List of Policies and Procedures for JCC Review 4-13-26

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	LHHPP	27-10	Transfer Techniques	**D. Swiger**	1. Added "Staff will comply with the standard of work defining the steps involved for manual transfer techniques' types. " 2. Added " For Transfer Techniques using Battery Operated Lift (Refer to NPP D6 1.1 Battery Operated Lift)" 3. Removed the following sections: - Prior to Transfer - Transfer Techniques - Reporting and/or Documentation - Documentation - Care Plan
Revised	LHHPP	29-06	Caring for the Deceased, Use of Morgue, and Provision of Death Certificates	**E. Guina**	1. Updated LHH to Laguna Honda. 2. Removed EVS and A&E from policy. 3. Added Nursing Operations, Social Services and Utilization Department to policy. 4. Update legal representative and guardians to designated decision maker. 5. Removed Guidelines for the Completion of the MDB and Require Forms section. 6. Removed A&E responsible to file MDB and updated to Nursing Ops to compile MDB, which will be kept in Nursing office. 7. Added Monitoring Morgue Capacity where notification when morgue is near capacity, Social Services is to contact Public Authority to expedite transfer of cases, Services will contact families and Directors of Nursing to identify decedents to be transferred to ZSFG. 8. Removed Transportation Arrangements due to overcapacity section.
Revised	LHHPP	50-11	Procurement Card	**J. Drew**	1. Added "If Amazon is used for this program, then an Amazon Prime monthly membership subscription may be used from November through January." 2. Removed "Purchases over $1000 require approval from the Controller's Accounting Operations Director".
Deletion	Admissions & Eligibility	02-06	Patients from Other Hospitals for Re-Admission to LHH	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	02-12	Authorization Process for Out of County Referrals	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	03-03	Registrations for Patients Referred LHH Post Discharge, Infection Control and Other Clinic Registrations referred from SFGH and DPH Clinics	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	03-04	Payer Requirements on Outpatient Registrations	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	04-05	Procedure for Financial Counselor to Track New Admissions with Temporary Conservatorship through the Public Guardian	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	04-13	Procedure for Communication between the Eligibility Departments and Business Office	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	04-15	AUTHORIZED CONTACT FIELD IN INVISION COMPUTER SYSTEM	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	04-18	INVISION Race and Multi Race fields	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	05-09	Laguna Honda Medi-Cal Managed Care Disenrollments	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	09-01	Medical Transportation Policy & Procedures	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	09-02	TRANSPORTATION PHONE NUMBERS	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	09-03	TRANSPORTATION PRESCRIPTION	**G. Villavicencio**	No longer required
Deletion	Admissions & Eligibility	09/04	Request for Ambulance Transport	**G. Villavicencio**	No longer required

Deletion	Admissions & Eligibility	09-05	PHYSICIAN'S CERTIFICATION STATEMENT	**G. Villavicencio**	No longer required
Revised	0	A.3	Compressed Gas Cylinder Safety	**G. Cozzi**	1. Deleted "Cylinder of gas" 2. Added "Regulator is attached to Cylinder" 3. Deleted "Secure that regulator that is pin-indexed to fit the ordered cylinder. " 4. Deleted "Remove any cylinder seal and crack the cylinder by quickly opening and closing the main valve." 5. Deleted "Attach the regulator making sure appropriate gasket is in place (small cylinder only). " 6. Deleted "Tighten the regulator securely and open tank valve with regulator flow obstructed to test for leaks." 7. Deleted "Attach appropriate flow regulating device. " 8. Deleted "Large cylinder attachment " 9. Deleted "Read level to determine contents." 10. Deleted "Place in large cylinder carrier with safety chain." 11. Deleted "Secure that appropriate regulator that is indexed to fit the ordered cylindered gas." 12. Deleted "Remove any cylinder seal and crack the cylinder by quickly opening and closing the main valve." 13. Deleted "Tighten the regulator securely and open the tank valve with regulator flow obstructed to test for leaks." 14. Deleted "Attach appropriate flow regulating device. "
Revised	Respiratory Services	A.6	Oxygen Administration: Nasal Cannula	**G. Cozzi**	1. Deleted "Sterile H20 " 2. Deleted "Oxygen tank and regulator" 3. Replaced "Review physician order" with "View RT order by Physician in Epic" 4. Deleted "Assemble humidifier adding sterile water, if not pre-filled. " 5. Replaced "Connect humidifier to tank" with "Attach Humidifier to Flowmeter if delivering about 4 LPM"
Revised	Respiratory Services	A.7	Oxygen Administration: Simple-Oxygen Mask	**G. Cozzi**	1. Deleted "(i.e., transporting patients from one are of the hospital to another) " 2. Replaced "cylinder regulator" with "flowmeter" 3. Deleted "Oxygen tank and regulator" 4. Deleted "Review the patient's chart carefully for documentation of sensitivity to oxygen administration." 5. Deleted "Review patient chart for arterial blood gas analysis, noting F102 patient was receiving at the time." 6. Deleted "If no arterial blood gases have been done, it is appropriate to request the physician draw a blood sample for analysis as a way to determine appropriate oxygen administration." 7. Replaced "ambulation" with "transport"
Revised	Respiratory Services	A.8	Oxygen Administration: Non Re-breather Mask	**G. Cozzi**	1. Replaced "orifice" with "port" 2. Replaced "Oxygen tank and regulator" with "Oxygen Flowmeter" 3. Added "in EPIC"
Revised	Respiratory Services	A.9	Oxygen Administration: Venturi-Mask	**G. Cozzi**	1. Replaced "Oxygen tank and regulator" with "Oxygen Flowmeter" 2. Corrected minor typos.
Revised	Respiratory Services	A.11	Hand Held Nebulizer	**G. Cozzi**	1. Deleted "or cylinder" 2. Replaced "chart" with "electronic health record (EHR)" 3. Added "in EHR"
Revised	Respiratory Services	A.12	Continuous Aersol Therapy	**G. Cozzi**	1. Replaced "Comatose" with "Non-compliant" 2. Added "into the electronic health record (EHR)."
Revised	Respiratory Services	A.13	Incentive Spirometer	**G. Cozzi**	1. Added "and analysis" 2. Corrected minor typos.
Revised	Respiratory Services	A.15	Pulse Oximetry	**G. Cozzi**	1. Deleted "Written respiratory registration is to be filled out by charge nurse." 2. Replaced "Respiratory Services Department" with "Nursing Unit" 3. Added "in the patients electronic health record (EHR). " 4. Deleted "or charge nurse in the chart"

Revised	Respiratory Services	A.16	Arterial Blood Gas Collection	**G. Cozzi**	1. Deleted "or specially trained nurses" 2. Deleted "To aspirate blood sample:" 3. Deleted "Depress the plumber all the way to the bottom of the syringe. " 4. Deleted "Collect sample by withdrawing the plunger." 5. Added "Sample is taken to the Respiratory Services Department for analyzing. " 6. Added "Quality Control # 3 is performed prior to running of the obtained arterial blood sample." 7. Added "Sample is analyzed with pertinent information of the patient drawn" 8. Added "Results are obtained and written on external document." 9. Added "Results are also entered into electronic health record (EHR) of patients." 10. Added "# 1 Quality Control sample is run post-ABG."
Deletion	Respiratory Services	A1	Mission Statement	**G. Cozzi**	No longer required
Deletion	Respiratory Services	A5	Procedure for Aerostar Booth	**G. Cozzi**	No longer required

Revised Hospital-wide Policies and Procedures

TRANSFER TECHNIQUES

POLICY

1. The Licensed Nurse and/or Rehab staff assesses the resident's ability to transfer with or without staff assistance or adaptive devices upon admission and as needed.

2. The proper level of assistance will be utilized in transferring resident based on their functional status.

3. Each resident who requires a battery-operated lift transfer must have their own assigned sling for transfer and bathing. Sling tags are to be labeled, using permanent marker, with resident's full name and the month/year first opened. Manufacturer recommends slings are to be replaced every 6 months, or if damaged. Damaged slings must be discarded and replaced with a new sling.

4. The principles of good body mechanics are to be adhered to at all times to avoid injuries to either the resident or the staff members.

5. Nursing staff ~~{~~{licensed nurse (LN), nursing assistant (CNA/PCA)~~}~~} may perform transfer procedure. Check care plan for transfer technique and required number of staff assistance during transfer, level of assistance, use of assistive or adaptive device including gait belt (refer to Appendix A: Gait Belts FAQs)

6. Residents on a low ~~air loss~~air-loss mattress shall require two person assist for all transfers.

7. Two nursing staff members are always required for operation of battery-operated lifts.

8. Criteria for assessing use of gait belt with transfers, as follows, but not limited to:

    a. Inclusion Criteria:

        i. Level of assist requires hands on or physical assist

        ii. Due to resident related factors, resident requires supervision and/or stand by assist for safety

    b. Exclusion:

        i. Resident is independent or modified independent and do not require a gait belt for safety, as per resident's care plan.

        ii. Mechanical lift used for transfers that do not require use of gait belt for safety, as per resident's care plan.

PURPOSE

To ensure resident's and staff's safety when moving the resident from one surface to another.

PROCEDURE

Staff will comply with the standard of work defining the steps involved for manual transfer ~~techniques'~~technique's types.

For **Transfer Techniques using Battery Operated Lift** (Refer to NPP D6 1.1 Battery Operated Lift)

~~**1. Prior to Transfer**~~

~~a. Review Resident Care Plan prior to transfer of resident.~~

~~**2. Transfer Techniques**~~

~~a. **Slide Transfer Technique** (Gurney to Bed and Vice Versa)~~

~~i. Place the gurney parallel to the bed.~~

~~ii. Position the bed and the gurney at the same height with head of the bed and gurney in a flat position.~~

~~iii. If any motor weakness or sensory deficit or neglect is present on one side, place the gurney next to the strongest side.~~

~~iv. Set all brakes on all equipment in a "locked" position after the equipment is positioned.~~

~~v. Use a draw sheet or slider sheet to assist with transfer.~~

~~vi. Always have drainage bags lower than the area being drained.~~

~~b. **Pivot Transfer Technique**~~

~~i. Stand in front of resident or along resident's weak side~~

~~ii. Position resident's feet flat on the floor~~

~~iii. Grasp gait belt at each side from underneath~~

~~iv. Brace knees against resident's weak lower extremities~~

~~v. Use knee and foot to block the resident's weak leg or foot, and place your other foot slightly behind you for balance or straddle your legs around the~~

