired and has a prior history of, or a new episode of, wandering, elopement, or inability to return to the neighborhood without help, the RCT will discuss the risks and benefits of monitoring the resident with the locator system.

c. If deciding to use the locator system, the RCT will identify the resident's risk category as one of the following:

i. Not safe to leave the neighborhood unescorted (resident category is "Unauthorized").

ii. Safe to walk unescorted through LHH's new building (resident category is "Indoor Only").

d. The RCT will discuss the plan and describe the nature and purpose of tracking with the resident and/or surrogate decision maker. The physician then obtains Informed Consent from the resident and/or the surrogate decision maker.

e. The physician will order in EHR for both the application of the locator tag and the category of AeroScout® authorization (i.e., "Unauthorized" or "Indoor Only").

f. If the resident's condition improves and the AeroScout® tag is discontinued based on the RCT's determination, the resident and the decision maker will be notified. The notification will be documented in EHR.

g. If an AeroScout® tag is needed to be reapplied based on the RCT's determination, a new consent will be obtained. This also applies to a readmission after a 7-day bed hold has ~~been loss~~occurred.

2. Placement of the Resident Locator Tag:

a. The resident's care plan shall include location tracking.~~, t~~ The Charge Nurse or designee shall:

i. Use the system database to assign a tag; place the tag on the resident (usually with a wristband; other options might include attaching to a wheelchair); and set the resident's tag to the appropriate risk category (i.e., "Unauthorized" or "Indoor Only").

ii. Check that the database correctly associates the tag to the resident's full name, Medical Record Number (MRN), date of birth, gender, primary language, and photograph.

iii. Test that the locator tag appears on the monitoring map.

3. Resident Locator System and Communication of Alerts:

a. Location Monitoring: From a nursing station computer, the neighborhood staff can locate the resident's tag on maps of the neighborhoods and inside the hospital building.

b. When a Stage 1 Alert is triggered, an audible alert (i.e., "Stop, go back") is heard through the speakers above the first set of exit doors on the neighborhood.

c. When a Stage 2, 3, or 4 alert is triggered, designated AeroScout® computers at the nursing station will display a pop-up message with the resident's name, photograph, and current location on a facility map. Neighborhood staff will also receive alerts on their wireless devices containing the resident's name and location.

d. North and South Residence Neighborhood Alerts:

i. A Stage 1 Alert (Redirection) is triggered if an "Unauthorized" resident approaches the exciters above the neighborhood's first main exit door. The audible alert is a pre-recorded message that states, "Stop, go back.". (Messages are available in several languages).

ii. A Stage 2 Alert is triggered if an "Unauthorized" resident does not respond to the Stage 1 Alert and continues to the door adjacent to the elevators. The resident's name and location is sent to neighborhood staff's wireless devices

iii. Pavilion Mezzanine and Pavilion Acute Neighborhood Alerts:

- Due to architectural reasons, the Pavilion Mezzanine and Pavilion Acute neighborhoods will only use Stage 3 and Stage 4 elopement alerts. Staff on these neighborhoods will be trained to monitor the elevator area for elopement risk residents that attempt to leave the neighborhood.

iv. A Stage 3 Alert is triggered for the following:

- If an "Unauthorized" or "Indoor Only" resident exits via a delayed egress fire door. The resident's name and location is sent to the neighborhood staffs wireless devices.

- If an "Unauthorized" resident approaches or enters an elevator. The resident's name and location is sent to neighborhood staffs wireless devices and the resident's tag status is automatically updated to "Wandering".

v. A Stage 4 Alert is triggered if a resident with an "Unauthorized" or "Indoor Only" tag exits the Pavilion main doors, a loading dock door, a ground floor exterior fire exit door, or enters the pool area. The resident's name and last known location is sent to the neighborhood staff's wireless devices. A pop-up notification will also appear on the neighborhood's designated AeroScout® computers as well as the Sheriff's designated AeroScout® computer. The resident's tag status is automatically updated to "Wandering Outdoors".

vi. Staff should verify the resident's last point of exit within the hospital to determine the resident's last known location as the icon on the hospital map will be seen bouncing around while it is attempting to find the tag it's

associated with.

4. Authorized Exits:

a. For All Neighborhoods:

i. Appointments and Activities within LHH: The neighborhood staff can temporarily change a resident's tag status from "Unauthorized" to "Indoor Authorization" via MobileView software. The resident can then be escorted off the neighborhood without triggering an alert.

ii. Appointments and Activities outside of LHH: If a resident needs to be escorted off campus (e.g. SFGH appointment) without triggering an alert, neighborhood staff can change a resident's tag status via MobileView software to "Full Authorization".

iii. For the North and South resident neighborhoods, the resident's AeroScout® tag will automatically reset to the resident's original status upon re-entry to the unit. Once the resident has returned to the unit, staff is responsible for verifying that the resident is present and that the resident's tag status has been updated correctly. For Pavilion Residence Neighborhoods, the neighborhood staff must manually reset the resident's tag to the original status using MobileView.

5. Responding to Resident Locator System Alerts:

a. Neighborhood staff is responsible for responding to resident locator system alerts by locating and redirecting the resident safely back to the neighborhood.

b. If the resident cannot be located, staff will initiate post-elopement response procedures. (See Elopement Response Procedure.)

6. Checking Resident Locator Tag and Function:

a. The neighborhood Charge Nurse or designee is responsible for maintaining the database of neighborhood residents who wear locator tags, and for communicating to neighborhood staff which residents wear the tags.

b. The neighborhood Charge Nurse or designee is responsible for the following:

i. Upon admission, readmission, or relocation of a resident assigned an AeroScout® tag, the Charge nurse/designee will assign and/or check that the resident has the appropriate category of authorization on the MobileView as per physician order.

ii. The Charge Nurse or designee will verify that when a resident with an assigned tag returns to his/her neighborhood (e.g. from OOP, outside appointments, ER visits, LHH clinic or rehab appointments), the resident is still wearing the assigned tag. The Charge Nurse/ designee will also confirm through MobileView that the resident's name, MRN number, category, and status are accurate and have reverted back to the original form.

iii. Every shift, the Charge Nurse/designee will:

- Ensure that each nursing assistant verifies the placement of a resident's AeroScout® tag and documents this information in the electronic health record (EHR).

- Print an AeroScout® assets list report and check that each resident with an assigned tag has an associated tag ID, has the correct MRN associated with the resident, has the correct Category and Status, resident is detected in the neighborhood, or the resident's location is otherwise known (e.g., out on pass), and the last update time is current.

iv. Upon discharge of a resident with an AeroScout® tag to home or community, the Charge Nurse or designee will remove the AeroScout® tag from the resident.

c. The neighborhood Charge Nurse or designee is responsible for checking at each shift the tag's battery status using the AeroScout® battery level report.

i. If battery level is below 20%", the Charge Nurse or designee immediately issues a new tag to the resident and places the low-battery tag in a bin to return for battery replacement.

d. Clinical informatics department conducts weekly battery checks and replaces batteries of AeroScout® devices.

~~d.~~e. The assigned caregiver checks the resident's tag and strap for wear and tear at each shift.

7. Staff Education:

a. Neighborhood staff shall be trained upon orientation or if transferred within LHH on the use of the resident locator system and response to its alerts.

b. Additional education shall be provided to staff if a significant system enhancement is implemented or whenever indicated.

c. Neighborhood staff will be trained that residents with elopement/wander risk must be always escorted by staff while in the garden areas (detectors do not currently

cover the garden areas).

~~c.~~d. All staff are to be educated to be cautious when entering or exiting controlled areas to prevent accidental resident elopement.

8. Performance Improvement:

a. The Licensed Nurse shall complete an Unusual Occurrence report if a resident elopes from the neighborhood.

b. Resident elopement incidents will be periodically reviewed to identify process improvement opportunities and staff training needs.

9. Other Uses:

a. If the Resident Care Team (RCT) identifies possible uses for the locator system that would enhance the resident's safety and quality of life, these possibilities may be discussed with the resident and/or surrogate decision-maker for approval. The use of the resident locator system shall be described in the resident's care plan.

ATTACHMENT:
None.

REFERENCE:
AeroScout® Operation Manual
Nursing System Manual (LagunaNet: Nursing)
LHHPP 24-01 Missing Resident Procedures
LHHPP 24-04 Resident Found Off Grounds
LHHPP 60-04 Unusual Occurrences

Revised: 11/07/26; 12/03/27, 16/07/12, 19/07/09, 23/01/10, 23/10/10
(Year/Month/Day)
Original adoption: 10/12/03

PROVISION FOR ACUTE CARE SERVICES NOT AVAILABLE AT LAGUNA HONDA HOSPITAL

POLICY:

Laguna Honda Hospital and Rehabilitation Center (~~Laguna Honda~~LHH) shall provide all service requirements to meet the standards of Title 22. Laguna Honda maintains a written understanding with Zuckerberg San Francisco General (ZSFG) for surgery, emergency services, acute psychiatric, laboratory, and other required services.

PURPOSE:

To provide a comprehensive program of patient care in accordance with our general acute care hospital licensure requirements.

PROCEDURE:

1. ~~Laguna Honda Hospital and Rehabilitation Center (Laguna Honda)~~LHH will retain the services of ZSFG for the provision of certain acute patient care services that are not offered at Laguna Honda, such as surgery and emergency services.

2. Copies of all agreements for this purpose will be maintained in Administration and shall include descriptions of services to be provided as well as time frames and amendments.

3. Contract services for programs not required by Title 22 are arranged by the Chief Medical Officer.

4. Contracts and agreements are on file within the Medical Service and Hospital Administration.

5. Program flexibility approval(s) from the State Department of Health Services (now known as the California Department of Public Health (CDPH)) shall be posted adjacent to the hospital license.

6. The Administration office is responsible for maintaining posting of the Laguna Honda's original hospital license and the approval letter(s) for program flexibility.

ATTACHMENT:

None.

REFERENCE:

None.

Revised: 92/05/20, 13/01/29, 20/10/13 (Year/Month/Day)

RESIDENT AS PHOTOGRAPHY OR INTERVIEW SUBJECT

POLICY:

1. No photograph, interview (recorded or unrecorded), video, or other image, nor any taped or other recording of any resident shall be permitted by hospital staff or others to be taken or made, unless the resident/decision maker has provided signed written consent and release according to this approved process prior to the event.

2. Laguna Honda staff shall comply with Department of Public Health policies and procedures on Authorization for Use and Disclosure of Protected Health Information (PHI) and other Privacy policies.

PURPOSE:

To protect the right of residents to privacy and to assure that public access and scrutiny does not subject residents to an invasion of privacy.

CHARACTERISTIC:

The right to privacy is an established right of all residents. The nature of "privacy" has been established in the courts to include freedom from unwilling participation in visual and audio recording made on the hospital premises as well as interviews unrequested or unwanted by the resident/decision maker. Acknowledgment of the resident's participation in control of the environment is essential to everyone's well-being.

PROCEDURE:

1. Laguna Honda routinely obtains authorization and consent to photograph as part of the admissions process for resident identification purposes, clinical purposes, and emergency use **only**, as outlined in the admissions agreement.

2. Obtain a signed written consent and release prior to photographing, interviewing, and other recording of the resident (use form DPH form C.14.1MR802). The original signed form must be filed in the resident's chart and the copy is offered to the resident/decision maker.

3. Staff must not allow visual/audio recordings until proper written authorization is requested and granted in writing by the resident/decision maker. Media visits or requests that originate from a resident request require the same written approval by the resident.

   LHH staff and others are not to include identifiable residents in photos or personal stories that disclose their current or past mental health issues or substance use, HIV status, or engagement in behavioral health services.

4. The original signed form must be filed in the residents chart and the yellow copy is offered to the resident/ decision maker.

5. Failure of employees to enforce this policy and procedure may result in disciplinary action.

6. Media inquiries: refer to LHHPP 01-08 Media Relations Policy

ATTACHMENT:
None.

REFERENCES:
LHHPP 01-08 Media Relations Policy
DPH Policy Authorization for Use and Disclosure of PHI (Source: https://www.sf.gov/sites/default/files/2023-05/C.1.0_DPH_Use_and_Disc_of_PHI_FINAL_06.08.22.pdfhttp://10.80.12.69/dph/files/HIPAAdocs/PrivacyPolicies/HIPAAPrivacy- AuthorizationPol02242010.pdf))

Revised: 92/05/20, 10/04/27, 10/08/24, 13/01/29, 15/07/30, 15/09/08 (Year/Month/Day)
Original adoption: 92/05/20

PROPOSED NON-EMERGENT MEDICAL INTERVENTION THAT REQUIRES INFORMED CONSENT FOR AN INCAPACITATED RESIDENT WHOM LACKS A HEALTH CARE DECISION MAKER

PURPOSE:

When any resident (a "Resident") at Laguna Honda Hospital and Rehabilitation Center ("LHH") needs a non-emergent medical intervention that requires informed consent and the Resident both lacks capacity to make the decision and also lacks a health care decision maker authorized to consent to the treatment, state law requires that LHH follow procedures set forth in Health and Safety Code section 1418.8. This policy ensures that all statutory requirements are met before the medical intervention may be administered in accordance with due process rights discussed in *California Advocates for Nursing Home Reform, et al. v. Smith* (2019) 38 Cal.App.5th 838.

PROCEDURE:

In order to determine whether this policy is triggered, there are two threshold issues (listed in Sections (1) and (2) below). If those issues indicate that this policy applies, then follow the remaining statutory requirements to ensure that the Resident's rights under state law are protected before the medical intervention is performed. In the event that the situation becomes an emergency, standard policies around emergent care should be followed.

State law identifies the following issues for determining when a Resident's care falls under the statutory requirements and then lists the steps that must be taken, as follow:

a. ~~1.~~ Medical Intervention Ordered
b. ~~2.~~ No Informed Consent and No Health Care Decision Maker
c. ~~3.~~ Designate Patient Representative
d. ~~4.~~ Interdisciplinary Team[1]
e. ~~5.~~ Emergency
f. ~~6.~~ Administration of Medical Intervention
g. ~~7.~~ Judicial Review
h. ~~8.~~ Documentation

1. **Medical Intervention Ordered.** Resident's attending physician orders a medical intervention that requires informed consent prior to the administration of the medical intervention. Informed consent is required where there is a known risk of death, serious bodily harm, or significant potential complications as a result of a recommended treatment.

2. **No Informed Consent & No Health Care Decision Maker.** Resident's attending physician needs to attempt to obtain informed consent from the Resident consistent with LHH's policies.

[1] Interdisciplinary Team (IDT) also refers to Resident Care Team (RCT) or Resident Care Conference (RCC).

a. ~~(a)~~ Resident lacks the capacity to make their own health care decisions if Resident ~~—~~is unable to understand the nature and consequence of the proposed medical intervention, ~~——~~including its risks and benefits, or is unable to express a preference regarding the intervention.

i. ~~i.~~ Attending physician shall make the capacity determination by ~~————————~~interviewing Resident; reviewing Resident's medical records; ~~————————~~consulting with LHH staff, Resident's family members and ~~————————————~~friends.

b. ~~(b)~~ A person with legal authority to make medical treatment decisions on behalf of ~~—~~Resident is a person designated under a valid Durable Power of Attorney for Health Care, ~~–~~a guardian, a conservator, or next of kin.

~~——~~i. ~~——~~Attending physician shall determine the existence of a person with legal authority by interviewing Resident, reviewing Resident's medical records; consulting with LHH staff, Resident's family members and friends.

3. **Designate Patient Representative.** A patient representative must be designated for each Resident determined to lack capacity as soon as that determination is made.

(a) A patient representative must be "unaffiliated" with LHH and may include a Resident's family member or friend who is unable to take full responsibility for the Resident's health care decisions but has agreed to serve on the interdisciplinary team (IDT); or other person authorized by state or federal law (e.g., ~~local ombudsman,~~ , Office of Long Term Care Patient Representative (OLTCPR), public guardian, or equivalent county officers).

4. **Interdisciplinary Team (IDT).** Except in emergencies (see (5) below), LHH shall conduct an IDT review of the ordered medical intervention prior to the administration of the medical intervention.

(a) Notice

i. Oral and written notice to Resident.
ii. Written notice to another competent person whose interest are aligned with Resident and is willing and able to discuss the meaning of the notice with Resident.
See Appendices A & B for sample written notice templates.

(b) Notice must include:
i. The incapacity decision.
ii. The lack of a legal surrogate.

iii. The proposed medical intervention.
iv. The IDT will make a decision on the proposed medical invention.
v. The right to have a patient representative on the IDT.
vi. The right to seek judicial review (includes Resident be given a reasonable opportunity to seek judicial review).

(c) The IDT shall include Resident's attending physician, a registered professional nurse with responsibility for Resident, other appropriate staff in disciplines as determined by Resident's needs, and a patient representative.

(d) The IDT review shall include:

i. A review of the physician's assessment of Resident's condition.
ii. The reason for the proposed use of the medical intervention.
iii. If known, a discussion of Resident's wishes.
iv. The type of medical intervention to be used, including its probable frequency and duration.
v. The probable impact on Resident's condition, with or without the use of the medical intervention.
vi. Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness.

(e) The IDT shall periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in Resident's medical condition.

(f) Medical interventions may include decisions made in anticipation of end of life. For example, to impose or change a Physician Orders for Life-Sustaining Treatment, Do Not Resuscitate Orders, or comfort care orders, or any decision to provide hospice care to a terminally ill Resident. The process may not be used to make a determination regarding the withdrawal of life support (e.g. withdrawal of ventilatory support); that decision must be made through a court process. (See Medical Probate Standard Work.)

(g) Medical interventions may include the administration of antipsychotic medications consistent with LHH's policies.

5. **Emergency.** In an emergency, after obtaining a physician's order as necessary, LHH may administer a medical intervention that requires informed consent prior to LHH convening an IDT review. If the emergency results in the application of physical or chemical restraints, the IDT shall meet within one week of the emergency for an evaluation of the medical intervention.

6. **Administration of Medical Intervention.** The medical intervention may be administered once the IDT reaches a consensus (e.g., all IDT members must agree to proceed forward with the proposed medical intervention) and after Resident has had an opportunity to seek judicial review (see (7) below).

7. **Judicial Review.** Resident has a right to seek judicial relief. If anyone on the IDT disagrees with the incapacity decision, lack of surrogacy decision, or proposed medical intervention there is an opportunity to be heard in court upon a petition under Probate Code section 3201.

If a petition is required, please contact the City Attorney's Office. (See Medical Probate Standard Work.)

8. **Documentation.** The following determinations and the basis for those determinations shall be documented in Resident's medical record and shall be made available for the patient representative's review:

(a) Attending physician's determination that Resident lacks the capacity to make their own health care decisions, and there is no person with legal authority to make those decisions on Resident's behalf.
(b) IDT's review of the medical intervention.
(c) IDT's review of the medical intervention at least quarterly or upon a significant change in Resident's medical condition.

ATTACHMENT:
Appendix A: Notice to Resident
Appendix B: Notice to Patient Representative

REFERENCE:
California Health and Safety Code section 1418.8
California Advocates for Nursing Home Reform, et al. v. Smith (2019) 38 Cal.App.5th 838.
Cobbs v. Grant (1972) 8 Cal.3d 229
California Hospital Association, California Hospital Consent Manual (2020)

Revised: 20/11/10 (Year/Month/Day)
Original adoption: 19/03/12

Appendix A
Notice to Resident

[Hospital letterhead]

Month __, 2020

Jane Doe
Laguna Honda Hospital and Rehabilitation Center
375 Laguna Honda Blvd.
Neighborhood XX, Room XX
San Francisco, California 94116

Re: Interdisciplinary Team Meeting for Proposed Medical Intervention

Dear Ms. Doe:

On April 27, 2020, Laguna Honda Hospital and Rehabilitation Center (LHH) will convene an interdisciplinary team (IDT) meeting at 1:00 p.m. in conference room X.

The purpose of this notice is to inform you of the following:

1. Dr. XXX determined that you lack the capacity to make your own medical decisions;

2. Dr. XXX determined that there is no person with legal authority to make medical treatment decisions on your behalf;

3. Dr. XXX ordered [list proposed medical intervention(s)];

4. During the IDT meeting, participants will discuss and vote on the proposed medical intervention(s);

5. You have a right to have a patient representative on the IDT review panel; and,

6. You have a right to seek judicial review of the incapacity determination, lack of health care decision maker determination, or proposed medical intervention(s).

The IDT meeting participants will include: Dr. XXX, Registered Nurse XX, XX [include any other appropriate staff in disciplines as determined by the Resident's

needs], and your patient representative [name].

LHH will provide similar notice of your upcoming IDT meeting to your patient representative [name].

If you have any questions, please contact XXX at (415) XXX-XXXX; your patient representative [name] at (415) XXX-XXXX; or the Long-Term Care Ombudsman Program at (415) XXX-XXXX.

Sincerely,

First & Last Name
LHH Title

Appendix B
Notice to Patient Representative

[Hospital letterhead]

Month __, 2020

First & Last Name
0000 XXXX Street,
San Francisco, California 94121

Re: Interdisciplinary Team Meeting for Resident Jane Doe

Dear Mr./Ms. XXX:

On April 27, 2020, Laguna Honda Hospital and Rehabilitation Center (LHH) will convene an interdisciplinary team (IDT) meeting for Resident Jane Doe at 1:00 p.m. in conference room X. You are receiving this notice because you are Ms. Doe's designated patient representative. As a patient representative, your presence at the meeting is legally required. (Health & Safety Code § 1418.8(e) and (f); *California Advocates for Nursing Home Reform, et al. v. Smith* (2019) 38 Cal.App.5th 838, 874.)

Additionally, this notice seeks to inform you of the following:

1. Dr. XXX determined that Ms. Doe lacks the capacity to make her own medical decisions;

2. Dr. XXX determined that there is no person with legal authority to make medical treatment decisions on Ms. Doe's behalf;

3. Dr. XXX ordered [list proposed medical intervention(s)];

4. During the IDT meeting, participants will discuss and vote on the proposed medical intervention(s);

5. Ms. Doe has a right to have a patient representative on the IDT review panel; and,

6. Ms. Doe has a right to seek judicial review of the incapacity determination, lack of health care decision maker determination, or proposed medical intervention(s).

The IDT meeting participants will include: Dr. XXX, Registered Nurse XX, XX [include any other appropriate staff in disciplines as determined by the resident's needs], and you as Ms. Doe's patient representative.

Lastly, state law requires LHH to provide written notice to a person whose interest are aligned with Ms. Doe, and who is willing and able to discuss the meaning of this notice with Ms. Doe. Please contact us to confirm your attendance for the upcoming IDT meeting and
your ability to meet with Ms. Doe prior to the IDT meeting to discuss this notice. Ms. Doe's residence is located in [neighborhood] room #.

