List of Policies and Procedures for JCC Review 1-12-26

Blue (Hospital-wide); Grey (Departmental)

Status	Dept.	Policy #	Title	Owner/ Reviser	Notes
Revised	LHHPP	73-02	Asbestos and Lead Management Plan	**W. Spaul**	1. Added "To address procedures when Environmental Services staff may be exposed to lead or asbestos from settled dust during routine housecleaning." 2. Added "To address procedures to address where potential asbestos and lead exposures may be occurring to office employees in the Administration Building 3. Added "housecleaning" and "ACMAsbestos Containing Materials or lead-containing coatings" 4. Added "unless tested and shown otherwise" 5. Added section on "Procedure for Suspect Background Exposures while Working in the Administration Building" 6. Added "In the absence of a NEA for this type of activity, worker full shift breathing zone samples for lead and/or asbestos may be required to develop a NEA. " 7. Replaced "Workplace Safety & Emergency Management (WSEM)" with "Industrial Hygiene (IH) "throughout document. 8. Added "involving a visual inspection, bulk or surface wipe sampling, or " and "unexpected" 9. Added "and Environmental Services " 10. Deleted "Information about public health organizations that provide smoking cessation programs;" 11. Added parts iii, iv and v to the Environmental Services section 12. Added "Office Employees in the Administration Building Offices" section 13. Added "PACCM means Presumed Asbestos Containing Construction Materials and are building materials that have not been tested but are assumed to contain asbestos based on age and material type. PACCM may be rebutted following bulk testing of the material. " to Appendix A 14. Added "and a disposable protective covering, such as a breathable Tyvek disposable suit over their work clothes" and "N95 respirators are not approved for this work. Industrial hygiene should be contacted for training and fit testing for this type of respirator, and the Facilities Services department shall purchase the N100 respirators." to Appendix B. 15. Added "Procedures for Cleaning Surfaces where Asbestos- or Lead-containing Dusts have Settled" section to Appendix B
Revised	LHHPP	25-10	Use of Psychotropic Medications	**Q. Yifang**	1. Consolidated previous HWPP 25-10 Use of Psychotropic Medications with MSPP D01-05 Psychotropic Medication Management 2. Deleted "Philosophy" section 3. Shortened "Policy" paragraph 4. Added language about CMS regulations and Title 22 reference in the "Policy" paragraph 5. Clarified definition for "psychotropic drug" 6. Added definition for "psychotherapeutic drug" 7. Reorganized "Procedure" section by • Adding subsections "Prescribing Provider", "General Principles" "Assessment Prior to Prescribing" "Family Notification" and "Quality Assurance" • Updated subsections "Informed Consent" by including new requirements from AFL 24-07 and referencing new standard work for "Informed Consent for Psychotropic Medications"; "Emergency use of psychotropic medications" "Prn psychotropic medications"; "GDR" and "Monitoring and Documentation" 8. Updated reference list
Revised	LHHPP	72-01 A3	Infection Preventionist	**M. Barajas**	1. Changed: "Infection Preventionist" to "IP" 2. Added: "and is a registered nurse" 3. Removed: "The IP must be professionally trained in nursing, medical technology, microbiology, epidemiology, or other related field. These may include: A professionally trained nurse with a certificate/diploma or degree in nursing; a professionally trained medical technologist (also known as clinical laboratory scientist) that has earned at least an associate's degree in medical technology or clinical laboratory science; a professionally trained microbiologyst that has earned at least a bachelor's degree in microbiology; a professionally trained epidemiologist that has earned at least a bachelors degree in epidemiology; other fields of training such as physicians, pharmacists, and physician's assistant" 4. Removed: The IP must be employeed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its infection prevention and control program (IPCP). Designated IP hours per week may vary based on the facility and its patient/resident population. 5. Changed:"Director" to "Manager" 6. Added: "who reports to the SFHN Director of Infection Prevention" 7. Added: Reference
Revised	LHHPP	72-01 A8	Outbreak/Epidemic Investigation Protocol	**M. Barajas**	1. Changed: "infection prevention and control (ICP)" to "LHH Infection Prevention and Control (IPC)" 2. Changed: "the ICN and ICC Chair" to "IPC" 3. Changed: "and ICC Chair" to "the Quality Management Regulatory Affairs team" 4. Added: "to the ICC" 5. Removed: "to the Performance Improvement and Patient Safety (PIPS) Committee/Risk Committee for follow up"
Revised	LHHPP	72-01 B5	Transmission Based Precautions	**M. Barajas**	1. Changed: "Droplet" to "Droplet - N95" throughout policy Removed: If the patient/resident is currently in a room that is air negative pressure and then the patient's/resident's status changes to need air negative pressure, the nurse needs to notify on-call engineer to check the room for correct pressure daily." 2. Updated: Rooms to be used for negative airflow or AIIR 3. Added: *Notify facilities to retrofit room 4. Changed: "surgical or procedural mask" under Droplet to "N-95 particulate respirator" 5. Added: to Droplet-N95 "If a private room is not available ensure greater than 6 feet from head-to-head. Patient/Resident to perform hand hygiene and don isolation mask when entering shared spaces (e.g. bathroom)." 6. Changed: under Airborne/Contact/Droplet: "suspected" to "suspect/confirmed" 7. Removed: under Airborne/Contact/Droplet "Are placed in rooms that are not AIIRs" 8. Added: under Airborne/Contact/Droplet "Patients/Residents will be placed in an airborne infection transmission (negative pressure) room with a minimum of 6 – 12 air exchanges per hour with ventilation either outside or through a high efficiency particulate air filter. When a patient/resident is placed in an Airborne Precaution room, Plant Facilities must be notified, as these rooms must be tested daily using a physical test while in use. Nursing will notify on-call engineer upon admission or transfer of a patient/resident requiring air negative pressure. Patients/Residents diagnosed with an ATD will be placed in the following respiratory isolation rooms: (listed rooms). Doors must remain closed for the airborne negative pressure rooms to work. *Confirmed cases will be placed in negative airflow or AII room. 9. Added: under Airborne/Contact/Droplet "Doors must remain closed" 10. Removed: under Airborne/Contact/Droplet "A portable HEPA filter unit may be added to the room" 11. Removed: under Contact Enteric "alcohol based hand rubs are an alternative substitute when hand washing sinks are not in close proximity to patient/resident care locations" 12. Removed: Under Enhanced Barrier Precautions "if available but" 13. Added: Under Enhanced Barrier Precautions " if applicable" 14. Updated: Appendix A and Appendix C - Airborne, Droplet -N95, Airborne/Contact/Droplet

Revised	LHHPP	72-01 C16	Scabies Management	**M. Barajas**	1. Removed: "Or their household, sexual" 2. Changed: "Decontaminated by machine washing in hot water and drying using the hot dryer cycle (or dry clean)" to "laundered"
Revised	LHHPP	72-01 C17	Pediculosis (Lice) Management	**M. Barajas**	1. Changed: "machine wash and dry" to "ensure laundering of" 2. Removed: "using the hot water laundry cycle and the high heat drying cycle"
Revised	LHHPP	72-01 C18	Clostridioides difficile Guidelines	**M. Barajas**	1. Changed/Updated: Appendix A from LHH C difficile Testing Algorithm to Diarrhea Decision Tree 2. Added: Appendix B: SFHN Adult Population: Clostridioides Difficile (C. Diff) Prevention Guidelines
Revised	LHHPP	72-01 F1	Renovation/Construction Infection Control Guidelines	**M. Barajas**	1. Updated: Appendix A 2. Removed Appendix B
Revised	LHHPP	72-01 F3	Management of Resident's Personal Clothing	**M. Barajas**	1. Added: "once collected, is transported to an off-site facility for laundering" 2. Removed: washed, dried, folded, and placed in the resident's clothing storage area using the proper washing and drying temperatures and using appropriate facility laundry detergent following manufacturer's recommendations" 3. Added: "Resident's personal clothing will arrive to unit cleaned and folded then placed in resident's closet and drawers"
Revised	LHHPP	73-02	Asbestos and Lead Management Plan	**W. Spaul**	1. Added "To address procedures when Environmental Services staff may be exposed to lead or asbestos from settled dust during routine housecleaning." 2. Added "To address procedures to address where potential asbestos and lead exposures may be occurring to office employees in the Administration Building 3. Added "housecleaning" and "ACMAsbestos Containing Materials or lead-containing coatings" 4. Added "unless tested and shown otherwise" 5. Added section on "Procedure for Suspect Background Exposures while Working in the Administration Building" 6. Added "In the absence of a NEA for this type of activity, worker full shift breathing zone samples for lead and/or asbestos may be required to develop a NEA. " 7. Replaced "Workplace Safety & Emergency Management (WSEM)" with "Industrial Hygiene (IH) "throughout document. 8. Added "involving a visual inspection, bulk or surface wipe sampling, or " and "unexpected" 9. Added "and Environmental Services " 10. Deleted "Information about public health organizations that provide smoking cessation programs;" 11. Added parts iii, iv and v to the Environmental Services section 12. Added "Office Employees in the Administration Building Offices" section 13. Added "PACCM means Presumed Asbestos Containing Construction Materials and are building materials that have not been tested but are assumed to contain asbestos based on age and material type. PACCM may be rebutted following bulk testing of the material. " to Appendix A 14. Added "and a disposable protective covering, such as a breathable Tyvek disposable suit over their work clothes" and "N95 respirators are not approved for this work. Industrial hygiene should be contacted for training and fit testing for this type of respirator, and the Facilities Services department shall purchase the N100 respirators." to Appendix B. 15. Added "Procedures for Cleaning Surfaces where Asbestos- or Lead-containing Dusts have Settled" section to Appendix B
Revised	LHHPP	80-05	Staff Education Program	**C. Figlietti**	1. Updated DET"s core learning principles 2. Incorporated more details around the scope of this program 3. Included a section on "roles" to highlight all stakeholders and their responsibilities 4. Organized procedure into the grouping of programs that DET is responsible for, e.g. NEO, annual education, CE's, etc.
Deletion	Medical Services	MSPP D01-05	Psychotropic Med Management	**Y. Qian**	1. Combined into the revised LHHPP25-10
New	Nursing	I-06.0	Non- Invasive Ventilation Support	**C. Figlietti**	1. RNs and/or RCPs can manipulate and operate non-invasive ventilator (CPAP/BiPAP). LVNs cannot as this is outside the LVN scope of practice.
Revised	Nursing	A-05.0	Nursing Clinical Affiliations	**C. Figlietti**	1. Removed HHA 2. Updated "preceptor" to "trainer" 3. Revise timeline to "6 weeks prior to the start of the clinical rotation" (currently states 2 months) for meeting requirements such as sending required documents, sending list of students with complete demographics for pre-boarding and onboarding, scheduling tour, etc 4. Removed "A written agreement is reached describing the clinical experience among the facility, etc… The written agreement will specify in writing the faculty's responsibility related to supervising pre-licensure students' administration of medication or treatment." 5. Updated Clinical Instructor orientation to indicate that orientation will be provided via SF Learning ELM to cover regulatory and compliance requirements. 6. Removed statements re: medication pass. Students will NOT be able to pass meds or document in EHR. 7. Removed statement about students reviewing medical records prior to clinical rotation.
Revised	Nursing	D1 2.1	Nurse and Resident Call System	**C. Figlietti**	1. Removed HHA
Revised	Nursing	D9-09.0	Maintaining Temperatures via TempTrak	**C. Figlietti**	1. Removed HHA 2. Updated temperature ranges to current ranges 3. Updated responsibility for checking any outdated food or meds in the med and nourishment refrigerators to PM shift (currently states AM shift). 4. Referred to NEW Standard Work on Checking Temperature or Medication and Nourishment Refrigerators via Temptrak NEW Standard Work - Temptrak 5. Referred to HWPP 31-01 Wireless Refrigeration and Warming Temperature Monitoring System for refrigerator maintenance
Revised	Nursing	I-03.0	Tracheostomy Care	**C. Figlietti**	1. Ambu bag always at bedside 2. Only Registered Nurse (RN)/Respiratory Care Practitioner (RT) may replace outer cannula 3. Added: "LVNs may perform basic respiratory tasks within their scope of practice per the Board of Vocational Nursing and Psychiatric Technicians." 4. Clarified "Site care can be performed by LVN, RN, or RT. Inner cannula change can be performed by RN or RT" 5. Added Appendix to end of policy (California Code of Regulation, title 16, section 1399.365
Revised	Nursing	I-04.0	Laryngectomy Tube Care	**C. Figlietti**	1. Added RT/RCP can also change laryngectomy (LaryTube) 2. Added Routine LaryTube Change performed by RN or RT
Revised	Nursing	I-05.0	Oxygen Administration	**C. Figlietti**	1. New policy: Registered Nurses and Licensed Vocational Nurses will follow their California licensing boards scope of practice for respiratory care and management. 2. Clarified that an RN may administer oxygen during an urgent situation pending physician evaluation 3. LVN can use a manual resuscitation device and other cpr technical skills (basic life support level) in the event of an emergency 4. LVN CANNOT perform initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration
Deletion	Nursing	D9-09.0_Attachment 1	Emergency Equipment	**C. Figlietti**	This is already on the LHH Forms link on intranet