~~resident's weak leg~~

vi. ~~Ask resident to push down on the mattress and on the count of "3" have the resident bend and lean forward (like a see-sawing motion)~~

vii. ~~*Do NOT carry resident*~~

viii. ~~Assist resident to a standing position as you straighten your knees.~~

ix. ~~Encourage resident to take small steps towards the chair or wheelchair if resident is able.~~

x. ~~Turn resident so they can grasp the far arm of the chair or wheelchair. Legs will touch the edge of the seat.~~

xi. ~~Continue turning resident until the other armrest is grasped.~~

xii. ~~Lower resident into the chair or wheelchair as you bend your hips and knees. To assist, the resident leans forward and bends the elbows and knees.~~

xiii. ~~Make sure resident's hips are to the back of the seat. Position resident in good alignment.~~

xiv. ~~Position the resident's feet on the wheelchair footrests.~~

xv. ~~Remove gait belt.~~

xvi. ~~Position the chair as resident prefers and keep belongings and call light within reach.~~

xvii. ~~After completing transfer, check in with the resident for any adverse effects: dizziness, pale complexion, pain, and/or decreased consciousness. Report any change in condition to the license nurse.~~

c. ~~**Sliding Board Transfer Technique**~~

i. ~~Use sliding board or transfer board as a bridge between the bed and chair or wheelchair.~~

ii. ~~Lower the bed to the same height as the seat of the chair or wheelchair.~~

iii. ~~Lock all bed and wheelchair brakes.~~

iv. ~~Move armrest and fold wheelchair footrests back.~~

v. ~~Assist the resident in a seated position to prepare for bed to chair transfer. Place gait belt on the resident.~~

vi. ~~Place one end of the board beneath the resident and the other end on the seat of the chair or wheelchair.~~

vii. ~~Slide the resident along the board to reach the chair.~~

viii. ~~Remove the gait belt and the sliding board.~~

i. ~~Secure armrest and footrest back in position.~~

d. ~~**Transfer Techniques using Battery Operated Lift** (Refer to NPP D6 1.1 Battery Operated Lift)~~

~~3. Reporting and/or Documentation~~

a. ~~All care teams will report and communicate to the physician and rehab staff when additional transfer training is warranted.~~

~~4. Documentation~~

a. ~~Electronic Health Record (EHR)~~

i. ~~The CNA/PCA documents the highest level of assistance needed and number of staff required during transfer with/without use of assistive device or adaptive equipment and gait belt respectively.~~

ii. ~~The Licensed Nurse documents weekly, monthly, and as needed any change in functional level and reports this during the 24-hour report, handoff for all nursing shifts, and RCT team meetings.~~

iii. ~~Nursing will document any unexpected outcomes and related interventions.~~

~~5. Care Plan~~

a. ~~The Licensed Nurse documents in the Care Plan the type and level of assistance needed for transfer with or without use of assistive device or adaptive equipment, and with or without use of gait belt, and the position of the device (i.e., wheelchair place on strong side).~~

b. ~~All residents who require battery-operated lift transfer must have documented on their care plan/Kardex the type of lift, type and size of sling used, and color of straps to apply for the resident.~~

c. ~~For residents in active rehabilitation, collaborate with Rehab Services and with the RCT to write an individualized care plan entry on functional transfer (bed <> chair; toilet transfers; may include shower transfer).~~

APPENDIX:

Appendix A: Gait Belt FAQs

REFERENCES:

Elsevier (2024) Transfer Technique: Pivot Transfer https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Elsevier (2024) Transfer Technique: Bed to Wheelchair using Slide Board https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Elsevier (2024) Transfer Technique: Assisting Patients to Sitting Position https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on March 26, 2025

Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills and techniques* (10th ed.). St. Louis: Elsevier.

CROSS-REFERENCES:

NSPP D6 1.1 Battery Operated Lift

Revised: ~~23/~~10/10/23, ~~25/~~05/12/25, 04/20/26 (~~Year/~~Month/Day/Year)

Adopted from Nursing D6. 2.0 on 23/10/10 (~~Year/~~Month/Day/Year)

Original: ~~2000/~~08/2000 (~~Year/~~Month/Year)

Appendix A: Gait Belt FAQs

1. What is a gait belt?
    a. Gait belts are thick fabric or vinyl belts that give staff a place to hold onto the resident to assist with balance and support of the resident. Contact your supervisor for location of gait belts on your unit.
2. Why should you use a gait belt?
    a. Gait belts should be worn to ensure safe mobility for resident and staff.
3. Who should use a gait belt?
    a. Every staff member that assists resident with mobility, including transfers and ambulation, provided resident meets inclusion criteria for gait belt use. Criteria for assessing use of gait belts with transfers, as follows, but not limited to:
        i. Inclusion Criteria:
            - Level of assist requires hands on or physical assist
            - Due to resident related factors, resident require supervision and/or stand by assist for safety
        ii. Exclusion:
            - Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.
            - Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.
4. Where should you place a gait belt?
    a. Most gait belts are placed at the waist level. Some residents have injuries, surgery, drainage, and tubes that require the belt to be placed higher or lower than waist level.
5. When should you use a gait belt?
    a. Gait belts should be worn every time you assist a resident with mobility. ~~!!!~~ Exceptions to this are the following:
    b. Exclusion Criteria:

i. Resident is independent or modified independent and does not require a gait belt for safety, as per resident's care plan.

ii. Mechanical lift used for transfers that does not require use of gait belt for safety, as per resident's care plan.

c. Gait belts should be worn in resident's room, in the halls if ambulating, or any place resident will need to transfer from one surface to another.

6. How do you use a gait belt?

a. Refer to Gait Belt Competency.

Reference:
Institute for Healthcare Improvement. How to Guide: Reducing Patient Injuries from Falls. (December 2012).

CARING FOR THE DECEASED, USE OF MORGUE, AND PROVISION OF DEATH CERTIFICATES

POLICY:

~~LHH~~ Laguna Honda Hospital and Rehabilitation Center (LHH) maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue, or the Zuckerberg San Francisco General Hospital (ZSFG) Morgue. ~~Environment Services (EVS)Admitting & Eligibility (A&E) and~~ Nursing Operations ~~Departments~~ and the Social Service Department~~s~~ shall collaborate to release and transfer decedents in a timely manner.

PURPOSE:

To assist the family or ~~legal representative~~designated decision maker ~~-~~with the decedent's final arrangements while maintaining respect for the decedent.

PROCEDURE:

1. **Guidelines for the Notification of Families / ~~Guardians~~ Designated Decision Maker of a Resident's Death**

a. Notification of Death	Responsible Party
~~-~~Family / ~~Guardian~~Designated Decision ~~maker~~Maker	Physician who pronounced death ~~Physician who pronounced death~~
Mortuary	Family or ~~Legal Guardian~~Designated Decision Maker~~-~~, ~~Nurse, or~~ ~~Admissions & Eligibility (A&E) staff~~Social Worker ~~Environment Services (EVS) staff~~
Medical Examiner when appropriate	Physician who pronounced death

b. Funeral Arrangements	Responsible Party
Routine	Family or ~~Legal Guardian~~Designated Decision maker
Public Administrator ~~/~~	~~A&E~~Social Worker ~~EVS~~
~~Medical Examiner~~	~~Physician who pronounced death~~

2. **Guidelines for the Completion of the Required Forms**

a. Documentation	Responsible Party
Death Registry	~~Medical Records~~Health Information Management Services (HIMS)

Death Certificate	Medical Staff
Release Form	Completed by Mortician/ Public Administrator
Deceased Resident's Morgue Data Base Deceased Registry	Nursing Office~~/A&E~~

Documentation	Responsible Party (continued)
Transfer Authorization Form Application/ Permit for Human Remains through Electronic Death Registry System (EDRS) (If decedent is still in the morgue after 8 days)	Mortician ~~A&E Staff~~ ~~Medical Records~~HIMS ~~-~~

3. Death Certificate

a. ~~Health Information Services (HIS)~~HIMS transfers the death certificate into the Electronic Death Registration System (EDRS) to the mortuary or vice versa. ~~-~~ HIS contacts the physician to obtain the signature on the death certificate and retains a copy of the death certificate on file.

b. If the resident expires in the evening hours, on a legal holiday, or during the weekend (between the hours of 5 p.m. Friday and 8 a.m. Monday):

i. The death certificate shall be signed by the primary attending physician or designee by the next business day

ii. Under exceptional circumstances, if the family of the deceased, their ~~legal representative~~designated decision maker or mortician requires immediate completion of the death certificate, the on-call night/weekend physician may sign the death certificate as the "certifier" using his/her own signature and printed name and California Medical License ~~#.~~ number. The name and address of the primary attending physician will be entered into block 118: *Attending Physician's Name.*

4. Morgue Monitoring: ~~Laguna Honda~~ LHH ~~Nursing~~ Utilization Management and ~~A&E department~~Social Services department uses the Morgue Data Base (MDB) to document final disposition of the deceased and to monitor the morgue capacity.

a. ~~Laguna Honda Hospital and Rehabilitation Center (LHH)~~LHH maintains decedents in the morgue when necessary until transfer to a mortuary, the Medical Examiner morgue or the ZSFG morgue.

b. ~~A&E and~~ Nursing ~~Ops~~ Operations~~departments~~ shall collaborate to release and transfer ~~of~~the decedents in a timely manner.

c. Nursing Operation~~s~~ shall be responsible for data entry of resident information in the morgue database (MDB). ~~A&E~~ Utilization ~~management~~Management ~~department~~ and Social Services ~~Department~~ shall be responsible in monitoring the MDB for morgue capacity and accuracy.

~~d. **Guidelines for the Completion of the MDB and Required Forms:** Nursing Ops shall enter data to MDB when the resident's body is transferred to the morgue or picked up by the mortuary or examiner's office.~~

~~i. **Steps for creating MDB record:**~~

- ~~Type in last name of Resident.~~
- ~~Select resident from drop down box and click on select button to display record.~~
- ~~To complete entry, select boxes to indicate if resident was picked up from Neighborhood or transferred to LHH morgue. If picked up from Neighborhood, name of mortuary and date of pick-up from drop down menu. If transferred to LHH morgue, select drawer number locations.~~
  - ~~Old Morgue drawer location numbers: Drawers O1-O12~~
  - ~~New Morgue drawer location numbers: H15 – H20~~

~~e.~~d. **Forms and Responsible Staff:**

i. Nursing Operations is responsible for the MDB Record printed from MDB and signed by Mortuary attendant picking up the decedent. ~~– Nursing Ops.~~

ii. ~~Nursing Ops or designee shall scan MDB records to A&E. Original forms shall be placed in a designate A&E box located in the nursing office and shall be picked up by A&E staff~~. Nursing ~~Ops~~ Operations will compile the ~~MDB original~~original MDB form in a folder kept in the nursing office.

~~f.~~e. **MDB Monitoring:**

i. The MDB shall be monitored and updated by the ~~nursing~~Nursing Operations, ~~office and A&E. Social Services department and~~ and Utilization Management department~~s~~.

ii. Nursing Operations~~,~~ ~~A&E Census Desk~~ and ~~—~~Utilization Management ~~department and Social Services departments~~ shall monitor the MDB daily to check number and status of decedents remaining in the morgue.

f. **Monitoring Morgue Capacity:**

i. Nursing Operations or the Utilization Management department shall notify the Directors of Nursing (DON) if the morgue is nearing capacity (16 decedents).

ii. Social Services shall contact the Public Authority to expedite transfer of cases. If the Medical Examiner's office has accepted jurisdiction, Social Services shall request expedited pick-up.

iii. Social S~~s~~ervices shall contact families to determine which decedents can be promptly transferred to mortuaries.

iv. The Directors of Nursing or designee shall identify decedents to be transferred to ZSFG and contact ZSFG Morgue to arrange transfer in the event of overcapacity.~~Transfer to ZSFG due to overcapacity or autopsy:~~

~~iii.~~v. During normal business hours ~~A&E Manager or designee~~the EVS Manager or designee, Utilization Management and Social Services departments shall arrange transport of decedents(s) to ZSFG or the Medical Examiner's office. During non-business hours, weekends and holidays, Nursing ~~Ops~~ Operations shall arrange transportation to ZSFG or the Medical Examiner's office.