If you have any questions, please contact XXX at (415) XXX-XXXX.

Sincerely,
First & Last Name; LHH Title

INVENTORY AND DISPOSAL OF HOSPITAL PROPERTY

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) departments take responsibility for inventory and tracking of capital and minor equipment.

2. The Information Systems Department (IS) is responsible for the inventory of computer equipment such as desktop and laptop computers, and peripheral devices used by staff throughout the hospital.

3. The Accounting Department is responsible for recording capital equipment.

4. The disposal of hospital property is done in accordance with established procedures.

5. Staff shall adhere to the City's reuse program through the Virtual Warehouse online system.

6. Reusable items from the Virtual Warehouse are for city-use only and cannot be acquired for personal use.

7. Employees may not remove from the premises any hospital property without a Property Pass.

PURPOSE:

1. To ensure the effective utilization of departmental assets and resources.

2. To meet disposal requirements of the City and County of San Francisco for inventoried property.

3. To prevent unauthorized removal from the premises of inventoried Hospital property.

4. To provide a means to remove property from the asset ledger and preventive maintenance schedules when it is purged from inventory.

DEFINITION:

1. Minor Equipment - The larger class of Hospital property, furniture, and other equipment with a purchase value of $200 up to $5000.

2. Capital Equipment – Stand-alone equipment with a purchase price of $5000 or greater and an anticipated life of one year or greater.

3. Identified Hospital Property: Hospital property to which is affixed a CCSF inventory sticker, an LHH preventive maintenance program sticker, or upon which is imprinted or painted any CCSF, DPH, or LHH identifier.

4. "DISCARD – Laguna Honda": Items marked by Central Processing Department (CPD) that are defined as "no longer Hospital property."

5. Property Pass: An item specific document obtained from LHH's CPD Manager.

6. Virtual Warehouse – City and County of San Francisco's web-based program to facilitate the reuse of City owned office furniture, electronics, equipment, and supplies.

PROCEDURE:

1. Equipment is received by CPD.

    a. Designated staff from CPD affixes an "A" inventory and asset tag to equipment designated as bio-medical.

2. CPD contacts Facility Services Department to evaluate equipment covered under the Hospital's preventive maintenance program (PM).

    a. Facility Services affixes a "C" or "D" asset inventory tag depending on the PM program.

3. IS receives ordered technology equipment from the IT Procurement Storekeeper.

    a. IS affixes a "B" or "Q" asset inventory tag to the equipment used by staff, records the equipment in its database, and deploys the equipment.

    b. IS affixes a "D" asset inventory tag to computer equipment that is used by residents but not supported by IS and facilitates delivery to the appropriate department.

4. Upon receiving minor equipment, not covered by the hospital's PM program, hospital departments are responsible to maintain an inventory of all equipment with a "D" tag.

5. Donated equipment is included under departmental responsibility for tagging and inventorying of the equipment.

6. Each department maintains a listing of identified hospital equipment under its operation. Departments are not responsible for inventory of technology equipment designated for staff use. Technology equipment designated for resident use is included in departmental responsibility for inventory.

    a. The listing includes a general description of the item (i.e. iPad), the number of items and the location of the equipment.

b. The listing is updated as existing equipment is disposed of, and as new equipment is acquired.

7. Departments shall conduct an inventory count of their equipment on an annual basis by the end of the fiscal year to confirm the accuracy of their equipment lists.

   a. Any equipment missing from the list shall be marked either as missing, stolen, or disposed. Departments shall attach a report for all missing or stolen equipment detailing the circumstances with a plan to prevent missing or stolen equipment in their departments in the future.

   b. The lists shall be forwarded to the Accounting Department by the 31st of July.

8. Central Processing Department is responsible to facilitate the disposal of all identified property.

   a. Department heads are responsible for completing the Virtual Warehouse form and submitting to the CPD Manager, the LHH Virtual Warehouse Authorized contact (CCSF Virtual Warehouse - MM Template.xls).

   b. Reusable items shall be posted to the Virtual Warehouse online inventory for other departments and organizations to view. These items must be available for a minimum of 30 days.

   c. Items for disposal must be submitted to the Virtual Warehouse prior to disposal or removal, even if the item is already broken or obsolete.

   d. Broken or obsolete items shall not be posted and can be recycled or donated in less than 30 days. They may be donated or recycled to various non-profits per Virtual Warehouse approval and receipts must be submitted.

   e. If after 30 days it is determined that the item is to be disposed, CPD shall contact Environmental Services Department (EVS) and/or Facility Services for arrangement. Prior to disposal of any stickered-identified property in a hospital trash bin, CPD shall coordinate with EVS or Facility Services to place a red tag "DISCARD – Laguna Honda" in a visible location on the item.

      i. If item is considered technology equipment, CPD shall arrange for e-waste disposal.

   f. Any hospital employee or volunteer who wants to remove from the premises any discarded item with red tag “DISCARD – Laguna Honda” must obtain a Property Pass from LHH's CPD Manager.

9. CPD shall notify the Accounting Department of disposed equipment. Information provided to the Accounting Department shall include the inventory and asset tag number.

10. The Food Services Department shall forward information on disposed food to the Accounting Department at the end of each month.

11. EVS shall report disposed linen to the Accounting Department at the end of each month.

12. The Pharmacy Services Department shall report any incidental disposal of any pharmaceuticals other than the expired drugs to the Accounting Department.

ATTACHMENT:
None.

REFERENCE:
LHHPP 31-05 Preventive Maintenance Plan
LHHPP 50-09 Capital Asset Administration Policy
City & County of San Francisco Virtual Warehouse website –
~~warehouse.sfenvironment.org~~ https://www.sfenvironment.org/virtualwarehouse

Revised: 96/07/15, 12/09/25, 19/03/12, 23/03/14
(Year/Month/Day)
Original adoption: 96/02/09

PROCUREMENT CARD

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) utilizes procurement cards (P-Card) for the acquisition of materials, supplies, and services that are not readily available through the normal purchasing mechanisms due to the unique needs of resident programing, disaster response, and on-line business transactions.

PURPOSE:

To ensure a process for the procurement of materials, supplies, and services that is efficient and maintains appropriate internal controls in compliance with City Controller's policy.

CHARACTERISTICS:

1. P-Cards are used to procure non-medical resident related materials, supplies and services within the Activity Therapy, and Substance Treatment and Recovery Services (STARS) programs. The LHH Gift Fund is the funding source for these programs.

    a. Allowable purchases for the Activity Therapy program include:

        i. Game prizes (bingo prizes, etc.) Average cost per prize is $5-10.

        ii. Tickets to community events including concerts, lectures, and other cultural events and snacks/refreshments and/or meals for outing events. Allowable expenses include tickets and food for residents and staff who lead and chaperone the events. The food will adhere to the DPH Healthy Food and Food Expenditure Policy.

        iii. Monthly subscriptions to one Netflix account and one Spotify account (or similar service) for use in activity programming (parties, movie nights, etc). Because of the limitation of 4 devices to one Netflix account, if a need arises for more devices, then ~~more Netflix accounts~~ no more than 4 Netflix accounts are~~are~~ acceptable. A log will be established that will show staff who are owners of the account, who has access to the account, and how the password will be managed.

        iv. Gifts for the annual holiday gift program. P-Cards are ideal for this program given that they charge a lower markup or financing percentage than do comparable fiscal intermediary firms. The Department must obtain approval from the Controller's Office annually to authorize a temporary credit limit increase to match the budget for this program. The increase in credit limit necessary to purchase all of the gifts will be temporary and immediately reduced after the gifts are purchased and paid.

a. The holiday gift program happens once annually during October and December. The holiday gift program is a long-established program and an essential part of therapeutic care and treatment for Laguna Honda residents.

b. Residents are given a catalogue of items to choose gifts from within a per- person budgeted amount of up to $50. After they mark their selection, orders are aggregated on a single master order sheet tracking orders/gifts by resident.

c. All residents participate in the program.

d. Spending on the program is a not to exceed amount as approved in advance by the Health Commission. The source of funds will be Laguna Honda's Gift Fund.

e. The program is administered by LHH Volunteer Coordinators and the Activity Therapy Department. Volunteer coordinators develop the catalogue, process orders, and maintaining order sheets detailing items by name, unit and record of delivery. Staff in the Activity Therapy Department are responsible for collecting orders, distributing items, confirming receipts with resident acknowledgement of item receipt, and retaining packing slips and/or receipts from the retailer. The log of orders and record of receipts will be maintained by Laguna Honda Accounts Payable for future audit purposes.

f. Due to the high volume and variety of items, an online retailer such as Amazon or Walmart is preferred for this program.

b. Incentive prizes for the STARS program. Average cost per prize is $5-10.

2. P-Cards are used for physician credentialing, hospital certifications, and emergency and disaster response. P-Cards are also used to maintain appropriate balances for the hospital's Fastrak accounts.

3. P-cards are used by the Social Services Department to purchase items on behalf of residents using their trust fund accounts. Purchases must be at the request of the resident and be in accordance with the Resident Trust Fund Policy.

    a. One card will be assigned to the Social Services department. Requests for additional cards will require evaluation and approval by the Controller's Office.

    b. The card limit and average monthly spend is $5,000.

    c. Purchases over $1,000 require approval from the Controller's Accounting Operations Director.

    d. Allowable purchases include:
        - Food & snacks
        - Toiletries & personal hygiene products
        - Clothing & shoes
        - Health & wellness products
        - Personal entertainment devices (e.g., DVD Player, iPad…)
        - Games & puzzles
        - Prepaid Gift Cards
        - Other items requested by the residents

e. Due to the volume and variety of items, an online retailer such as Amazon or Walmart is preferred for this program.

f. Payment for this card will be processed through a separate voucher to US Bank. The voucher cannot be comingled with other LHH P-Card payments. The chart fields used must be the one dedicated to the Resident Trust Fund.

4. P-Cards may be used for hotel reservations when a group of 3 or more attend a conference or industry event. Lodging must be purchased at the conference rate, or the prevailing GSA rate of the event location as defined in the Controller's Office (CON) Accounting Policies & Procedures. All P-Card purchases are subject to audit. Any deviation from the CON/LHH accounting policies may lead to termination of the P-Card program.

ROLES

1. The Finance Director or designee maintains the role of **Department Coordinator** for the P-Card program. Responsibilities include:

    a. Oversight of the P-Card program for the hospital.

    b. Approve requests for P-Cards from Approving Officials.

    c. Pre-approve cardholder expenditures over $200.

    d. Review and approves reports for P-Card use and performance.

    e. Approve payments to US Bank for P-Card transactions.

    f. Liaison with the P-Card Coordinator in the Controller's Office.

2. The Director of Wellness and Therapeutic Activities and the Director of Psychology, or designees maintain the role of **Approving Officials** for the P-Card program within their respective departments. The Director of Environmental Services maintains the role of Approving Officer for Fastrak expenditures. The Chief Medical Officer is the Approving Official for physician credentialing expenditures. Responsibilities include:

    a. Oversight of proper P-Card use within their departments and programs.

    b. Make requests to Department Coordinator for P-Cards for employees under their supervision. Notify Department Coordinator of change of employment status of cardholders within their departments.

    c. Pre-approve cardholder expenditures and verify that Expenditures are made for official hospital business.

    d. Review and certify the reconciled Cardholder Statements of Account and ensure that original receipts and documents are in order.

    e. Ensure that each cardholder statement of account is accounted for and forward them to the Billing Official.

3. The Accounts Receivable Supervisor or designee maintains the role of **Billing Official**. Responsibilities include:

    a. Receive, review, and ensure accuracy of account statements, receipts, and reconciliation reports.

    b. Facilitate monthly P-Card payments to U. S. Bank and charges expenses to proper accounts.

    c. Determine whether proper sales tax has been paid and accrue any use tax.

    d. Prepare reports for the Department Coordinator.

e. Execute payments to US Bank within the City's Financial System.

4. Assigned staff of the above referenced programs are **Cardholders**. Responsibilities include:

   a. Review and consent the CCSF P-Card Cardholder Guide.

   b. Maintain security of the account number and P-Card.

   c. Secure pre-approval of all expenditures to be made by P-Card.

   d. Make appropriate purchases while securing the value for the hospital.

   e. Secure itemized original receipt at the point of purchase and verify for accuracy.

   f. Complete expense form.

   g. Reconcile all transactions and forward original receipts and expense forms to Approving Official.

   h. Cardholders shall return P-Card to Department Coordinator if position duties change.

PROCEDURE:

1. Procurement Card Management.

   a. All staff involved with P-Card, shall complete training developed by the Controller's Office and comply with the standards established in the City and County of San Francisco's policy on Procurement Card.

   b. All P-Cards issued to cardholders will have a default credit limit of $1,000.

   c. The expenses in support of Activity Therapy, and STARS programs may not exceed Gift Fund budget limits established by the Gift Fund Committee and approved by the Health Commission.

   d. Potential cardholders/requesters shall complete a Procurement Card Request Form with approval from their department head and the Department Coordinator. The requesters shall indicate and sign the request form acknowledging that they have read and understand the Controller's and LHH P-Card policy.

   e. P-Cards are surrendered to the Accounting Department and cancelled promptly when the position, responsibilities, or employment status of a Cardholder changes.
   f. The Accounting Department maintains a spreadsheet of P-Cards/Cardholder accounts.

2. Prior to any expenditures made with a P-Card, Cardholders shall obtain prior written approval from the Approving Officials related to the programs for which expenditures are made in support of department programs documented on the Procurement Card Pre-Expenditure Authorization Form.

   a. Expenditures exceeding $200 require Department Coordinator approval in addition pre-approval by Approving Official

   b. Expenditures for Disaster Response expenditures and Fastrak account replenishment do not require written pre-authorization.

3. The Cardholder shall make the purchases within the limits of the pre-authorization.

4. Cardholders shall download and print monthly statements, reconcile all transactions, and forward all documentation including original receipts and The Direct Payment Request Form to their respective Approving Officials prior to the 28th of each month. If the 28th falls on a weekend, the original receipts are forwarded to the Approving Official on the previous business day.

5. Approving Officials shall review P-Card documentation and approve Cardholder transactions, then forward P-Card documentation to the Billing Official by the 2nd of the following month unless it falls on the weekend, then the previous business day.

6. The Billing Official shall review and reconcile P-Card documentation and direct Accounting staff to set up payment to U.S. Bank in the City's Financial System by the 4th of each month or prior if that date falls on the weekend.

7. The Billing Official forwards P-Card documentation to the Department Coordinator for review and approval by the 6th of the month or prior if that date falls on the weekend.

8. Upon approval by the Department Coordinator, the Billing Official will approve payment to U.S. Bank in the City's Financial System by the 8th of each month or prior if that date falls on the weekend.

P-Card statements generated on the ***25th*** of each month or previous business day if the 25th falls on a weekend. Card payment due ***14 days*** from the statement date		
Staff/Role	**Description**	**Monthly Due Date**
Cardholder	Downloads statement, reconciles transactions and submits original receipts with expense form to Approving Officer	28th or prior if weekend
Approving Official or Designee	Reviews & approves Cardholder documents and submits them to Billing Officer/Accounting Department	2nd or prior if weekend

Billing Official/Accounting	Reviews and reconciles all documents including on-line bank statements, sets up payment in City's Financial System, and submits to the Department Coordinator	4th or prior if weekend
Department Coordinator or Designee	Reviews all documentation and approves payment.	6th or prior if weekend
Billing Official/Accounting	Approves payment in the City's Financial System	8th or prior if weekend

9. A P-Card is issued to the Medical Staff Secretary to transact on-line physician credentialing charges. The Medical Staff Secretary assumes the role and responsibilities of the card holder. The Medical Director assumes the role of Approving Official.

10. Medicare/Medi-Cal certification and Fastrak account payments are transactions for which an Accounting staff member is assigned the role of Cardholder.

    a. Hospital staff responsible for Medicare/Medi-Cal Certification contacts the Accounting staff member to facilitate on-line payment and assumes the role of Approving Officials for the transactions. The Procurement Card Pre-Expenditure Authorization Form is presented at the time of contact.

    b. The designated Accounting Department staff person monitors the hospital's Fastrak account in which automatic payments are set up using the purchase card issued to the Accounting Staff member.

        i. Two Fastrak transponders each are provided to the Activity Therapy Department and Administration.

        ii. Staff checking out transponders document usage of the transponders on the Fastrak transponder logs.

        iii. The logs are reconciled with monthly Fastrak statements to ensure appropriate use of the transponders for hospital business

    c. When the automatic Fastrak charges are generated, Accounting Department staff persons collaborate to facilitate payment on the account. The Director of Environmental Services executes the role and responsibility or the Approving Official for Fastrak payments.

    d. The Accounting staff member fulfils the responsibilities of the Cardholder and forwards all documentation to the Approving Official who in turns submits approved documents to the Billing Official, all within the established timelines.

11. Declared Emergency and Natural Disasters

    a. Emergency purchases during Declared Emergencies and Natural Disaster. Refer to San Francisco Administrative Code Section 21.15 and Section 6.60 for emergency procurement procedures and who can declare emergency. Disaster P-Cards do NOT replace the City's existing Emergency Purchasing Procedures but will supplement the procedures.

    b. A P-Card is issued to the Director of Emergency Response and Workplace Safety. The default credit limit for that card is $1000. When an emergency is declared, the department will take the following steps to increase P-Card credit limit should the need of credit limit increase arise:

        i. The Finance Director or designee will contact the Citywide P-Card Administrator to request an emergency increase to the P-Card credit limit.

        ii. The City Controller's Office will contact U.S. Bank to increase the credit limit.

    c. The Director of Emergency Response and Workplace Safety will coordinate all purchases in response to an emergency or disaster.

    d. The Director of Emergency Response and Workplace Safety is responsible for reconciling all transactions and forwarding original receipts and expense forms to the Finance Director for verification.

    e. All Documentation related to emergency and disaster purchases are forwarded to the Office of the Controller for financial processing.

ATTACHMENT:
Attachment A: Procurement Card Request Form
Attachment B: Procurement Card Pre-Expenditure Authorization Form
Attachment C: Direct Payment Request Form

REFERENCE:
LHHPP 45-01 Gift Fund Management
CCSF Procurement Card Policy and Procedures
CCSF Purchasing Cardholder Guide
San Francisco Administrative Code Section 21.15 and Section 6.60

Revised: 18/05/08, 20/01/14, 22/07/12 (Year/Month/Day)
Original adoption: 16/11/08

Attachment A: Procurement Card Request Form

Procurement Card Request Form

Name		DSW #	
Department Level 1	Department of Public Health	Department Code	DPH
Department Level 2	Laguna Honda Hospital	Division Code	HLH
Program			
Job Title		Job Class #	
Address	375 Laguna Honda Boulevard	Room #	
City	San Francisco	State/Zip Code	California, 94116
Work E-mail		Work Phone	
Approving Officer of Designee			

☐ I have read and understand the hospital policy and procedure of the use of Procurement Cards and the CCSF P-Card Cardholder Guide

Name	Signature		
		Denise Payton, Finance Director	
Department Head	Signature		Signature

MONITORING OF THIRD PARTY AGREEMENTS

POLICY:

1. Third party agreements are defined as agreements that Laguna Honda works with the DPH Central Contract office to execute. This includes, but is not limited to contracts, Memorandums of Understanding, and intern and school agreements.

2. The Contract Manager (Laguna Honda Managers who oversee third party agreements) is responsible for establishing written agreements that define clear expectations and standards of quality. Written agreements must be developed in accordance with City and DPH contract policies and be approved by DPH contract office and City Attorney. The Laguna Honda Executive Administrator signs the agreement prior to the start date of goods and services.

3. All third party agreements shall have a formal evaluation annually to assure accountability and compliance with contractual standards, identify problem areas and provide information for future planning. Any contractual service which has not been monitored will not be considered for contract renewal unless good cause can be shown.

4. Laguna Honda Administration Office is responsible for centralizing all agreements and Monitoring Reports. The Executive Administrator or designee will delegate this task to support staff.

PURPOSE:

To ensure that third party agreements between Department of Public Health/Laguna Honda and the party providing the good or service meet clear objectives, standards of quality, City regulations and are formally monitored annually.

PROCEDURE:

1. Respective Laguna Honda Contract Managers are responsible for:
    a. Establishing agreements with third party vendors through DPH Central Contracts and City Attorney's Office. The Laguna Honda Executive Administrator signs the agreement.
    b. Submitting on a timely basis a copy of signed written agreements to Laguna Honda Administration, including extensions, modifications and/or new agreements.
    c. Reading and clearly understanding the expectations and quality of services rendered by the third party vendor.
    d. Verifying and approving invoices (if any) submitted for payment from the third party.

e. Completing the annual *Third Party Agreement: Monitoring Report* (refer to Appendix A). The Monitoring Report is due to Laguna Honda Administration by JulyJanuary 30th every year. The review period is the previous fiscalcalendar year. If multiple departments work with the third party under the same contract, it is the responsibility of the designated Contract Manager to gather performance input from all individuals involved.
f. Provide ongoing review of the third party work as needed. Throughout the year if performance concerns arise, the Contract Manager must document these issues and speak with the appropriate person at the time. If needed, the Monitoring Report may be used at this point to document concerns and to develop Performance Improvement Plans (PIP).

2. Instructions for completing the *Third Party Agreement: Monitoring Report*
   a. Part A: The Contract Manager rates the third party's performance on a scale from 1 (unacceptable) to 4 (exceeds standards) for four overall measures.
   b. If the average performance rating is less than a three (< 3) then the Contract Manager and the third party shall develop a Performance Improvement Plan.
      i. The plan describes what will be done to improve performance and compliance. It also includes a timeline and no later than quarterly progress reports.
      ii. For the PIP, the Contract Manager documents regular progress assessments and provides status updates to their Direct Supervisor. If program performance does not improve, this will be handled on a case by case basis
   c. Part B: The Contract Manager communicates the findings from the monitoring report in Part A with the appropriate representative from the third party. The third party documents the response to the performance rating by either responding in an email to questions specified, or acknowledging and signing a paper version.
   d. Part C: The direct supervisor of the Laguna Honda Contract Manager reviews Part A, including the PIP, and Part B. The direct supervisor responds to the questions in Part C. When sufficient work has been completed, the direct supervisor and Contract Manager will provide their final signatures to complete the monitoring process.

3. Laguna Honda Administration Office support staff is responsible for:
   a. Maintaining paper and electronic copies of all third party agreements for Laguna Honda, as submitted by the Contract Manager.
   b. Tracking agreements in an electronic spreadsheet, including the annual overall performance rating.
   c. Providing reports to Contract Managers, direct supervisors and Executive Committee as requested.