Deletion	Nursing	D9-09.0_Attachment 2	Refrigerator TempTrak Brief Reference Guide	**C. Figlietti**	Creating a NEW standard work for this D9

JCC Follow-up

ASBESTOS AND LEAD MANAGEMENT PLAN

POLICY:

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

PURPOSE:

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

2. To establish a process for periodic inspections, updated assessments, renovation or demolition of areas of the Administration building that may contain asbestos and/or lead. Since the potential for asbestos or lead aerosol releases can also change over time due to various environmental reasons, periodic inspections are to be conducted. Periodic inspections should be done at least annually, and more often in some areas that might have a higher risk of disturbance.

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

4. To address procedures when Environmental Services staff may be exposed to lead or asbestos from settled ~~dusts~~dust during routine housecleaning.

5. To address procedures to address where potential asbestos and lead exposures may be occurring to office employees in the Administration Building.

PROCEDURE:

1. Asbestos and Lead-Containing Materials

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

b. Any construction, alterations, installations, maintenance, housecleaning, or repair work in the Administration building (which has potential ~~ACM~~Asbestos-Containing

Materials or lead-containing coatings) at LHH has the potential to disturb asbestos and/or lead.

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

c. All painted surfaces in the Administration building are assumed to contain lead~~.~~, unless tested and shown otherwise.

d. Negative Exposure Assessment (NEA). A NEA is defined by OSHA as when the workplace conditions "closely resemble" the process, type of material, control methods, work practices, and environmental conditions, and the employer has demonstrated by air testing that the planned work is consistently less than the occupational exposure limit. The NEA is job specific, and is not defined by location, but more so by the process to be used on a specific material wherever it might be at LHH. A NEA for asbestos is based on prior monitoring of similar operations within the past 12 months, and on sampling that has a high degree of statistical certainty. For lead, there is no time limitation of the prior monitoring for the NEA, but the NEA must show that the exposure level is statistically less than the Action Limit of 2 micrograms per cubic meter for an 8- hour time-weighted-average exposure.

2. Procedure for Suspect Background Exposures while Working in the Administration Building

a. Although asbestos and lead may be present in areas of the Administrative Building, the presence of asbestos or lead in building materials is not evidence of an environmental health risk. Asbestos and lead must be released into the air and in sufficient airborne concentrations to present an increased exposure risk.A determination of the exposure risk is made by comparing measured personal breathing zone air samples to the CAL OSHA Permissible Exposure Limits for Asbestos and the Action Limit for Lead.

b. In areas where ~~dusts~~dust on work surfaces are suspected of containing elevated concentrations of lead or asbestos, the LHH Senior Certified Industrial Hygienist may decide to collect occupational worker full shift breathing zone samples if a Negative Exposure Assessment (NEA) has not been performed for a similar exposure situation to determine if an inhalation risk exists. If a NEA for similar exposures has been conducted, then the NEA data may be used to determine exposure risk.

c. Some housekeeping activities by LHH Environmental Services (ENV SVS) staff may expose EVS workers to suspended or settled lead or asbestos ~~dusts~~dust. Periodic surface lead and asbestos dust analyses may be required along with full-shift worker breathing zone sampling, if a Negative Exposure Assessment has not

been performed to determine risks to EVS staff. If a NEA for similar exposures has been conducted, then the NEA data may be used to determine exposure risk.

~~2.~~3. Procedures for Work Order Maintenance and Repair Activities

a. Work orders for maintenance and repairs that involve minimal disturbance of building materials, and for which a ~~negative exposure assessment (NEA)~~Negative Exposure Assessment has been completed, may be assigned to LHH Facility Services staff who have been trained according to paragraph 7~~6a~~. In the absence of a NEA for this type of activity, worker full shift breathing zone samples for lead and/or asbestos may be required to develop a NEA. These staff may complete the work ~~following~~according to the standard procedures in Appendix B.

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

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

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

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

~~3.~~4. Procedures for Building Renovations and Large-Scale Maintenance

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

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

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

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

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

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

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

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

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

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

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

~~4.~~5. Procedures for Addressing Unexpected Asbestos or Lead Encountered by Contractors

a. A thorough assessment, typically involving a visual inspection, bulk sampling, surface wipe sampling, or air sampling, is required to determine the presence of lead and asbestos, in areas where they can reasonably be expected to occur. The Industrial Hygienist will conduct or oversee the assessment, and the types of sampling to be used in the assessment will be based on the professional opinions of the Industrial Hygienist. For these areas, when a determination is made that neither asbestos nor lead is present in the vicinity of work being done, LHH will provide an Asbestos Information Notice, advising them to stop work and contact the Facilities Director if they feel at any point that they may have encountered unexpected asbestos or lead.

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

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

~~5.~~6. Communication of Asbestos Hazard

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

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

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

iii. At entrances to locations of asbestos abatement work.

b. The sign must say the following or something similar: "Danger Asbestos May Cause Cancer. Causes Damage ~~T~~to Lungs. Some Areas Are Authorized to Trained Personnel Only, and~~.~~ ~~Wear~~ Respiratory Protection ~~And~~and Protective Clothing May Be Required for Some Spaces. Check with the LHH Senior Industrial Hygienist Before Disturbing Any Building Materials that May Release Asbestos Fibers."

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

~~6.~~7. Education And Training:

a. Facility Services Department

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

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

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

~~• **Information about public health organizations that provide smoking cessation programs;**~~

~~**7.**~~

~~**8. Respiratory protection (provided in a separate training session).**~~

b. Environmental Services Department (EVS)

~~i.~~

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

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

~~b. Workplace Safety and Emergency Management (WSEM)~~

iii. EVS porter staff in some limited situations may have the potential to be exposed to settled lead and asbestos dusts when cleaning surfaces, and when there is a question about a possible exposure, the employee should contact their supervisor, who may then contact the LHH Industrial Hygienist.

iv. The lead and asbestos awareness training should cover the health effects from lead and asbestos, exposure limits, PPE, safe work practices, and the importance of medical surveillance. This awareness training shall be conducted initially at hiring and annually thereafter.

v. Employees who perform housekeeping in an area with ACM or PACM must receive annual asbestos awareness training, while employees potentially exposed to airborne asbestos levels at or above the **Permissible Exposure Limit (PEL)** or **Excursion Limit (EL)** must receive more comprehensive training before initial assignment and annually thereafter.

c. Industrial Hygiene

i. Industrial Hygienists in ~~WSEM~~the Department of ~~Industial~~Industrial Hygiene shall complete the following classes to maintain AHERA accreditation:

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

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

8. Office Employees in the Administration Building Offices

a. Cal/OSHA does not require universal asbestos training for all office employees; rather, the requirement depends on potential exposures to asbestos-containing materials (ACM) or presumed asbestos-containing materials (PACM) in the workplace that could result in elevated exposure air ~~concnetrations~~concentrations.

b. ~~Employees who perform housekeeping in an area with ACM or PACM must receive annual asbestos awareness training, while employees potentially exposed to airborne asbestos levels at or above the Permissible Exposure Limit (PEL) or Excursion Limit (EL) must receive more comprehensive training before initial assignment and annually thereafter.~~ California OSHA regulations require lead awareness training in office workers only when the exposure is above the OSHA Action Limit for airborne lead, and this determination for lead or asbestos can be based on airborne testing by the employer or on a NEA under similar exposure situations that had been previously performed.

c. Awareness training for housekeepers or routine maintenance who are not likely to disturb lead or asbestos

i. Health effects of asbestos and lead: Information on the dangers of asbestos or lead exposures.

ii. The purpose of medical surveillance program and medical removal program~~.~~

iii. Locations of ACM/PACM and lead coatings: Identification of where these materials are located within the building.

iv. Recognizing damage: The ability to identify damaged or deteriorating ACM/PACM or lead coatings.

v. Good housekeeping practices. Dry sweeping is prohibited where there is the potential to disturb lead or asbestos dusts.~~.~~

vi. Proper response procedures: What to do if ACM lead coatings are accidentally disturbed and these materials are released.