~~g. The A&E ManagerNursing Operations or, Utilization Management department or Social services department or designee shall notify the Chief Nursing Officer (CNO) and Director of Social Services if the morgue is nearing capacity (16 decedents).~~

~~h. Social services shall contact families to determine which decedents can be promptly transferred to mortuaries.~~

~~i. A&E Manager or designee Social services shall contact the Public Authority to expedite transfer of cases. If the Medical Examiner's office has accepted jurisdiction, the A&E manager or designee social services shall request expedited pick-up.~~

~~j. The CNO Director of Nursing or designee shall identify decedents to be transferred to ZSFG and contact ZSFG Morgue to arrange transfer.~~

~~k. **Transportation Arrangements due to overcapacity:**~~

~~i. A&EEVS, Utilization Management or Social services contacts Green Street Mortuary for availability and quote.~~

~~ii. EVS, Utilization Management or Social services A&E completes RPO to Materials Management (requires signature from Chief Financial Officer (CFO) or designee).~~

~~iii. EVS, Utilization Management or Social services A&E finalizes pick-up/drop-off arrangements with Green Street Mortuary. and ZSFG morgue attendant.~~

~~iv. EVS, Utilization Management or Social services A&E contacts CNO or designee with transfer arrangement information.~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-11 Notification of Family/Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death
MSPP C01-01 Patient Expiration
NPP D8.0 Post Mortem Care

Revised: 15/07/14, 16/09/13, 16/11/08, 25/04/14 26/01/09 (Year/Month/Day)

Original adoption: 03/05/08

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~~are efficient and ~~maintains~~maintain 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~~Substance Use Disorder (SUD) ~~S~~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.) ~~A~~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 three Spotify accounts (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 no more than 4 Netflix accounts are acceptable. A log will be established that will show staff who are owners of the account, who ~~has~~have 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~~than 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~~all the gifts will be temporary and immediately reduced after the gifts are purchased and paid.

- 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.

- Residents are given a catalogue of items to choose gifts from within a per~~- person-~~person budgeted amount of up to $75. After they mark their selection, orders are aggregated on a single master order sheet tracking orders/gifts by resident.

- All residents participate in the program.

- 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.

- The program is administered by LHH Volunteer Coordinators and the Activity Therapy Department. Volunteer coordinators develop the catalogue, process orders, and ~~maintaining~~maintain 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. As an additional control measure, there shall be at least two Activity Therapists simultaneously when distributing gifts as well as a second signature for the logs.

- Due to the high volume and variety of items, an online retailer such as Amazon or Walmart is preferred for this program. If Amazon is used for this program, then an Amazon Prime monthly membership subscription may be used from November through January.

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.~~c. Allowable purchases include:

      i. Food & snacks

      ii. Toiletries & personal hygiene products

      iii. Clothing & shoes

      iv. Health & wellness products

      v. Personal entertainment devices (e.g., DVD Player, iPad…)

      vi. Games & puzzles

      vii. Prepaid Gift Cards

      viii. Other items requested by the residents

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

   ~~f.~~e. 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

~~b.~~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.

~~c.~~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~~for the 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, 25/01/13
(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

Deleted Admissions and Eligibility Policies and Procedures

Patients from Other Hospitals for Re-Admission to LHH

LHH patients who have been discharged to an acute hospital for care, and are ready for re-admission to LHH, must be approved by the LHH attending physician prior to patient transport. The expectation is that the sending hospital MD and LHH MD will converse and LHH MD will accept the patient for re-admission on a given day. If no confirmation can be obtained that LHH MD has approved the patient to return, the transfer will be deferred/halted until LHH admissions department is notified by LHH MD.

LHH Admissions Staff Procedure

1. LHH admissions staff shall receive a phone call from sending hospital informing that a LHH patient is returning, and that the LHH attending MD has approved. Date and approximate time of return shall be included in notification. Name of person making the notification should be clearly identified.
2. LHH admissions staff will promptly notify the care unit to which the patient will return. Notification shall be to attending MD and/or care unit nurse manager. Admissions staff should obtain confirmation that the patient has been accepted for return and record the name of person confirming.
3. 1. Should the admission staff be unable to confirm acceptance of the patient's return from attending MD, an immediate call to the sending facility contact person shall be made to defer the transport of the patient pending MD approval.

Authorization Process for Out of County Referrals

PURPOSE: To expedite the process of referrals of out of county residents.

POLICY: Admission priority to Laguna Honda Hospital and Rehabilitation Center shall be given to residents of San Francisco.

PROCEDURE:

1. **OUT OF COUNTY REFERRALS:** Non-San Francisco residents will be reviewed periodically, if appropriate, for return to services in their county of origin. Examples are:
    a. **Repatriated residents referred by Target Case Management**
    b. **Referrals from the Public Guardian**
    c. **San Francisco residents referred from an acute facility**
    d. **Hardship cases (Requires Hardship letter)**

        i. Admission Authorized:
            1. Eligibility Worker will update waitlist to clear eligibility.
            2. Eligibility Worker will process referral for review by screening committee or appropriate physician for medical clearance.

        ii. Admission not Authorized:
            1. The Eligibility Worker completes the Short Admission data sheet and requests financial denial from supervisor.
            2. The Eligibility Worker updates the waitlist.
            3. The Eligibility Worker completes the short admission data sheet and obtains financial approval/denial from supervisor.
            4. A&E Admissions Coordinator contacts facility/family.
            5. Files the referral

Exceptions may be made by the Laguna Honda Executive Administrator/Designee based on Special clinical or humanitarian circumstances.

Registrations for Patients Referred LHH Post Discharge, Infection Control and Other Clinic Registrations referred from SFGH and DPH Clinics

POLICY:
Laguna Honda A&E will provide accurate, timely, and insurance verification and registration for services and appropriate charges.

PROCEDURE:

1) Outpatient service is determined by hospital clinic staff.

2) Prior to the date of service, the clinic staff will notify the Admissions and Eligibility staff via email with the following information:

3) patient's name,

4) DOB,

5) MR#,

6) Clinic Service

7) Physician's name

8) DOS.

9) On initial DOS, patient reports to Admissions at least 45 minutes prior to appointment time

10) Registration staff person creates in Invision an outpatient "O" that is valid for the current date of service completes the following forms

    a) Medicare Secondary Payer Form (MSPF) is completed (only if patient has never been to LHH or SFGH previously)
    b) DPH Privacy Notice-HIPAA form is signed by patient (first-time visit only)
    c) Condition of Treatment (COT) form is signed by patient (first-time visit only)
    d) Outpatient patient data card and face sheet are generated and issued to patient.

11) Patient reports to the outpatient clinic with patient data card, face sheet, COT, and HIPAA notice to submit for services and for filing in outpatient medical record.

12) Each outpatient visit requires a separate registration and account number for each subsequent outpatient service appointment. A new patient data card is issued, which is only valid for the current registration date.

13) If patients arrive and they are not on the email list, the A&E clerical staff will contact the clinic to confirm if the patient has a scheduled appointment.

14) Confirmed Appt.: Patients with a confirm appointment will be registered and sent to the clinic with patient data card, face sheet, COT, and HIPAA

15)1) No Appt: Clinic will add the patient to the appt. scheduling system and A&E will register patient and send the patient to the clinic with patient data card, face sheet, COT, and HIPAA

Payer Requirements on Outpatient Registrations

1. **SFHP- CHN Plans** - LHH will accept CHN clinic referral to for CHN - SFHP Plans. **Notification to the Health Plan needed.**

2. **SFHP – Non CHN -** will require a SFHP authorization before scheduling patient's ID visit. **Authorization** is required and must be faxed to A&E prior to visit.

3. **Other Managed Care Plans - Authorization Required**

    i. LHH must obtain payer Plan authorization prior to Clinic visits for patients enrolled in to the following:
        (a) Medi-cal Blue Cross
        (b) Medi-Cal Managed Care Out of County
        (c) Medicare HMO (Not Contracted)
        (d) Commercial HMO
        (e) SFHP NON-CHN

2. **No Authorization Required**

    1. Medicare (Traditional)
    2. Medicare (Traditional)/Medi-cal
    3. San Francisco Health Plan Medi-cal CHN
    4. Healthy San Francisco
    5. SFHP Healthy Workers
    6. SF Path below138% FPL – As of January 1, 2014
    7. As of January 1, 2013, Patients who are currently SF Path over 138% FPL must apply for Covered California. Patients will be covered by the sliding scale while waiting for Covered California approval.

Procedure for Financial Counselor to Track New Admissions with Temporary Conservatorship through the Public Guardian

POLICY: Laguna Honda Hospital Financial Counselor will track temporary conservatorships for residents admitted to hospital. This procedure will alert financial counselors when to update Guarantor Section of Invision system and update Bill Summary.

=

PROCEDURE:

- Financial Counselor Supervisor while completing New Admission Chart Review will place the names of residents that have temporary conservatorship on the established spread sheet on the "L" drive with the following information:
  1. resident's name
  2. date of admission
  3. date of discontinuance

- The assigned Financial Counselor will monitor the spread sheet monthly and notify appropriate financial counselor when temporary conservatorship is about to end.

The financial counselor assigned to resident will follow-up with Public Guardian to see if conservatorship is to continue. If permanent conservatorship has been established, a copy should be requested and the name should be removed from spread sheet. If temporary conservatorship has been discontinued, the Guarantor section and Bill Summary should be updated and date noted on spread sheet.

Procedure for Communication between the Eligibility Departments and Business Office

It is necessary to have clear and timely communication on account information in order to have a positive outcome on the eligibility and billing process,

The following instances require communication between A&E and Patient Accounting departments.

1. Bill summary for New Admissions
2. Bill summary for Re-Admissions
3. Steps for completing and submitting bill summary. Distribution of Funds Form(D1)
4. Follow-up on previous requests (Telephone or email)

1. Bill Summary for New Admissions:

a. The bill summary must be completed and submitted to the Eligibility Supervisor within two (2) business days of the date of admission or request from the business office.

b. Steps for Completing and Submitting Bill Summary for new admissions:

i) Complete Bill Summary with all known pay resources and applicable information needed by the Billing Department, including:
(1) Demographic , Guarantor and payer information
(2) Medicare with A and B effective dates,
(3) Medi-Cal Information, including Medi-Cal SOC, Aid Code
(4) Insurance billing address, policy number, group number, ID number and phone number.
(5) Attachments: denial letter/authorization, Cal-Meds printout (INQM) and copy of face sheet.

c. Financial counselor will submit completed bill summary to the eligibility supervision within two (2) business days of admission.

d. The supervisor will sign the bill summary and return yellow copy to the financial counselor to file in the resident's eligibility chart.

e. The eligibility supervisor will deliver bill summaries for admission/re-admission to the patient accounting (billing) supervisor on Friday of each week. All bill summaries that may affect the current months billing cycle are delivered before the end of the month.

2. **Bill Summary for Re-Admissions:**
   a. A&E financial counselor must re-verify HDX and Meds and complete a new bill summary when there is a change in demographic, guarantor information, payer, or a change in Medi-Cal coverage, or SOC liability.
   b. If no changes, financial counselor will send a copy of bill summary from prior admission.
   c. Financial counselor will submit completed bill summary to the eligibility supervision within two (2) business days of admission.

   d. The supervisor will sign the bill summary and return yellow copy to the financial counselor to file in the resident's eligibility chart.

   e. The eligibility supervisor will deliver bill summaries for admission/re-admission to the patient accounting (billing) supervisor on Friday of each week. All bill summaries that may affect the current months billing cycle are delivered before the end of the month.