4. Direct Supervisor is responsible for:

a. Communicating as needed with the Contract Manager about the performance of third party agreements.
b. Providing supervisory support as needed during the Monitoring Report process. Completing Part C of the Monitoring Report after ensuring the Part A and B are completed.
c. Working with the Contract Manager to address performance measures rated less than a three (< 3). Providing oversight during the PIP development, implementation and review process.

5. The Executive Committee is responsible for:
    a. Reviewing aggregate performance ratings of all third party agreements on an annual basis. Reviewing PIPs more frequently as needed.
    b. Providing guidance on how to handle low performing third party vendors.

ATTACHMENT:
Appendix A: Monitoring Report Summary

REFERENCE:
Health Commission Contract Policies
Revised: N/A
Original adoption: 14/11/25

Appendix A

PART A

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

THIRD PARTY AGREEMENTS: MONITORING REPORT

Third Party Provider:		
Scope of Services:		
Laguna Honda Contract Manager:	Department:	Today's Date:
This is: ☐ New contract ☐ Ongoing contract	Fiscal~~Calendar~~ Year in Review:	

Rating Scale: Use the following 1 through 4 metrics when rating the Third Party's program performance and compliancy.
*A Performance Improvement Plan is required for *any* measure that is less than a three (< 3).

1. * Unacceptable	2. * Improvement Needed/ Below Standards	3. Acceptable/ Meets Standards	4. Commendable/ Exceeds Standards

A) Were the requested goods and/or services completed in a *satisfactory* manner?	☐1.* ☐2.* ☐3. ☐4.
B) Were the requested goods and/or services completed in a *timely* manner?	☐1.* ☐2.* ☐3. ☐4.
C) Did the requested goods and/or services follow the necessary *policies, procedures and regulations*?	☐1.* ☐2.* ☐3. ☐4.
D) Did the completed good and/or services match the invoice(s)? (Write NA if not applicable.)	☐1.* ☐2.* ☐3. ☐4.
E) Other measures specific to contract:	☐1.* ☐2.* ☐3. ☐4.

Overall Performance Rating: Average the ratings for the measures (round to the nearest 10th of a point): _____

Findings and Commendations:

*** Performance Improvement Plan (Required for Any Rating < 3):** Working with the Third Party Provider, describe what will be done to improve performance and compliancy. Include a timeline and regular progress checks.

Laguna Honda Manager: Please complete Monitoring Report for every third party agreement you oversee.
Return to Laguna Honda Administration by January 30 every calendar year. Rev: 7/8/14

PART B

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

Note: Additional comments or a detailed report may be attached as needed.

THIRD PARTY AGREEMENTS: MONITORING REPORT
THIRD PARTY PROVIDER RESPONSE

1) **Option 1 — Email Response:** The Third Party Representative Replies via email that they have reviewed the Monitoring Report and must answer the following questions:

   a) I have received the Monitoring Report and acknowledge the findings. *(Yes; No)*
   b) I have assisted in developing the Performance Improvement Plan. *(Yes; No; Not Applicable)*
   c) I have received Monitoring Report and disagree with the findings. My response is included. *(Yes; No; Not Applicable)*

   Third Party Provider also includes standard email signature to identify the company name and job tittle. Attach email response to this form.

2) **Option 2 — Hard Copy Signature:** The Third Party complete the form below and sends the signed copy back to the Laguna Honda Contract Manager.

   Checks all that applies below:

I have received the Monitoring Report and acknowledge the findings.	☐ Yes ☐No ☐ Not Applicable
I have assisted in developing the Performance Improvement Plan.	☐ Yes ☐No ☐ Not Applicable
I have received Monitoring Report and disagree with the findings. My response is attached.	☐ Yes ☐No ☐ Not Applicable

_____ _____
Signature of Authorizing Contract or Provider Representative Date

_____
Name and title

Laguna Honda Manager: Please complete Monitoring Report for every third party agreement you oversee.
Return to Laguna Honda Administration by January 30 every fiscal year. Rev: 7/8/14

PART C

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

THIRD PARTY AGREEMENTS: MONITORING REPORT
DIRECT SUPERVISOR REVIEW AND SIGNATURES

Laguna Honda Direct Supervisor reviews the following items:

1) completed Part A of the Monitoring Report;
2) the Performance Improvement Plans (if any); and,
3) Part B with the Third Party response.

Director Supervisor checks all that apply below:

Third Party Provider performance is adequate and no action is needed.	☐
Performance Improvement Plan is comprehensive and I will continue to received regular updates on the progress	☐
The Third Party Provider performance is unacceptable. Terms of current contract needs to be reviewed. Renewal of contract needs to be reconsidered.	☐

Other Comments:

Final Signatures

Signature of Laguna Honda Contract Manager	Signature of Director Supervisor
Date	Date
Name and Title	Name and Title
Date	Date
Department	Department

Laguna Honda Manager: Please complete Monitoring Report for every third party agreement you oversee.
Return to Laguna Honda Administration by January 30 every fiscal year. Rev: 7/8/14

Date	Date

LAGUNA HONDA HOSPITAL ~~MDF/IDF~~MAIN/INTERMEDIATE DISTRIBUTION FRAME SUPPORT – FACILITIES

PURPOSE:

The purpose of this document is to inform the Information Technology (IT) Service Desk and Facilities support personnel of proper escalation procedures during an outage involving Laguna Honda Hospital and Rehabilitation Center (LHH) facility systems that could impact IT services.

The systems covered provide services to the Main Distribution Frame (MDF) (South Data Center), Building Distribution Frames (BDF) and Intermediate Distribution Frames (IDF) at LHH.

Please see the glossary in Appendix 1 to clarify terms/acronyms outlined below.

PROCEDURE:

1. **Notification Procedure for Facility Systems outages**

The LHH Watch Engineer~~Desk~~ monitors the following systems 24x7: Cooling, Fire Suppression Alarm, Power, Water Detection events. After the Facilities Watch Desk is alerted of a problem with one of these systems, the Facilities Engineer shall investigate the alarm and then contact the Nursing office to coordinate communication to the following in order:

- A. Department of Public Health (DPH) IT Service Desk (6-7378) (24/7) – use appropriate language if IT escalation is required (e.g. "cooling system is off", "server room is offline", "temperatures are rising in the following critical areas: _____").
- B. AOD/Nursing Operations (4-2999) to inform them of a potential problem.

~~Courtesy pages are sent to key DPH IT staff and the DPH IT Service Desk by the monitoring system if a problem occurs with a facilities system. The Service Desk staff keeps a pager (415-327-1729) where these alarms are sent. If the Service Desk receives a page and is not contacted within 15 minutes by LHH the Service Desk staff must call 415-370-8259 to ensure the Watch Desk is aware of the potential issue.~~

C. The Watch Engineer~~Desk~~ will contact Service Desk (ext. 6-7378) when key indicators are present:
   a. Temperature in the MDF reaches 80 degrees.
   b. Temperature in the BDF/IDFs reaches 90 degrees
D. Service Desk will inform the various IT OPS team with hardware residing in the affected area via email for awareness.

E. Once Service Desk receive~~sd~~ an all clear from the Watch Desk, Service Desk will send out a follow up email to the potentially impacted teams so the teams can check on their hardware.
F. If Service Desk was informed of any possible hardware damage, Service Desk will open a ServiceNow incident and call the On Call staff for the impacted team(s).

~~**2. Key Indicators:**~~

~~The Watch Engineer shall validate that the system in question is working as designed. The Watch Engineer shall alert the DPH IT Service Desk if any of the key indicators are present:~~

- ~~Temperature in the MDF exceeds 80 degrees.~~
- ~~Temperature in the BDF/IDFs exceeds 90 degrees~~

~~3.~~2. Important Notes:

In the event of a cooling failure in the MDF please see Appendix 2 for appropriate locations of fans to provide some cooling while IT staff travel to site.

ATTACHMENT:
Appendix 1: Types of Systems Operated by Facilities; Contact List; Glossary
Appendix 2: Fan Locations Sign to be Posted in Server Room

REFERENCE:
None.

Original adoption: 2020/09/08 (Year/Month/Day)

Appendix 1:

Glossary

MDF (Main Distribution Frame)	Main Data Center located @ S1032
IDF (Intermediate Distribution Frame)	Equipment closets connected to the MDFs used to distribute services to the hospital's work areas. These are often referred to as network closets. There is an IDF closet on every resident unit. For the North & South Towers they are in the Great room.
BDF	Building Distribution Frame- basement of each tower and Pavillion
EPO	Emergency Power Off
UPS	Uninterruptable Power System
VESDA	Very Early Smoke Detection Alarm

Types of Systems Operated by Facilities

Cooling	(Water Pumps, Fans, Chillers, etc.)
Fire Suppression	(VESDA components, Gas, etc.)
Power	(UPS, PG&E, Generator, etc.)
Security	(Cabinet Locks, Badge Access, Keys, etc.)

Contact List

Name	Role	Number

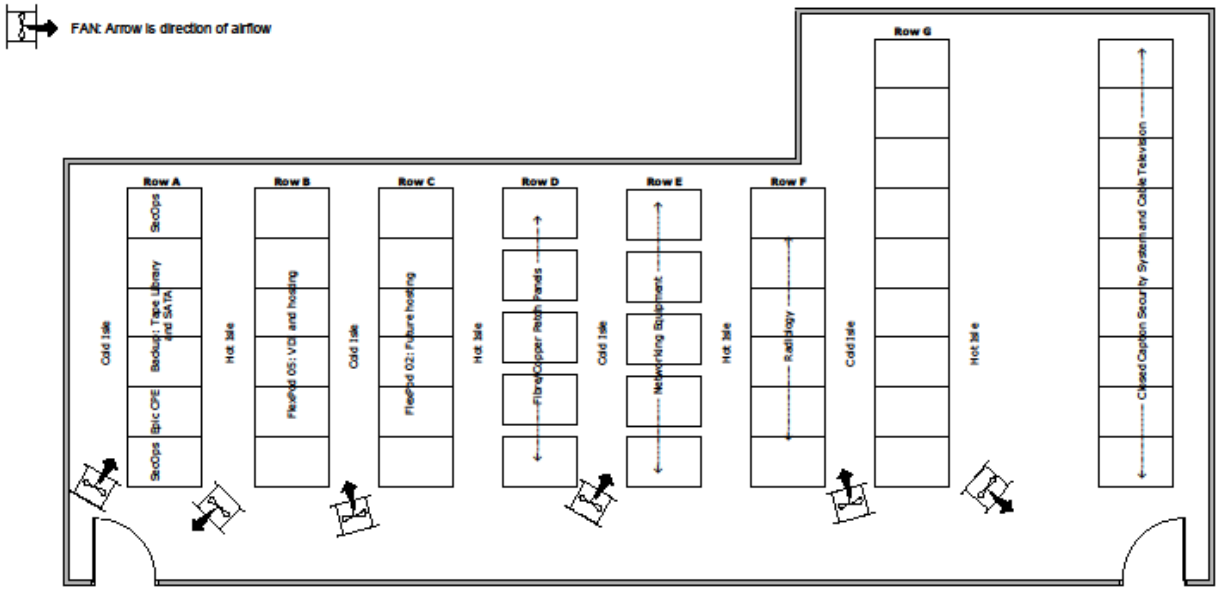
~~Facilities Watch Desk~~	~~Functions as 24/7 Service Desk for Facilities voicemail~~	~~415-759-2397~~
Facilities Watch Engineer	Direct access to Watch Engineer 24/7	415-370-8259
IT Service Desk	24/7 Service Desk for IT	628-206-7378
Mark Cantor	Chief Engineer - LHH	415-759-3571

~~Glossary~~

~~MDF (Main Distribution Frame)~~	~~Main Data Center located @ S1032~~
~~IDF (Intermediate Distribution Frame)~~	~~Equipment closets connected to the MDFs used to distribute services to the hospital's work areas. These are often referred to as network closets.~~
~~BDF~~	~~Building Distribution Frame~~
~~EPO~~	~~Emergency Power Off~~
~~UPS~~	~~Uninterruptable Power System~~
~~VESDA~~	~~Very Early Smoke Detection Alarm~~

Appendix 2: Fan Locations Sign to be Posted in Server Room

Laguna Honda Hospital Data Center



Document Date: Monday, May 20, 2019

STUDENT, VOLUNTEER, AND CONSULTANT ORIENTATION

POLICY:

New students, consultants, registry/travelers and volunteers are required to attend or complete ~~o attend an~~ orientation training prior to rendering care and supportive services to residents at Laguna Honda Hospital and Rehabilitation Center (LHH).

PURPOSE:

To assure the delivery of resident-centered care according to standard LHH operating procedures.

PROCEDURE:

1. Prior to commencing of ancillary activity within LHH, all new persons will be scheduled to participate in a documented orientation training:

Orientation Target Group	Responsible Manager
Volunteers	Manager/Coordinator, Volunteer Department
Students/Interns	Manager/Coordinator responsible for respective student/intern
Non-employee consultants	Manager/Coordinator responsible for contract/agreement
Registry and Travelers	Manager/Coordinator responsible for respective registry or traveler

2. Failure to comply with this policy will result in appropriate action, including denial of ancillary participant's privileges.

3. Staff from Volunteer Services Department, Department of Education and Training (DET), or the responsible manager/coordinator shall provide orientation in these areas: tour of LHH, resident population served, specific job duties, introduction of relevant personnel and LHH policies and procedures, including resident's rights, timely abuse reporting, fire safety standard and response, emergency preparedness, infection control, hazard communication, smoke free campus, quality assurance performance improvement (QAPI), cultural competency, trauma-informed care, compliance and ethics, communication, behavioral health, and confidentiality of resident health information.

4. DET shall review departmental orientation training materials for students, volunteers, consultants, and registry staff for compliance with regulatory requirements at least annually.

5. Responsible departmental manager/coordinator is ~~responible~~responsible for providing DET with annual compliance documents for students, volunteers, and consultants for inclusion in education records.

~~4.~~6. Responsible departmental manager/coordinator is responsible for providing DET with name and dates of new students, consultants, registry/travelers, and volunteers for on-boarding and off-boarding for education record keeping.

~~5.~~7. Department Manager or designee shall complete necessary documents to request training and access to the electronic health record (EHR) for students, registry, and travelers.

ATTACHMENT:
None.

REFERENCE:
LHHPP 80-02 Employee and Volunteer Identification
NPP A5.0 Nursing Educational Affiliations

Revised: 97/06/11, 02/11/14, 08/04/22, 15/03/10, 19/07/09 (Year/Month/Day)
Original adoption: 92/05/20

STAFF EDUCATION PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall maintain an effective staff training, orientation, and education program to uphold and improve staff competencies in the provision of person-centered, culturally respectful and inclusive interdisciplinary services.

2. LHH education and training programs shall be consistent with LHH strategic goals and regulatory requirements.

3. LHH education programs shall support individual development and group needs identified through the performance improvement activities and performance appraisals.

4. Department of Education and Training (DET) shall conduct a biannual review and revision of the topics of its in-service training program for submission to CDPH. Prior to submission to CDPH, DET will present its proposed in-service training program to Nursing Executive Committee (NEC) for review. After ~~approval~~review from NEC, the proposed in-service training program will be sent to Performance Improvement and Patient Safety Committee for a final review. Thereafter it will be sent to CDPH for approval. This process is to ensure that topics are relevant to the facility and its needs.

5. Human Resources staff shall notify the Department of Education and Training (DET) of the names of new hires and their start dates; staff who have left and their separation dates; and staff who are on an extended leaves and their anticipated return dates.

PURPOSE:

The purpose of this policy is to delineate staff responsibilities related to the provision of staff education and development at LHH.

CORE PRINCIPLES OF LEARNING:

1. To promote learning that supports resident-centered care and improves outcomes at the bedside consistent with the hospital's mission and vision.

2. The model shall be integrated, partnership-oriented, collaborative, and supportive of all LHH staff, based in the hospital’s organizational development goals and linked to the neighborhoods.

3. Everyone learns and everyone teaches. All staff can participate in teaching opportunities. While the staff development team can provide the guidance, consultations and support in the delivery of training, all staff are engaged.

4. Compliance shall continue to be a high priority of our education program, and we shall exceed regulatory standards so that we can see long-lasting behavioral changes.

5. Education shall be dynamic, participatory and customized for the learners. The facilitator or instructor shall be able to apply teaching methods that the audience can relate to and find meaning which they can apply to their essential job functions and responsibilities.
6. Effective education supports all departments; clinical and non-clinical, and assesses interests and needs of staff and programs by identifying quality indicators in high risk, high volume, or problem-prone areas.

7. Education shall promote effective communication and positive interactions among peers. Teaching opportunities can include both residents and staff.

8. Education is focused on developing individual and collective capacities for high performance, with training that leads to individualized care.

9. Learning opportunities are used to develop leadership skills at all levels that promote accountability and are linked to the hospital's goals and objectives.

PROCEDURE:

1. Staff Training and In-services

a. Human Resources shall schedule new employees to attend New Employee Orientation (NEO) upon hire.

b. New employees shall receive a 2-day in-person and computer-based NEO training to the culture, strategic goals, safety and regulatory requirements of LHH.

c. The NEO program shall be scheduled at a minimum on monthly basis beginning the first business day of a pay period.

d. Annually, employees shall be provided with year-round mandatory in-services that meet State, Federal and City requirements.

e. A monthly calendar of scheduled educational in-services shall be sent electronically to staff with DPH email accounts and posted on the intranet.

f. DET shall provide live classes for CNAs, PCAs and HHAs to meet the 24-hour CNA certification requirements.

g. A variety of initial and annual health and safety classes shall be provided to specific classifications of employees in compliance with Cal OSHA regulations.

h. Live classes may also be provided for specific staff audiences.

i. Computer based or live training shall be provided to other employees at the discretion of department supervisors.

j. In-service training is provided by qualified personnel (in house or outside entities) in a variety of formats (e.g., facilitated training, computer-based training, self-directed learning, mentoring and/or coaching, etc.).

k. Mandatory live classes are open to all staff, students and volunteers.

l. Training content includes, at a minimum:
   i. Effective communication for direct care staff.
   ii. Resident rights and facility responsibilities for caring of residents.
   iii. Elements and goals of the facility's QAPI program.
   iv. Written standards, policies, and procedures for the facility's infection prevention and control program.
   v. Written standards, policies, and procedures for the facility's compliance and ethics program.
   vi. Behavioral health.
   vii. Dementia management and care of the cognitively impaired.
   viii. Abuse, neglect, and exploitation prevention.
   ix. Safety and emergency procedures.

m. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment.

2. Employee Responsibilities

a. Every employee shall

   i. Be accountable and responsible for their own development, competency, and compliance with educational requirements for licensure or certification.

      - Be present and sign in when attending educational requirements.

      - Employees shall not have another person represent them or sign in for them in their absence.

   ii. Participate in formal and informal needs assessment processes to identify learning needs.

   iii. Participate in LHH orientation, mandatory in-service, and needs based training such as, Mandatory Plan of Correction – related trainings, unit based training, or individual training.

iv. Participate in professional educational activities, with supervisory approval as needed, during paid time or continuing education leave.

v. Report learning needs and knowledge or skill deficiencies to their supervisor or manager during orientation, annual performance appraisal, and on an ongoing basis.

vi. Collaborate with their supervisor and manager in meeting identified learning needs.

vii. Perform duties within their respective scopes of practice, according to LHH policies and procedures in a culturally effective manner.

viii. Maintain adequate continuing education hours to meet the requirements of their license or certification.

3. Manager Responsibilities

a. Department leaders: including directors, supervisors, and managers shall collaborate with DET educator(s) to perform the following functions:

i. Provide department and unit based orientation for employees new to the department or to a job within the department.

ii. Assess, plan, develop, implement, and evaluate unit based orientation and educational activities within their own area(s) or departments.

iii. Utilize pertinent data, including aggregate data, concerning resident satisfaction, quality indicators, competency findings and other outcome data to assist in the needs assessment process.

iv. Provide in-service education documentation including original sign-in sheets, outlines, evaluations or post-tests to the DET for inclusion into the LHH education database within 2 weeks of the training.

v. Monitor employee compliance with mandatory in-services by reviewing the monthly compliance report, following up with individual staff who have not completed their mandatory in-services within 30 days of assignment and addressing timely completion of mandatory in-services as part of the annual performance appraisal process.

vi. Oversee that the environment is inclusive of diversity (i.e. pictures, role-modeling inclusive behavior) and supports cultural humility.

vii. Collaborate with DET if any employee was placed on administrative leave for abuse or any disciplinary issue to identify training needs prior to returning to full duty.

4. Staff Development Steering Committee (SDSC)

a. The Staff Development Steering Committee was developed to increase staff awareness and support LHH's core principles of learning.

b. The Staff Development Steering Committee comprise of an interdisciplinary team of members from Administration, Nursing, Medicine, Social Services, Clinical Nutrition, Activity Therapy, Pharmacy, Rehabilitation Services, Environmental Services, Human Resources, and Quality Management.

c. Additional members from other departments may join the Committee with approval from their Division head and the Chair.

d. Functions of Core Team Members:

i. Core team members shall meet biannually to discuss and collaborate on the development and implementation of the vision and strategic planning goals for learning for LHH.

ii. Participate in reviewing and developing hospital-wide education programs and their respective departmental education plans for current and new staff members, or assign this task to a staff member(s) within their division or department.

iii. Contribute to improving vertical and horizontal communications within the facility.

iv. Review and develop education policies and procedures.

v. Cultivate a culture of compliance to support the mission and vision of the organization.

vi. Promote continuous quality assurance and performance improvement (QAPI) approach to improve patient/resident outcomes and organizational effectiveness.

vii. Evaluate the effectiveness of education programs based on resident outcomes data and staff performance appraisal information.

viii. Establish annual hospital-wide educational priorities

e. Other Functions of a Sub-group of SDSC Members

i. Determine LHH's hospital-wide education and training needs by reviewing performance improvement data and reports:

- Resident outcome data, such as satisfaction surveys, quality indicators, State survey results, and demographics identifying the problems and needs of the resident population
- QAPI Team and committee educational recommendations. (e.g., Infection Control, Safety, Code Blue, Abuse Prevention, etc.)
- Risk management data
- Department of Public Health recommendations
- LHH strategic goals
- Current evidence based practice and healthcare research
- Competency and Performance Appraisal trends provided by Human Resources
- Educational needs surveys
- Class / Course evaluations

ii. Develop and implement an annual hospital-wide education and training program and orientation programs that address identified needs and meet or exceed healthcare industry standards and regulatory requirements.

iii. Collaborate to develop and maintain Program Approvals (HS279A and B) for annual in-service and C.N.A. orientation from the California Department of Public Health (CDPH), licensing and certification division in collaboration with DET and the Chief Nursing Officer.

iv. Provide assistance and consultation to facility leadership to determine educational needs and to enhance competency, cultural effectiveness and performance.