ATTACHMENT:
Appendix A: Asbestos Containing Construction Materials (ACCM) and Presumed Asbestos Containing Construction Materials (PACCM)
Appendix B: Standard Procedures for Maintenance Tasks Resulting in Minimal Disturbance of Asbestos and/or Lead

~~REFERENCE~~REFERENCES:
CCR Title 8 Section 1529~~ –~~ Cal OSHA Asbestos in Construction Standard
CCR Title 8 Section 1532.1 Cal OSHA Lead in Construction Standard
CCR Title 8 Section5198. Lead (Cal OSHA Standard for Lead in General Industry, which includes LHH)
CCR Title 8 Section 5208 Asbestos. General Industry
40 CFR Part 61 – National Emissions Standard for Hazardous Air Pollutants (NESHAP)
Bay Area Air Quality Management District (BAAQMD) Regulation 11 Rule 2 – Asbestos Demolition, Renovation, and Manufacturing.

Revised: ~~13/~~05/28/13, ~~18/~~09/11/18, ~~23/~~09/12/23, ~~25/09/1112/29~~1/20~~11/18~~/26
(~~Year/~~Month/Day/Year)

Appendix A:

ASBESTOS CONTAINING CONSTRUCTION MATERIALS (ACCM) AND PRESUMED ABESTOS CONTAINING CONSTRUCTION MATERALS (PACCM)

Materials	Locations
ACCM: Steam & domestic hot water pipe & fitting insulation, and block type insulation on tanks and heat exchangers	Found in mechanical rooms throughout hospital and throughout the buildings. Some piping insulation is concealed in walls and ceiling and in metal cladding.
ACCM: Acoustical Ceiling Plaster	Main hallways on 3rd, 4th, 5th, & 6th Floors
ACCM: Ceiling Tile (transite), screwed-in	~~Ward~~Wing G Rooms 301, 401, 501, and 601
ACCM & PACCM: 2' x 2' laid-in ceiling tiles	2nd, 3rd, 4th and 5th Floors of old patient's ~~ward~~wing C
ACCM: Vinyl floor sheeting, linoleum, vinyl floor tiles, and mastic	Throughout the hospital – consult the survey reports for actual locations
ACCM: Vinyl composite wall Coverings	Various areas of all buildings
ACCM & PACCM: Fire door core insulation	Various areas of all buildings
ACCM: Wall heater transite behind radiators	Throughout building
ACCM: Heater Insulation, behind sheet metal	H-Wing Library
ACCM: Exterior ~~Paint~~Paints	~~Ward~~Wing G exterior
ACCM: Undercoating on Sinks	Throughout building
ACCM: Tar coating, back of splined ceiling tiles	~~Ward~~Wing D, Room 314, and may be in other wings
PACCM: Wall & Ceiling Sheetrock	Throughout building
PACCM: Baseboard glue	Throughout building
PACCM: Insulators/contactors for elevator Control	Elevators & elevator mechanical rooms
PACCM: Ceramic tile grout, mastic and underlying vapor barrier	Throughout building
PACCM: Vapor barrier under concrete floor	Assumed to be present where there are floor drains in concrete floors.
PACCM: Mastic under Formica	Throughout building

PACCM: Asphalt & gravel roofing and vapor barrier under terracotta tiles	On various roofs
PACCM: Caulking & glazing putty on windows and doors	Throughout the exterior
PACCM: Asbestos cement (transite) panels	On bathroom balconies, in ~~Wards~~Wings

ACCM means any manufactured construction material, including structural, mechanical and building material, which contains more than one-tenth of 1 percent (0.1%) asbestos by weight. PACCM means Presumed Asbestos Containing Construction Materials and are building materials that have not been tested but are assumed to contain asbestos based on age and material type. PACCM may be rebutted following bulk testing of the material.

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

Procedures for Small Lead Paint Stabilization Jobs

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

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

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

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

4. Painters will wear disposable nitrile gloves, and a disposable protective covering, such as a breathable Tyvek disposable suit over their work clothes. The protective suit should include a hood and booties to cover their shoes.

5. Use of a half mask respirator with HEPA filters is recommended during paint stabilization. N95 respirators are not approved for this work. Industrial hygiene should be contacted for training and fit testing for this type of respirator, and the Facilities Services department shall purchase the N100 respirators, which is the minimum level of required respiratory protection.

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

    a. Open flame burning or torching.

    b. Machine sanding or grinding without a high-efficiency particulate air (HEPA) local exhaust control that is attached to the sander or grinder.

    c. Abrasive blasting or sandblasting without HEPA local exhaust control.

    d. Heat guns operating above 1100 degrees Fahrenheit or charring the paint.

e. Dry sanding or dry scraping, except dry scraping in conjunction with heat guns or within 1.0 ft. (0.30 m.) of electrical outlets, or when treating defective paint spots totaling no more than 2 sq. ft. (0.2 sq. m.) in any one interior room or space or totaling no more than 20 sq. ft. (2.0 sq. m.) on exterior surfaces.

f. Paint stripping in a poorly ventilated space using a volatile stripper.

~~f.~~g. Sweeping with a broom is prohibited for both lead and asbestos projects

7. Paint stabilization will include the application of fresh, non-lead ~~-~~based paint, sealer, or primer coating.

8. Upon completion of work, the entire work area must be vacuumed with a HEPA-filtered vacuum cleaner, and/or wet wiped clean.

9. Plastic sheeting/drop cloths that have been cleaned of debris and gloves may be disposed ~~thrown out~~ in the regular trash. Paint chips and contents of HEPA ~~vacuum~~-filtered vacuum cleaners, including used HEPA-filters, are hazardous waste and must be sealed in plastic bags, labelled as hazardous lead waste and placed in the hazardous waste storage area at the East Parking Lot Hazardous Waste Enclosure. The waste bags are to be stored in one of the flammable lockers to protect them from exposure to weather.

10. Once clean-up is complete, remove gloves, disposable protective suit, and lastly, the respirator, and wash hands and face.

~~11. Work clothes should not be worn home.~~

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

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

1. Don disposable, nitrile gloves.

2. Use a vacuum equipped with a HEPA filter to vacuum all painted surfaces that will be disturbed during repair or maintenance and will be used to remove all loose paint chips.

3. Wipe down surface with a wet rag. Brooms and dry sweeping are not permitted on this type of project. Clean up shall be by either wet wiping or by using a HEPA-filter equipped vacuum cleaner.

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

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

6. Remove and dispose of gloves.

7. Wash hands.

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

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

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

1. Don disposable, nitrile gloves.

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

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

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

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

6. Remove and dispose of gloves.

7. Wash hands.

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

Procedures for Cleaning Surfaces where Asbestos- or Lead-containing Dusts or Particles have Settled

1. Don disposable, nitrile gloves.

2. Use only a HEPA-filtered vacuum cleaner to vacuum up dusts or debris. Do not use a broom or dry sweeping.

3. Remove and dispose of gloves; wash hands.

4. Dispose of gloves immediately after use in regular trash

5. Dirty HEPA-filters from vacuum cleaners will be bagged, labelled as Hazardous Waste, and disposed as RCRA Hazardous Waste.

Revised Hospital-wide Policies and Procedures

USE OF PSYCHOTROPIC MEDICATIONS

P~~HILOSOPHY~~OLICY:

LHH provides psychotropic medications for LHH residents as clinically indicated in accordance ~~to~~with state and federal regulations. This policy complies with CMS Appendix PP F757 (Drug Regimen Review) and F758 (Unnecessary Drugs) and 42 CFR § 483.45(c)–(e). Psychotropic medication use shall align with Title 22 § 72311 and § 72533. LHH shall continuously monitor each resident's drug/medication regimen to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being.

~~POLICY:~~

~~1. Informed consent shall be obtained as described in MSPP D01-05 Psychotropic Medication Management, regardless of indication for use.~~

~~2. Resident Care Team (RCT) shall ensure that each resident's drug regimen shall be free from unnecessary psychotropic[1] medication and conform to State and Federal regulations.~~

~~3. Non-pharmacological interventions (such as behavioral interventions) shall be the first consideration whenever indicated, instead of, or in addition to, psychotropic medication.~~

~~4. Residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.~~

~~5. Residents shall not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed, specific condition that is documented in the clinical record. PRN use of psychotropic medications shall be limited as follows:~~

~~a. PRN non-antipsychotic medications shall be limited to 14 days unless a longer time frame is deemed appropriate by a physician and there is documentation of their rationale and the duration of the PRN order in the medical record.~~

~~b. PRN antipsychotic medications shall be limited to 14 days and may not be renewed unless the attending physician evaluates the resident for the appropriateness of that medication.~~

~~6. Psychotropic medications shall never be used for reasons of staff convenience and/or to discipline a resident.~~

~~7. Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue or taper the dosage of these drugs.~~

[1] ~~Also known as psychiatric medication.~~

~~8. Providers will document specific observable and quantifiable target behaviors to be monitored in a target symptom order for any resident on psychotropic medications.~~

~~9. Target symptoms are not required when psychotropic medications are used to treat other medical conditions such as seizures, spastic disorders, hiccups, terminal delirium, pain, etc.~~

~~10. The licensed nurse is responsible for monitoring the specific target behaviors and documenting in the electronic health record (EHR).~~

~~11. Care teams shall be responsible for monitoring for potential side effects of psychotropic medications in the antipsychotic class:~~

~~a. Physicians will perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications:~~

~~i. Within the first 30 days of admission (if new to LHH) or within the first 30 days of starting or discontinuing an antipsychotic medication at LHH~~

~~ii. Every 6 months while on an antipsychotic~~

~~iii. When clinically indicated~~

~~b. Nurses will document in their care plans monitoring for symptoms of tardive dyskinesia and develop an individualized care plan for any resident with tardive dyskinesia.~~

~~c. The Unit Based Quality Assurance and Performance Improvement (QAPI) for psychotropic medications will review of side effects, including tardive dyskinesia, for residents on antipsychotics.~~

~~12. The provider is responsible reviewing the target symptom monitoring to inform their assessment of the effectiveness of the psychotropic regimen.~~

~~13. Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s).~~

PURPOSE:

To assure that the use of psychotropic medications is appropriate and justified, is in compliance with state and federal regulations, and that informed consents are obtained from residents and their families or surrogate decision makers (SDMs) ~~are informed about,~~

~~and consent to~~ for the utilization of psychotropic medications. Residents have the right to be informed of risks/benefits and to refuse treatment unless emergency danger exists.