3. **Distribution of Funds (D1) via email:**

   a. Before distribution of funds of a final discharged or expired resident, the financial counselor must initiate the distribution of fund request (D1) via email to the assigned biller. The reply email will report if the resident has any outstanding balances.

   b. Billers will respond with information on all patient balances within two (2) business days.

4. Requests for additional information may be initiated between patient accounting billers and A&E financial counselors.
   a. Verbal and email requests for information must receive a response within two (2) hours.
   b. First requests will be between the biller and financial counselor.

   c. If no response to first request, a second request is sent via email with a copy to the billing and eligibility supervisors.

5. **Monthly Eligibility Verification Report:**
   a. Financial Counselors will use the monthly Invision report to compare with the following monthly reports to identify eligibility changes for the following month:

      i) 26RSP HDX RESPONSE MEDI-CAL CERTIFIED CASES **
         (1) Aid code, county code Share of Cost, Medicare Status and Type, Medicare Advantage, and Other Coverage information.

Most Recent Review:
Revised:
Original Adoption: 08/23/2010

ii) 26NR- NO RESPONSE:

(1) No Response to HDX: coverage may be discontinued or the financial counselor may need to manually verified coverage.

b. The first seven (7) days or the month the financial will review the two reports listed above to identify any eligibility changes for the following month.

c. The financial counselor will complete invision revisions and submit a completed billing summary to the eligibility supervisor by the 15th of the month..

d. Bill summaries will be reviewed and signed by the eligibility supervisor and delivered to the patient accounting (billing) supervisor by the 18th of the month.

Funds returned to the Trust Fund:

Trust accounts must remain below Medi-Cal property limits for residents to maintain Medi-Cal eligibility. To allow financial counselors to monitor funds deposited into the trust account, patient accounting will notify A&E financial counselor before depositing money into a resident's account.

Most Recent Review:
Revised:
Original Adoption: 08/23/2010

AUTHORIZED CONTACT FIELD IN INVISION COMPUTER SYSTEM

POLICY: The Authorized Contact field is located in the Invision computer system in the Guarantor Section. It is used for whomever the resident has designated as the person they authorize to receive confidential information on their behalf.

PROCEDURE: There are two scenarios when inputting information into this field.

I. Resident is competent

A. If this information is not gathered at the time of admission, the social worker would ask the resident who they want to designate as their representative for confidential information. If there is no one designated, this field would remain blank.

II. Resident is incompetent

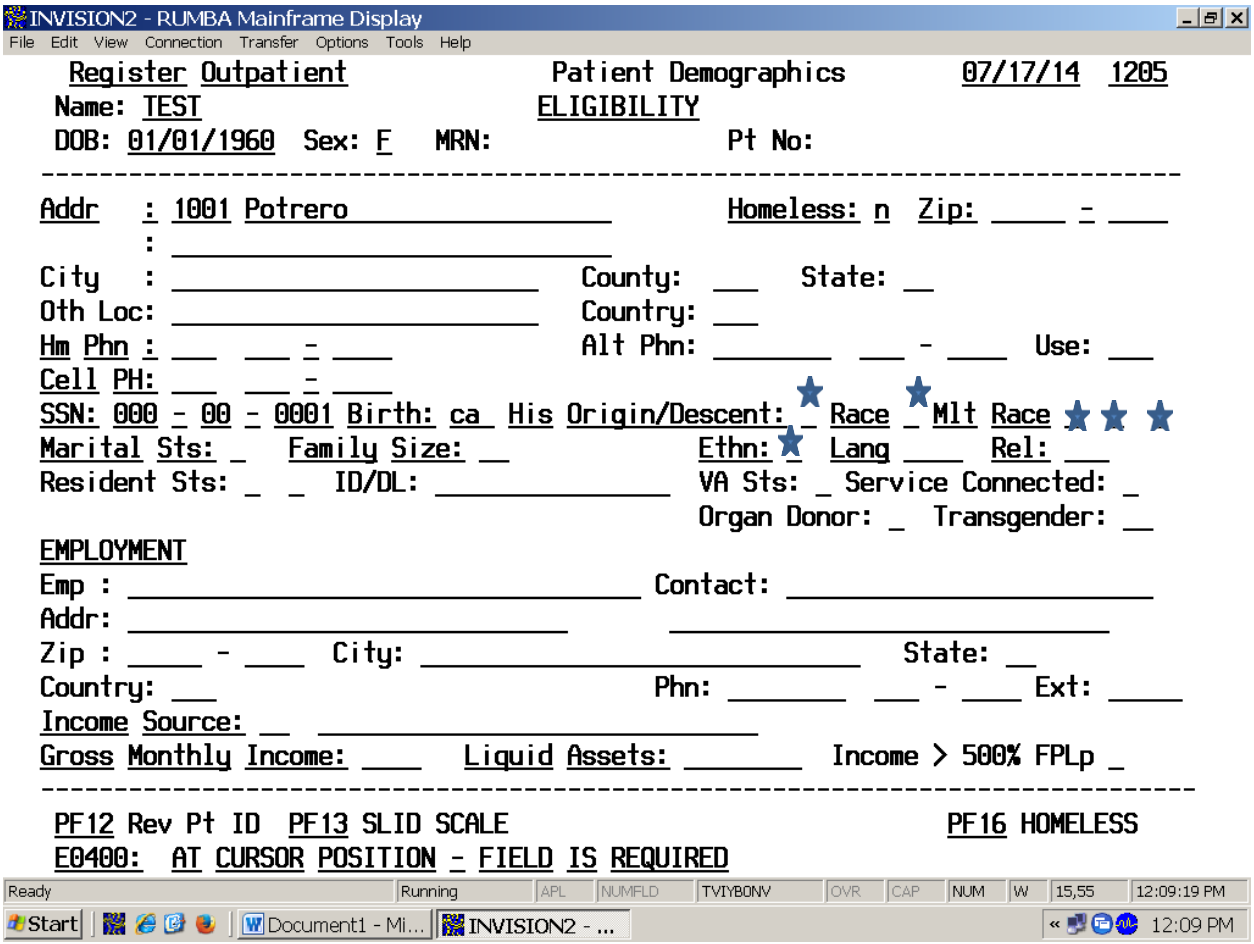
If this information is not gathered at the time of admission and there is no family or conservator, Laguna Honda Hospital will be the Authorized Contact and decisions will be made by the Inter-Disciplinary Team (IDT).

INVISION Race and Multi Race fields

OSHPD has revised their reporting requirements for reporting Race and Ethnicity. Based on OSHPD reporting requirements, Hispanic will be reported as an ethnicity. This will be the first question asked to all of our new patients. We will also be able to collect up to 3 races for our multi-racial patients.

New fields have been added to the Invision Registration and Admission Screens to collect the required information:

1. **Hispanic Origin/Descent: (New)**
2. **Race (Up to 3 Races can be collected/NEW)**
3. **Multi Race**
4. **Ethnicity**



Hispanic Origin/Descent: (New)

HISPANIC ORIGIN/DESCENT HELP SCREEN ?HISPAN 07/23/14

OSHPD REQUIRES A FURTHER QUESTION FOR REPORTING A PATIENTS ETHNICITY.

ASK THE PATIENT "ARE YOU OF HISPANIC ORIGIN OR DESCENT"?

THE ALLOWABLE VALUES ARE:

D - DECLINED TO SPECIFY

H - HISPANIC OR LATINO

N - NOT HISPANIC OR LATINO

U - UNKNOWN

Race – There are some changes on how OSHPD reports Race. To comply, Invision now requires asking if our patients are of Hispanic origin or descent first. Then all patients can further identify with the available racial groups below.

RACE DESCRIPTION

1 WHITE - A PERSON HAVING ORIGINS IN EUROPE, THE MIDDLE EAST OR NORTH AFRICA

2 BLACK OR AFRICAN AMERICAN - A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA

3 OTHER RACE - PERSON HAVING ORIGINS NOT PROVIDED AS ANOTHER RACE CODE.

5 ASIAN - A PERSON HAVING ORIGINS IN THE FAR EAST, SOUTHEAST ASIA OR THE INDIAN SUBCONTINENT INCLUDING CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND AND VIETNAM

6 AMERICAN INDIAN/ALASKAN NATIVE - A PERSON HAVING ORIGINS IN NORTH OR SOUTH AMERICA (INCLUDING CENTRAL AMERICA) AND WHO MAINTAINS TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT

7 NATIVE HAWAIIAN/PACIFIC ISLANDER - A PERSON HAVING ORIGINS IN HAWAII, GUAM, SAMOA OR OTHER PACIFIC ISLANDS

D DECLINE TO SPECIFY: VALUE IS NOT ALLOWED IN MULT RACE FIELDS.

Multi Race: Users can now report on Multi-Racial. The first field is used to report whether the patient is multi-racial

THIS FIELD INDICATES WHETHER THE PATIENT IDENTIFIES AS

MULTI-RACIAL. ALLOWABLE VALUES ARE:

"Y" - MULTI-RACIAL

"N" - NOT MULTI-RACIAL

"U" - UNKNOWN

Then we can collect 2 additional Races – Total of 3 Races for Multi-Racial patients

RACE DESCRIPTION

1 WHITE - A PERSON HAVING ORIGINS IN EUROPE, THE MIDDLE EAST OR NORTH AFRICA

2 BLACK OR AFRICAN AMERICAN - A PERSON HAVING ORIGINS IN ANY OF THE BLACK RACIAL GROUPS OF AFRICA

3 OTHER RACE - PERSON HAVING ORIGINS NOT PROVIDED AS ANOTHER RACE CODE.

5 ASIAN - A PERSON HAVING ORIGINS IN THE FAR EAST, SOUTHEAST ASIA OR THE INDIAN SUBCONTINENT INCLUDING CAMBODIA, CHINA, INDIA, JAPAN, KOREA, MALAYSIA, PAKISTAN, THE PHILIPPINE ISLANDS, THAILAND AND VIETNAM

6 AMERICAN INDIAN/ALASKAN NATIVE - A PERSON HAVING ORIGINS IN NORTH OR SOUTH AMERICA (INCLUDING CENTRAL AMERICA) AND WHO MAINTAINS TRIBAL AFFILIATION OR COMMUNITY ATTACHMENT

7 NATIVE HAWAIIAN/PACIFIC ISLANDER - A PERSON HAVING ORIGINS IN HAWAII, GUAM, SAMOA OR OTHER PACIFIC ISLANDS

D DECLINE TO SPECIFY: VALUE IS NOT ALLOWED IN MULT RACE FIELDS.

ETHNICITY IS A MORE DETAILED BREAKDOWN OF THE PATIENT'S RACE/ETHNIC ORIGIN.