5. Documentation of Formal Educational Activities

a. Educational activities are documented to meet minimum requirements of the State Department of Health Services and California Board of Registered Nurses or other pertinent regulatory bodies.

b. Documentation of in-services shall include:

i. An in-service cover sheet containing the following information:

- Title of the program
- Date
- Instructor(s)
- Length (number of hours)
- Assessed need (or purpose)
- Performance
- Behavioral Objectives
- Equipment needed
- Materials needed
- Outline of content (with adequate detail to discern what was taught)
- Method of Evaluation (to assure that learning has occurred)

ii. Original sign-in sheets

iii. Course evaluations (a representative sample are kept on file after the end of the course)

iv. Posttests or other evidence of evaluation of learning (a representative sample are kept on file after the end of the course)

c. Documentation for continuing education credits under LHH's Board of Registered Nursing provider number shall comply with the current BRN CEU requirements including:

i. Title of Program

ii. Date(s)

iii. CE hours

iv. Objectives

v. Overview

vi. Course Outline

vii. Method of Evaluation

viii. Course evaluations and / or posttests (kept on file in DET)

ix. A brochure or flyer posted at least 30 days before the start of the class that includes the first 5 bullets, cost and refund policy if there is a fee, course cancellation policy and the required BRN CEU provider statement.

d. Transcripts of individual staff attendance are available to staff and managers.

e. Education compliance tracking reports are available through the computerized education database and can be accessed from the database by designated staff from DET or designees with administrative access to the database.

f. DET maintains files of educational programs submitted for a minimum period of 4 years for in-services and continuing education courses.

g. NEO records are maintained for a minimum of 10 years by Human Resources and DET departments.

ATTACHMENT:
None.

REFERENCE:
~~Visioning and Strategic Planning for Learning in the New Laguna Honda~~
None

Reviewed: 07/01/03, 08/11/25, 12/09/25, 15/03/10, 16/09/13, 19/07/09, 21/02/09, 22/12/13 (Year/Month/Day)
Original adoption: 07/01/03

Deletion Hospital-wide Policies and Procedures

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

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

Policy:

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

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

3. Attempt to minimize viral aerosolization during emergency situations.

Purpose:

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

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

3. First Responder

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

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

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

4. Physician Staff Response Daytime 8-5pm Monday-Friday

    a. Non-Quarantined units and Quarantined units

        i. Both Urgent Care physicians (North Side 415-327-4914, South Side 415-327-4912)

ii. All physicians in the tower.(For PMS/PMA-All PM physicians and S2 physicians)

iii. Code Blue Committee Physicians

b. Physicians of quarantined units are exempt from responding to Codes outside of their units.

5. Physician Staff Response Nights/Weekends

a. Non-Quarantined units and Quarantined Units

i. All In house physicians.

6. Nursing Staff Response

a. South Building

i. Nursing staff from the unit and a Registered Nurse (RN) from Pavilion Mezzanine.

b. North Building

i. Nursing staff from the unit and an RN from Pavilion Mezzanine.

c. Pavilion Mezzanine Skilled Nursing Facility (PMS) and Pavilion Acute

i. RNs from PMS and Pavilion Acute

d. Wellness Center and Serenity Park (Harmony Park)

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

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

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

7. Other Healthcare Responders

a. Please refer to Nursing Policy

b. Respiratory Therapist for assigned tower when available.

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

8. Units Under Quarantine

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

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

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

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

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

10. Calls requiring additional assistance

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

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

11. Additional Protective Measures to Minimize Transmission

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

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

Revised Clinical Nutrition Policies and Procedures

Laguna Honda Hospital and Rehabilitation Center
Clinical Nutrition - Diet Manual

Updated & Revised: December 1, 2023

Table of Contents

INTRODUCTION

The Laguna Honda Diet Manual serves as a guideline and informational tool for Laguna Honda Hospital (LHH) dietetic personnel and licensed healthcare practitioners acting within the scope of their professional licensure or certification. The LHH Diet Manual is tailored to the therapeutic needs of the population.

Once a diet is ordered, the diet is processed, and a meal tray is prepared for the resident by Food and Nutrition Services. Based on the facility's reasonable efforts, it is the role of the dietitian to accommodate the resident's nutrient needs with appropriate interventions within the patient's personal, cultural, and religious food preferences. All menus are coordinated for color, taste, consistency and texture, appeal, and presentation. Menus are adjusted to include seasonal commodities as available.

Nutritional Adequacy

All LHH Diets shall provide food of the quality and quantity to meet each patient's needs in accordance with the most current Recommended Dietary Allowance (RDA) and Daily Reference Intakes (DRIs) adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. Due to the lack of manufacturer information, not all vitamins and minerals can be reported. Vitamins and Minerals which do not have DRI/RDAs established and are not readily available in the USDA or vendor database cannot be evaluated for complete nutritional adequacy in the patient menu. When a diet order does not meet the nutritional adequacy as determined by the RDAs, the clinical nutrition team works to individualize nutritional care of the patient considering their food preferences.

Diet Liberalization

Therapeutic diets are considered both textured modified diets as well as therapeutics diets. The Regular diet is not considered a therapeutic diet. Diet liberalization is a nutritional component that may enhance the quality of life and nutritional status of older adults residing in health care communities. According to Federal Regulations (F692), "diet liberalization could be beneficial to minimize restrictions, such as therapeutic or mechanically altered diet, and provide preferred foods before using supplementation." The registered dietitian will assess, evaluate, and recommend appropriate and individualized nutrition interventions. Collaboration between the interdisciplinary team and the patient and/or decision maker is necessary to assess the risks versus benefits of liberalizing a therapeutic diet. On days when holiday menus are provided, residents quality of life may be prioritized and resident may be allotted foods outside of their therapeutic parameters, per discretion of the registered dietitian and interdisciplinary team.

28-Day Cycle Menu Analysis

The complete 28-Day Laguna Honda Diet cycle was analyzed using the nutrition database CBORD. Each meal, for the 28 days, was analyzed for calories, protein, carbohydrates, fats, minerals, and vitamins. Totals and averages were determined using Excel. Further information or a hardcopy of the nutrient analysis can be found in the Clinical Nutrition Department or by contacting (415) 682-5776.

The Laguna Honda Diet Manual format of each diet is as follows:

I. Purpose denotes characteristics of each diet as a modification of the diet.
II. Indications lists specific medical concerns for which the diets can be used.
III. Adequacy indicates the nutritional adequacy of the diet based on the Dietary Reference Intakes (DRI), and the Recommended Daily Allowance (RDA).
IV. Approximate Composition lists approximate calories, protein, and carbohydrate, fat and, as needed, specific nutrients provided in each diet.
V. Suggested Meal Patterns show basic meal-planning guides with approximate amounts of foods specified according to dietary restrictions. The dietitian may adjust meal patterns to meet a resident's cultural, ethnic, food likes and dislikes and meal service preferences.

DIETS AT-A-GLANCE

Diet	Description	Average Calories	Average Protein (g)	Average Carbs (g)	Average Fat (g)
Regular	Designed to achieve or maintain optimal nutritional status in residents who do not require a therapeutic diet.	2300	110	280	90
Dental Soft	Includes soft textured foods that are moist, easily crumbled, or served with sauce to increase moisture. For residents with difficulties chewing solid foods.	2250	105	280	80
Mechanical Soft	Designed to minimize the amount of chewing necessary to safely swallow food. For residents who have difficulty chewing or swallowing.	2150	105	270	75
Semi-Puree	Contains food with a smooth consistency to facilitate ease of chewing and swallowing. A more liberal puree diet, which includes plain breads, muffins, pancakes, banana, etc.	2050	100	260	70
Full Puree	Contains food with a smooth consistency to facilitate ease of chewing and swallowing. For residents who are unable to chew or have difficulty swallowing.	1800	100	240	50
Clear Liquid	A temporary and transitional diet intended to leave a minimal amount of residue in the gastrointestinal tract. Consists of clear fluids or foods which are fluid at body temperature.	1100	30	260	0
Full Liquid	Consists of a variety of foods that are liquid or very soft in texture. Includes liquid nutritional formula products. For residents who are unable to chew or tolerate solid foods.	2200	125	280	70
Thickened Liquids	This diet is a modifier to any diet. Honey thick is the thickest consistency. Nectar thick is an upgraded liquid consistency. (Honey < Nectar < Thin)	1900	85	260	50
Fluid Restriction	This is a diet modifier designed to prevent fluid retention (1000, 1200, 1500 and 1800 mL available). The amount of fluids delivered on the tray will equate to up to half of the daily allowance or as adjusted by RD for quality of life.	2050	95	245	90
Consistent Carbohydrate	Provides consistent levels of carbohydrate at each meal for optimal glycemic control. Three levels available: 60g, 75g and 90g of carbohydrates per meal.	**60g**: 1600 **75g**: 2000 **90g**: 2200	100 105 110	180 225 260	60 75 90
Renal	60g Protein, 2g Sodium, 2-3g Potassium, 800-1000mg Phosphorous. Designed for impaired renal function.	1600	60	200	60
Potassium Controlled	3g Potassium. Designed to achieve and maintain normal potassium levels.	1750	85	220	60
Low Phosphorous	800-1000mg Phosphorous. Designed to achieve and maintain normal phosphorus levels.	1700	70	215	65
Sodium Controlled	Helps to prevent fluid retention, promote the loss of excess fluids, and aid in blood pressure control. • No Added Salt (3-5g sodium)– mild sodium restriction	**NAS**: 2250 **2g**: 2100	105 105	275 260	80 75

	• 2 Gram Sodium–moderate sodium restriction				
Low Fat/ Low Cholesterol	Restricts intake of cholesterol to a level of approximately 300 milligrams per day. The percentage of fat in the diet is below 30% of the total calories, with the intake of saturated fat about 10%. Indicated for residents with high blood cholesterol levels and at risk for heart disease.	1800	95	245	45
Modified Bland-Low Fiber	Reduce the frequency and volume of stools which lessens irritation to the gastrointestinal tract. Incorporates soft, non-irritating foods. Limits fiber, pepper, citrus fruits, raw fruits (except banana), raw vegetables, fatty foods, sources of caffeine and foods known to be gas-forming.	2000	105	225	75
Vegetarian/ Vegan	Encompass a variety of plant-derived foods and exclude some foods derived from animals. Preferred avoidance of all animal products in the diet except dairy and eggs. Vegan menu options can be provided through adjusted diet preferences upon resident request.	2200	90	295	80
Allergens	To eliminate the eight food allergens, that are regulated by the Food and Drug Administration (FDA), from diets to prevent harmful food reactions to: Egg, fish, peanut, milk/lactose, shellfish, soy, tree nut, wheat/gluten	N/A	N/A	N/A	N/A

REGULAR DIET

I. PURPOSE

The regular diet is designed to achieve or maintain optimal nutritional status in persons who do not require a therapeutic diet. Offers choices that promote intake of whole grains, fresh fruits, and vegetables, soups, fish, and poultry. However, there are no restrictions and individual preferences may necessitate the exclusion of certain food items.

II. INDICATIONS

The regular diet is used to promote health and reduce the risks for the development of major, chronic, and nutrition-related diseases.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2300	110	280	90

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or Salad w/ Dressing
3 oz. Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. General, Healthful Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=6. Accessed July 6, 2023.

TEXTURE MODIFIED DIETS

Dysphagia is the impaired ability to swallow. Diagnoses that may be indicative of potential swallowing problems include any resulting in neurological impairment, head and neck cancer or surgery, patients with tracheostomy, vocal cord dysfunction, aspiration pneumonia, and dementia.

A dysphagia diet or diet texture modification may reduce the risk of aspiration. Speech Language Pathologists (SLP) evaluate for swallowing deficits and recommend the least restrictive diet. The SLP works with the dietitian to optimize food variety while meeting the resident's nutritional and safety needs.

Signs to look for which may indicate possible dysphagia include:

- Coughing
- Choking
- Holding food in mouth
- Significant pocketing of food
- Significantly delayed swallow
- Significant leakage of food or liquid form the mouth
- Food or liquid coming from a tracheostomy (Serious sign of aspiration!)
- Excessive drooling
- Recurrent pneumonias

Note: Some persons with dysphagia can aspirate silently without exhibiting any of the above signs.

Dietary considerations for dysphagia:

1. Avoid small pieces of food for residents with reduced sensations as they can become lost in the mouth and increase the chance of choking.
2. Select foods that form a bolus within the mouth and do not break apart (e.g., bananas, mashed potatoes, macaroni, and cheese).
3. Avoid sticky foods that adhere to the roof of the mouth. These can cause fatigue in residents with muscle weakness and risk of airway obstruction.
4. Thickening of thin liquids may be tried with select pureed foods.
5. Residents with decreased salivation need moist foods. Gravies, extra margarine, sauces, salad dressing may be used. Dry foods may be dunked in soup or beverage.
6. Avoid milk products if excess mucus formation is a problem as they increase salivation.
7. Individualize diets for consistency.
8. High calorie, high protein foods should be emphasized for dysphagia residents managing limited intakes at a time.
9. Offer small frequent meals when minimizing fatigue and optimizing food temperature and total nutrient intake is desirable.
10. Residents requiring thickened liquids are at increased risk for dehydration. Thickened water and thickened juice should be offered several times a day between meals.

DENTAL SOFT DIET

I. PURPOSE

This diet provides soft-textured foods that can be easily chewed, requiring minimal biting. Foods are moist, easily crumbled, or served with sauce or gravy to increase moisture.

II. INDICATIONS

This diet may be ordered for residents who have difficulty chewing solid foods because of missing teeth, poorly fitting dentures, and mouth pain. The diet is not intended for residents who have identified choking or swallowing problems.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2250	105	280	80

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Low Fat Milk
1 Serving Dessert
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or 6 oz. Soft Salad
3 oz. Meat or Chopped Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Slice White or Wheat Bread
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

DENTAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	Milk, buttermilk, milkshakes, Plain or fruited yogurt.	Yogurt with nuts.
Meats, Fish, Poultry	Tender or chopped meats and poultry, baked, boiled, steamed meat or chicken, Such as ground beef, cold cuts. Thinly sliced deli meats, ham, beef, turkey. Soft sandwich mixes, chicken nuggets. Baked, steamed or sauté fish & shrimp.	Crispy fried or breaded meats, fish, and poultry. Hot dog. Thick sliced roasts or ham. Dry salami.
Cheese	Soft meat or cheese casseroles. Cottage cheese, soft cheeses.	Hard cheese.
Eggs	Soft scrambled eggs, soft Cooked egg, poached egg, fried egg, plain egg salad.	None.
Vegetables	Soft, cooked vegetables. Sliced tomato, leaf lettuce. Tomato juice.	Kernel corn. Other raw vegetables. Crunchy vegetables.
Fruits	Canned fruit. Soft fresh fruit: melon, strawberries, Ripe banana, grapes, orange And grapefruit sections. Stewed prunes, raisins. Fruit juices.	All other raw fruit, fruit that contains. pits, seeds, and skin. Other dried fruit.
Starches	Soft potatoes or yams, Cream corn, rice, noodles. French fries.	Whole kernel corn. Crunchy noodles.
Cereals	Hot cereals. Cold flaked cereal.	All coarse cold cereals And those with nuts or dried fruits.
Breads	White, wheat, or rye bread. Pancakes, waffles, French toast. Cornbread, soft rolls, sweet muffins, crumpets.	All breads that Contain nuts.
Fats and Oils	Margarine, butter, strained Gravy, creamers, sour cream, mayonnaise, salad dressings. Crisp bacon and sausage links.	None.

DENTAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Soups	Soups made with allowed foods.	All other soups.
Beverages	Coffee, tea, sodas, milk. Liquid nourishment supplements.	None.
Desserts	Ice cream, sherbet, smooth puddings, gelatin, custard. Plain pies, cakes, cookies.	All desserts which Contain fibrous fruits And nuts.
Miscellaneous	Sugar, jelly, syrup, honey. Salt, spices. Hard candy.	Hard to chew snacks. Chewy candy. Pretzels

MECHANICAL SOFT DIET

I. PURPOSE

This diet is designed to minimize the amount of chewing necessary to safely swallow food by residents.

II. INDICATIONS

This diet may be ordered for residents who have difficulty chewing or swallowing solid foods because of facial paralysis, poor or broken teeth, missing or poorly fitting dentures.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2150	105	270	75

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or 6 oz. Soft Salad
3 oz. Chopped Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Slice White or Wheat Bread
1 Pat Butter
1 Serving Dessert
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

The mechanical soft diet can be reduced in texture as necessary to meet the resident's needs. These adjustments may include: *mechanical soft with puree vegetables and mechanical soft with puree fruits and vegetables*. This provides the resident with soft foods without all foods having to be pureed. The diet may also be partially upgraded in texture to regular with mechanical soft entrée.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 5 Minced and Moist (Orange) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=420. Accessed July 6, 2023.

MECHANICAL SOFT DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	All milk: buttermilk, milkshakes, Plain or fruited yogurt. Ice cream.	Yogurt with nuts. Ice cream with nuts.
Meats, Fish, Poultry	Chopped meats, and poultry. Baked or tender grilled fish. Soft meat, fish or cheese Casseroles, quiche, eggs.	All whole meats, poultry, Fried fish, stringy meats. Hot dogs, hamburgers. Crunchy fried foods. Luncheon meats.
Cheese	Cottage cheese, soft cheese. Smooth peanut butter.	Hard or strong cheeses. Crunchy Peanut butter.
Eggs	Soft scrambled eggs, soft Cooked, poached, fried egg. Plain egg salad.	None.
Vegetables	Tender cooked or pureed vegetables. Tomato Juice. Asparagus tips, F.C. beans.	Cut green beans, peas, corn, leafy greens. Fibrous, tough Vegetables, Brussel sprouts, Broccoli, raw vegetables.
Fruits	Soft canned fruit, ripe banana. Fruit juices.	All other raw fruit or fruit Containing pits, seeds, skin.
Starches	Soft potatoes or yams, Juk. Cream corn, rice, noodles. Spaghetti, macaroni, other pastas.	Kernel corn. Snack chips. Crunchy fried foods. Snack crackers.
Cereals and Breads	Hot cooked cereals. Cold flaked or puffed cereal. White, wheat, or rye bread. Pancakes, waffles, French toast, Plain muffins, soft rolls.	All coarse cold cereals And breads that contain Nuts, dried fruit, seeds, Crisp snacks, pretzels. Popcorn.
Fats and Oils	Margarine, butter, strained gravy, sauces, sour cream, cream, mayonnaise, mild salad dressings.	Crisp bacon, ham patty, sausage links and Other breakfast meats.
Soups	Soups made with allowed foods and Salt, mild herbs, spices, and seasonings.	all other soups.
Beverages	Coffee, tea, sodas, milk. Liquid nourishment supplements.	None.
Desserts	Ice cream, sherbet, gelatin, smooth puddings, plain pies, cakes, Sugar, jelly, syrup, honey.	All desserts containing nuts. and fibrous fruits. Hard to chew snacks, chewy candy. Dried fruit. Cookies

SEMI-PUREE DIET

I. PURPOSE

The Semi-Puree Diet contains food which has a smooth consistency to facilitate ease of chewing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs.

The Semi-Puree diet is a more liberal puree diet in several ways and when tolerated is well accepted by the resident. In addition to pureed foods, the following foods are allowed: plain breads, muffins, and pancakes, baked desserts, such as cakes, ripe banana, prepared eggs and soft sandwich mixes, cottage cheese, soft cheeses, and fruit yogurt.

II. INDICATIONS

This diet is designed for residents who are unable to chew or swallow solid foods due to: poor or broken teeth, missing or poorly fitting dentures, sore gums, or decreased mentation that interferes with eating. Food consistency is based on resident clinical condition and individual tolerance.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2050	100	260	70

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cooked Cereal
1 Egg or Alternate
1 Slice Bread
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Strained Soup
4 oz. Pureed Meat or Alternate w/Gravy.
3 oz. Mashed Potato or Alternate
3 oz. Pureed Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served as tolerated.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 4 Pureed (Green) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July 6, 2023.

SEMI-PUREE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream With seeds, nuts, fruit Pulp or fruit skin.
Meats, Fish, Poultry	Meat, poultry, and fish which are smooth pureed consistency. Soft sandwich mixes made from tuna, egg, chicken with mayonnaise.	All regular meats, Fish and poultry if not pureed. Casseroles made w/ whole meats or vegetables. Lunchmeats.
Cheese	Cottage cheese, soft cheeses.	Hard cheeses.
Eggs	Eggs, soft boiled, scrambled. Plain egg salad with mayonnaise.	All other eggs.
Vegetables	Pureed vegetable consistency, tomato juice.	Whole or fresh vegetables Unless blended until smooth.
Fruits	All fruit that is finely pureed. Applesauce, fruit juices, nectar Thickened juices, ripe banana.	All other whole, canned or fresh fruit. Coconut.
Starches	Smooth mashed potatoes or yams, Smooth polenta, cream of rice, corn puree, pasta puree. Juk.	All other potatoes, rice or noodles. Kernel corn, French fries.
Breads, Cereals, Grains	Hot smooth cooked cereals, e.g. cream of wheat, farina, malt-o-meal. Plain Rice Porridge, Oatmeal Plain muffins, pancakes. White, wheat bread or soft rolls. Soft cakes	All hard breads, crackers, And those containing seeds, nuts or dried fruit. Waffles, French toast. Cold cereal, pizza, tortillas.
Fats and Oils	Margarine, sour cream, mayonnaise, Strained gravies.	All fried foods. Avocado. Chunky sauces, tartar sauce.
Soups	Thickened strained cream soups, Strained broth soups.	Chunky soups containing Foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements	None.
Desserts	Soft baked products, cake. Custard, smooth puddings, gelatin, Ice cream and sherbet.	Cookies, candy, jam, peanut butter. Baked products containing whole fruits, nuts, seeds. Doughnuts and pastries.
Miscellaneous	Sugar, salt, mild seasonings	Sticky /chewy food. Snack chips, pretzels, popcorn.

FULL PUREE DIET

I. PURPOSE

The Full Puree Diet contains food that has a smooth consistency to facilitate ease of swallowing and swallowing. Food choices are based on resident tolerance and the resident's individualized needs.

II. INDICATIONS

The Full Puree diet is designed to facilitate eating for residents who are unable to chew, have difficulty swallowing or who may have other problems identified with feeding.

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1800	100	240	50

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit Juice
6 oz. Refined Hot Cereal
1 Serving Pureed Eggs
1 Serving Custard
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Half & Half
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Strained Soup/4 oz. Juice
4 oz. Puree Meat/Alternate
3 oz. Puree Starch/Gravy
3 oz. Puree Vegetable
1 Pat Butter
4 oz. Puree Fruit/Dessert
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Level 4 Pureed (Green) Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=421. Accessed July 6, 2023.