DEFINITION:

1. **"Psychotropic drug"** (also known as psychotropic medication, psychiatric medication): any drug that affects brain activities associated with mental processes and behavior. These include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety and hypnotic §483.45(c)(3)~~. agents, anti-depressants, anti-psychotics, anti-manic drugs, and sedative- hypnotics.~~ Mood stabilizers, when used for behavioral control, are included (Title 9 CCR § 850–857 and CDPH AFL 23-08). (For LHH, this definition is used in policies and procedures unless otherwise specified.)

2. **"Psychotherapeutic drug"** is a drug to control behavior or to treat thought disorder processes, excluding antidepressants. (CDPH AFL 24-07). [For LHH, this definition is relevant under the procedure for Informed Consent (Section 4, Procedure).]

3. **"Adverse consequence"**: is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition, or functional or psychosocial status.

4. **"Behavioral Interventions"**: individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial well-being.

5. **"Anti-psychotic medication"**: any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders, per Title 9 of California Regulations, Section 850-857.

PROCEDURE:

1. Prescribing Provider

a. LHH prescribing providers of psychotropic medications include all LHH Medical Staff members with prescribing authority as defined by the State of California, i.e. primary physicians and consulting psychiatrists (daytime and after hour on-call).

b. The referring primary physician and the consulting psychiatrist shall determine who will assume responsibility for prescription of psychotropic medication, EXCEPT when a resident whose mental health conditions meet medical necessity for Specialty Mental Health (SMH, i.e. psychiatric conditions resulting in moderate to severe functional impairment), in which case the psychotropic medication management shall be assumed by the psychiatrist, with the consent of the resident or surrogate decision maker. This is to ensure that the resident's SMH service

needs can be met by specialists under the LHH Psychiatry SMH program (psychiatrist services and other mental health services).

c. Some residents who meet SMH criteria are LPS conserved. For LPS conserved residents, the psychiatrist is responsible for prescribing psychotropic medications.

d. In urgent situations and/or if a psychiatrist is unavailable, psychotropic medication management for residents who meet SMH criteria (including LPS conserved residents) may be provided by a covering member of the medical staff until a psychiatrist is available.

e. For obtaining services of an LHH consulting psychiatrist, please refer to MSPP D08-03, Access to LHH Psychiatry Services.

~~1.~~2. General Principles

a. Resident Care Team (RCT) shall ensure that each resident's drug regimen shall be free from unnecessary psychotropic medication and conform to state and federal regulations.

b. Non-pharmacological interventions (such as behavioral interventions) shall be the first consideration whenever indicated, instead of, or in addition to, psychotropic medication. The prescribing provider shall ensure that the use of psychotropic medication is clinically appropriate and only after inadequate response to non-pharmacologic interventions.

c. Residents who have not used psychotropic drugs are not given these drugs unless psychotropic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

d. Psychotropic medications shall never be used for reasons of staff convenience and/or to discipline a resident.

e. Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s).

f. Use of antipsychotic medications for dementia-related behaviors should be avoided unless there is a strong clinical indication, and in those instances, should be used at the lowest possible doses, for the shortest possible period of time, and with clearly documented discussion of risk versus benefit.

g. Prescribing provider Responsibilities:
The LHH prescribing provider of psychotropic medications, whether PCP or psychiatrist, shall follow all LHH practice and documentation standards related to psychotropic medications use including, but not limited to, review and use of:

i. Informed consent for psychotropic medication and timely renewals

ii. Unit Based Quality Assurance and Performance Improvement (QAPI) for psychotropic medications

iii. Behavioral monitoring procedure

iv. Licensed Nurse Weekly Behavior Summary

v. Gradual dose reduction and documentation

vi. Perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications upon initiation and periodically

vii. Regulatory guidelines regarding the use of psychotropic medications in skilled nursing facilities

3. ~~Initiation~~Assessment Prior to Prescribing

~~a. Non-pharmacological interventions (such as behavioral interventions) shall be the first consideration whenever indicated, instead of, or in addition to, psychotropic medication.~~

a. The resident shall receive proper clinical assessment prior to being prescribed psychotropic medications.

b. The assessment may be performed by the Primary Care Physician (PCP) or by an LHH consulting psychiatrist.

c. If the assessment is performed by an LHH consulting psychiatrist, the psychiatrist shall discuss the findings of the assessment with the referring physician including diagnosis, medical necessity, and the suggested treatment plan.

a. The assessment shall include documentation of the medical indication and identify target behaviors for the psychotropic medications.

~~i.~~ The prescribing p~~P~~roviders ~~sha~~will document specific observable and quantifiable target behaviors to be monitored in a target symptom order for any resident on psychotropic medications.

i.

~~ii.~~ Target symptoms are not required when psychotropic medications are used to treat other medical conditions such as seizures, spastic disorders, hiccups, terminal delirium, pain, etc.

ii.

iii. The licensed nurse is responsible for monitoring the specific target behaviors and documenting in the electronic health record (EHR).

~~iii.~~ The provider is responsible for reviewing the target symptom monitoring to inform their assessment of the effectiveness of the psychotropic regimen.

iv.

d. The assessment must identify attempted non-pharmacologic interventions, and ~~documented~~document rationale per F758 and Title 22 § 72533. Document alternatives tried and resident response.

~~a.~~

~~Refer to MSPP D01-05 Psychotropic Medication Management Procedure 1, prior to initiating a resident on psychotropic medication(s).~~

~~4. Informed~~. Informed Consent

Informed consent shall be obtained for all psychotropic medications regardless of indication for use. Obtain written informed consent prior to initiation and renew every six (6) months and whenever the ~~medication,~~medication dose (including range increase), route, or indication changes. Maintain signed copy in the record. Refer to standard work for Informed Consent for Psychotropic Medications. Workflow shall comply with requirements for psychotherapeutic drugs (which exclude antidepressants), where applicable (CDPH AFL 24-07).

5. Family Notification Regarding Antipsychotic Medications for Residents with Decision Making Capacity HSC § 1418.9(b)

The prescribing provider shall seek the consent of the resident to notify the resident's interested family member, as designated in the medical record. If the resident consents to the notice, the prescribing provider shall make reasonable attempts, either personally or through a designee, to notify the interested family member, as designated in the medical record, **within 48 hours** of the prescription, order, or increase of an order. The prescribing provider shall document the notice attempt in EHR.

Notification of an interested family member is not required if any of the following circumstances exist:

a. There is no interested family member designated in the medical record.

b. The resident has not consented to the notification.

As used in this section, the following definitions shall apply:

a. "Resident" means a patient of a skilled nursing facility who has the capacity to consent to make decisions concerning his or her health care, including medications.

b. "Designee" means a person who has agreed with the prescribing provider to provide the notice required by this section.

c. "Antipsychotic medication" means a medication approved by the United States Food and Drug Administration for the treatment of psychosis.

d. "Increase of an order" means an increase of the dosage of the medication above the dosage range stated in a prior consent from the resident.

~~**2. Informed Consent**~~

~~Refer to MSPP D01-05 Psychotropic Medication Management Procedure 3, for obtaining informed consent.~~

6. Emergency use of psychotropic medications

a. In an emergency, psychotropic medications may be ordered by the prescribing provider when necessary to ensure the physical safety of the resident, other residents, or members of the staff. This shall be done in accordance with all applicable state and federal regulations.

b. The prescribing provider shall document in the EHR the specific circumstances for which the medication is prescribed.

c. ~~The~~. The resident will be monitored by the nursing staff for the effectiveness of the medications and any adverse reactions.

d. ~~Emergency~~. Emergency orders will be limited to a single administration per episode. RCT must review within 72 hours, or an agreed upon time frame to evaluate appropriateness, obtain consent if continued, and document follow-up.

e. ~~When psychotropic medications have been used in an emergency situation and the resident is unable to consent and there is no surrogate, informed consent must be obtained through the RCT.~~

f. ~~The form, Nursing Assessment and Progress Note: Potential Emergent/Unplanned Psychotropic Drug Use, will be completed by nursing and signed by the prescribing physician when psychotropic medications are used in emergency situations.~~

Nursing staff shall follow the pertinent workflow in EHR to document the emergency medication administration.

~~Refer to MSPP D01-05 Psychotropic Medication Management Procedure Standard Work on Emergent Medications.~~

7. PRN Psychotropic Medications

Residents shall not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed, specific condition that is documented in the clinical record. PRN use of psychotropic medications shall be limited as follows:

a. PRN non-antipsychotic medications shall be limited to 14 days unless a longer time frame is deemed appropriate by a physician and there is documentation of their rationale and the duration of the PRN order in the medical record.

b. Each PRN order must specify indication and target symptom. Renewal requires in-person assessment and new consent.

c. PRN antipsychotic medications shall be limited to 14 days and may not be renewed unless the attending physician evaluates the resident for the appropriateness of that medication.

8. Gradual Dose Reduction (GDR)

Residents who use psychotropic drugs shall receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue or taper the dosage of these drugs.

Unless clinically contraindicated and documented, attempt GDR in two separate quarters of the first year after initiation (at least one month apart) and annually ~~T~~thereafter.

9. Monitoring and Documentation

Refer to Nursing J-02.5 Monitoring Behavior & the Effects of Psychoactive Medications, ~~MSPP D01-05 Psychotropic Medication Management, procedure 1,~~ and Pharmacy Services 6.00 Clinical Pharmacy 06.01.01 Psychotropic Medication Procedure for monitoring residents who are on psychotropic medication(s) and documentation procedures.

a. RCT~~Care teams~~ shall be responsible for monitoring for potential side effects of psychotropic medications in the antipsychotic class:

~~a.~~ Physicians shall ~~will~~ perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications:

~~i.~~ Within the first 30 days of admission (if new to LHH and already on antipsychotic) or within the first 30 days of starting or discontinuing an antipsychotic medication at LHH

i.

~~ii.~~ Every 6 months while on an antipsychotic

ii.

iii. When clinically indicated

b. Nurses will document in their care plans monitoring for symptoms of tardive dyskinesia and develop an individualized care plan for any resident with tardive dyskinesia.

c. Nursing shall document target behaviors and resident response weekly.