There are no changes to our Ethnicity Screens

```
_ETHNICITY HELP SCREEN                    ?NATION              07/23/14  1
--------------------------------------------------------------------------------


          ETHNICITY IS A MORE DETAILED BREAKDOWN OF THE PATIENT'S

          RACE/ETHNIC ORIGIN.  PLEASE PRESS ENTER TO VIEW ETHNICITY

          CODES.




--------------------------------------------------------------------------------
  !PF13 RETURN                                          PRESS ENTER TO CONTI
```

ETHNICITY PROFILE DISPLAY PRHNADSP 07/23/14 140

A	CAMBODIAN	S	SAMOAN
B	CENTRAL AMERICAN	T	OTHER EUROPEAN
C	CHINESE	U	OTHER HISPANIC/LATINO
D	CUBAN	V	VIETNAMESE
E	MIDDLE EASTERN	W	OTHER SOUTHEAST ASIAN
F	FILIPINO	X	RUSSIAN JEW
G	GUAMANIAN	1	WHITE/CAUCASIAN
H	HAWAIIAN	2	AFRICAN AMERICAN/BLACK
I	INDIAN	3	HISPANIC/LATIN AMERICAN
J	JAPANESE	4	NATIVE AMERICAN/ESKIMO/ALEUT
K	KOREAN	5	ASIAN
L	LAOTIAN	6	OTHER
M	MEXICAN	7	ASIAN/PACIFIC ISLANDER
N	MEXICAN AMERICAN/CHICANO	8	UNKNOWN/UNDECLARED
O	OTHER NON-WHITE		
P	PUERTO RICAN		
Q	OTHER ASIAN		
R	RUSSIAN		

!PF13 RETURN

RESIDENT NAME: _____ **MRN:** _____ **UNIT#:** _____

Race Questions:

1. What is your Ethnicity? Please check as many as two to describe your Ethnicity. (Third MR& Fourth Questions in Invision)**

- ☐ A Cambodian
- ☐ B Central American
- ☐ C Chinese
- ☐ D Cuban
- ☐ E Middle Eastern
- ☐ F Filipino
- ☐ L Laotian
- ☐ M Mexican
- ☐ N Mexican American/Chicano
- ☐ O Other Non-White
- ☐ P Puerto Rican
- ☐ Q Other Asian
- ☐ W Other Southeast Asian
- ☐ X Russian Jew
- ☐ 1 White/Caucasian
- ☐ 2 Black/African American
- ☐ 3 Hispanic/Latin American

~~☐ G Guamanian~~
~~☐ H Hawaiian~~
~~☐ I Indian~~
~~☐ J Japanese~~
~~☐ K Korean~~
~~☐ R Russian~~
~~☐ S Samoan~~
~~☐ T Other European~~
~~☐ U Other Hispanic/Latino~~
~~☐ V Vietnamese~~
~~☐ 4 Native American/Eskimo/ Aleut~~
~~☐ 5 Asian~~
~~☐ 6 Other~~
~~☐ 7 Asian/Pacific Islander~~
~~☐ 8 Unknown/Undeclared~~

~~2. Are you of Hispanic Origin or Descent? (First Question in Invision)~~

~~☐ D Declined to Specify~~
~~☐ H Hispanic or Latino~~
~~☐ N Not Hispanic or Latino~~
~~☐ U Unknown~~

~~3. What is your Race? (Second Question in Invision)~~

~~☐ 1 White – A person having origins in Europe, The Middle East or North Africa~~
~~☐ 2 Black or African American – A person having origins in any of the Black Racial Groups or Africa~~
~~☐ 3 Other Race – Person having origins not provided as another race code.~~
~~☐ 5 Asian – A person having origins in the Far East, Southeast Asia or the Indian subcontinent including Cambodia, China, India , Japan, Korea, Malaysia, Pakistan, The Philippine Islands, Thailand and Vietnam~~
~~☐ 6 American Indian/Alaskan Native – A person having origins in the North or South America (Including Central America) and who maintains Tribal Affiliation or Community Attachment~~
~~☐ 7 Native Hawaiian/Pacific Islander – A person having origins in Hawaii, Guam, Samoa or Other Pacific Islands~~
~~☐ D Declined to Specify – Value is not allowed in Multi Race fields.~~

~~4. Are you Multi-Racial? (Third Question in Invision)~~

~~☐ Y Multi-Racial~~
~~☐ N Not Multi-Racial~~
~~☐ U Unknown~~

~~Language:~~
~~Primary Language:~~ _____ **~~English Speaking:~~** ~~☐ Yes~~ ~~☐ No~~

~~Name of Person Interviewed (Print Name)~~

_____

~~Relationship:~~ _____

~~Patient/Resident, Spouse, Next of Kin, Guardian, Conservator, Power of Attorney or Other Legal Representative~~

~~**Financial Counselor (Print Name):**~~ ~~**Date:**~~

☐ ~~**Updated in Invision, Revised Face Sheet and distribute**~~

Laguna Honda Medi-Cal Managed Care Disenrollments

PROCEDURE:

Effective January 1, 2014 Medi-Cal Managed Care enrollments will require that the patient is confirmed to be in a Skilled Nursing Facility for 60 days before the patient can be dis-enrolled from Managed Care.
Laguna Honda Hospital (LHH) financial counselors will to work with the Utilization department to determine whether or not a resident will be in long term care more than 60 days.

Effective Immediately, A&E will use the following guidelines to dis-enroll managed care members:

- Upon admission, the admissions person will enter the SNF date in the Invision system. The SNF date is the date that the patient/resident was admitted to a SNF. This date may be prior to admission to Laguna Honda Hospital.
- Residents admitted for Respite are not dis-enrolled from their Managed Care Plan.
- Utilization Management will notify A&E financial counselor when resident is considered LTC and should be dis-enrolled from the Managed Care Plan

Disenrollment Process for Residents Admitted with Managed Care Pending Notification from Utilization Review

1. MSW will notify UM of estimated length of stay.

2. If length of stay will be more than 60 days, UM will notify Eligibility Department to dis-enroll patient from SFHP or Anthem Blue Cross.

3. EW will request dis-enrollment, after UM notification. Once resident is dis-enrolled EW will update Invision.

Disenrollment Process for Residents who are converted from FFS Medi-Cal during the stay: (No UM notification required)

1. Financial counselor will initiated disenrollment and
    a. On the first of the month, the Financial Counselor with receive the Olie HMORSP report, which lists HDX response of residents with Medi-Cal Managed Care. The report lists converted to a managed care plan

b. No later than the 7th of the month, the Financial Counselors will request disenrollment via email or fax. The request for disenrollment will include retroactive disenrollment to date that the member was converted to the health plan.
c. After bill drop Financial Counselors revised Invision and send manual updates to billing and Utilization Management

Steps for Disenrollment:

1. For San Francisco Health plan, fax a copy of the face sheet and disenrollment request to San Francisco Health Plan. (415) 547-7822
2. For Blue Cross, contact Blue Cross at (888) 831-2246 –option#3. Follow the instructions on the "Request for disenrollment for Anthem Blue Cross-Medi-Cal form" to complete the request for disenrollment.

3. Update Invision and complete and email the Eligibility Update to UM and Billing.(After bill drop)

4.1. A copy of the email/fax request will be submitted to the supervisor. The supervisor review the HMO on a weekly bases to ensure that staff are following the disenrollment process.

Medical Transportation Policy & Procedures

October 30, 2007

SUBJECT: MEDICAL TRANSPORTATION

POLICY: To arrange accurate and timely transports by appropriate carrier for LHH residents to medical appointments.

PROCEDURE: Designated A&E staff person will

1. Transportation prescriptions (Section Number 5.03) and Ambulance Requests (Section Number 5.04) to schedule a transport are received at A&E via fax or hand delivered from staff at care unit.
2. Designated A&E staff person will review transportation prescription or ambulance request for completeness, legibility, and pay source. (CIN# is to be used on Transportation Prescriptions for carrier to bill CMS.
3. Designated A&E staff person will fax completed transportation prescription to carrier. If ambulance request, will call to schedule and then fax Physician's Certification Statement (PCS form, Section Number 5.05) as requested by carrier. PCS form is kept on file.
4. To confirm receipt of prescription and that the resident is scheduled, carrier will call to A&E or designated A&E staff person will contact carrier.
5. Designated A&E staff person will enter pertinent data into transportation schedule on the "N" drive. This is then available to hospital care unit staff to view as confirmation that the resident has been scheduled. Only confirmed scheduled transports should appear on the system schedule. The "N" drive transportation schedule is automatically updated every two (2) hours between 5:00 AM and 4:30 PM daily.
6. Designated A&E staff person will file the confirmed transportation prescriptions in the Transportation Log Book under the specified date of the month.

These procedures are in effect and shall remain until management and staff agree on a change or revision based upon valid circumstances impact the medical transportation for LHH residents.

TRANSPORTATION PHONE NUMBERS

WHEEL CHAIR SERVICE	
PROVIDER:	**CONTACT INFORMATION:**
SEMAX **640 Cesar Chavez** **San Francisco, CA 94124**	**Helen, Office Mgr. (415) 439-9836 Cell** **Fax number : (888) 315-5419**
AMBULANCE SERVICE	
PRO-TRANSPORT **720 Portal St.** **Cotati, CA 94931**	**800) 650-4003, Office** **(707) 585-6341, Fax** **Dialysis – Ryan**
KING AMERICAN **2570 Bush St.** **San Francisco, CA 94115**	**(415) 931-1400, Office** **(415) 621-2100, Fax**
A M R **6200 S. Syracuse Way, #200** **Greenwood Village, CO 80111** **Billing Service:** **4701 Stoddard Ave.** **Modesto, CA 95356**	**(800) 540-3066, Office** **(916) 643-2051, Fax**
OTHER COMPANIES	
S. F. PARATRANSIT	**(415) 351-7040, Office** **(415) 351-3135, Fax** ***Authorization by Social Services Department is needed***
WHEELCARE **(Back up to Semax for Dialysis Only)**	**(415) 777-2236, Office** **(510) 436-5040, Heidi** **(510) 436-5044, Fax** **Note: Dr. apt. Tues/Thurs 10am-2pm (appt.), last pick up to return to LHH 4pm.**

City and County of San Francisco
Department of Public Health

LAGUNA HONDA HOSPITAL & REHABILITATION CENTER

TRANSPORTATION PRESCRIPTION

PATIENT'S ADDRESSOGRAPH

LHH Patient/Resident Transport for Medical Purposes

DATE: _____

MEDI-CAL ID#:

REQUESTING UNIT/BED: _____ / _____

MEDICARE HIC#:

UNIT /WARD DIRECT PHONE#:

COMPLETED BY:

INSTRUCTIONS: COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT LEGIBLY. INCOMPLETE FORM WILL NOT BE HONORED.

TRIP IS

- ☐ ONE WAY
- ☐ ROUND TRIP
- ☐ CAN NOT TRAVEL ALONE, ESCORT NEEDED

REASON FOR SERVICE

- ☐ SERVICE NOT AVAILABLE AT LAGUNA HONDA HOSPITAL
- ☐ REQUIRES ACUTE INPATIENT CARE

DATE OF APPOINTMENT:

APPOINTMENT TIME: ☐ AM ☐ PM

TRANSPORTATION CO. & PICK UP TIME: _____ / _____ ☐ AM ☐ PM

DESTINATION FACILITY/DEPT/ CLINIC:

DEPT/ CLINIC PHONE#:

ESTIMATED RETURN PICK UP TIME: ☐ AM ☐ PM

PICK UP WILL BE SAME AS DESTINATION UNLESS OTHERWISE SPECIFIED:

PATIENT STATUS

- ☐ UNABLE TO TRANSFER
- ☐ REQUIRES WHEELCHAIR
- ☐ REQUIRES OTHER ASSISTANCE FOR MOBILITY
- ☐ UNSTEADY GAIT
- ☐ REQUIRES OXYGEN
- ☐ CONFUSED/ DISORIENTED
- ☐ POOR VISION/ BLIND
- ☐ HEARING IMPAIRED
- ☐ NON-ENGLISH SPEAKING,
  LANGUAGE: _____
- ☐ OTHER, PLEASE SPECIFY: _____

DIAGNOSIS: _____
(DIAGNOSIS MUST BE RELATED TO THIS VISIT)

PURPOSE OF VISIT & CERTIFICATION OF MEDICAL NECESSITY:

ANTICIPATED FRQUENCY: ☐ ONCE ☐ WEEKLY ☐ MONTHLY ☐ OTHER

PHYSICIAN'S SIGNATURE REQUIRED FOR SERVICE TO BE PROVIDED:
By Signing, I verify the above information to be true and correct.