FULL PUREE DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Milk and Dairy	Buttermilk, milkshakes, custard smooth yogurt, plain ice cream. Milk and cream.	Yogurt or ice cream With seeds, nuts, fruit Pulp or fruit skin.
Meats, Fish, Poultry, Cheese	Meat, poultry, and fish which are smooth pureed consistency	All regular meats, fish and poultry if not pureed. Lunchmeats. Cheese.
Eggs	Custard. Pureed scrambled eggs.	All regular eggs **(**boiled, scrambled, fried.)
Vegetables	Vegetables which are pureed Consistency, tomato juice	Whole or fresh vegetables.
Fruits	All fruit that is finely pureed. Applesauce, fruit nectars, Thickened juices.	All other whole, canned or fresh fruit and juices. Banana. Coconut.
Starches	Smooth mashed potatoes or yams, smooth polenta, cream of rice.	All other potatoes, Rice or noodles.
Breads, Cereals, Grains	Hot smooth cooked cereals, cream of wheat, farina, malt-o-meal, cream of rice, Plain Rice Porridge, Oatmeal	**All breads,** coarse grains, oatmeal, cornmeal, rolled wheat. All crackers. Pancakes, waffles, tortillas. Cold cereal.
Fats and Oils	Margarine, sour cream, Mayonnaise, strained gravies.	All fried foods. Avocado. Chunky sauces.
Soup	Thickened strained cream soups. Strained broth soups.	Chunky soups containing Foods to avoid.
Beverages	Milk and water, coffee, tea, sodas. Milkshakes. Liquid supplements.	None.
Desserts	Smooth puddings, custard, plain ice cream, gelatin, sherbet.	All baked products, including pies, cakes, Cookies, pastry, nuts, dried fruit, jam.
Miscellaneous	Sugar, clear jelly, salt, Mild spices.	Candy, peanut butter. Pizza, popcorn, chips. Sticky or chewy food.

CLEAR LIQUID

I. PURPOSE

This temporary, transitional diet intended to leave a minimal amount of residue in the gastrointestinal tract. It supplies fluid, electrolytes and energy in a form that requires minimal digestion. This diet consists of clear fluid or foods which are fluid at body temperature.

II. INDICATIONS

This diet is designed to provide fluids and calories to prevent dehydration in residents who have diarrhea and or vomiting. This diet is also used for test diets requiring a clear G.I. tract.

III. ADEQUACY

This diet does not meet the Recommended Daily Allowances for most nutrients. If residents are on this diet for more than three days, the rationale for the diet should be reviewed and revised, if necessary.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1100	30	260	0

V. SUGGESTED MEAL PATTERN:

BREAKFAST, LUNCH & DINNER
8 oz. Juice
Coffee/Tea/Decaf
Chicken or Beef Broth
4 oz. Fruit Gelatin
Ensure Clear 8 oz.

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	DO NOT SERVE
Clear Liquid Foods		
Soups	Clear broth or bouillon	All Others
Sweets and Desserts	Clear, flavored gelatin, Clear fruit ices/popsicles, sugar, honey, hard candy, sugar substitutes.	All Others
Beverages	Clear fruit juices, such as apple, cranberry, or grape juice. Clear coffee or tea and carbonated beverages, as allowed and tolerated.	All Others including Nectars, milk, cream, juices with pulp.
Miscellaneous	High caloric clear supplement beverages	All Others

FULL LIQUID DIET

I. PURPOSE

This diet consists of a variety of foods that are liquid or very soft in texture. In addition, supplements such as liquid nutritional formula products are served. The primary foods allowed on this diet are strained soup, custard, gelatin, juice, milk, pudding, and ice cream.

II. INDICATIONS

This diet is designed for residents who are unable to chew due to recent dental surgery or are unable to tolerate solid foods due to cancer of the mouth, throat, stomach, or G.I. tract. This diet may be used as the interim diet in weaning residents from enteral diets, when swallowing semi-soft solid foods is a problem. This diet should be advanced as tolerated. However, long term use of this diet may be warranted for quality of life and pleasure.

III. ADEQUACY

The Full Liquid Diet is not nutritionally adequate and therefore should not be used for extended periods of time without consultation with the dietitian.

IV. APPROXIMATE COMPOSITION: (includes the use of supplements)

	Calories (kcal)	**Protein (g)**	**Carbohydrate (g)**	**Fat (g)**
Average	2200	125	280	70

V. SUGGESTED MEAL PATTERNS:

BREAKFAST
Refined Cereal
Custard
Low Fat Milk
8 oz. Juice
Coffee/Tea/Decaf
8 oz. Nx Liquid

LUNCH & DINNER
Strained Cream Soup
Custard
Yogurt
Low Fat Milk
8 oz. Juice
Coffee, Tea, Decaf
8 oz. Nx Liquid

THICKENED LIQUIDS

I. PURPOSE

Thickened liquids are recommended for people with swallowing difficulty. Consuming thickened liquids will decease aspiration risk. Laguna Honda Hospital currently supplies thin, nectar, and honey thick liquids. Honey thick is the thickest consistency << Nectar thick is an upgraded liquid consistency << thin liquids (no diet order required, automatically supplied on tray with any diet order without liquid consistency specially ordered by MD). Liquid consistency may be ordered with a swallow evaluation recommendation, MD/RD/Nursing observation or resident preference for quality of life.

II. INDICATIONS

Dysphagia, difficulty swallowing, head/throat/esophageal cancer, radiation therapy, cognitive impairment, thin liquids are observed not to be tolerated by speech therapist, RD, nursing staff, MD, resident, or family member.

III. ADEQUACY

This diet is a modifier to any diet.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	**Protein (g)**	**Carbohydrate (g)**	**Fat (g)**
Average	1900	85	260	50

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Honey or Nectar Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Honey or Nectar Low Fat Milk
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Nectar Thick Soup or Salad w/ Dressing
3 oz. Meat or Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Butter
8 oz. Honey or Nectar Low Fat Milk
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

VI. LIQUID FOOD GUIDE

All puree and strain soups may be ordered w/specialized feeding plan and/or MD order for quality of life and can be thickened with honey or nectar thick packets using manufacturer's instructions.

Beverages such as milk, juices without pulp, coffee, tea, soda, carbonated beverages, alcoholic beverages, eggnog, and nutritional supplements should be thickened to the right thickness as ordered by MD.

Frozen beverages such as malts and milk shakes should be avoided.

THICKENED LIQUIDS

VI. LIQUID FOOD GUIDE

Sherbet, frozen yogurt, and ice cream should be avoided.

Gelatin should also be avoided.

Yogurt is acceptable for honey and nectar thick liquid consistency.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. IDDSI Thickened Liquid Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=424. Accessed July 6, 2023.

FLUID RESTRICTION

I. PURPOSE

This is a diet modifier designed to prevent fluid retention. It can be added to any diet order and specifies the daily fluid allowance in milliliters (mL) as 1000 mL, 1200 mL, 1500mL and 1800 mL. The amount of fluids delivered on the tray will equate to up to half of the daily allowance or as adjusted by RD for quality life. The quantity of fluids provided may have slight variations due to resident preferences and/or menu offerings available. This allows the remaining fluids to be administered by nursing for medication administration and floor stock fluid requests.

II. INDICATIONS

Residents with the following diagnosis may have a fluid restriction ordered by the MD: heart failure, renal dialysis disease, hepatic disease, hypervolemia; hyponatremia.

III. ADEQUACY

Fluid adequacy is based on the physician order.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	**Protein (g)**	**Carbohydrate (g)**	**Fat (g)**
Average	2050	95	245	90

V. FLUID RESTRICITON MEAL PATTERN:

BREAKFAST
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Low Fat Milk
Sugar, Salt, Pepper

4 oz. fruit juice, 8 oz. Milk and/or 8 oz. Coffee

LUNCH & DINNER
3 oz. Meat Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread
Sugar, Salt, Pepper

Restriction	Breakfast	Lunch	Dinner	Total Dietary
1800 mL	300 mL	300 mL	300 mL	900 mL
1500 mL	240 mL	240 mL	240 mL	720 mL
1200 mL	240 mL	120 mL	240 mL	600 mL
1000 mL	240 mL	120 mL	120 mL	480 mL

*Fluids provided may vary due to resident preferences and/or menu offerings available

FLUID RESTRICTION

VI. FLUID AND CONTENT OF SELECTED FOODS

Food Item	Fluid (mL)	Food Item	Fluid (mL)
Broth (6 oz.)	180	Ice Cream	120
Hot Cocoa (8 oz.)	240	Gelatin	120
Coffee/Tea (8 oz.)	240	Milk (8 oz.)	240
Creamer	15	Soup (6 oz.)	180
Fruit Ice (4 oz.)	120	Ensure Clear (8 oz.)	240
Fruit Juice (4 oz.)	120	Ensure Van, Choc, Straw (8 oz.)	240
Sherbet (4 oz.)	120	Ensure Enlive (8 oz.)	240

Supplements:
Fluids provided from supplements should be accounted for in the fluid restriction.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Fluid-Restricted Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=413. Accessed July 6, 2023.

CONSISTENT CARBOHYDRATE DIETS

I. PURPOSE

The goals of nutritional therapy and diabetes management for all people are:

- to improve blood glucose and lipid levels
- to promote consistent day-to-day intake for people with insulin-dependent diabetes
- weight management for people with non-insulin-dependent diabetes
- to encourage healthy eating habits for residents during their stay at LHH, for residents with diabetes and for those with coexisting medical conditions.

The consistent carbohydrate diets are based on recommendations from the Academy of Nutrition and Dietetics, which recommends consistent carbohydrate intake at snacks and meal on a day-to-day basis for improved glycemic control. The diet provides consistent levels of carbohydrate at each meal. There are three levels available: 60g, 75g and 90g of carbohydrates per meal.

Consistency in meal schedules and portion sizes assist in normalizing blood sugar. Protein, fat, and carbohydrate are divided throughout the day; foods high in added sugars are avoided.

Institutional menus are carefully planned and served to accommodate a resident's preferences. The dietitian adjusts dietary patterns for individual preferences and tolerances, to maximize compliance with dietary restrictions and consistency in carbohydrates. A variance of +- 15g of carbohydrate is allotted per meal to allow for variety and adequacy in the diet.

Morning, afternoon, or evening nourishments, composed of both protein and carbohydrate, may be planned when necessary or by request.

II. INDICATIONS:

Diabetes mellitus or altered glucose tolerance.

III. ADEQUACY

Diets are nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION

See individual dietary patterns by carbohydrate level in section VII.

CONSISTENT CARBOHYDRATE DIETS

V. FOODS TO AVOID:

Condiments: Sugar, honey, jam, jelly, molasses, maple syrup, corn syrup

Breakfast Foods: Sweetened or sugar-coated cereals, doughnuts, sweet rolls.

Fruits: Dried fruit, frozen or canned fruit with added sugar or syrup.

Beverages**: S**weetened sodas or other beverages containing sugar.

Desserts: Cakes, pies, cookies, ice cream, gelatin, pudding.

Snacks: Candy, milkshakes, snack chips and snack crackers.

VI. FOODS CONSIDERED ACCEPTABLE IN UNLIMITED AMOUNTS

Sugar substitutes	Fat Free broth
Coffee, tea, Decaf	Bouillon
Unsweetened Gelatin	Consommé
Vinegar	Unsweetened Cranberries
Spices and Herbs	Unsweetened Lemons and Limes
Mustard	Unsweetened Pickles
Raw Vegetables	Horseradish
Lettuce	Sugar Free Beverages
Cucumber	Radish
Parsley	

CONSISTENT CARBOHYDRATE DIETS

VII. MEAL PATTERN BY CARBOHYDRATE LEVEL

Carbohydrate Level	60g	75g	90g
Calories:	1600	2000	2200
Protein (g):	100	105	110
Carbohydrate (g):	180	225	260
Fat (g):	60	75	90

Diabetic Exchange Groups (Approximate) Served at Meals for Each Carbohydrate Level

	60g (4 CHO/meal)	**75g (5 CHO/meal)**	**90g (6 CHO/meal)**
Breakfast:			
Fruit	1 (15 g CHO)	1 (15 g CHO)	1 (15 g CHO)
Bread/Starch	2 (15 g CHO)	3 (15 g CHO)	4 (15 g CHO)
Egg/Protein	1	1	2
Fat	1	1	1
Milk	1 (12 g CHO)	1 (12 g CHO)	1 (12 g CHO)
Lunch/Dinner:			
Meat/Protein	2	3	3
Bread/Starch	2 (15 g CHO)	3 15 g CHO)	4 (15 g CHO)
Vegetable	1	1	1
Fruit	1 (15 g CHO)	1 (15 g CHO)	1 (15 g CHO)
Fat	1	1	1
Milk	1 (12 g CHO)	1 (12 g CHO)	1 (12 g CHO)

*1 Exchange Group = 15 grams Carbohydrate

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Carbohydrate Counting for People with Diabetes. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=123. Accessed July 6, 2023

https://diabetes.org/healthy-living/recipes-nutrition/understanding-carbs/carb-counting-and-diabetes. Accessed July 6, 2023.

RENAL DIET

I. PURPOSE

The protein (60 gm.), sodium (2.0 gm.), potassium (2-3 gm.) and phosphorus (800-1000 mg.) controlled diet is designed to provide adequate amounts of essential nutrients and sufficient calories to maintain optimal nutritional status in those residents with impaired renal function. Modifications in the diet may be moderate or may require complex modification depending on the stage of kidney disease. Refer to individual sodium, potassium, phosphorus restricted diets for comprehensive information on food recommendations.

II. INDICATIONS

This diet provides a guide for planning diets for persons with acute or chronic renal failure, and for residents on hemodialysis and peritoneal dialysis. The cause and the degree of kidney dysfunction should determine the level of protein, sodium, and potassium restriction in the diet.

Protein intake needs to be controlled to avoid excessive amounts of nitrogenous waste products in the blood and to prevent negative nitrogen balance.

Sodium content of the diet is controlled to help maintain normal hydration status, to avoid fluid retention, hypertension, and to help prevent congestive heart failure. Pyelonephritis and polycystic kidney diseases tend to be salt wasting conditions that require increased sodium.

Potassium content of the diet is controlled to prevent hyperkalemia, as well as hypokalemia in some instances. Consideration for the level of potassium in the diet includes checking serum potassium levels, urinary potassium level, and drug therapy (such as digoxin, furosemide, etc.). Stress, catabolism, and diabetic ketoacidosis can increase potassium levels.

III. ADEQUACY

This diet is potentially low in calories, minerals, and vitamins. A nutrition supplement with low protein, high calories may be recommended to bring the calories, minerals, and vitamins up to optimal. Calcium-based phosphate binders are often used with this patient population and should be taken into consideration when analyzing overall calcium intake.

IV. APPROXIMATE COMPOSITION:

RENAL - 60 gm Protein, 2 gm Sodium, 2 – 3 gm Potassium, 800-1000 mg Phosphorus

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1600	60	200	60

V. SUGGESTED MEAL PATTERN:

RENAL - 60 Gram Protein, 2 Gram Sodium, 2 – 3 Gram Potassium, 800-1000 mg Phosphorus

BREAKFAST
4 oz. Fruit Juice (low potassium)
1 Serving Cereal – Half & Half
1 Slice Toas½
1 Pat Butter ½
1 Egg
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Pepper

LUNCH & DINNER
Salad w/Diet Dressing (Lunch)
½ Portion LS entrée (limited beans and processed meat)
1/2 Portion LS Starch
1/2 Portion LS Vegetable (low potassium)
1 Slice –read - 1 Pat Butter
1 Serving Fruit (low potassium)
4 oz. Nondairy Substitute (Lunch or Dinner)
Sugar, Pepper, Half & Half

RENAL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products	All in limited quantities within 8 fl. oz. restriction per day	Soy milk, malted milk. Excess of 8 fl. oz./ day of milk, chocolate milk, buttermilk, puddings, cream soups, light cheese, soy milk
Meats, Fish, Poultry	All except those excluded, tofu ok	Canned, cured, smoked, pickled, spiced or Processed meats, such as bacon, Sausage, luncheon meats, frozen dinner, Canned meats, dried peas, limit beans and lentils, avoid salted nuts.
Meat Alternates	1 egg daily, tofu ok	Beans
Vegetables	All those not high in potassium Vegetables included but not limited To green and wax beans, beets, Cabbage, carrots, cauliflower, celery Corn, cucumber, green peas, summer squash, turnips, peppers, onions, asparagus, zucchini, greens (mustard, collard)	All those high in potassium Canned vegetables, vegetables in brine, artichoke, potato, sweet potato, spinach, Brussel sprouts, chard, pumpkin, yams, okra tomato and tomato sauce
Fruits	All those not high in potassium Fruits included but not limited to apple, Blueberry, cranberry, fruit cocktail, grape Juice, grapes, peaches, pears, pineapple, Strawberry, watermelon	All those high in potassium Dried fruits, bananas, orange and juice, raisins, prunes, and juice, avocado, apricots, Limit: cherries, cantaloupe, grapefruit, mango
Breads, Cereals	Most bread, cereals (1 cup), pasta, rice	Whole wheat breads, croissants, Sweet potatoes, potato chips, bran Avoid potatoes.
Fats and Oils	Butter or margarine. All fats and oils, low salt gravy, mayo, Salad dressings	Bacon, cream sauces, sour cream
Soups	All except those not recommended	Meat bouillon, broth, consommé. Soups made with meat stock. base or with tomatoes. Butternut.
Beverages	Carbonated beverages other than cola, Coffee, tea, milk limited to 1 cup/day	Cola, cocoa, tomato/veg juice, canned soup, coconut water.
Desserts	All except foods not recommended	Chocolate, nuts, cream/pumpkin pies,
Miscellaneous	Herbs and spices without added salt, all Except those listed in foods not Recommended	Salt, monosodium glutamate, olives, soy sauce, teriyaki sauce, barbeque. sauce, ketchup, phosphorus. containing ingredients (e.g., calcium phosphate, disodium phosphate, phosphoric acid, etc.)

RENAL DIET

Reference

Nutrition Care Manual. Chronic Kidney Disease Stage 3-5 Nutrition Therapy https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157. Accessed July 6, 2023.

Nutrition Care Manual. Chronic Kidney Disease Stage 5 Tips for People Not on Dialysis Receiving Conservative, Supportive or Medical Care Nutrition Therapy https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=160. Accessed July 6, 2023.

POTASSIUM CONTROLLED DIET

2-3 gram Potassium

I. PURPOSE

The diet is designed to achieve and maintain normal potassium levels in individuals at risk for hyperkalemia. This diet also allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

II. INDICATIONS

Elevated serum potassium and resident medical condition determine level of potassium restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are receiving Renal Dialysis, hyperkalemia, receiving potassium sparing medications and extensive tissue damage.

III. ADEQUACY

This diet may not meet all the Recommended Dietary Allowances; therefore, supplements may be required. The 2-3 gram potassium level is recommended where moderate control is desired.

IV. APPROXIMATE COMPOSITION:

	Potassium (g)	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2.5	1750	85	220	60

V. SAMPLE MEAL PATTERN: 2-3 Gram Potassium

BREAKFAST
4 oz. Juice (low potassium)
1 Serving Cereal
1 Egg
1 Slice Toast
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea
Sugar, Pepper

LUNCH & DINNER
6 oz. Salad/Soup - Lunch **or** Dinner
3 oz. Meat or Alternate (limit intake of fish/bean/turkey)
3 oz. Rice or Noodles (avoid potatoes)
3 oz. Vegetable (low potassium)
1 Serving Fruit Dessert (low potassium)
1 Slice Bread
1 Pat Butter
Coffee, Tea
Sugar, Pepper

Snacks included per patient preference and/or to meet nutrient needs.

Reference

Academy of Nutrition Dietetics. Nutrition Care Manual. Chronic Kidney Disease Stages 3-5 Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157. Accessed July 6, 2023.

Academy of Nutrition and Dietetics. Nutrition Care Manual. Potassium Content of Foods. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=478. Accessed July 6, 2023.

POTASSIUM CONTROLLED DIET

2-3 gram Potassium

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products	All in limited quantities within 8 fl. oz. restriction per day	Soy milk, malted milk. Excess of 8 fl. oz. per day of milk, chocolate milk, buttermilk, yogurt, puddings, cream soups, Cheese, cottage cheese, custard, ice cream
Meats, Fish, Poultry	Meats; Fish except those not Recommended	Fish-halibut, tuna, cod, snapper, Turkey
Meat Alternates	1 egg daily.	Beans
Vegetables	Beets (canned), Broccoli, Cabbage, Carrots, Cauliflower, Corn, Cucumber, Eggplant, Green Beans, Kale, Lettuce (1 cup), Mushrooms, Onions, Radishes, Snow Peas, Summer Squash, Turnips	Artichokes, Avocado, Brussel Sprouts, Butternut Squash, Greens (Mustard /Collard), Okra, Parsnips, Potato, Pumpkin Spinach, Sweet potatoes, Swiss Chard Tomatoes, Tomato Sauce/Puree/ Juice, Wax Beans, Winter Squash, Yam
Fruits	Apples, Applesauce, Blueberries Cranberry Fruit/Juice, Fruit Cocktail Grape Juice, Grapes, Lemon, Lemon Juice, Limes, Lime Juice, Peaches (canned), Pineapples, Plums (1), Strawberries, Tangerines (1), Watermelon	Pomegranate, Prune Juice, Prunes, Raisins
Breads, Cereals	White and Brown Rice, Tortilla, flour Or corn, Waffles, Bagels, English Muffin, Oatmeal, White Bread/Pasta	Bran Muffins, dark rye bread, gingerbread, granola, Avoid potatoes.
Fats and Oils (Limit meat gravies)	Butter or margarine. All fats and oils.	Limit intake of nuts/seeds
Soups	All except those not recommended	Meat bouillon, broth, consommé. Soups made with meat stock. base or with tomatoes. Butternut.
Beverages	Cranberry juice, tea	Limit dairy intake, fruit/veg juices. high in Potassium, soy milk
Desserts	Marshmallows, gelatin, ice pops	Desserts made with high amounts of dairy or high potassium veg/fruits.
Miscellaneous	All except foods not recommended	Salt-Substitutes, chocolate, maple syrup, barbeque sauce, soy sauce, steak sauce, Worcestershire sauce

LOW PHOSPHORUS DIET
800-1000 mg Phosphorus

I. PURPOSE
This diet is to achieve and maintain normal phosphorus levels in individuals at risk for elevated phosphorus levels in the blood. It is a modifier of the regular diet that excludes/limit foods high in phosphorus and limit phosphorus intake from meals to less than 1000 mg per day. This allows single nutrient customization for Renal Dialysis patients who otherwise do not have other necessary restrictions.