The Unit Based Quality Assurance and Performance Improvement (QAPI) for

psychotropic medications shall ~~will~~ review ~~of~~ side effects, including tardive dyskinesia, for residents on antipsychotics.

d.

e. LHH psychiatrists will also follow documentation guidelines and instructions of San Francisco Health Network Behavioral Health Services (SFHN BHS) for SMH services where applicable.

~~6.~~10. Quality Assurance

LHH shall develop facility process(es) to review psychotropic utilization, consent, GDR compliance, PRN usage, and adverse event data.

ATTACHMENT:
None

REFERENCE:
~~MSPP D01-05 Psychoactive Medications~~
California Health and Safety Code, § 1418.9; § 1599.15
CDPH AFL-24-07 (2024 Psychotherapeutic Drugs Consent Form); HSC
CMS Appendix PP of the Long-Term Care State Operations Manual F757-F758 (Rev 2024)
NPP J2.5 Monitoring Behavior and the Effects of Psychoactive Medications
Pharmaceutical Services Policy and Procedure 06.01.00 Medication Regimen Review
Pharmaceutical Services Policy and Procedure 06.01.01 Psychotropic Medication
Nursing Standard Work on Emergent Medications
American Association of Post-Acute Care Nursing: Psychotropic Medications in the Skilled Nursing Facility: How to Manage the Process; July 25, 2023
Standard Work: Informed Consent for Psychotropic Medications

Revised: ~~12/~~09/25/12, ~~13/~~05/28/13, ~~19/~~05/14/19, ~~21/~~09/14/21, ~~23/~~04/11/23, ~~23/~~08/08/23, 01/20/26 (~~Year/~~Month/Day/Year)
Original adoption: ~~12/~~05/22/12

INFECTION PREVENTIONIST

POLICY:

The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.

DEFINITION:

"Infection Preventionist" is defined as the individual(s) designated by the facility to be responsible for the infection prevention and control program who has been appropriately trained and educated according to CMS requirements.

PROCEDURE:

The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program and consult with the water management program as needed. The facility will ensure the ~~Infection Preventionist~~IP is qualified by education, training, experience, or certification, and is a~~. The IP must be a~~ registered nurse.

1.

~~1. The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field. These may include:~~

~~a. A professionally-trained nurse with a certificate/diploma or degree in nursing;~~

~~b. A professionally-trained medical technologist (also known as a clinical laboratory scientist) that has earned at least an associate's degree in medical technology or clinical laboratory science;~~

~~c. A professionally-trained microbiologist that has earned at least a bachelor's degree in microbiology;~~

~~d. A professionally-trained epidemiologist that has earned at least a bachelor's degree in epidemiology;~~

~~e. Other related fields of training such as physicians, pharmacists, and physician's assistants.~~

2. The IP will have the knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities.

~~2.~~3. The facility will ensure that the individual selected as the IP has the background and ability to fully carry out the requirements of the IP based on the needs of the patient/resident population, such as interpreting clinical and laboratory data.

~~The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its infection prevention and control program (IPCP). Designated IP hours per week may vary based on the facility and its patient/resident population.~~

~~3.~~4. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as the quality assessment and assurance committee (QAA).

~~4.~~5. The IP will physically work onsite in the facility.

~~5.~~6. The IP must be sufficiently trained in infection prevention and control. Specialized training in infection prevention and control may include care for patients/residents with invasive medical devices, patient/resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high-acuity conditions. If the facility's patient/resident population changes, the IP may need to obtain additional training for the change in the facility's scope of care, based upon re-evaluation of the IP's knowledge and skills.

~~6.~~7. The IP must have obtained specialized infection prevention and control (IPC) training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation. Specialized training should include the following topics:

a. Infection prevention and control program overview;

b. Infection preventionist's role;

c. Infection surveillance;

d. Outbreaks;

e. Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable patient/resident care equipment);

f. Principles of transmission-based precautions;

g. Patient/resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing);

h. Water management;

i. Linen management;

j. Preventing respiratory infections (e.g., influenza, pneumonia);

k. Tuberculosis prevention;

l. Occupational health consideration (e.g., employee vaccinations, exposure control plan and work exclusions);

m. Quality assurance and performance improvement (QAPI);

n. Antibiotic stewardship; and

o. Care transitions.

~~7.~~8. The Infection Preventionist reports to the SFHN ~~Director~~Manager of Infection Prevention who reports to the SFHN Director of Infection Prevention.

~~8.~~9. Responsibilities of the Infection Preventionist include but are not limited to:

a. Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment.

b. Establish facility-wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of patients/residents, staff and visitors.

c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control.

d. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program.

e. Oversight of patient/resident care activities (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, performing fingersticks, medication administration, etc.)

f. Review and/or revise the facility's infection prevention and control program, its standards, policies and procedures annually and as needed for changes to the

facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections.

g. Review/revise and approve infection prevention and control training topics and content, and ensure facility staff are trained on IPCP. The infection preventionist is not necessarily required to perform the IPCP training if the facility has designated staff development personnel.

~~9.~~10. The Infection Control Preventionist will participate on and is part of the quality assessment and assurance committee (QAA) and will report regularly on the infection prevention and control program activities.

ATTACHMENT:
None.

REFERENCE:
Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (August 2024 Revision) F882 – Infection Prevention and Control. 42 C.F.R. §483.80(b)(1)-(4)(c).
California Department of Public Health, Assembly Bill (AB) 2644 – Skilled Nursing Facilities: Infection Preventionist and Communicable Disease Reporting available at: https://www.cdph.ca.gov/programs/CHCQ/LCP/Pages/AFL-20-85.aspx

Revise: 08/31/23, 01/09/24, 02/03/25, 01/20/26 (Month/Day/Year)

Original adoption: 12/13/22

OUTBREAK/EPIDEMIC INVESTIGATION PROTOCOL

POLICY:

It is the policy of this facility that Laguna Honda Hospital and Rehabilitation (LHH) will comply with the local and state health departments for reporting unusual occurrences that many constitute an outbreak or epidemic occurrence. Health facilities licensed by California Department of Public Health (CDPH) Licensing and Certification (L&C) including LHH, are required to report outbreaks and unusual infectious disease occurrences to the local public health officer and their respective District Office (DO).

Upon receipt of a report of an outbreak or unusual occurrence, the local public health department recommends control actions and may conduct an epidemiologic investigation. The DO decides on regulatory follow-up action, which may include an onsite survey. The CDPH Healthcare-Associated Infections (HAI) Program is available to local public health authorities and L&C for consultation on infection control and containment measures. The ~~infection prevention and control (ICP)~~LHH Infection Prevention and Control (IPC) department will coordinate services with both the local health department, the San Francisco Department of Public Health (SFDPH), and CDPH to mitigate transmission of the disease to others.

When necessary, the Hospital Incident Command (HIC) will be activated should the occurrence/outbreak reach a level that requires extraordinary measures for containment or additional services to meet the safety needs of the facility. Protocols specific to HICs will be followed for public communication dissemination, reassignment of staff as needed and protection of supply chain.

If in doubt of reporting a specific concern, report it.

Designated members of the Infection Control Committee (ICC) have the responsibility for investigating outbreaks/epidemics and developing policies aimed at preventing the spread and control of healthcare-associated infections.

The threshold for determination of an outbreak is based on All Facilities Letter (AFL) 23-08 and guidance from San Francisco Department of Public Health (SFDPH). One case of any infection shall trigger additional investigation by the facility. Two or more of a similar infection in a period of 72 hours occurring on one neighborhood shall trigger an investigation of a possible outbreak to include reportability to SFDPH and CDPH.

DEFINTION:

Outbreak: California Department of Public Health (CDPH) defines an outbreak as the occurrence of cases of a disease (illness) above the expected or baseline level, usually over a given period of time, in a geographic area or facility, or in a specific population group. The number of cases indicating the presence of an outbreak will vary according to

the disease agent, size and type of population exposed, previous exposure to the agent, and the time and place of occurrence.

Thus, the designation of an outbreak is relative to the usual frequency of the disease in the same facility or community, among the specified population, over a comparable period of time. For example, a single case of measles in this population may be considered an outbreak.

A single case of a communicable disease long absent from a population or the first invasion by a disease not previously recognized requires immediate reporting and epidemiologic investigation. The Infection Control Nurse (ICN) in conjunction with the ICC Chair will provide guidance when an outbreak /epidemic is occurring or suspected.

Unusual Disease: A rare disease or a newly apparent or emerging disease or syndrome of uncertain etiology which a health care provider has reason to believe could possibly be caused by a transmissible infectious agent or microbial toxin.

Unusual Occurrences: Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients/residents, personnel or visitors.
https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-08.aspx
Example of Reportable Incidents

Epidemic: Centers for Disease Control and Prevention (CDC) defines an epidemic the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.

Transmission of Infection: CDC defines as any mode of mechanism by which an infectious agent is spread through the environment or to another person.

Virulence: CDC defines virulence as the proportion of persons with clinical disease who, after becoming infected, become severely ill or die.

PURPOSE:

The purpose of this policy is to provide staff with information to identify and report when information becomes known that a patient(s)/resident(s) may be infected with a pathogen that is highly transmissible and/or virulent and how to reduce transmission.

PROCEDURE:

1. The neighborhood Charge Nurse (CN) or House Supervisor is responsible for contacting the ICN when there are two or more of a similar infection in a period of 72

hours occurring on the neighborhood or when there is a single case involving a highly transmissible and/or virulent pathogen.

2. The ICN shall determine whether the situation is an infectious outbreak and collaborate with the ICC Chair, to determine whether the situation is an infectious outbreak or cluster that poses a threat to the health and safety of patients/residents and employees. Once ~~the ICN and ICC Chair~~Infection Prevention and ControlIPC determines that an outbreak has occurred, the neighborhood and other appropriate individuals shall be notified. If there is doubt, report to CDPH for further consultation.

3. If investigation indicates that an outbreak or epidemic exists, the ICN or designee shall notify the San Francisco Department of Public Health (SFDPH) Communicable Disease Unit and the Regulatory Affairs Nurse shall notify CDPH when appropriate.

4. The ICN ~~and ICC Chair~~and ~~regulatory affairs~~the Quality Management Regulatory Affairs team will remain in contact with local and state departments for similar outbreaks in the surrounding areas. The ICN nurse will work in conjunction with the local health department investigations for contact tracing and implement recommendations to prevent further transmission.

5. An interdisciplinary team may be convened to provide a rapid response to the outbreak including the ICN team members. If the outbreak involves a high potential for morbidity and/or mortality based upon the local, state, and/or federal health departments, the Hospital Incident Command System (HICS) shall be initiated. The HICS Incident Commander will determine membership of their team, assign roles in the HICS structure, and include subject matter experts as needed.