Referring MD (Please Print) : _____

MD Signature: _____ Date:

375 Laguna Honda Boulevard, San Francisco, CA 94116/ A&E Transportation Contact Information: Tele #:(415) 682-5681/Fax #: (415) 682-5689

LHH A&E Revised 06/28/17 P&P Section 9.03

Request for Ambulance Transport

This form is only for requesting non-emergent transport by ambulance

Transportation by ambulance is requested for:

Date: _____

Patient/ Resident Name: _____ **Weight:** _____

Care Unit & Bed#: _____/_____ **Care Unit telephone #:** _____

Medicare HIC#: _____ **Medi-Cal BIC#:** _____

Appointment Time: _____ □ AM □ PM **Pick up Time:** _____ □ AM □ PM

Date Confirmed: _____ **Name of Person:** _____

Confirmed Pick up Time: _____ □ AM □ PM **A&E Staff:** _____

Destination: _____

Frequency of transports: _____

Duration of transport request: _____

It is understood that Medi-Cal (and Medicare) benefits do not cover non-emergent ambulance service unless it is medically necessary and patient's condition is definitely unstable and/or medical support devices are required, and all justified so in writing by a licensed physician.

The completed *Physician's Certification Statement* (PCS)* is attached and signed by the attending/ referring physician.

Request Submitted by: _____ **Date:** _____

*** Must be submitted before tranportation arrangement is finalized and confirmed.**

PHYSICIAN'S CERTIFICATION STATEMENT

Required for Non-emergency Medical Tranportation Services of Medicare and Medi-Cal Beneficiaries

Transport Date: **Expiration Date (max 60 days):** _____

Patient's Name: _____ **Weight:** _____

Gender: □ Male □ Female **Date of Birth:** _____

Health Insurance: **Medicare #:** _____ **Medi-Cal #:** _____

Calling Facility Name: Laguna Honda Hospital & Rehabilitation Ctr **Patient currently in Unit:** _____, **Rm:** _____

Patient being transported to:

Physician's Printed Name: _____ **Medical License #:**

DESCRIPTION OF MEDICAL NECESSITY

(Required for all ambulance transports to be billed to Medicare and Medi-Cal)

1. Primary Diagnosis: _____, **2** _____, _____, _____,

3. Other means of transportation are contraindicated because they would endanger the health of the patient. The following describes the condition(s) of the patient requiring ambulance transport.

Ambulance transportation is medically necessary for the following reasons:

Check All Applicable Items Below

Check one or more below as applies:

[ ] Requires continuous oxygen (other than self-administered)	[ ] Requires isolation precautions (VRE, MSRA, etc.)
[ ] Requires airway monitoring or suctioning	[ ] Has decubitus ulcers and requires would precautions
[ ] Is ventilator dependent	[ ] Unable to get out of bed safely with one oerson assisting
[ ] Requires cardiac EKG monitoring	[ ] Can not support themselves safely while seated in wheelchair or is able to tolerate wheelchair but is unstable due to other conditions (explain below)
[ ] Is comatose and requires trained monitoring	
[ ] Hip precautions and can not sit safely	[ ] Requires medical supervision during transport (explain Below)
[ ] Immobilization required (explain below)	[ ] Other condition (explain below)
[ ] Has continuously running intravenous devices	[ ] Does not meet medical necessity

4. Is the beneficiary bed confined at time of transport? Please elaborate or explain the reason for Bed Confinement.

Note: Bed Confinement is described as; 1) The beneficiary is unable to get up from bed without assistance;and 2) The beneficiary is unable to ambulate; and 3) The beneficary is unable to sit in a chair; including wheelchair. All three must be met at the time of transport.

Explanation:

_____

_____

The undersigned physician/representative certifies that he/she is familiar with the patient's condition, has reviewed the foregoing certification and has determined that ambulance transportation is medically necessary for the reasons specified. Ambulance service is hereby ordered.

Date: _____ **Signature:** _____

For Medi-Cal primary patients, only a physician's signature is valid for ambulance transportation orders per state Medi-Cal program requirements.

Return this form to: **A&E TRANSPORTATION UNIT** **Fax #:** **(415) 682-5689**

TRANSPORTATION PHONE NUMBERS

WHEELCHAIR SERVICES

SEMAX — Cellular Number 415-439-9836 → 640 Cesar Chavez
Office Number 415-632-2941 San Francisco, CA 94124
FAX 530-419-0733

AMBULANCE SERVICES

AMR 800-540-3066 → Main: 6200 S. Syracuse Way #200
FAX 888-887-6112 Greenwood Village, CO 80111

→ Billing/Service: 4701 Stoddard Ave.
Modesto, CA 95356

ST. JOSEPH 415-921-0707
FAX 415-460-6038

KING AMERICAN 415-931-1400 → 2570 Bush St.
FAX 415-621-2100 San Francisco, CA 94115

BAYSHORE 650-525-9700
FAX 650-345-5256

PRO-TRANSPORT 800-650-4003 → 720 Portal St.
FAX 707-585-6341 Cotati, CA 94931

OTHER COMPANIES

PARATRANSIT
Authorization by Social Services Department is needed
TEL 415-351-7040
FAX 415-351-3135

WHEELCARE 415-777-2236
Dialysis patients only. Can be used if resident refuses Semax

G-WORT 415-379-9972
FAX 415-751-4647

City and County of San Francisco
Department of Public Health

LAGUNA HONDA HOSPITAL & Rehabilitation Center

PATIENT'S ADDRESSOGRAPH

TRANSPORTATION PRESCRIPTION

LHH Patient/Resident Transport for Medical Purposes

REQUESTING UNIT/WARD	DATE	MEDI-CAL NO.
UNIT /WARD DIRECT LINE PHONE NO.		COMPLETED BY

INSTRUCTION: COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT LEGIBLY. INCOMPLETE FORM WILL NOT BE HONORED.

TRIP IS

- ☐ ONE WAY
- ☐ ROUND TRIP
- ☐ CAN NOT TRAVEL ALONE, ESCORT NEEDED

REASON FOR SERVICE

- ☐ SERVICE NOT AVAILABLE AT LAGUNA HONDA HOSPITAL
- ☐ REQUIRES ACUTE INPATIENT CARE

DATE OF APPOINTMENT	APPOINTMENT TIME ☐ AM ☐ PM	DESTINATION
DEPT/ CLINIC		DEPT/ CLINIC TEL NO.
ESTIMATED RETURN PICK UP TIME ☐ AM ☐ PM	PICK UP WILL BE SAME AS DESTINATION UNLESS OTHERWISE SPECIFIED	

PATIENT STATUS

- ☐ UNABLE TO TRANSFER
- ☐ REQUIRES WHEELCHAIR
- ☐ REQUIRES OTHER ASSISTANCE FOR MOBILITY
- ☐ UNSTEADY GAIT
- ☐ REQUIRES OXYGEN
- ☐ CONFUSED/ DISORIENTED
- ☐ POOR VISION/ BLIND
- ☐ HEARING IMPAIRED
- ☐ NON-ENGLISH SPEAKING, LANGUAGE: _____

☐ OTHER, PLEASE SPECIFY: _____

DIAGNOSIS

(DIAGNOSIS MUST BE RELATED TO THIS VISIT)

PURPOSE OF VISIT & CERTIFICATION OF Medical Necessity

ANTICIPATED FRQUENCY ☐ ONCE ☐ WEEKLY ☐ MONTHLY ☐ OTHER _____

PHYSICIAN'S SIGNATURE REQUIRED FOR SERVICE TO BE PROVIDED

By Signing, I verify the above information to be true and correct.

Referring MD (Please Print) _____

MD Signature Date:

`

Laguna Honda Hospital
& Rehabilitation Center
375 Laguna Honda Blvd.
San Francisco, CA 94116

(Addressograph)

Request for Ambulance Transport

This form is only for requesting non-emergent transport by ambulance

Transportation by ambulance is requested for:

Date: _____

Appointment Time: _____ specify a.m. or p.m.

Patient/ Resident _____

Care Unit _____ Medi-Cal # _____

Destination _____

Frequency of transports _____

Duration of transport request _____

→ It is understood that Medi-Cal (and Medicare) benefits do not cover non-emergent ambulance service **unless** it is medically necessary and patient's condition is definitely unstable and/or medical support devices are required, and all justified so in writing by a licensed physician.

→ The completed *Physician's Certification Statement* (PCS)* is attached and signed by the attending/ referring physician.

Request Submitted by _____ Date _____

* Must be submitted before tranportation arrangement is finalized and confirmed.

PHYSICIAN'S CERTIFICATION STATEMENT

Required for Non-emergency Medical Tranportation Services of Medicare and Medi-Cal Beneficiaries

Transport Date _____ Expiration Date (max 60 days) _____

Patient's Name _____

Gender: [ ] Male [ ] Female Date of Birth _____

Health Insurance Claim # _____

Calling Facility Name _____ Patient currently at _____

Patient being transported to _____

Physician's Printed Name _____ Medical License # _____

DESCRIPTION OF MEDICAL NECESSITY

(Required for all ambulance transports to be billed to Medicare and Medi-Cal)

1. Primary Diagnosis _____ 2 _____

Ambulance transportation is medically necessary for the following reasons:

Check All Applicable Items Below

3. Other means of transportation are contraindicated because they would endanger the health of the patient. The following describes the condition(s) of the patient requiring ambulance transport. (Check one or more below as applies)

[ ] Requires continuous oxygen (other than self-administered)
[ ] Requires airway monitoring or suctioning
[ ] is ventilator dependent
[ ] Requires cardiac EKG monitoring
[ ] Is comatose and requires trained monitoring
[ ] Hip precautions and can not sit safely
[ ] Immobilization required (explain below)
[ ] Has continuously running intravenous devices
[ ] Requires isolation precautions (VRE, MSRA, etc.)
[ ] Has decubitus ulcers and requires would precautions
[ ] Unable to get out of bed safely with one person assisting
[ ] Can not support themselves safely while seated in wheelchair or is able to tolerate wheelchair but is unstable due to other conditions (explain below)
[ ] Requires medical supervision during transport (explain below)
[ ] Other condition (explain below)
[ ] Does not meet medical necessity

4. Is the beneficiary bed confined at time of transport? Please elaborate or explain the reason for Bed Confinement. Note: Bed Confinement is described as 1) The beneficiary is unable to get up from bed without assistance; and 2) The beneficiary is unable to ambulate; and 3) The beneficiary is unable to sit in a chair, including wheelchair. All three must be met at the time of transport.

The undersigned physician/representative certifies that he/she is familiar with the patient's condition, has reviewed the foregoing certification and has determined that ambulance transportation is medically necessary for the reasons specified. Ambulance service is hereby ordered.

Date _____ Signature _____

For Medi-Cal primary patients, only a physician's signature is valid for ambulance transportation orders per state Medi-Cal program requirements.