II. INDICATIONS:

Elevated serum phosphorus and resident medical condition determine level of phosphorus restriction when blood and tissue concentrations are elevated. Conditions where control may be indicated are: Renal Dialysis disease, autoimmune activating mutations of the calcium-sensing receptor, parathyroid disease, Vitamin D or Vitamin A intoxication, granulomatous disease, immobilization, osteolytic metastases, milk-alkali syndrome and severe hypermagnesemia or hypomagnesemia.

III. ADEQUACY:

This diet may not meet all the RDAS, therefore, supplements may be required. The 800–1000-gram phosphorus level is recommended where moderate control is desired.

V. APPROXIMATE COMPOSITION:

	Phosphorus (mg)	**Calories (kcal)**	**Protein (g)**	**Carbohydrate (g)**	**Fat (g)**
Average	1000	1700	70	215	65

V. SAMPLE MEAL PATTERN: 800-1000 mg Phosphorus

BREAKFAST
4 oz. Juice
1 Serving Cereal
1 Egg
1 Slice Toast
1 Pat Butter
Coffee, Tea (non-dairy creamer)
Sugar, Pepper

LUNCH & DINNER
6 oz. Soup - Lunch or Dinner
3 oz. Meat or Alternate (limit meat and legume)
3 oz. Rice or Noodles (avoid whole grains)
3 oz. Bland Vegetable
1 Serving Fruit Dessert
1 Slice Bread
1 Pat Butter
8 oz. Low Fat Milk (limited quantity, no more than 1 cup/day)
Coffee, Tea
Sugar, Pepper

Additional snacks may be added based on individual patient needs if total phosphorus intake within limit.

LOW PHOSPHORUS DIET
800-1000 grams Phosphorus

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk and Milk Products	Whole, low fat or nonfat milk Cheese. Ice cream, sherbet. (8 oz. milk/day)	Commercial milk drinks, milkshakes. Cocoa, cream soups, cottage cheese, yogurt, puddings, custard, ice cream, buttermilk
Meats, Fish, Poultry	Limit meats	Organ meats (1 oz.), nuts (1/4 cup),
Meat Alternates	1 egg daily	Tofu (1/4 cup), Vegetarian meat replacements
Vegetables	All, except peas	Peas
Fruits	All fresh or canned fruits and fruit juices	None
Breads, Cereals and Starches	Refined white grains, bread, pasta bagel (1/2 small); bread, all kinds (1 slice); dinner roll (1 ea.); English Muffin (1/2)	Biscuits, muffin (1 small); granola/oatmeal (1/2 cup); pancakes/waffles (1 ea.); whole wheat cereal, bran cereal (1/2 cup). tortillas, corn (2 ea.); whole grain bread; brown rice
Fats and Oils	All fats and oils.	Limit intake of nut and nut butters
Soups	None.	Meat bouillon, broth, consommé. Soups made with meat stock base or with tomatoes.
Beverages	All, except those not recommended	Chocolate drinks, cocoa, drinks made w/milk, canned iced teas, dark colas.
Desserts	All, except those excluded.	Chocolate, caramels, desserts made primarily from dairy products (cheesecake)
Miscellaneous	All, except those not recommended	Phosphorus-containing ingredients (e.g. calcium phosphate, disodium phosphate, Phosphoric acid, etc.)

Reference

Nutrition Care Manual. Chronic Kidney Disease Stage 3-5 Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=157 . Accessed July 6, 2023

Nutrition Care Manual. Phosphorus Content of Foods. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=477. Accessed July 6, 2023

SODIUM CONTROLLED DIETS

I. PURPOSE

The goal of sodium restriction is to help prevent fluid retention, promote the loss of excess fluids, and aid in blood pressure control.

II. INDICATIONS:

Restriction of dietary sodium may decrease body fluid volume and relieve symptoms of diseases, e.g., congestive heart failure or other cardiovascular diseases, cirrhosis, hypertension, ascites, SIADH, other conditions that may cause fluid retention, hypernatremia, or renal diseases where the kidneys cannot get rid of excess sodium and water. The physician should specify the level of sodium restriction desired using the following guide:

No Added Salt (3-5 grams sodium - 130-217 mEq)--mild sodium restriction
2 Gram Sodium (87 mEq)--moderate sodium restriction

For greater flexibility and resident compliance, it is preferred that the No Added Salt diet be ordered for

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

2 gm Sodium (87 mEq), moderate sodium restriction

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2100	105	260	75

No Added Salt Diet (3–5-gram sodium - 130-217 mEq)--mild sodium restriction

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2250	105	275	80

SODIUM CONTROLLED DIETS

SUGGESTED MEAL PATTERN:

2 Gram Sodium

BREAKFAST	LUNCH & DINNER
4 oz. Fruit or Juice	6 oz. Low Sodium Soup or Salad w/Diet Dressing
1 Serving Low Sodium Cereal	3 oz. Low Sodium Meat or Alternate
1 Serving Low Sodium Egg	2 oz. Low Sodium Gravy
1 Slice Toast	3 oz. Low Sodium Starch
1 Pat Butter	3 oz. Low Sodium Vegetable
8 oz. Low Fat Milk	1 Serving Dessert
Coffee, Tea, Decaf	1 Sl. Bread - 1 Pat Butter
Sugar, Pepper	8 oz. Low Fat Milk LS herbs and spices
Coffee, Tea, Decaf	Sugar, Pepper, LS herbs and spices

No Added Salt

BREAKFAST	LUNCH & DINNER
4 oz. Fruit or Juice	6 oz. Low Sodium Soup or Salad w/Diet Dressing
1 Serving Cereal	3 oz. Meat or Alternate
1 Serving Egg or Alternate	2 oz. Gravy
1 Slice Toast	3 oz. Starch
1 Pat Butter	3 oz. Cooked Vegetable
8 oz. Low Fat Milk	1 Serving Dessert
Coffee, Tea, Decaf	1 Sl. Bread - 1 Pat Butter
Sugar, Pepper	8 oz. Low Fat Milk
LS herbs and spices	Coffee, Tea, Decaf
	Sugar, Pepper, LS herbs and spices

Whole grain breads, cereals and starches are served daily.

SODIUM CONTROLLED DIETS

VI. FOODS TO BE AVOIDED:

FOOD GROUP	2 Gram Sodium	No Added Salt
Milk	More than 3 cups/ day Buttermilk, milkshake.	More than 3 cups per day, Buttermilk
Meat, Fish, Poultry/ Eggs/ Cheese	Same, including commercially packaged foods and instant mixes.	Highly salted meats as listed. Processed foods (except low sodium products). Limit cheese and salted peanut butter.
Vegetables (Limit to 4 serv./ day with no added salt)	Canned vegetables. Sauerkraut. Tomato juice	Limit use of drained canned vegetables. Tomato juice with salt added.
Fruits (all ok)	---	---
Breads and Cereals	Same, except: 3 slices of regular bread allowed per day.	Salted crackers, Potato chips. Bread with salted tops. Snack foods. Instant commercially prepared mixes.
Fat and Oils	Same except 3 pats of regular margarine per day	Salt pork, bacon, bacon bits, salted nuts and seeds
Soups (Limit to 1 svg. per day)	Bouillon cubes and canned/dehydrated soup or broth; all soups prepared with added salt or highly salted ingredients. Canned soups.	Same
Beverages	Bottled, powdered, frozen or canned beverages containing salt or sodium preservatives.	None
Desserts (Limit to 2 svgs per day)	Commercial bakery products	None

SODIUM CONTROLLED DIETS

VI. FOODS TO BE AVOIDED

FOOD GROUP	2 Gram Sodium	No Added Salt
Miscellaneous	Salt. Seasoned salts such as garlic salt, onion salt, celery salt variety salt mixtures and packaged seasoning mixes, MSG. Olives, pickles, relish. Soy, barbecue, and prepared sauces, ketchup, prepared mustard, pickles, salted popcorn. Snack dips.	Limit all items on this list. Any Salt added in cooking. Limit salted peanut butter.

Supplements: All nutrition supplements are permitted with order.

Read product labels when purchasing commercially packaged foods. Choose low sodium foods with no added salt or sodium compounds.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Low-Sodium Nutrition Therapy http://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=121. Accessed July 6, 2023.

LOW FAT/ LOW CHOLESTEROL DIET

I. PURPOSE

This diet restricts intake of cholesterol to a level of approximately 300 milligrams per day. The percentage of fat in the diet is below 30% of the total calories, with the intake of saturated fat about 10%.

II. INDICATIONS

This diet is indicated for the residents who have high blood cholesterol levels and are at risk for heart disease. This diet may be useful in weight loss programs.

III. ADEQUACY:

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	1800	95	245	45

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate (* 3/week)
1 Slice Toast
1 Pat Butter
1 Pkt Jelly
8 oz. Non-Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
Green Salad/Diet Dressing or
6 oz. Calculated Soup/Crackers
3 oz. Calculated Meat or Alternate
3 oz. Calculated Starch
3 oz. Calculated Vegetable
1 Serving Fruit
1 Slice Bread/1 Pat Butter
8 oz. Non-Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Whole grain breads, cereals and starches are served daily.

Reference

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. LDL Cholesterol-Lowering Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=466. Accessed July 6, 2023

Academy of Nutrition and Dietetic Association. Nutrition Care Manual. Heart-Healthy Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=107. Accessed July 6, 2023

LOW FAT/ LOW CHOLESTEROL DIET

VI. FOODS ALLOWED AND FOODS TO BE AVOIDED:

FOOD GROUP	FOODS ALLOWED	FOODS AVOIDED
Milk	Nonfat milk, 0% fat milk, drinks made with nonfat milk, fruit drinks except those listed to avoid.	All beverages made with cream, whole milk, 2% low-fat milk ice cream or egg yolk.
Meat, Fish, Poultry, Cheese (Use alternates to red meat at least 5 times a week)	Lean meat, fish, poultry, without skin. Low-fat cottage cheese, low-fat yogurt. cheese made with nonfat milk. Dry beans and peas.	Fatty or heavily marbled meats and luncheon meats, frankfurters, bacon, sausages. Cheese made with milk or cream.
Eggs (Limit 3 per week)	Any prepared without added fat. Egg substitutes. Egg whites.	Fried eggs.
Vegetables	All prepared without added fat, 3-5 servings each day.	Any prepared with added fat, sauces or cheese.
Breads, Grains, Cereals	Enriched breads, whole grain cereals graham crackers, low fat crackers.	Any made with butter, cream, egg yolk, whole milk.
Fruits	All fruits and juices, 2-4 servings/day.	Smoothies made with milk.
Potatoes or Starches	Plain rice, low fat noodles and pasta, white and sweet potatoes and yams. Grits.	Fried potatoes, potato chips, snack chips. Any prepared with fat, milk, butter, or cream.
Desserts	Fruits, gelatin desserts, Fruit ices, angel food cake.	any made with butter, chocolate, egg yolks, milk.
Sugar, Sweets	Sugar, honey, jam, jelly, syrup, molasses, plain sugar	Candy containing nuts, chocolate, milk, or cream. Most commercial desserts.
Fats, Vegetable Oils (Limit to no more than 5 teaspoons per day)	Margarine, vegetable oil and soft tub low-fat spreads.	Gravy, fatty sauces, butter, lard, any deep-fried foods. No palm & coconut oils.
Soups	Fat-free, broth-base soups; soups made with nonfat milk.	Commercial soups; soups prepared with cream, fat, or milk.
Beverages	Coffee, tea, decaf. Sodas.	See Milk and Fruits sections.
Miscellaneous	Salt, flavorings, spices. Cocoa powder.	Butter, nuts, olives, cream. Sauces, peanut butter, popcorn.

MODIFIED BLAND - LOW FIBER DIET

I. PURPOSE

The modified bland-low fiber diet is used to reduce the frequency and volume of stools which lessens irritation to the gastrointestinal tract. It incorporates soft, non-irritating foods. This diet limits fiber, pepper, citrus fruits, raw fruits (except banana) and raw vegetables. It limits fatty foods, sources of caffeine and foods known to be gas-forming. Dairy products are used. Adjustments are made for individual preferences and tolerances.

II. INDICATIONS

The intended use of this diet is for people with stated sensitivity to gas-forming foods, "sensitive stomach", a history of peptic ulcer disease, hiatal hernia or reflux, recent GI surgery, radiation therapy to the pelvis and lower bowel. It is not intended for those individuals with a history of diverticulosis unless specifically requested by the resident.

III. ADEOUACY

This diet may be inadequate in fiber.

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2000	105	225	75

V. SUGGESTED MEAL PATTERN

BREAKFAST
4 oz. Fruit or Juice
1 Serving Hot Cereal
1 Egg or Alternate
1 Sl. White Toast
1 Pat Butter
8 oz. Low Fat Milk
Decaf, Sugar, Salt

LUNCH & DINNER
6 oz. Soup (Lunch or Dinner)
3 oz. Meat or Alternate
2 oz. Cream Gravy
3 oz. Potato or Alternate
3 oz. Cooked Bland Vegetable
1 Serving Dessert
1 Sl. Bread, 1 Pat Butter
8 oz. Low Fat Milk
Decaf, Sugar, Salt

MODIFIED BLAND – LOW FIBER DIET

VI. FOODS ALLOWED AND FOODS TO AVOID:

FOOD GROUP	FOODS ALLOWED	FOODS ALLOWED AS TOLERATED	FOODS TO AVOID
Milk	All		None
Meats, Fish, Poultry, Cheese	All eggs, meats poultry, fish, cheese, except as noted.	Fried foods.	Highly spiced or cured meats.
Vegetables	All cooked vegetables, except those to avoid.	Gas producing or irritating vegetables onions, peppers, corn, broccoli, Brussel sprouts, celery, cabbage, lima beans. cauliflower. Tomato products.	Raw vegetables. Legumes.
Fruits and Juices	All as tolerated.	Raw fruits and citrus.	None.
Breads, Cereals, starches	All refined breads, cereals, Pancake, waffle, French toast, potatoes, rice. .	All whole grain breads. All coarse cereals. Potato chips French fried potatoes.	None.
Fats and Oils	All fats in moderation.	All as tolerated.	Highly spiced salad dressings, sauces, gravies.
Soups	Cream soups made with allowed vegetables.		Soups made with foods to avoid.
Beverages	All fruit juices.	Caffeinated and decaffeinated coffee and soft drinks.	Alcoholic beverages.
Desserts	All as tolerated.		
Miscellaneous	Salt in moderation. Coconut, catsup, mustard, vinegar.	Popcorn, nuts. Strong spices, and seasoning. Chocolate.	Black pepper. Red Pepper Chili powder. Pickles.

Reference

Academy of Nutrition and Dietetics. Nutrition Care Manual. Heart-Healthy Fiber Tips. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=101. Accessed July 6, 2023.

VEGETARIAN DIET

I. PURPOSE

Vegetarian meal plans encompass a variety of plant-derived foods and exclude some foods derived from animals. Vegan and plant-based options can be provided through adjusted diet preferences upon resident request.

II. INDICATIONS

Preferred avoidance of all animal products in the diet except dairy and eggs (vegetarian). Preferred avoidance of all animal products in the diet (vegan).

III. ADEQUACY

This diet is nutritionally adequate when planned to meet current DRI/RDAs (Appendix Table 1).

IV. APPROXIMATE COMPOSITION:

	Calories (kcal)	Protein (g)	Carbohydrate (g)	Fat (g)
Average	2200	90	295	80

V. SUGGESTED MEAL PATTERN:

BREAKFAST
4 oz. Fruit or Juice
1 Serving Cereal
1 Egg or Alternate
1 Slice Toast or Alternate
1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

LUNCH & DINNER
6 oz. Soup or Salad w/ Dressing
3 oz. Meat Alternate
2 oz. Gravy
3 oz. Starch
3 oz. Cooked Vegetable
1 Serving Dessert
1 Slice Bread, 1 Pat Butter
8 oz. Low Fat Milk
Coffee, Tea, Decaf
Sugar, Salt, Pepper

Supplements: Supplements are permitted with order.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. General, Healthful Vegetarian Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=7 . Accessed July 6, 2023.

American Heart Association. Vegetarian, Vegan and Meals without Meat. http://www.heart.org/en/healthy-living/healthy-eating/eat-smart/nutrition-basics/vegetarian-vegan-and-meals-without-meat. Accessed July 6, 2023.

ALLERGENS

I. PURPOSE

To eliminate the eight food allergens, that are regulated by the Food and Drug Administration (FDA), from diets to prevent harmful food reactions.

II. INDICATIONS

Harmful food reactions to:

1. Egg
2. Fish
3. Peanut
4. Milk/Lactose
5. Shellfish
6. Soy
7. Tree Nut
8. Wheat/Gluten

All manufactured food products regulated by the Food and Drug Administration (FDA) that contain food allergens as an ingredient must list the "food allergy" on the product label. Food allergens are identified using the USDA or vendor database, when available.

Other food allergens may include beef, citrus, hot dog, mushroom, pork, red meat, and tuna. To accommodate food allergens/intolerances outside the FDA regulated food allergens, the Clinical Nutrition and Food Service Department can modify any diet to eliminate specific foods in food preferences.

Reference

Academy of Nutrition and Dietetics: Nutrition Care Manual. Multiple Food Allergies Nutrition Therapy. https://www.nutritioncaremanual.org/client_ed.cfm?ncm_client_ed_id=29. Accessed July 6, 2023.

ENTERAL NUTRITION

Physicians must order a tube feeding according to the product desired, volume required to meet caloric and nutritional needs, the amount of water to assure adequate hydration and the frequency and mode of feeding. The dietitian will provide specific information and calculations for the formula order. However, the MD may order less than the dietitians' estimated nutrition support needs due to medical indications or for quality of life.

The following diet orders are available for physicians to order.

1. **Tube Feeding, NPO (TF-NPO):** residents who require total nutrition support via enteral nutrition.
2. **Tube Feeding W Food (TF-FOOD):** residents who require supplemental nutrition via enteral nutrition in addition to an oral diet. This order must be accompanied by a diet order specifying texture, therapeutics, etc.

Appendix Table 3 provides Laguna Honda's nutrition support formulary.

APPENDIX TABLE 1: DIETARY REFERENCES BASED ON AGE-SEX

	Source of Goal	Female, 19-30	Female, 31-50	Female, 51-70	Female, >70	Male, 19-30	Male, 31-50	Male, 51-70	Male, >70
Calorie Level Assessed		2000	1800	1600	1600	2400	2200	2000	2000
Macronutrients									
Protein (% kcal)	AMDR	10-35%	10-35%	10-35%	10-35%	10-35%	10-35%	10-35%	10-35%
Protein (g)	RDA	46	46	46	56	56	56	56	46
Carbohydrate (% kcal)	AMDR	45-65	45-65	45-65	45-65	45-65	45-65	45-65	45-65
Carbohydrate (g)	RDA	130	130	130	130	130	130	130	130
Fiber (g)	14g/1000 kcal	25	25	21	21	38	38	30	30
Added Sugars (% kcal)	DGA	<10	<10	<10	<10	<10	<10	<10	<10
Total Lipid (% kcal)	AMDR	20-35	20-35	20-35	20-35	20-35	20-35	20-35	20-35
Saturated Fatty Acids (% kcal)	DGA	<10	<10	<10	<10	<10	<10	<10	<10
18:2 Linoleic Acid (g)	AI	12	12	11	11	17	17	14	14
18:3 Linoleic Acid (g)	AI	1.1	1.1	1.1	1.1	1.6	1.6	1.6	1.6

	Source of Goal	Female, 19-30	Female, 31-50	Female, 51-70	Female, >70	Male, 19-30	Male, 31-50	Male, 51-70	Male, >70
Minerals									
Calcium (mg/d)	RDA	1000	1000	1200	1200	1000	1000	1000	1200
Chromium (mcg/d)	AI	25	25	20	20	35	35	30	30
Fluoride (mg/d)	AI	3	3	3	3	3	4	4	4
Copper (mcg/d)	RDA	900	900	900	900	900	900	900	900
Iodine (mg/d)	RDA	150	150	150	150	150	150	150	150
Manganese (mg/d)	AI	1.8	1.8	1.8	1.8	2.3	2.3	2.3	2.3
Selenium (mcg/d)	RDA	55	55	55	55	55	55	55	55
Chloride (g/d)	AI	2.3	2.3	2	1.8	2.3	2.3	2	1.8
Molybdenum (mcg/d)	RDA	45	45	45	45	45	45	45	45
Iron (mg/d)	RDA	18	18	8	8	8	8	8	8
Magnesium (mg/d)	RDA	310	320	320	320	400	420	420	420
Phosphorus (mg/d)	RDA	700	700	700	700	700	700	700	700
Potassium (mg/d)	AI	2600	2600	2600	2600	3400	3400	3400	3400
Sodium (mg/d)	AI	1500	1500	1500	1500	1500	1500	1500	1500
Zinc (mg/d)	RDA	8	8	8	8	11	11	11	11

	Source of Goal	Female, 19-30	Female, 31-50	Female, 51-70	Female, >70	Male, 19-30	Male, 31-50	Male, 51-70	Male, >70
Vitamins									
Vitamin A (mcg/d)	RDA	700	700	700	700	900	900	900	900
Vitamin E (mg/d)	RDA	15	15	15	15	15	15	15	15
Vitamin D (mcg/d)	RDA	15	15	15	20	15	15	15	20
Vitamin K (mcg/d)	AI	90	90	90	90	120	120	120	120
Vitamin C (mg/d)	RDA	75	75	75	75	90	90	90	90
Thiamin (mg/d)	RDA	1.1	1.1	1.1	1.1	1.2	1.2	1.2	1.2
Riboflavin (mg/d)	RDA	1.1	1.1	1.1	1.1	1.3	1.3	1.3	1.3
Niacin (mg/d)	RDA	14	14	14	14	16	16	16	16
Vitamin B-6 (mg/d)	RDA	1.3	1.3	1.5	1.5	1.3	1.3	1.7	1.7
Vitamin B-12 (mg/d)	RDA	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
Choline (mg/d)	AI	425	425	425	425	550	550	550	550
Pantothenic Acid (mg/d)	AI	5	5	5	5	5	5	5	5
Biotin (mcg/d)	AI	30	30	30	30	30	30	30	30
Folate (mcg/d)	RDA	400	400	400	400	400	400	400	400