6. The HICS Incident Commander may call an immediate meeting of such individuals and disciplines to:

    a. Clarify the nature and extent of the potential problem.

    b. Discuss proposed investigative steps.

    c. Determine and assign responsibility of each department; determine who shall collect and record specific data.

    d. Anticipate questions that may arise and develop a frequently asked question (FAQ) fact sheet.

7. Decisions involving a major disruption of services affecting large numbers of patients/residents, personnel, or considerable expense (such as "closing" a neighborhood), shall be made in conjunction with the investigating personnel, attending staff, and administration.

8. In the event that prophylactic or therapeutic medication is required for patients/residents, the prescribing physicians shall be notified by the ICC Chair.

9. The frequency of interdisciplinary meetings will be determined on a case-by-case basis.

10. The ICN shall collaborate with clinical members of the ICC to write the investigation report and distribute the report to involved departments. Communication with upline and downline stakeholders will be developed either by the HICS team and/or in conjunction with the ICN and ICC Chair and provided on a regular basis.

11. A summary of the investigation will be provided to the ~~by the~~ ICC. ~~to the Performance Improvement and Patient Safety (PIPS) Committee/Risk Committee for follow up~~. Recommendations will be reviewed for implementation.

Refer to Outbreaks and Unusual Disease Occurrence Plan, including COVID-19, Influenza, and MDRO's.

ATTACHMENT:
None.

REFERENCE:
CDPH AFL 23-08 Requirements to Report Outbreaks and Unusual Infectious Disease Occurrences (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-08.aspx)
San Francisco Department of Public Health, Respiratory illness guidance for high risk settings (https://www.sf.gov/resource/2022/respiraotry-illness-guidance-high-risk-settings)
Centers for Disease Control (http://www.cdc.gov)
U.S. Department of Health and Human Services
LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 C5 Emergency Responder Antibiotic Dispensing Plan
LHHPP 72-01 A9 Contact/Exposure Investigation
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 11/25/2014, 03/12/2019, 07/09/2019, 06/23/2020, 10/11/22 08/31/23, 01/09/24, 02/03/25, 01/20/26 (Month/Day/Year)

Original adoption: Est. 11/01/2005

TRANSMISSION-BASED PRECAUTIONS AND PATIENT/RESIDENT ROOM PLACEMENT

POLICY:

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

RESPONSIBILITES:

1. This policy applies to all employees of Laguna Honda Hospital and Rehabilitation and to all medical staff, volunteers, contract workers and students.

2. Supervisors, managers, and directors are required to enforce the provisions of this policy in their areas. Employees who do not follow the contents of this plan may be subject to disciplinary action.

3. The Infection Prevention Department is available to provide consultation regarding transmission-based precautions.

4. Any patient/resident known or suspected to have a disease or condition that warrants transmission-based precautions will be placed in the appropriate transmission precautions upon admission. Physicians and/or nurses will promptly order the precautions category for newly diagnosed or suspected cases.

    a. The nurse is responsible for ensuring that the precautions are initiated and maintained according to the specified protocol.

    b. The infection prevention staff or the patient's/resident's nurse may initiate transmission -based precautions without the physician's order based upon a lab report, or patient's/resident's changing status (e.g., diarrhea) or based on a prior known admission infectious status. In those instances, the physician will be notified that the patient/resident was placed on transmission-based precautions, and a note for the rationale will be entered in the nurse's notes.

5. PPE will be located ~~in~~ on each patient/resident unit and care location/department.

PROCEDURE:

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

a. **Signs. TBP** signs will be placed in a visible location outside of resident room.

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

c. **Room Selection.** Patients/Residents placed under transmission-based precautions will be placed in a private room if possible or cohorted with another patient/resident infected with the same pathogen in consultation with the Infection Prevention Department.

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

   i. Handle soiled linen as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen.

   ii. Linen will not be sorted or rinsed in patient/resident care areas.

   iii. Place all linen in the designated leak-proof, laundry bags. It is not necessary to put any linen in a red bag.

   iv. Caution must be exercised to help prevent laundry bags from being overfilled.~~OVERFILLED~~.

   v. Filled linen bags will be closed securely.

   vi. Linen should not be stockpiled in rooms.

   vii. Double bagging will be utilized only when the original linen bag is torn, punctured, or visibly contaminated on the outside; or if the linen contains such a large amount of fluid that the original bag may leak.

e. **Food service.** Disposable trays and utensils for foodservice are not necessary for patients/residents under transmission-based precautions. Dietary carts are cleaned per hospital-approved policy.

f. **Visitors**

   i. **Airborne**: Visitation should be limited to only those who Nursing agrees will support patient's/resident's safety/wellbeing. Visitors should wear a well-fitting mask (N95 - perform seal check). If visitor is unable to tolerate a respirator/N95, a surgical mask can be used (Sfeir, 2018). Visitors are reminded to keep their

hands off of their face and perform hand hygiene prior to entry and upon leaving the room.

ii. **Droplet - N95:** Visitation should be limited to only those who Nursing agrees will support patient's/resident's safety/well -being. Visitors shall wear ~~a~~ surgical mask. Visitors are reminded to keep their hands off of their face and perform hand hygiene prior to entry and upon leaving the room.

iii. **Contact**: Visitors are not required to wear PPE for contact precautions unless the visitor is going to participate in direct patient/resident care, visit another patient/resident in the hospital, or patient/resident is infected or colonized with a San Francisco Department of Public Health (SFDPH) targeted Multidrug-resistant Organisms (MDRO). An information sheet is available to educate families of patients/residents on contact precautions to determine if the visitor is at risk for infection (e.g., visitor has an open wound, catheter, etc.).

iv. **Contact Enteric:** Visitation should be limited to only those who Nursing agrees will support the patient/resident's safety/well-being. Visitors shall wear ~~a~~ gown and gloves. Visitors are to be reminded to keep their hands off their face and perform hand hygiene upon entry and with soap and water leaving the room.

v. **Enhanced Barrier Precautions:** Visitors are not required to wear PPE unless performing any of the 6 high contact activities while visiting patient/resident. Instruct visitors to clean hands before entering and exiting patient/resident room or care area.

g. **Terminal Room Cleaning**

i. When patients/residents are discharged or transferred, the TBP sign must stay in place until the designated employee has cleaned the room.

ii. All room surfaces and equipment are terminally cleaned according to EnvironmentalServices cleaning procedures. Privacy curtains are removed and sent to the laundry.

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

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

2. CATEGORIES OF PRECAUTIONS

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

b. All patients/residents who are:

i. diagnosed with confirmed active ATD Airborne Transmissible Disease and are infectious, or

ii. under clinical suspicion of active pulmonary ATD or who show signs or symptoms indicative of a possible ATD infection should be placed in airborne precautions (i.e., negative pressure, private room with the door kept closed, N-95 particulate respirator for those entering the room).

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

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

~~ii.~~ When a patient/resident is placed in an Airborne Precaution room, Plant Facilities must be notified, as these rooms must be tested daily using a physical test while in use. Nursing will notify the on-call engineer upon admission or transfer of a patient/resident requiring air negative pressure. ~~If the patient/resident is currently in a room that is not air negative pressure and then the patient's/resident's status changes to need air negative pressure, the nurse needs to notify on-call engineer to check the room for correct pressure daily.~~

iii. Patients/Residents diagnosed with an ATD will be placed in the following respiratory isolation rooms:

Location	Room(s)
North Mezzanine	28*
North 1	28*
North 2	28*
North 3	28*
North 4	28*
North 5	28*
North 6	28*

South 2	28*
South 3	28*
South 4	28, 48
South 5	28, 48
South 6	28, 48
Pavilion Mezzanine SNF	13*
Pavilion Mezzanine Acute	~~48~~56
Pavilion Mezzanine Acute Rehab	51*

*Notify facilities to retrofit room

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

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

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

vi. An N-95 particulate respirator must be worn when entering the room of a patient/resident in Airborne Precautions. Personnel will have a documented fit test prior to being assigned duties requiring the use of an N-95 particulate respirator and will perform a fit check (put mask on and make sure that no air escapes while exhaling) prior to each use. NOTE: Gloves and gowns are not required for airborne precautions unless standard precautions require them (COVID-19.)

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

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

ix. Patient/Resident will wear a surgical or procedural mask during transport and any time they are ~~-~~out of the airborne negative pressure room.

3. **DROPLET ~~-~~ N95 Precautions** are designed to reduce the risk of droplet transmission of infectious agents. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large particle droplets (larger than 5 um in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets are generated by the source person during coughing, sneezing, or talking and/or during the performance of certain procedures such as suctioning and bronchoscopy. Transmission via large particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only short distances, usually 6 feet or less.

   a. A ~~surgical or procedural mask~~N-95 particulate respirator and eye protection shall be donned before entering the patient/resident room. An airborne transmission negative pressure room is unnecessary. NOTE: Gloves and gowns are not required for droplet precautions unless standard precautions require them.

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

   c. A private room if possible or cohorted with another patient/resident infected with the same pathogen in consultation with the Infection Prevention Department. If a private room is not available ensure greater than 6 feet from ~~head to head~~head-to-head. Patient/Resident to perform hand hygiene and don isolation mask when entering shared spaces (e.g. bathroom).

4. **Airborne/Contact/Droplet Precautions** are used when patient/residents with ~~suspected~~ suspect/confirmed novel pathogens (such as COVID-19)~~. are placed in rooms that are not AIIRs.~~ Patients/Residents in Airborne/Contact/Droplet precautions require:

a. Private room if available or cohorted with another patient/resident infected with the same pathogen in consultation with the Infection Prevention Department.

i. Patients/Residents will be placed in an airborne infection isolation room or retrofitted negative airflow room with a minimum of 6 – 12 air exchanges per hour with ventilation either outside or through a high efficiency particulate air filter.

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

ii. Patients/Residents diagnosed with an ATD will be placed in the following respiratory isolation rooms:

Confirmed cases with be placed in negative airflow or AII room.

Location	**Room(s)**
North Mezzanine	28*
North 1	28*
North 2	28*
North 3	28*
North 4	28*
North 5	28*
North 6	28*
South 2	28*
South 3	28*
South 4	28, 48
South 5	28, 48
South 6	28, 48
Pavilion Mezzanine SNF	13*
Pavilion Mezzanine Acute	56
Pavilion Mezzanine Acute Rehab	51*

*Notify facility to retrofit room

~~i.~~iii. Doors must remain closed.