Return this form to _____ Fax _____

Revised Respiratory Services Policies and Procedures

SAFETY REGULATIONS

COMPRESSED GAS CYLINDERS:

PURPOSE:

To insure uniform standards for the safe handling of compressed gases~~1~~.

=

EQUIPMENT:

~~Cylinder of gas~~

A. ~~-~~Appropriate carrier

~~A.~~B. Appropriate regulator

PROCEDURE:

A. Small cylinder regulator attachment

1. Read label to determine contents.

~~1.~~ Place in small cylinder carrier.

2.

3. Regulator is attached to Cylinder

~~2. Secure that regulator that is pin-indexed to fit the ordered cylinder.~~

~~3. Remove any cylinder seal and crack the cylinder by quickly opening and closing the main valve.~~

~~4. Attach the regulator making sure appropriate gasket is in place (small cylinder only).~~

~~5. Tighten the regulator securely and open tank valve with regulator flow obstructed to test for leaks.~~

~~6. Attach appropriate flow regulating device.~~

~~**B. Large cylinder attachment**~~
~~**C. Read level to determine contents.**~~

~~1. Place in large cylinder carrier with safety chain.~~

~~2. Secure that appropriate regulator that is indexed to fit the ordered cylindered gas.~~

~~3. Remove any cylinder seal and crack the cylinder by quickly opening and closing the main valve.~~

~~4. Tighten the regulator securely and open the tank valve with regulator flow obstructed to test for leaks.~~

~~5. Attach appropriate flow regulating device.~~

~~D.~~**B. Precautions**

1. Oxygen, while a non-flammable gas vigorously supports combustion.

2. Oil and grease, in the presence of oxygen, create a potential hazard.

~~1 Must comply with CGA and NEPA regulations~~

~~1.~~3. Never allow oil or grease to come in contact with cylinder regulator, or valve guage or fitting as this creates a fire hazard.

~~Every cylinder must only be used with the proper diameter indexed regulator.~~

1 Must comply with CGA and NEPA regulations

OXYGEN ADMINISTRATION

NASAL CANNULA:

POLICY AND PURPOSE:

1. The nasal cannula is a device to deliver low to moderate concentrations of oxygen (24-35%)

–

PROCEDURE:

A. Equipment

~~1.~~ Humidifier
~~2.~~1. ~~Sterile H20~~
~~3.~~2. Nasal cannula
~~Oxygen tank and regulator~~

B. Application

1. Take all equipment to patient floor.
2. ~~Review physician order.~~View RT order by Physician in Epic.
3. Enter patient's room with necessary equipment.
4. Check patient's identification wristband and introduce yourself.
5. Explain the procedure to the patient.
~~6.~~ Wash hands.
~~7.~~6. ~~Assemble humidifier adding sterile water, if not pre-filled.~~
~~8.~~7. ~~Connect humidifier to tank.~~ Attach Humidifier to Flowmeter if delivering about 4 LPM.
~~9.~~8. Attach cannula to humidifier.
~~10.~~9. Place cannula on patient carefully and adjust for firm but comfortable fit.
~~11.~~10. Adjust liter flow according to physician order.
~~12.~~11. Ask patient if he/she is comfortable~~,~~ and answer any questions concerning the equipment the patient might have.

C. Advantages

1. The nasal cannula is the most comfortable oxygen administration device for most patients.
2. It provides ~~for~~ easy ambulation, speaking, eating, and mouth care.
3. It is simple to set-up and maintain.
4. It requires minimal supervision for reliable operation.

D. Disadvantages

1. The concentration of oxygen delivered will vary, depending on liter flow and patient's ventilatory pattern.
2. Some patients develop contact dermatitis.
3. The device should never be run at higher than 8 liters per minute as this will cause patient discomfort, while not increasing the oxygen concentration.

OXYGEN ADMINISTRATION

SIMPLE OXYGEN MASK:

POLICY:

1. The simple oxygen mask is a device to deliver 35% to 50% oxygen. Most often used for short term gas administration ~~(i.e., transporting patients from one are of the hospital to another).~~

PROCEDURE:

A. Description

1. The simple oxygen mask consists of clear plastic mask with a small bore tubing connection. The exhalation ports are relatively small, to prevent a large amount of room air entrainment. The small bore connection tube is used to attach the device to oxygen ~~cylinder regulator.~~flowmeter

B. Equipment

~~1.~~ Simple oxygen mask

~~2.~~1. ~~Oxygen tank and regulator~~

C. Application

1. Take all equipment to patient floor.
2. Review physician order.
3. Enter patient's room with necessary equipment.
4. Check patient's identification wristband and introduce yourself.
5. Explain the procedure to the patient.
6. Wash hands.
7. Attach mask to humidifier and adjust flowmeter to prescribed liter flow (liter flow should be higher than 6 liter per minute for proper application).
8. Place mask on patient carefully and adjust for firm but comfortable fit.
9. Ask patient if he/she is comfortable~~,~~ and answer any questions concerning the equipment the patient might have.

D. Precautions

1. Review the physician's order completely.
2. ~~2.~~ Be aware of the fact that some patients may have adverse reactions from concentrations of oxygen over 30%.
3. ~~3. Review the patient's chart carefully for documentation of sensitivity to oxygen administration.~~

~~4. Review patient chart for arterial blood gas analysis, noting F102 patient was receiving at the time.~~

~~5.~~2. ~~If no arterial blood gases have been done, it is appropriate to request the physician draw a blood sample for analysis as a way to determine appropriate oxygen administration.~~

~~6.~~3. If the patient is comatose and/or has poor airway reflexes, a nasal cannula may be a more appropriate device, as it allows free access to patient's upper airway.

~~7.~~4. Some patients may experience a sense of "confinement anxiety" from the placement of the mask.

~~8.~~5. Check to see that liter flow into the mask is sufficient to eliminate exhales gases and provide maximum comfort for the patient (greater than 6 liters per minute).

E. Advantages

1. Concentrations of oxygen up to 55% are achieved.
2. Convenient for connection to transport cylinder for patient ~~ambulation.~~transport.

F. Disadvantages

1. Most patients become uncomfortable and will not wear the mask for extended periods of time.
2. Creates the potential of aspiration in patients who have a diminished airway protective mechanism.
3. Oxygen concentrations delivered will vary according to the patient's ventilatory pattern, and the liter flow at which the device is run.

OXYGEN ADMINISTRATION

NON-REBREATHING OXYGEN MASK:

POLICY:

1. The non-rebreathing oxygen mask is a device to deliver high concentrations of oxygen (up to 100%) to the patient.

PROCEDURE:

A. Description

1. These lightweight plastic face masks are equipped with a one-way valve and a reservoir bag. Gas enters the mask through an inhalation valve ~~,~~ and is expired through an exhalation ~~orifice~~port. ~~.~~ The liter flow may be adjusted to meet the patient's individual demands by watching the reservoir bag. The oxygen flow is regulated so that the reservoir bag does not completely collapse when the patient inspires. The bag also has a safety air inlet valve. In case of bag collapse, this allows room air to flow in freely.

B. Equipment

1. Plastic non-rebreathing mask with reservoir bag and tubing.
2. ~~Oxygen tank and regulator~~ Oxygen Flowmeter.

C. Application

1. Take all equipment to patient floor.
2. Review physician order in Epic.
3. Enter patient's room with necessary equipment.
4. Check patient's identification wristband and introduce yourself.
5. Explain the procedure to the patient.
6. Wash hands.
7. Attach tubing to cylinder.
8. Check out the system by turning the liter flow rate to 10-12 liters per minute. Allow reservoir bag to completely fill.
9. Place the face mask on patient's face and adjust the straps.
10. Observe the reservoir bag, being certain that it does not collapse during any inspiratory cycle. Adjust the liter flow, if necessary to keep the reservoir bag full at the beginning of inhalation.
11. Reassure the patient and answer any questions concerning the equipment the patient might have.

D. Advantages

1. Will deliver oxygen concentrations up to 100%.
2. Can be used for short term transporting of patients who need high oxygen concentrations.
3. Simple to set-up and maintain.

E. Disadvantages

1. The concentration of oxygen will vary depending on the fit of the face mask.
2. Most patients become uncomfortable and will not wear the mask for extended periods of time.
3. Creates the potential for aspiration in patients who have a diminished airway protective mechanism.
4. Review patient's chart for arterial blood gas analysis, noting F102 patient was receiving at this time.
5. If no arterial blood gases have been done, it is appropriate to request that physician draw a blood sample to monitor appropriate oxygen therapy.
6. This device must be monitored frequently. Patients requiring these high concentrations of oxygen cannot tolerate malfunctions of equipment or accidental disconnection.

OXYGEN ADMINISTRATION

VENTURI MASK:

POLICY:

1. The Venturi mask system is to deliver a certain percentage of oxygen determined by a physician order.

–

PROCEDURE:

A. Description

1. This light weight oxygen mask is equipped with device for setting certain concentrations of oxygen from 24% to 50% using adapters provided in the set. The percentage is determined by a physician order. The device actually gives you the correct liter flow to deliver desired circumstances.

B. Equipment

1. Plastic Venturi mask with adapters and supply tubing.
2. ~~Oxygen cylinder and regulator.~~Oxygen Flowmeter.

C. Application

1. Take all equipment to patient unit.
2. Review and confirm physician order.
3. Check patient identification wristband and explain the type of mask being used.
4. Wash hands.
5. Place appropriate oxygen diluter on mask barred for concentration desired. Green diluter for lower concentration 24-30%, white diluter for concentration of 35 to 50%.
6. Attach supply tubing provided to mask barrel and to connector on oxygen cylinder.
7. Set regulator to the recommended liter flow.
8. Place face mask on patient face and adjust elastic straps on each side for a snug fit.
9. Keep the other diluter at patient beside for ease of changing concentration.
10. Oxygen saturation should be performed.

D. Advantages

1. Ease of determining and assuring F102 is delivered and set on the mask
2. Simple to set up and maintain.

E. Disadvantages

1. Although there is adequate flow of oxygen, patients may become uncomfortable over a long period of time.
2. The device must be maintained frequently. Patients requiring this type of mask cannot tolerate malfunction of equipment or accidental disconnection.

TREATMENT

HAND HELD NEBULIZER

PURPOSE:

1. Delivery of aerosolized medications to the pulmonary tree.

PROCEDURE:

A. Equipment

1. Hand-held nebulizer with mouthpiece.
2. Connecting tubing – small bore.
3. Compensated flow meter with nipple adaptor attachable to wall oxygen supply. ~~or cylinder~~ reducing valve, or small air compressor.
4. Appropriate medications.

B. Preparation

1. Review patient's ~~chart~~ electronic health record (EHR) for the following information:
    a. Therapy modality
    b. Frequency
    c. Medications

2. Patient History
    a. Medical
    b. Surgical

3. Patient Diagnosis
    a. Pulmonary function if available
    b. Chest X-Ray
    c. Sputum cytology
    d. Arterial blood gases

4. Wash hands thoroughly.

5. Explain to patient what treatment consists of, and why it has been ordered by physician. Answer any questions the patient might have about the procedure.

C. Setting up the equipment

1. If using small air compressor:
    a. Place securely on flat surface.
    b. Plug into electrical outlet.
    c. Attach connecting tubing to compressor outlet.

2. If using compensated flowmeter:
    a. Connect flowmeter to the ~~approrpate~~appropriate high pressure outlet.
    b. Attach connecting tubing to nipple adapter.