APPENDIX TABLE 2: LAGUNA HONDA HOSPITAL ORAL SUPPLEMENT FORMULARY

Oral Supplements									
Formula	**KCAL**	**CHO (g)**	**PRO (g)**	**FAT (g)**	**Gluten Free**	**Suitable for Lactose Intolerance**	**Kosher**	**Halal**	**Notes**
Ensure Original 237 mL/8 oz. (Vanilla, Chocolate, Strawberry)	250	41 (42, choc)	9	6	Yes	Yes	Yes	Yes	*Standard formula*
Ensure Enlive ***Ensure Plus High Protein** 237 mL/8 oz. (Vanilla) *substitute	350	44 (40 *)	20	11 (13*)	Yes	Yes	Yes	N/A	*Concentrated, high protein formula*
LHH Fortified Pudding 118.3 mL/4 oz. (Vanilla, Chocolate)	246 (243, choc)	42 (40, choc)	8	5	Yes	No	Yes	N/A	*Pudding Thick*
Ensure Clear 237 mL/8 oz. (Apple, Mixed Berry)	240	52	8	0	Yes	Yes	Yes	Apple Only	*Clear Liquid*
Glucerna Shake 237 mL/ 8oz. (Vanilla)	220	26	10	9	Yes	Yes	Yes	Yes	*Diabetes*
Nepro w/ Carb Steady 237 mL/ 8oz. (Vanilla)	425	38	19	23	Yes	Yes	Yes	Yes	*Dialysis; low in phosphorus, potassium, and sodium*
Suplena w/ Carb Steady 237 mL/ 8oz. (Vanilla)	425	46.4	10.6	23	Yes	Yes	Yes	Yes	*Chronic Kidney Disease, not on dialysis*

Protein Modulars Formula	**KCAL**	**CHO (g)**	**PRO (g)**	**FAT (g)**	**Gluten Free**	**Suitable for Lactose Intolerance**	**Kosher**	**Halal**	**Notes**
Beneprotein 1 scoop/7 g (unflavored)	25	0	6	0	Yes	Yes	Yes	N/A	*Elevated protein requirements*
Juven 24g packet (orange)	80	8.4	7g L-Arg./ 7g L-Glu	0	Yes	Yes	Yes	N/A	*Elevated protein requirements. Contains Phenylalanine.*
Prostat 30 mL/1 oz. (Citrus splash)	100	10	15	0	Yes	Yes	Yes	N/A	*Elevated protein requirements*

APPENDIX TABLE 3: LAGUNA HONDA HOSPITAL ENTERAL NUTRITION FORMULARY

Formula	KCAL	CHO (g)	PRO (g)	FAT (g)	Fiber (g)	Osmolality (mOsm/kg H2O)	Na (mg)	K (mg)	P (mg)	Mg (mg)	Water (mL)	mL to meet 100% RDI	Notes
Jevity1.0 1000 mL	1060	154.7	44.3	34.7	14.4	300	930	1570	834	290	835	1500	*Standard formula*
Jevity 1.2 1000 mL	1200	169.4	55.5	39.3	17	450	1067	2390	1200	370	807	1250	*Standard formula*
Jevity 1.5 1000 mL	1500	215.7	63.8	49.8	21	525	1330	2180	1250	420	760	1000	*Standard formula*
Osmolite 1.0 1000 mL	1060	143.9	44.3	34.7	0	300	930	1570	835	290	835	1500	*Low-Residue formula*
Osmolite 1.2 1000 mL	1200	157.5	55.5	39.3	0	360	1067	2274	1200	370	820	1250	*Low-Residue formula*
Osmolite 1.5 1000 mL	1500	203.6	62.7	49.1	0	525	1330	2180	1250	420	762	1000	*Low-Residue formula*
Glucerna 1.0 1000 mL	1000	95.6	41.8	54.4	14.4	355	930	1325	705	285	853	1420	*Diabetic formula*
Glucerna 1.2 1000 mL	1200	114.5	60	60	16.1	720	1110	2020	1200	320	805	1250	*Diabetic formula*
Glucerna 1.5 1000 mL	1500	133.1	82.5	75	16.1	875	1380	2520	1000	400	759	1000	*Diabetic formula*
Nepro with Carb Steady 1000 mL	1800	160	81	96	25	745	1050	949	717	169	727	944	*Dialysis formula*
Perative 1000 mL	1300	180.3	66.7	37.3	6.5	460	1040	1735	870	350	790	1155	*Peptide-based. Contains arginine*
Promote 1000mL	1000	130	63	26	0	405	933	2667	833	280	839	1500	*High protein formula*
TwoCal HN 1000 mL	2000	218.6	83.5	90.5	5	710	844	2110	1321	414	700	948	*Calorie and protein dense*
Vital 1.0 1000 mL	1000	130	40	38.1	4.2	411	861	1477	833	280	834	1500	*Elemental*
Vital 1.5 1000 mL	1500	187	67.5	57.1	6	671	1139	2194	1251	422	764	1000	*Elemental, Calorically Dense*
Vital AF 1.2 1000 mL	1200	110.6	75	53.9	5.1	459	1266	1645	1004	337	811	1250	*Elemental*

APPENDIX TABLE 4: DIET RESTRICTION CODE AND DESCRIPTION

BLND	Bland/Low Fiber
CARB60G	Carb Control 60g
CARB75G	Carb Control 75g
CARB90G	Carb Control 90g
CLIQ	Clear Liquid
DS	Dental Soft
FLD10	Fluid Restricted 1000 cc
FLD12	Fluid Restricted 1200 cc
FLD15	Fluid Restricted 1500 cc
FLD18	Fluid Restricted 1800 cc
FLDNO	Fluid Restricted - No fluid
FLIQ	Full Liquid
HONEY	Thick Liquid Honey
LFATLCHOL	Low Fat/ Low Cholesterol
LOK	Low Potassium
LOPHOS	Low Phosphorus
MS	Mechanical Soft
MSPV	Mechanical Soft Puree Vegetables
MSPFV	Mechanical Soft Puree Fruits and Vegetables
NA2	Sodium 2 Gram
NAS	No Added Salt
NECT	Thick Liquid Nectar
NKA	No Known Allergy
NKFA	No Known Food Allergy
NOBEEF	No Beef
NOCITRS	No Citrus
NOEGG	No Egg
NOFISH	No Fish
NOGLUTWHEAT	No Gluten/Wheat
NOHOTDOG	No Hot Dog
NOLACT	No Lactose
NOMILKPROD	No Milk Products
NOMUSH	No Mushrooms
NOPNUT	No Peanut
NOPORK	No Pork
NORDMT	No Red Meat
NOSHELLFISH	No Shellfish
NOSOY	No Soy
NOTREENUT	No Tree Nuts
NO TUNA	No Tuna
NPO	Nothing By Mouth
PUR-FULL	Puree-Full
PUR-SEMI	Puree-Semi
REG	Regular
REN60	Renal Diet, 60 g protein
RMSE	Regular with Mechanical Entree
TF-FOOD	Tube Feeding with Food
TF-NPO	Tube Feeding, NPO
TFPR	Tube Feeding with Puree
VEG	Vegetarian

REFERENCES

Institute of Medicine. 2006. *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*. Washington, DC: The National Academies Press. https://doi.org/10.17226/11537.

IOM (Institute of Medicine). 2011. Dietary Reference Intakes for Calcium and Vitamin D. Washington, DC: The National Academies Press.

National Academies of Sciences, Engineering, and Medicine. 2019. *Dietary Reference Intakes for sodium and potassium.* Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25353.

Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: \ Long-Term Care, Post-Acute Care, and Other settings. *Journal of Academy of Nutrition and Dietetics.* 2018;118:724-735.

State Operations Manual Appendix PP-Guidance to Surveyors for Long Term Facilities. 2023, Rev 211: 375. Accessed 7/5/2023, https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

Deletion Nursing
Policies and Procedures

COLLECTION OF STOOL SPECIMENS

POLICY:

1. A physician's order is required to send specimens to the laboratory.

2. A Licensed Nurse who suspects some illness may collect or request a collection of stool and then confer with a physician to determine if the specimen should be sent to the laboratory.

3. The Licensed Nurse, Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA) may collect stool specimens.

4. Only the Licensed Nurse (or MD) may test and read the results for occult blood.

PURPOSE:

Stool specimens are collected appropriately to assist in the diagnosis of Gastro-Intestinal disease.

PROCEDURE:

A. Equipment needed for all stool collections

Completed self stick specimen identification label (date and time collected, stamped laboratory addressograph containing resident name, laboratory ID number, neighborhood, and bed number) Completed must be stamped with the laboratory addressograph and completed accurately, including the physician's ID number and ICD -9 codes.
Sterile screw-top container or correct collection tube
Specimen plastic bag
Two tongue blades
Bedpan, commode or specimen hat
Paper towel

B. Procedure common to collection of all stool specimens

1. Fresh stool specimens are required for accurate laboratory results.

2. See procedure described in approved text Nursing Interventions and Clinical Skills by Elkin, Perry and Potter.

3. Once stool specimen is collected, clipped or placed the laboratory requisitions in the outside pocket of the specimen plastic bag.

4. Alert: The Licensed Nurse should check the resident's electronic health record for the use of barium, magnesium or oil of any kind within three days prior to stool collection as these may invalidate results.

C. Procedure for testing for occult blood by the licensed nurse

1. Additional equipment: Hemoccult Test Kit.

2. Follow the directions on the Hemoccult Test Kit.

D. Procedure for collection of stool specimen for laboratory testing for occult blood

1. Additional equipment: Stool specimen container for guaiac obtained from Clinical Laboratory Office.

2. See specimen disposition.

E. Procedure for collection of a stool specimen to be tested for ova and parasites (O&P)

1. Additional equipment: O&P collection kit obtained from the clinical lab.

2. It is important to collect this specimen prior to the start of medications.

3. Take the specimen to the lab while still warm and notify the lab technician. The specimen is **not** to be refrigerated.

4. Specimens are usually collected on three different days or as requested by the physician.

F. Procedure for collection of stool for other enteric pathogens:

1. Additional equipment: Specimen container containing non nutritive transport medium e. g. Para Pak C&S containers.

2. The licensed nurse must take the specimen immediately to the lab and contact the lab technician so that the specimen will reach the SFGH lab within two (2) hours.

3. Specimens to be tested for Clostridium difficile toxin assay or fecal leukocytes must be sent without transport medium or fixative. After collection these specimens must be taken immediately to the Clinical Laboratory at the Pavilion Mezzanine and placed in the refrigerator.

4. If collecting for C. Diff and another pathogen, use two different specific-containers, with separate laboratory requisitions and placed in the outside pocket for each specimen plastic bags.

G. Procedure for collection of stool for Pinworms

1. Additional equipment: Perianal SWUBE paddle in tube, found in the clinical lab. Follow the directions in the packet for obtaining specimen.

2. Collect specimen first thing in am before bathing or using toilet.

3. Usually collected on three consecutive mornings.

H. Disposition of Urine Specimens

1. For regular working hours, send stool specimens directly to the Clinical Laboratory by any Nursing Staff for regular lab courier pick-up. For STAT-order, inform Lab Technician to include stool specimen in the earliest lab courier pick-up time.

   Note: Please refer to type of lab test requested for stool specimen.

2. For non-STAT order, on weekends, holidays, or after hours, stool specimens are stored in the laboratory refrigerator (unless contraindicated) located in the North 1 and South 2 Residence Buildings. A designated A.M. shift nursing staff will bring all the stool specimens with requisition to the Clinical Laboratory for the first lab courier pick-up at 0830, Monday to Friday.

3. For STAT order, on weekends, holidays, or after hours, Licensed Nurse to call Nursing Operations / Nurse Manager / Nursing Supervisor to arrange Lab courier transportation to pick-up specimen.

4. Refer to Clinical Lab P&P for laboratory hours and courier pick-up times.

I. Documentation of Collection Stool Specimen

1. Licensed Nurse will document the collection on the electronic health record.

2. Nursing Assistant will document the bowel movement on the electronic health record.

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins

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

CROSS REFERENCES:

Clinical Laboratory Policies and Procedures

Nursing Policies and Procedures
H6.0 After Hours STAT Blood Draw

Revised: 2001/08, 2008/11, 2010/10, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

SPUTUM SPECIMENS

POLICY:

1. A physician's order is required to send specimens to the laboratory.
2. The Licensed Nurse, Certified Nursing Assistant (CNA), or Patient Care Assistant (PCA) may collect
3. Only Licensed Nurses, Respiratory Therapists and physicians may obtain sputum specimens collected by suctioning.

PURPOSE:
To collect expectorated or suctioned bronchial secretion in order to assist with medical diagnosis.

PROCEDURE:

For additional information, see procedure in attached reference list.

A. Equipment for collecting all sputum specimens

1. Completed self stick specimen identification label (date and time collected)
2. Completed lab requisition, including the physician's ID number and ICD -10 codes.
3. Sterile screw-top container (securely tightened after collection)
4. Specimen plastic bag(s)
5. Disposable gloves

B. Collection of specimens obtained by expectoration

1. First morning specimen is the most suitable, easier to obtain good quantity, quality of specimen.
2. Instruct resident to clear the nose and throat and rinse mouth with water.
3. If resident has pain due to a surgical incision or other factors, instruct to gently but firmly press a pillow over
4. Instruct resident to take several slow deep breaths, fully exhaling and performing a forceful cough; repeat as needed.
5. Instruct resident to cough deeply and expectorate sputum into the sterile specimen container.
6. Laboratory confirmations for acid-fast bacilli require 3 specimens collected on **different days** unless otherwise specified by physician**.**

C. Sputum collected by suctioning

Additional Equipment

Suction machine or wall suction if available
Suction catheter
Sputum trap (Mucous Specimen Trap)
Sterile lubricating gel
Sterile gloves

1. Administer supplemental oxygen prior to performing suctioning, if ordered.
2. Set-up suction equipment, setting suction to 100-150 mmHG for adults, and verify it is functional.
3. Visualize the nares to determine the most easily accessible passage
4. Perform hand hygiene and use eye protection.
5. Attach in-line specimen trap to suction tubing
6. Using sterile technique, open packages of sterile items. Use inner side of packaging for the sterile gloves as a “sterile drape” to place the catheter and container for sterile normal saline
7. Put on sterile gloves; consider the dominant hand sterile and the non-dominant hand non-sterile.
8. Using non-sterile hand, pour sterile saline into the sterile container and squeeze a small amount of water-soluble lubricant onto the “sterile drape.”
9. With the sterile hand, attach the catheter to the in-line trap attached to the suction tubing. Use the non-sterile hand to hold the suction tubing and to control the suction valve during the procedure
10. Using the sterile hand to manipulate catheter, dip the tip of the catheter into sterile saline to moisten the inside of the catheter.
11. Lightly coat end of the catheter with the lubricant.
12. Insert the suction catheter trip gently into the patient’s nasal passage. Twist the tip gently to help it advance through the turbinate.
13. Slowly advance the catheter tip into the patient’s trachea while instructing him/her to inhale **without swallowing.**
14. Instruct the resident to cough and, while the patient is coughing, use the nonsterile hand to apply suction 5-10 seconds by occluding the port on the suction tubing to collect 2-10 mL of sputum.
15. Rotate catheter gently while slowly withdrawing catheter.
16. Disconnect the in-line trap from the suction tubing and catheter and close tightly by connecting the rubber tubing to the trap male adaptor.
17. Clear the suction catheter with normal saline.

D. Disposition of specimens

1. Place the label on the container, place specimen(s) container in a clear plastic bag(s), and attach requisition(s).

2. Store sputum specimen in laboratory refrigerator until pick-up.

3. Laboratory Operation Hours and Regular Courier Pickup Hours (Refer to Clinical Laboratory P&P A1)

4. For STAT-order, inform Lab Technician to include sputum specimen in the earliest lab courier pick-up time.

E. Documentation

Licensed Nurse will document sputum collection onto the electronic health record once specimen is obtained.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Clinical Laboratory Policies and Procedures
A1 Clinical Laboratory

Nursing Policies and Procedures
H 6.0 After Hours STAT Blood Draw

Revised: 2001/08, 2008/11, 2010/10, 2010/12, 2016/03, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

GASTRIC SPECIMENS

POLICY:

1. Obtain a physician's order for desired test.

2. Licensed nurses collect gastric specimens.

PURPOSE:

To collect gastric contents for diagnostics.

PROCEDURE:

A. Equipment:

a. Basin for emesis (for gastric samples via emesis)
b. 35-60 ml syringe
c. Completed lab request
d. Sterile container with screw-top cover
e. Label for container
f. Clear plastic bag

B. Laboratory requisitions

1. Completed self-stick specimen identification label (date and time collected, stamped addressograph containing resident name, and neighborhood) and affix to the specimen container.

2. Completed requisition must be stamped with the addressograph and completed accurately, including the physician's ID number and ICD -10 codes.

C. Obtaining a <u>gastric sample if resident has had emesis</u>:

1. Provide resident with privacy.

2. Collect approximately 50ml, transfer to a sterile container with a screw top, and tightly close the container.

3. Affix the label on the specimen container. Place the specimen container inside the specimen plastic bag, then clip or place the laboratory requisitions in the outside pocket specimen plastic bag.

4. Assist resident to rinse his/her mouth.

D. Obtaining a gastric <u>sample directly from the stomach</u>:

1. Obtain and follow the specific instructions provided by the physician or clinical lab for the clinical test to be performed.

2. Position resident in High Fowlers position. Use a 35-60 ml syringe to withdraw 5-10 ml of gastric contents.

3. Affix the label on the specimen container. Place the specimen container inside the specimen plastic bag, then clipped or placed the laboratory requisitions in the outside pocket specimen plastic bag.

E. Disposition of Specimen

1. Place the label on the container, place specimen(s) container in a clear plastic bag(s), and attach requisition(s).

2. Store gastric specimen in laboratory refrigerator until pick-up.

3. Laboratory Operation Hours and Regular Courier Pickup Hours (Refer to Clinical Laboratory P&P A1)

4. For STAT-order, inform Lab Technician to include gastric specimen in the earliest lab courier pick-up time.

F. Documentation

1. Licensed Nurse will document specimen collection on the electronic health record.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

CROSS REFERENCES:

Clinical Laboratory Policies and Procedures
A1 Clinical Laboratory

Nursing Policies and Procedures
E 5.0 Enteral Tube Feeding Management
H 6.0 After Hours STAT Blood Draw

Revised: 2000/11, 2008/11, 2010/10, 2010/12, 2016/07, 2019/03/12

Reviewed: 2019/03/12

Approved: 2019/03/12

INCENTIVE SPIROMETRY

POLICY:

1. Nursing will initiate Incentive Spirometry order based upon physician's order.

2. Licensed personnel or the resident may administer the treatment.

PURPOSE:

To describe the safe and effective use of the Incentive Spirometer.

CHARACTERISTICS:

Definition:

The Incentive Spirometer maximizes voluntary lung inflation to prevent and treat Atelectasis and to mobilize secretions.

The device is used to induce the resident to take a deep breath and hold it for several seconds. This exercise establishes alveolar hyperinflation for a longer time than is possible with a normal deep breath, thus preventing and reversing the alveolar collapse that produces Atelectasis and Pneumonitis.

PROCEDURE:

A. Equipment:

Incentive Spirometer with disposable tube and mouthpiece are pre-packed for individual resident use ~~.~~and issued by CSR.

B. Preparation of Equipment:

1. Read the manufacturer's instructions for spirometer setup and operation. Remove the flow tube and mouthpiece from the package and attach them to the device.

C. ~~Preparation of Resident:~~

~~1. Assess the resident's ability to follow instructions in use of Incentive Spirometry device.~~

~~2. Explain the procedure to the resident, making sure he/she understands the importance of performing this exercise regularly to help prevent lung collapse and pneumonia.~~

~~3. Assist the resident to a comfortable sitting or semi-Fowler's position to promote optimal lung expansion.~~

~~4. Provide paper and pencil so the resident can note exercise times. Exercise frequency varies with condition and ability.~~

~~D. Procedure: Instruct the resident to:~~

~~1. Insert the mouthpiece and close lips tightly around it, because a weak seal may alter flow or volume readings.~~

~~2. Exhale normally and then inhale through the mouthpiece to the predetermined level for 3-5 seconds if able to.~~

~~3. Tell the resident to remove the mouthpiece and exhale normally. Allow resident to relax and take several normal breaths before attempting another breath with the spirometer. Usually one incentive breath per minute minimizes resident fatigue.~~

~~4. The standard frequency for using the Incentive Spirometer is 10 breaths a session, four times a day unless otherwise ordered differently by the physician.~~

~~5. Encourage resident to cough after each effort, because deep lung inflation may loosen secretion and facilitate their removal.~~

~~6. Note the character of any secretions expectorated.~~Refer to Elsevier for procedure: Search (elsevierperformancemanager.com)

E. Documentation ~~for Incentive Spirometry~~

1. Respiratory therapy documents initial instructions and set up.

2. ~~Record~~ Document teaching and resident's ability to participate in the treatment ~~in Interdisciplinary Progress Notes.~~in electronic health record (EHR).

3. Include Incentive Spirometry in the Resident's Care Plan.

4. Document progress towards goals in EHR~~the Interdisciplinary Progress Notes~~.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Search (elsevierperformancemanager.com)~~Elkin, Perry & Potter, Nursing Interventions & Clinical Skills, 5th edition, Elsevier Inc., 2012.~~

~~EBSCO - Nursing Reference Center - Patient Education: Incentive Spirometry at the Bedside~~

~~Lippincott, Williams, and Wilkins, Best Practices: Evidence-Based Nursing Procedures, 2nd edition (2007)~~

CROSS REFERENCES:

Respiratory Services Policies and Procedures
A.13 Incentive Spirometer

Revised: 2000/08~~/2000;~~ 2009/03~~/2009;~~ 2016/03~~/2016~~; 2023/12/21

Reviewed: _____

ORTHOSTATIC (OR POSTURAL) HYPOTENSION PROTOCOL

Definition:

- Decrease in systolic blood pressure (SBP) of at least 20 mm Hg or decrease in diastolic blood pressure (DBP) of at least 10 mm Hg, within three minutes of standing.
- Some patients may report associated symptoms: dizziness on position change, lightheadedness, weakness, nausea, blurred vision, syncope (fainting), and headache.

Interventions to Identify and Prevent Injury related to Orthostatic Hypotension

- Determine resident's medication history to identify medications that can predispose resident to orthostatic hypotension in the absence of hypovolemia.
- Monitor/ assess for orthostatic hypotension at admission for all residents (standard) unless otherwise indicated.
- Monitor/assess when resident reports symptoms suggestive of orthostatic hypotension, or if the resident has experienced a fall (nursing order).
- When assessing for orthostatic BP changes, provide standby assist when resident changes position to prevent injury, in event resident experiences symptoms.
- Check orthostatic blood pressure (see Attachment 1: If resident experiences orthostatic hypotension (20 mm Hg decrease in SBP or 10 mm Hg decrease in DBP), consult with physician and or pharmacist regarding possible adjustment in drug regimen to ensure safety.
- If resident experiences orthostatic hypotension, update care plan as appropriate.
- Discuss with physician and pharmacist the need to report possible adverse drug reaction (ADR) via ADR hotline (**ext 4-3361)** if medication-related hypotension is suspected.
- Resident education if orthostatic hypotension occurs, includes, when appropriate the following: dorsiflex feet several times before changing position from lying to sitting or to standing; slow position changes, small frequent meals (vs. large meal), increase fluid and salt intake (if appropriate), elevate HOB 5-20 degrees, use support hose to increase venous return, avoid heat and hot baths, avoid prolonged standing or sitting, avoid straining with urination or defecation and excessive reaching with arms above shoulder level.