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

~~c.~~b. Care providers must wear a fit-tested N-95 respirator or powered air purifying respirator (PAPR) if available, eye protection, ~~,~~gown and gloves.

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

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

~~f.~~e. Discontinuing Precautions:

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

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

a. Private room if available or cohorted with another patient/resident infected with the same pathogen in consultation with the Infection Prevention Department.

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

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

d. A~~NY~~ny reusable patient/resident equipment must be cleaned after use with hospital approved disinfectant products.

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

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

g. Immediately prior to exiting the patient/resident room, PPE will be removed. Gowns will be taken off prior to gloves, rolling inwards. Gloves will be taken off taking care to avoid contamination of the hands. At that time, hands will be immediately washed with soap and water, or an alcohol antiseptic gel will be used. Avoid recontamination of hands from environmental surfaces.

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

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

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

   a. Private room if available or cohorted with another patient/resident infected with the same pathogen in consultation with the Infection Prevention Department.

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

   c. Perform hand hygiene ~~-~~with soap and water. ~~Alcohol based hand rubs are an alternative substitute when hand washing sinks are not in close proximity to patient/resident care locations.~~

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

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

7. **ENHANCED Barrier Precautions (EBP) are** for Long Term Care residents with wounds, indwelling medical devices, and/or infected or colonized with a SFDPH-

targeted MDRO where contact precautions do not otherwise apply. EBP should be used during specific high-contact resident care activities commonly associated with MDRO transmission.

a. Private room ~~if available but~~ not required. May cohort with compatible roommate based on MDRO status if applicable.

b. Wear gowns and gloves while performing high-risk tasks:

i. Morning and evening care

ii. Device care (Urinary, Feeding tube, etc.) or giving medical treatments

iii. Toileting & changing incontinence briefs

iv. Cleaning and disinfecting the environment.

v. Wound Care

vi. Mobility assistance and preparing to transfer from their room

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

d. Gowns and Gloves should always be removed inside the room when care activity is complete. Gowns and Gloves should not be routinely worn outside the room.

e. Visitors do not need to routinely wear gown and gloves when visiting a resident unless the visitor is assisting in a resident care activity then they should wear gowns and gloves when providing care.

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

a. Empirically initiated transmission-based precautions may be adjusted or discontinued when additional clinical information becomes available (confirmatory laboratory results) by physician and/or Infection Prevention and Control RN.

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

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

Appendix B: Donning and Doffing Mask

Appendix C: Isolation Signage

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

CDC (2023) Infection Control Guidance: SARS-CoV-2

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

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

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

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

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Original adoption: 01/12/16

San Francisco Health Network
Laguna Honda Hospital
and Rehabilitation Center

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

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

Some of the organism/syndromes below require a higher level of protection above Standard. This is because of contamination of the environment (making transmission extremely easy), the mode of transmission (contact, droplet, airborne), or the epidemiological significance of the organism (i.e., antibiotic resistance, high virulence).

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact	Duration of illness	Until drainage stops or can be contained by dressing
Abscess Draining, minor or limited	Standard		If dressing covers and contains drainage.
Acquired human immunodeficiency syndrome (HIV)	Standard		Postexposure chemoprophylaxis for some blood exposures
Actinomycosis	Standard		Not transmitted from person to person.
Adenovirus infection (see agent-specific guidance under Gastroenteritis, Conjunctivitis, Pneumonia)			
Amebiasis	Standard		Person-to-person transmission is rare. Transmission in settings for the mentally challenged and in a family, group has been reported [1045]. Use care when handling diapered infants and mentally challenged persons [1046]
Anthrax	Standard		Infected persons do not generally pose a transmission risk.
Anthrax Cutaneous	Standard		Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to

			use of waterless alcohol-based antiseptics since alcohol does not have sporicidal activity [983].
Anthrax Pulmonary	Standard		Not transmitted from person to person.
Anthrax Environmental: Aerosolizable spore containing powder or other substance		Until environment completely decontaminated	Until decontamination of environment complete [203]. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (Notice to Readers: Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites — United States, 2001–2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.h tm accessed September 2018).) Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine gluconate after spore contact (alcohol handrubs inactive against spores [983].) Postexposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and Postexposure vaccine under IND.
Antibiotic-associated colitis (see Clostridium difficile)			
Arthropod-borne • viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and • viral fevers (dengue, yellow fever, Colorado tick fever)	Standard		Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally [530, 1047]. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.
Ascariasis	Standard		Not transmitted from person to person.
Aspergillosis	Standard		Add Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required [154].
Avian influenza (see Influenza, Avian below)			
Babesiosis	Standard		Not transmitted from person to person, except rarely by transfusion.
Blastomycosis, North American, cutaneous, or pulmonary	Standard		Not transmitted from person to person.
Botulism	Standard		Not transmitted from person to person.

Bronchiolitis (see Respiratory Infections in infants and young children)	Contact + Droplet - N95	Duration of illness	~~Use mask according to Standard Precautions.~~
Brucellosis (undulant, Malta, Mediterranean fever)	Standard		Not transmitted from person to person, except rarely via banked spermatozoa and sexual contact [1048, 1049]. Provide antimicrobial prophylaxis following laboratory exposure [1050]
Campylobacter gastroenteritis (see Gastroenteritis)			
Candida auris	Contact	Duration of hospitalization and all subsequent admissions	For SNF only: Potential downgrade to Enhanced Barrier Precautions will be determined in conjunction with SFDPH and Infection Control on a case-by-case basis.
Candidiasis, all forms including mucocutaneous	Standard		
Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard		Not transmitted from person to person.
Cellulitis	Standard		
Chancroid (soft chancre) (H. ducreyi)	Standard		Transmitted sexually from person to person.
Chickenpox (see Varicella)			
Chlamydia trachomatis Conjunctivitis	Standard		
Chlamydia trachomatis Genital (lymphogranuloma venereum)	Standard		
Chlamydia trachomatis Pneumonia (infants ≤3 mos. of age)	Standard		
Chlamydia pneumoniae	Standard		Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see Gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage	Standard		Add Contact Precautions if there is copious uncontained drainage.
Closed-cavity infection No drain or closed drainage system in place	Standard		

Clostridium botulinum	Standard		Not transmitted from person to person.
Clostridium difficile (see Gastroenteritis, C. difficile)			
Clostridium perfringens Food poisoning	Standard		Not transmitted from person to person.
Clostridium perfringens Gas gangrene	Standard		Transmission from person to person rare; 1 outbreak in a surgical setting reported [1053]. Use Contact Precautions if wound drainage is extensive
Coccidioidomycosis (valley fever) Draining lesions	Standard		Not transmitted from person to person except under extraordinary circumstances, because the infectious arthroconidial form of Coccidioides immitis is not produced in humans [1054].
Coccidioidomycosis (valley fever) Pneumonia	Standard		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of Coccidioides immitis is not produced in humans [1054, 1055].
Colorado tick fever	Standard		Not transmitted from person to person.
Congenital rubella	Contact	Until 1 yr. of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly negative after 3 mos. of age.
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial Chlamydia	Standard		
Conjunctivitis Acute bacterial Gonococcal	Standard		
Conjunctivitis Acute viral (acute hemorrhagic)	Contact	Duration of illness	Adenovirus most common; enterovirus 70 [1056], Coxsackie virus A24 [1057] also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling residents with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings. [460, 461, 814, 1058-1060]

Coronavirus (non SARS)	Droplet – N95 + Contact	Until 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer	~~Add Contact Precautions if copious moist secretions and close contact likely to occur.~~
Corona virus associated with SARS (SARS-CoV) (see Severe Acute Respiratory Syndrome)			
Coxsackie virus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures. [1061]
Croup (see Respiratory Infections in infants and young children)			
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	~~Standard~~		
Cryptococcosis	Standard		Not transmitted from person to person, except rarely via tissue and corneal transplant. [1062, 1063]
Cryptosporidiosis (see Gastroenteritis)			
Cysticercosis	Standard		Not transmitted from person to person.
Cytomegalovirus infection, including in neonates and immunosuppressed residents	Standard		No additional precautions for pregnant HCWs.
Decubitus ulcer (see Pressure Ulcer)			
Dengue fever	Standard		Not transmitted from person to person.

Diarrhea, acute-infective etiology suspected (see Gastroenteritis)			
Diphtheria Cutaneous	Contact ~~+ Standard~~	Until off antimicrobial treatment and 2 cultures collected at least 24 hours apart are negative~~-negative~~	~~Until 2 cultures taken 24 hours apart negative.~~
Diphtheria Pharyngeal	Droplet – N95 ~~+ Standard~~	Until off antimicrobial treatment and 2 cultures collected at least 24 hours apart are-negative	~~Until 2 cultures taken 24 hours apart negative.~~
Ebola virus (see Viral Hemorrhagic Fevers)			Ebola Virus Disease for Healthcare Workers [2014] Update: Recommendations for healthcare workers can be found at Ebola For Clinicians. (accessed September 2018).
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person.
Echovirus (see Enteroviral Infection)			
Encephalitis or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
Enterococcus species (see Multidrug-Resistant Organisms if epidemiologically significant or vancomycin-resistant)			

Enterocolitis, C. difficile (see Gastroenteritis, C. difficile)			
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses, Herpangina) (excludes polio virus)	Standard		~~Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks.~~
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses, Herpangina) (excludes polio virus) Infants and young children	Contact	Duration of Illness	
Epiglottitis, due to Haemophilus influenzae type b	Droplet - N95	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies.
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			
Escherichia coli gastroenteritis (see Gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person.
Food poisoning C. perfringens or welchii	Standard		Not transmitted from person to person.
Food poisoning Staphylococcal	Standard		Not transmitted from person to person.
Furunculosis, staphylococcal	Standard		Add Contact if drainage not controlled. Follow institutional policies if MRSA.
Furunculosis, staphylococcal Infants and young children	Contact	Duration of illness (with wound lesions,	

		until wounds stop draining)	
Gangrene (gas gangrene)	Standard		Not transmitted from person to person.
Gastroenteritis (acute-infective etiology suspected)	Contact ~~Plus~~Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Adenovirus	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Astrovirus	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Campylobacter species	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Cholera (Vibrio cholerae)	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis C. difficile	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis. Discontinue antibiotics if appropriate. Do not share electronic thermometers; [853, 854] ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning

			if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs [983].
Gastroenteritis Cryptosporidium species	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Cyclosporiasis	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Entamoeba histolytica	Standard		
Gastroenteritis E. coli Enteropathogenic O157:H7 and other Shiga toxin-producing strains	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis E. coli Other species	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Giardia lamblia	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Noroviruses	Contact Enteric	Duration of illness and 48 hours after the	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be

		resolution of symptoms	aerosolized from these body substances [142, 147 148]; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled [273, 1064]. Hypochlorite solutions may be required when there is continued transmission [290-292]. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination [294]. Cohorting of affected patients/residents to separate airspaces and toilet facilities may help interrupt transmission during outbreaks. Gastroenteritis, Noroviruses Precaution Update [April 2019] Update: The Type of Precaution was updated from "Standard" to "Contact + Standard" to align with Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (2011).
Gastroenteritis Rotavirus	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis. Ensure consistent environmental cleaning and disinfection and frequent removal of soiled briefs. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly [932, 933].
Gastroenteritis Sapovirus	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Salmonella species (including S. typhi)	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Shigella species (Bacillary dysentery)	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.