3. Add medication to nebulizer chamber.
4. Attach connecting tubing to bottom of nebulizer chamber.

D. Procedure

1. Positioning the patient:
    a. Therapist should position the patient so he/she is sitting high in the bed, with his/her back and head fully supported and knees slightly flexed so that the abdominal musculator is relaxed. If the patient is unable to tolerate a sitting position, the therapist may position the patient in a supine manner, with the head supported in a forward position shoulders down, the knees slightly flexed, to ease tension on the abdomen (six inch piece of flex tubing may be needed between the nebulizer and mouthpiece for flexibility). The procedure may be done with the patient sitting on the side of the bed if the patient's condition permits and chest excursions are not limited by this position.

2. Ausculate chest prior to beginning treatment.
3. Pulse rate should be taken before, during as necessary, and after treatment.
4. Turn on air compressor or flowmeter to flow rate that gives a moderate mist.
5. While holding nebulizer mouthpiece between lips, instruct patient to slowly inhale through his mouth until hi lungs are full. Encourage a short hold after each inspiration, and then a passive exhalation.
6. Treatment will last about ten minutes depending on the quantity of medication to be aerosolized.
7. Encourage coughing to clear secretions.
8. Ausculate chest.

E. Charting in EHR

1. Charting after each treatment will include:
    a. Patient acceptance
    b. Respiratory rate
    c. Pulse rate before, during, and after treatment.
    d. Color, quantity and consistency of any sputum produced.
    e. Breath sounds before and after treatment.

F Precautions

1. If pulse rate increases greater than 30 minute:
    a. Discontinue treatment and notify Physician.

2. Pulse rate changes less than 30 but patient becomes "shaky, nervous, nauseated, or highly apprehensive":
    a. Discontinue treatment and notify Physician.

CONTINOUS AEROSOL THERAPY

PROCEDURE:

A. Therapeutic Objectives of Aerosol without Added Medication

1. To add humidity to the airways and lung parenchyma to liquefy and mobilize secretions.

B. Indications for Initiating Treatment

1. Any of the following diagnoses or conditions:
    a. Atelectasis (sub-segmental, segmental, lobar or lung).
    b. Chronic obstructive lung disease (including asthma, emphysema, chronic bronchitis).
    c. Bronchiectasis
    d. Bronchitis
    e. Laryngotracheobronchitis
    f. Laryngeal edema
    g. Pneumonia
    h. Cystic fibrosis

OR

2. Induction of sputum for diagnosis and analysis.

C. Outcome

1. Mobilization of secretions
2. Reinflation of lung parenchyma
3. Clearing of pneumonia
4. Relief of obstruction
5. ~~Suptum~~~~Sputum Obtained~~Sputum Obtained for diagnosis purposes
6. If the patient is mobile, ~~should~~it should be transported via wheelchair to Respiratory Services Isolation Room for sputum induction, AFG, etc. 3.0% saline is administered to mobilize secretions.

D. Contraindications

1. Relative contraindications
2. Bronchospasm

E. Hazards

1. Bronchospasm
2. Transmission of infections
3. Systemic overhydration

F. Patient Education

1. The patient is informed of the purpose of therapy.
2. The patient is instructed in the correct use of the apparatus.

G. Continued Use of Aerosol

1. The continued need for aerosol therapy is assessed every 24 hours.

H. Ordering Protocol

1. The initiation of aerosol therapy is only on the written order of a physician.
2. The order must specify:
    a. The length and frequency of treatment.
    b. The F102.
    c. Continuous or ~~Intermitten~~Intermittent
3. The therapeutic objective(s) must be concurrently recorded by the physician in the patient's medical record.

INCENTIVE SPIROMETRY THERAPY

PURPOSE:

1. To encourage maximal sustained spontaneous inhalations at frequent intervals and therefore:
    a. Reinflate collapsed lung parenchyma
    b. Prevent collapse of lung parenchyma
    c. Mobilize secretions

PROCEDURE:

A. Indications for Initiating Incentive Spirometry

1. Any of the following diagnoses or conditions:
    a. Atelectasis (sub-segmental, segmental, lobar, or lung)
    b. Pulmonary edema
    c. Chronic obstructive lung disease (including asthma, emphysema, chronic bronchitis)
    d. Pneumonia
    e. Bronchiectasis
    f. Conditions where A-1 have an increase incidence:
        i. Obesity
        ii. Chest wall deformity
        iii. Prolonged immobilization
        iv. Following upper abdominal or thoracic surgical procedures

    AND

    g. Reduced vital capacity

    OR

    h. Poor patient motivation to effect spontaneous deep breathing without a physical incentive.

B. Outcome

1. Reinflation of lung parenchyma
2. Lung collapse does not develop
3. Resolution of pneumonia
4. Mobilization of secretions

C. Contraindications

1. ~~Comatose~~ Non-compliant patient

D. Hazards

1. Hyperventilation
2. Transmission of infections

E. Patient Education

1. The patient is informed of therapeutic objectives of the treatment
2. The patient is instructed in the correct use of the incentive spirometer

F. Continued Use of Incentive Spirometer

1. The continued need for incentive spirometry is documented every three days.

G. Ordering Protocol

1. The initiation of incentive spirometry is only on the written order of a physician into the electronic health record (EHR).
2. The order must state:
    a. The frequently of treatment by the patient.
    b. The frequently of treatment by the therapist

3. The therapeutic objective(s) must be concurrently recorded by the physician in the patient's medical record.

PULSE OXIMETRY

PURPOSE:

1. Pulse Oximetry (SpO_2) This is a vital tool for determining oxygen saturation in a safe and non-invasive way.

DESCRIPTION:

1. Pulse Oximetry provides estimates of arterial oxyhemoglobin saturation (SAO_2) by utilizing selected wavelength of light and non-invisibly determine the saturation of oxyhemoglobin.

PROCEDURE:

~~A.~~ Written or verbal physician order is required for oximetry to be performed, unless in emergency situations or acute care areas were oximetry is routine.

~~B.~~

~~C.~~A. ~~Written respiratory registration is to be filled out by charge nurse.~~

~~D.~~B. Equipment is obtained from ~~Respiratory Services Department~~ Nursing Unit and taken to bedside.

~~E.~~C. Fingernail bed should be clean and free of nail polish.

~~F.~~D. Probe light source should be placed on finger or earlobe using appropriate probe device.

~~G.~~E. Monitor visual and audible displays, should be observed to assess if a strong pulse is achieved for accuracy.

~~H.~~F. Notify physician and a charge nurse of findings. If oxygen saturation (SpO_2) is dangerously low (<85%), notify immediately. Written documentation is performed on integrated progress notes in chart. This should include date, time, department performing test, mode if any ie: oxygen in use, room air etc., signed by RCP performing test.

~~I.~~G. If physician orders oxygen therapy, ask nurse if assistance is needed. Please be sure order is written by physician in the patients electronic health record (EHR). ~~or charge nurse in the chart.~~

ARTERIAL BLOOD GAS COLLECTION

POLICY:

1. Arterial puncture may be performed by any physician or by the respiratory care practitioner ~~or specially trained nurses.~~

PURPOSE:

1. ~~–~~To procure arterial blood for analysis of PH, PCO_2 and PO_2. O_2 saturation is obtained externally.

PROCEDURE:

A. Drawing

1. Put on gloves before drawing the specimen.
2. Remove the pre-assembled syringe ~~foil pack.~~package.
3. Set plumber to desired sample size. (o.5 to 1ml)
4. Seat needle by pushing in firmly on needle sheath.
5. Prep puncture site.
6. Expose needle shaft by pulling needle sheath straight off.
7. Puncture artery and allow blood to fill syringe completely. NOTE: Air will vent from barrel automatically.
8. Terminate puncture and apply firm digital pressure to puncture site for 5 to 10 minute. If on blood thinning medication apply bandage or dressing with tape.
9. Insert the needle tip into the needle stopper.
10. Agitate the sample for 20-30 seconds to ensure dry heparin is mixing with blood sample.

B. If Blood Flow Stops before Syringe is completely filled:

1. Terminate puncture immediately.
2. Insert the needle tip into the needle stopper.
3. ~~3.~~ Hold the syringe upright (needle down) and depress plunger to evacuate air from syringe barrel.

~~4.~~3.

~~**C. To aspirate blood sample:**~~

~~1. Depress the plumber all the way to the bottom of the syringe.~~
~~Collect sample by withdrawing the plunger.~~

~~D.~~**C.** Place patient label on syringe and place syringe in ice bag if not analyzed immediately; ice is not necessary if analyzed immediately.

D. Sample is taken to the Respiratory Services Department for analyzing.
1.Quality Control # 3 is ~~perfromed~~performed prior to running of the obtained arterial blood sample.
2.Sample is analyzed with ~~pertenant~~pertinent information of the patient drawn
3.Results are obtained and ~~wrtitten~~written on external documents.
4.Results are also entered into the electronic health record (~~EHR~~EHR) of patients.
5. ~~#~~1 Quality Control sample is run post-ABG.

Deleted Respiratory Services Policies and Procedures

MISSION STATEMENT

POLICY:

Laguna Honda Hospital will be a center of excellence in providing a continuum of care that integrates residents in the least restrictive setting, thereby supporting their highest level of independence.

MISSION

As part of the Department of Public Health safety net, the mission of Laguna Honda Hospital is to provide high-quality, culturally competent rehabilitation and skilled nursing services to the diverse population of San Francisco.

Skilled nursing service includes long-term care for residents who cannot be cared for in the community and/or short-term care for those who can be rehabilitated and discharged to a lower level of care within the community.

=

PROCEDURE FOR AEROSTAR BOOTH

PURPOSE:

1. To insure proper usage of AEROSTAR Booth.

PROCEDURE:

A. Use of the Booth

1. The booth should be turned ON as soon as possible upon entering the room, to allow time for it to "prime" the HEPA filtering system. While the booth is warming up, prepare the patient and equipment. Following the completion of the procedure, leave the booth turned on while you tidy up and clean the booth. Leaving the booth turned on for a few minutes will insure that all aerosol is evacuated through the filter system when you stick your head in there to clean it!
2. During use, position patients so that they are within the confines of the booth, with the Plexiglas panels/countertop surrounding the patient. This is best accomplished by having the patient sit in a chair, or on the side of the bed, leaning on the booth countertop. Make sure that there is Kleenex available for the patient to cough into, and that your specimen containers are available. This will minimize patient coughing directly onto the inside surfaces of the booth itself.
3. Following use, wipe the booth down with disinfectant, alcohol (or equivalent) at the point of use, to include: outside surfaces, countertop, and Plexiglas panels (inside and out). Spray filter grid with disinfectant with unit running, and allow unit to run for 2-3 minutes.
4. Turn booth OFF, remove from room, and return booth to Respiratory Services as soon as possible after use, making sure that plastic cover is placed over booth.

B. Filter Changes for the AEROSTAR

1. Respiratory Services staff will be responsible for changing the filter on the AEROSTAR once a eek in an isolation room. Personal HEPA filtered respirators must be worn by the therapist doing the filter changing. The old filter will be placed in a red plastic bag and discarded in the biohazard trash can. The new filter will be dated each time it is changed. Additionally, if at any time a therapist using the booth feels that the filter should be changed, based upon increased use or the type of patient the booth is used on, the therapist may change/date the filter. Clean filters are available in the Respiratory Services department.