Background Information:

Medical Diagnoses or Conditions that May be Associated with OH

- Aortic Stenosis
- Arrhythmias
- Adrenal Insufficiency
- Dehydration
- CVA
- Prolonged standing or lying down
- Fever or Overheating (weather related)
- Alcohol intoxication
- Diabetes Insipidus
- Brainstem lesions
- Spinal Cord Injury
- Peripheral neuropathy
- Parkinsonism (also Postprandial)
- Multiple sclerosis

Medications that May be Associated with Orthostatic Hypotension

- Antihypertensives (e.g.Furosemide, Hydrochlorothiazide, Metoprolol, Prazosin, Clonidine)
- Heart Failure therapy (e.g. Amlodipine, Benazepril, Hydralazine, Carvedilol, Nitroglycerin, Isosorbide, Bumetanide)
- Antiarrhythmics (Quinidine, Tocainide)
- Anti-Benign Prostatic Hypertrophy therapy (alpha blockers such as Doxazosin, Prazosin, Terazosin etc.)
- Psychotropics (Amitriptyline, Bupropion, Quetiapine)
- Antiemetics (Dronabinol, Scopolamine, Promethazine)

References:

Lanier, JB, Moet, MG Clay, EC (2011). Evaluating and managing orthostatic hypotension***. American Family Physician,*** *84(5).*

Gupta, V, Lipsitz, LA (2007). Orthostatic hypotension in the elderly: diagnosis and treatment. ***American Journal of Medicine***, 120(10): 841-7.

PubMed Health. (updated 2011). Hypotension, URL: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004536/

National Institute of Neurological Disorders and Stroke, URL: http://www.ninds.nih.gov/disorders/orthostatic_hypotension/orthostatic_hypotension.htm

Revised: 04/2006; 01/29/2013

Reviewed: 01/29/2013

Approved: 01/29/2013

Skills

Assessment: Orthostatic Vital Signs - CE

Quick Sheet

ALERT
Do not check orthostatic vital signs in patients with supine hypotension, shock, or severe alteration in mental status, or in those who may have spinal, pelvic, or lower extremity injuries.

Medications that block a patient's normal vasomotor and chronotropic response will interfere with fluid volume assessment; however, for assessment of a patient's reaction to a medication, obtaining orthostatic vital signs can be helpful.

Anticipate that the patient may experience dizziness and that an assistant may be necessary to help move the patient from a lying to a standing position. Do not leave the patient alone during this procedure.

1. Perform hand hygiene before patient contact.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Determine the patient's medication history, because certain medications—such as sympatholytic drugs, diuretics, nitrates, opioids, antihistamines, psychotropic agents, barbiturates, antihypertensives, and anticholinergics—can predispose a patient to orthostatic hypotension in the absence of hypovolemia.
5. Have the patient lie in a supine position for 5 to 10 minutes before taking the initial measurements. **Prevent unreliable results by avoiding invasive or painful procedures during the measurement of orthostatic vital signs.**
6. Perform hand hygiene.
7. Explain the procedure to the patient and ensure that he or she agrees to treatment.
8. Measure blood pressure and heart rate after the patient has been in a supine position for 5 to 10 minutes. Use the appropriate-size blood pressure cuff. The correct cuff size is determined by arm circumference.
9.

Have the patient move from the supine to the standing position. If the patient is unable to stand for a blood pressure measurement, try either the high-Fowler or the sitting position, although the results may be less credible. A supine-to-standing measurement is more accurate than a supine-to-sitting measurement.

10. Question the patient about weakness, dizziness, or visual dimming associated with a change of position. Note any pallor or diaphoresis. These symptoms are as important as the measurement of vital signs. **Terminate the measurement if the patient becomes extremely dizzy and needs to lie down or experiences syncope.**

11. Take the standing or sitting blood pressure (in the same arm as the initial readings) and determine the heart rate at 1 and 3 minutes after the position change. Support the patient's arm at heart level when taking the blood pressure to prevent an inaccurate measurement. When measuring orthostatic vital signs, one or more of the following findings may indicate intravascular volume loss in adults:

    a. Decrease in systolic blood pressure of 20 mm Hg or more

    b. Decrease in diastolic blood pressure of 10 mm Hg or more

    c. Increase in heart rate of 20 bpm or more

12. Return the patient to a supine or sitting position.

13. Monitor for the resolution of symptoms such as dizziness, visual changes, or hypotension if any occurred during the measurement of orthostatic vital signs.

14. Perform hand hygiene.

15. Document the results in the patient's record.

Clinical Review: Susan Thibeault, MS, MBA, CRNA, APRN, EMT-P

Published: July 2018
Revised: September 2018

INSTALLATION AND CHECKING OF PORTABLE BED EXIT ALARMS OPERATING GUIDELINES

A. Definition:

Bed exit alarm is a portable safety device installed on a resident's bed is designed to alert the nursing staff and other Resident Care Team (RCT) members of when a resident unsafely attempts to get out of bed.

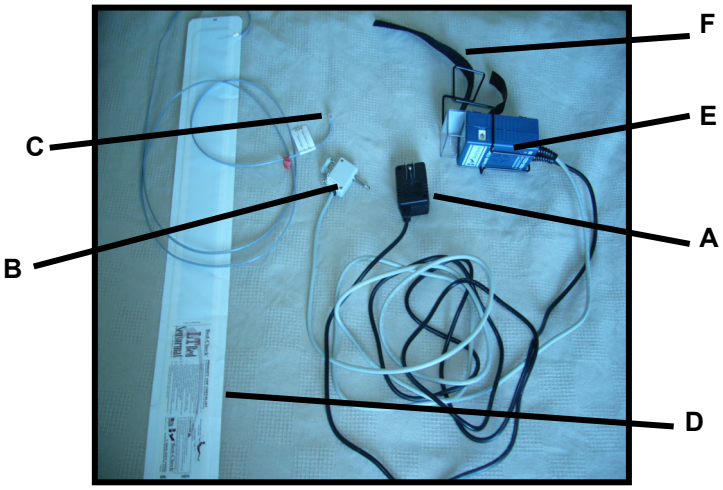
B. Resident Assessment Prior to Installation of Bed Exit Alarm:

1. Each resident is screened for fall risk upon admission or significant change of condition by the Registered Nurse (RN). If resident is determined to be high risk for fall from bed, the RN may commence to use bed exit alarm as part of the fall prevention care plan. (Refer to LHHPP File # 24-13 Falls).

2. After a fall: The RN will complete a Post-Fall Assessment Form (MR524). The RN may initiate to installation of bed exit alarm.

C. Setting-up and Installation of Bed Exit Alarm:

1. **Equipment:**



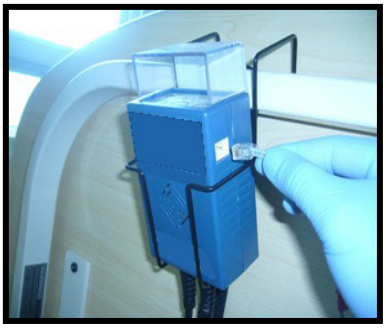
Equipment A – Power Cord Adapter
Equipment B – Nurse Call System Cord
Equipment C – Receptacle Adapter Connector
Equipment D – Sensormat Pad
Equipment E – Bed Exit Alarm
Equipment F – Velcro Strap

2. **Installation of Bed Exit Alarm:**

a. Any trained nursing staff (Licensed Nurse, CNA, or PCA) can set-up and install a bed exit alarm once the intervention is deemed appropriate by the RN.

b. Place the bed exit alarm (Equipment E) behind the headboard of the bed using the Velcro strap (Equipment F).

c. Insert the receptacle adapter (Equipment C) to the bed exit alarm (Equipment E).



d. Place the sensormat (Equipment D) under the bed pad (preferred location is directly under the resident's buttocks). Secure placement by clipping the mat to the bed sheets.

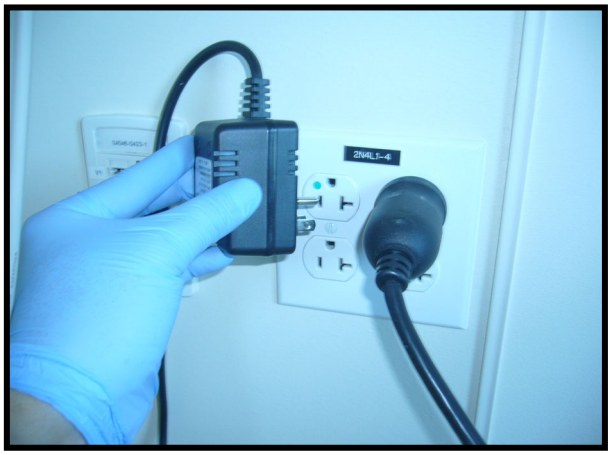
* Note: For fast-moving residents, an alternative location is behind the resident's back or under the shoulder blades area.

e. Write the date on the label when the sensormat is first opened and used. (Manufacturer's recommendation is to replace mat every 90 days for optimal function).

f. Document the location of sensormat in the Fall Risk care Plan.

g. Plug the nurse call system cord (Equipment B) to the patient's call panel.

h. Plug the power cord (Equipment A) into the power outlet.



D. Operating the Bed Exit Alarm:

1. **To activate the bed exit alarm:**

a. After initial installation, the bed exit alarm is activated after the resident is placed on the bed.

b. A yellow light (under “HOLD”) will flash for 5 seconds. (You can push RESET to bypass this step to proceed to “MON” or monitor mode).

c. After 5 seconds of the flashing yellow light, a blinking green light (under “MON”) will then follow. When the green light is blinking, the bed exit alarm is now on “Monitoring Mode”.

* Note: Staff needs to ensure that the green light is blinking (alarm is monitor/“MON” mode) before leaving the resident in bed. This means the alarm is activated.

If a steady yellow light is on (under "HOLD") the alarm is not activated. A steady yellow light indicates that the alarm is on standby mode.

Figure A Monitoring Mode

2. **To put bed exit alarm in a standby mode:**

a. A staff can set the bed exit alarm on “Standby Mode” when resident is being repositioned in bed or when resident is removed from the bed.

b. Push “RESET” button.

c. A yellow light will blink (under HOLD) for approximately 25 seconds indicating, that the nursing staff have approximately 25 seconds to reposition the resident in bed or assist the resident to get out of bed without re-activating the bed exit alarm.

Figure B Standby Mode

d. If the resident remains in bed after 25 seconds, the sensormat will detect the resident's weight and the bed exit alarm will automatically reset back to "Monitoring Mode" (Figure A).

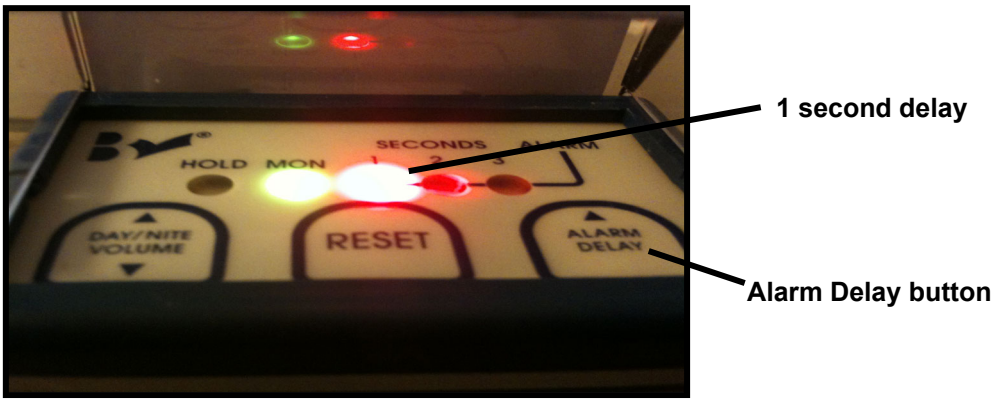
e. If resident is assisted out of the bed within 25 seconds, the sensormat will not detect any weight, the alarm will automatically switch back to "Standby Mode" (Figure B).

3. **To change the alarm delay setting to "delay to 1 second" mode:**

a. Alarm delay setting refers to how quickly the alarm sounds an audible alarm tone and signals the nurse call system once the sensormat pad senses the resident attempting to get out of bed. Alarm delay may vary from 1, 2, or 3seconds depending on the chosen setting.

b. New bed exit alarms are set at the default 3-seconds delay by the manufacturer. Laguna Honda will use a one-second alarm delay setting to ensure staff's quick response.

c. Press the "Alarm Delay" button repeatedly until the red light can be seen under the one second setting.



4. **To change the setting to "Day / Nite" Mode:**

a. Staff can use the options to change between "Day" or "Nite" mode settings.

b. Press the "Day/Nite" button once to change the settings.

c. For "Nite" mode setting, the bed exit alarm plastic cover (splash shield) will be illuminated with a blue light (see Figure C). This means that the alarm's nightlight is on. If the bed exit alarm is set on "Nite" mode, the volume of the bed exit alarm is also decreased to a lower level than the pre-set "Day" volume.

Figure C Nite Mode

E. Maintenance of Bed Exit Alarm and sensormat

1. Clean the bed exit alarm with pre-approved facility disinfectant wipes during designated day of bed cleaning.
2. Clean the sensormat with pre-approved facility disinfectant wipes as needed when soiled.
3. Sensormat pad is change every 90 days per manufacturer's recommendation for optimal functioning.
4. Nursing staff will bring to Central Supply the old sensormat for replacement.
5. Call Facility Service if the bed exit alarm is not properly functioning.

ATTACHMENT:

Bed Exit Check Alarm Skills Checklist

REFERENCE:

2008 Stanley Senior Technologies, Classic-Check Bed-Check Sensormat User Manual

CROSS REFERENCE:

LHHPP File: 24-13 Falls

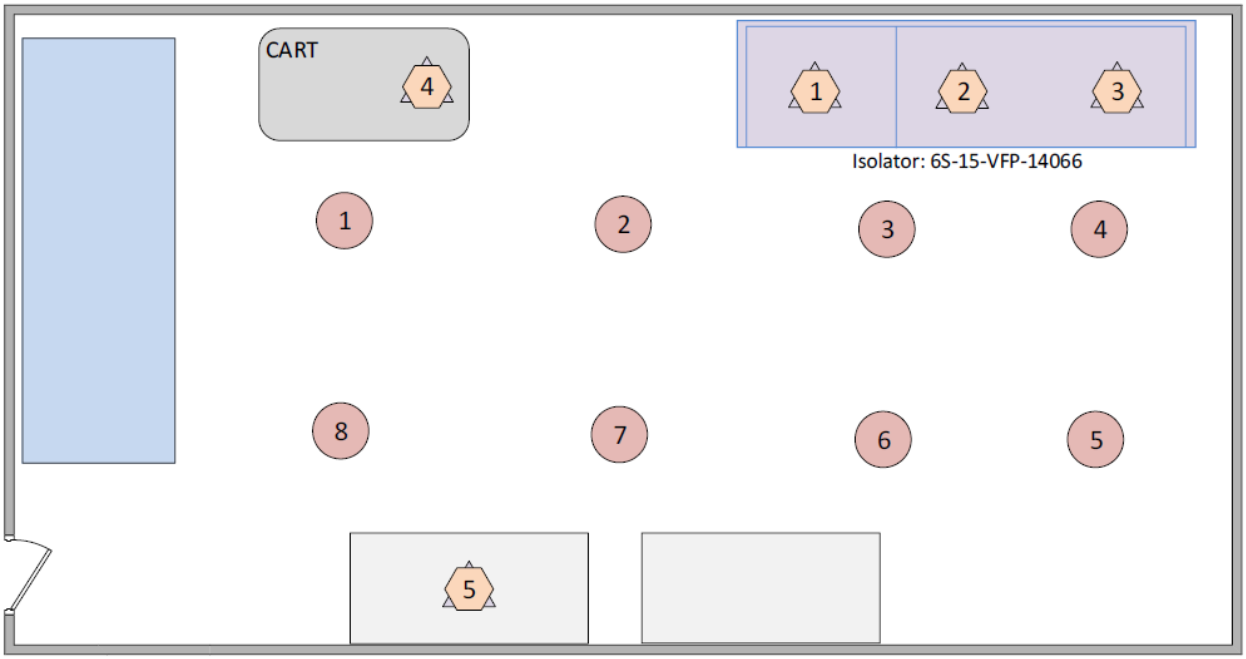
New Document: 03/27/2012

Reviewed: 03/27/2012

Approved: 03/27/2012

Revised Pharmacy Policies and Procedures

Diagram:



Samples CFU count:

S#	Description	CFU result	Alert level	Action level

Viable Surface Sampling: Bacterial & Fungal

Location: MAIN-IV see diagram

Collected by: _____ Reviewed by: _____

QUARTER: _____; Test Date: _____ _____

Media Type: TSA (w/ Lecithin and Polysorbate 80);

Incubation: 30 – 35~~o~~° C x (48 – 72 hours), and 20°– 25°C x 5 – 7 days for fungal testing

Media Manufacturer: QI Medical; Lot #: _____; Expiration: _____

POLICY

The purpose of this policy is to provide guidelines for surface sampling and testing of the compounding areas to maintain a controlled environment for the compounding of sterile preparations.

GENERAL GUIDELINES

1. Potential sources of contamination of compounding areas include improperly disinfected work surfaces, inadvertent touch contact by compounding personnel, damaged HEPA filters, improper room ventilation, and changes in personnel garbing procedures. Surface testing highlights conditions contributing to excessive microbial and particulate levels due to ineffective cleaning or personnel/equipment issues.

2. Random surface sampling shall be performed in all ISO classified areas on a periodic basis at the completion of compounding. Products for surface testing measure the number of microorganisms per area sampled and may utilize swabs for irregular surfaces and equipment or contact plates for regular or flat surfaces.

3. Contact plates are filled with an agar growth media with neutralizing agents above the rim of the plate. A common type of contact plate used for surface testing is the RODAC (Replicate Organism Detection and Counting plate. Plates need to be refrigerated until ready to use. Once sampling has occurred, plates are incubated to promote growth, the microorganisms are counted, and results reported as the number of colony forming units (CFUs) per area sampled.

4. For each classified area the sampling, testing, cleaning and retesting must be conducted monthly.

5. Surface sampling must be performed at the end of compounding activity or shift, but before the area has been cleaned and disinfected.

6. If microbial growth is elevated consistently, a review of garbing, cleaning and compounding practices shall be performed and documented with follow up personnel training.

EQUIPMENT AND SUPPLIES:

1. Contact plates, such as RODAC plates, and/or swabs;

2. Sterile 70% isopropyl alcohol (IPA);

3. Incubator; and

4. Colony counter pen, centimeter grate or use of an outside microbiology lab for colony counting.

PROCEDURE

1. Sample locations for testing include areas where there is little air movement or where airflows converge or are excessively turbulent. These conditions are most likely to occur:

a. ~~a.~~ Interior walls and surfaces of ISO Class 5 devices ("hoods") such as LAFWs, BSCs, CACIs, and CAIs.
b. ~~b.~~ Adjacent to doors.
c. ~~c.~~ In pass-through hatches.
d. ~~d.~~ At low level return air grilles.
e. ~~e.~~ Between HEPAs and clean rooms.
f. ~~f.~~ In corners of rooms; and
g. ~~g.~~ Areas within the clean room where there is personnel activity or where compounding processes occur.

2. Flat surfaces: Surface collection with use of contact plates is by gently pressing the rounded agar surface of the plate to the sample surface. Using a rolling motion, with a light uniform pressure, to ensure that the entire surface of the agar will contact the sample surface. Avoid pulling or sweeping the agar surface over the sample area, as this will destroy the agar surface, rendering the plate unusable. Immediately following the sampling, the area shall be thoroughly wiped with a non-shedding towel soaked in sterile 70% IPA.

3. Irregular surfaces: A sterile, cotton-tipped swab is moistened with sterile water and swabbed over such surfaces and into the corners of equipment. For other irregular surfaces, the swab should be rubbed over a surface area roughly the same size as the base of the contact plate three times in an opposite direction between each successive stroke. Following sampling, the swab head should be gently rotated over the surface of the agar three times, again rolling in opposite direction between each successive stroke.

4. After each sample is transferred to the contact plate, the lid should be replaced; taped shut and the bottom of the plate should be labeled with a description of the location the sample was obtained from. All labeling should be done with a waterproof marking pen. Plates should be stored upside down to prevent any condensation form dripping onto the agar.

5. After sampling, the sampled area must be thoroughly cleaned and disinfected.

6. Incubation and Counting:

a. ~~a.~~ The plates are placed upside down in an incubator. The incubator should be set at 30°– 35°C for no less than 48 hr., then 20°– 25°C x 5 days.

b. ~~b.~~ After no less than 48 hours, the plates are removed from the incubator and the colonies counted. Record the total number of discrete colonies of microorganisms on each device as CFU per sample on the environmental sampling forms. Note that counting areas containing a profuse growth may lead to considerable error.

c.
~~c.~~ Spreading colonies should be counted as one, but care should be taken to observe other distinct colonies intermingled in the growth around the plate periphery or along a hairline. These should also be counted as one colony, as should be colored colonies and halo-type spreaders.

8. After the colony counting results are documented, the plates are placed in a biohazard bag and disposed of accordingly.

9. When testing is completed for ISO Class 5 devices or hoods, clean the hood and test areas with sterile

70% isopropyl alcohol.

10. Colony counts exceeding recommended action levels for microbial contamination shall be met with remedial action. Recommended action levels with regard to ISO classification with surface sampling include:

Table 8. Action Levels for Surface Sampling

ISO Class	Surface Sampling Action Levels (cfu/media device)
5	>3
7	>5
8	>50

If levels measured during surface sampling exceed the levels listed above, an attempt must be made to identify any microorganism recovered to the genus level.

11. The Pharmacy Manager, or designee, shall determine the course of action to resolve any problems of this nature. The corrective action plan must be dependent on the CFU count and microorganism recovered. Corrective actions include:

a. ~~a.~~ Process or facility improvements
b. ~~b.~~ Personnel training
c. ~~c.~~ Cleaning and disinfecting
d. ~~d.~~ HEPA filter replacement and/or repair.

DOCUMENTATION A Surface Testing Log is used to document results and shall be maintained in the pharmacy for a minimum of three (3) years.