Gastroenteritis Vibrio parahaemolyticus	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Viral (if not covered elsewhere)	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
Gastroenteritis Yersinia enterocolitica	Contact Enteric	Duration of illness and 48 hours after the resolution of symptoms	Use Contact Enteric Precautions to control institutional outbreaks for gastroenteritis.
German measles (see Rubella; see Congenital Rubella)			
Giardiasis (see Gastroenteritis)			
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barré syndrome	Standard		Not an infectious condition.
Haemophilus influenzae (see disease-specific recommendations)			
Hand, foot, and mouth disease (see Enteroviral Infection)			
Hansen's Disease (see Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person.
Helicobacter pylori	Standard		

Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine postexposure as recommended. [1065]
Hepatitis, viral Type A - incontinent patient/residents	Contact Enteric	Infants and children < 3 years of age: Duration of hospitalization Age 3-14 years: Until 2 weeks after onset of symptoms 14 years and older: Until 1 week after the onset of symptoms	~~Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms [833, 1066, 1067].~~
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard		See specific recommendations for care of residents in hemodialysis centers. [778]
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard		See specific recommendations for care of residents in hemodialysis centers. [778]
Hepatitis, viral Type D (seen only with hepatitis B)	Standard		
Hepatitis, viral Type E	Standard		Use Contact Precautions for incontinent individuals for the duration of illness. [1068]
Hepatitis, viral Type G	Standard		
Herpangina (see Enteroviral Infection)			
Hookworm	Standard		
Herpes simplex (Herpesvirus hominis) Encephalitis	Standard		

Herpes simplex (Herpesvirus hominis) Mucocutaneous, disseminated or primary, severe	Contact	Until lesions dry and crusted	
Herpes simplex (Herpesvirus hominis) Mucocutaneous, recurrent (skin, oral, genital)	Standard		
Herpes simplex (Herpesvirus hominis) Neonatal	Contact	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours of age negative after 48 hours incubation. [1069, 1070]
Herpes zoster (varicella-zoster) (shingles) Disseminated disease in any resident. OR Localized disease in immunocompromised resident until disseminated infection ruled out	Airborne + Contact	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection (i.e. surgical mask or respirator) for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles) Localized in resident with lesions that cannot be contained/covered	Contact	Until lesions dry and crusted	Susceptible HCWs should not provide direct patient/resident care when other immune caregivers are available.
Herpes zoster (varicella-zoster) (shingles) Localized in resident with intact immune system with lesions that can be contained/covered	Standard	Until lesions dry and crusted	Susceptible HCWs should not provide direct patient/resident care when other immune caregivers are available.
Histoplasmosis	Standard		Not transmitted from person to person.
Hookworm	Standard		
Human immunodeficiency virus (HIV)	Standard		Postexposure chemoprophylaxis for some blood exposures [866].
Human metapneumovirus	Contact + Droplet - N95	Until 7 days after illness onset or until 24	HAI reported [1071], but route of transmission not established [823]. Assumed to be Contact transmission as for RSV since the viruses are

		hours after the resolution of fever and respiratory symptoms, whichever is longer	closely related and have similar clinical manifestations and epidemiology. ~~Wear masks according to Standard Precautions.~~
Impetigo	Contact	Until 24 hours after initiation of effective therapy	
Infectious mononucleosis	Standard		
Influenza Human (seasonal influenza)	Droplet - N95	Until 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer	See Prevention Strategies for Seasonal Influenza in Healthcare Settings (accessed September 2018). [Current version of this document may differ from original.] for current seasonal influenza guidance.
Influenza Avian (e.g., H5N1, H7, H9 strains)	Airborne + Contact + Droplet - N95	IPC consultation for duration of isolation	See [This link is no longer active: www.cdc.gov/flu/avian/professional/infect-control.htm. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (accessed September 2018).] for current avian influenza guidance.
Influenza Pandemic Influenza (also a human influenza virus)	Droplet - N95	IPC consultation for duration of isolation	See [This link is no longer active: http://www.pandemicflu.gov. Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection

			with Novel Influenza A Viruses Associated with Severe Disease (accessed September 2018).] for current pandemic influenza guidance.
Kawasaki syndrome	Standard		Not an infectious condition.
Lassa fever (see Viral Hemorrhagic Fevers)			
Legionnaires' disease	Standard		Not transmitted from person to person.
Leprosy	Standard		
Leptospirosis	Standard		Not transmitted from person to person.
Lice Head (pediculosis)	Contact	Until 24 hours after initiation of effective therapy	See [This link is no longer active: https://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm. Similar information may be found at CDC's Parasites – Lice (accessed September 2018).]
Lice Body	Standard		Transmitted person-to-person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance Parasites – Lice (accessed September 2018).
Lice Pubic	Standard		Transmitted person-to-person through sexual contact. See CDC's Parasites – Lice (accessed September 2018).
Listeriosis (listeria monocytogenes)	Standard		Person-to-person transmission rare; cross-transmission in neonatal settings reported. [1072-1075]
Lyme disease	Standard		Not transmitted from person to person.
Lymphocytic choriomeningitis	Standard		Not transmitted from person to person.
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person, except through transfusion rarely and through a failure to follow Standard Precautions during resident care. [1076-1079] Install screens in windows and doors in endemic areas. Use DEET- containing mosquito repellants and clothing to cover extremities.
Marburg virus disease (see Viral Hemorrhagic Fevers)			
Measles (rubeola)	Airborne	Until 4 days after onset of rash; duration of	Interim Measles Infection Control [July 2019] See Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings

		illness in immune compromised	Susceptible healthcare personnel (HCP) should not enter room if immune care providers are available; regardless of presumptive evidence of immunity, HCP should use respiratory protection that is at least as protective as a fit-tested, NIOSH-certified N95 respirator upon entry into the resident's room or care area. For exposed susceptibles, postexposure vaccine within 72 hours or immune globulin within 6 days when available [17, 1032, 1034]. Place exposed susceptible residents on Airborne Precautions and exclude susceptible healthcare personnel.
Melioidosis, all forms	Standard		Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see Enteroviral infections)	Standard		Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard		
Meningitis Fungal	Standard		
Meningitis Haemophilus Influenzae, type b known or suspected	Droplet - N95	Until 24 hours after initiation of effective therapy	
Meningitis Listeria monocytogenes (See Listeriosis)	Standard		
Meningitis Neisseria meningitidis (meningococcal) known or suspected	Droplet - N95	Until 24 hours after initiation of effective therapy	See Meningococcal Disease below.
Meningitis Streptococcus pneumoniae	Standard		

Meningitis M. tuberculosis	Standard		*Patient/Resident should be examined for evidence of active pulmonary tuberculosis. If suspect pulmonary tuberculosis – see Tuberculosis. Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne. For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see Tuberculosis below). [42]
Meningitis Other diagnosed bacterial	Standard		
Meningitis Varicella	Airborne		
Meningitis Unknown etiology	Droplet – N95	Until etiology is determined or Neisseria meningitidis is ruled out	
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet - N95	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks. [15, 17]
Middle East Respiratory Virus (MERS)	Airborne + Contact + Droplet – N95	IPC consultation for duration of isolation	
Molluscum contagiosum	Standard		
Mpox	Airborne + Contact	All lesions have crusted, those crusts have separated, and a fresh layer of healthy skin has formed underneath	See CDC's Monkeypox website (accessed May 2022) for information on infection prevention and control.

Mucormycosis	Standard		
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBL, ~~ESBLs~~, resistant S. pneumoniae, CRPA, CRAB, ~~Candida auris,~~ CP-CRE, CP-CRO)	Contact		MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 [870]. Contact state health department for guidance regarding new or emerging MDRO.
***For SNF**	Enhanced Barrier Precautions (EBP): 1. *Presence of indwelling devices (e.g., urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters)* *and/or* 2. *Wounds or presence of pressure ulcer (unhealed) that can be covered and contained* 3. *Residents infected and/or colonized with a*		Use of gowns and gloves for specific high contact care activities. • Morning and evening care • Device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter or providing medical treatments • Wound care • Mobility assistance and preparing to transfer from the room • Any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care • Changing bed linens • Any care activity involving contact with environmental surfaces likely contaminated by the resident, including cleaning and disinfection performed by environmental services (EVS) personnel. • In multi-bed rooms, consider each bed space as a separate room and change gowns and gloves and perform hand hygiene when moving from contact with one resident to contact with another resident. • Bundle high-contact care activities whenever possible.

	SFDPH targeted MDRO where contact precautions do not otherwise apply		• Dedicate daily-care equipment such as blood pressure cuffs, pulse oximeters, thermometers, and stethoscopes for use by only a single resident. Disinfect shared equipment after use on a resident and before removal from the room. • Visitors do not need to routinely wear gowns and gloves when visiting a resident on EBP; however, visitors should wear gowns and gloves if participating in high-contact care activities (e.g., assistance with bathing or toileting), especially if interacting with multiple residents. *Implement transmission-based precautions as necessary during an outbreak or for specific indications such as influenza or C.diff and for residents infected or colonized with an MDRO during an outbreak. In addition, public health may recommend Contact Precautions for residents infected or colonized with an MDRO not previously identified, or newly emerging in California or in the local health jurisdiction.
Mumps (infectious parotitis)	Droplet - N95	Until 5 days after the onset of swelling	Mumps [October 2017] Update: The Healthcare Infection Control Practices Advisory Committee (HICPAC) voted to change the recommendation of isolation for persons with mumps from 9 days to 5 days based on this 2008 MMWR report Updated Recommendations for Isolation of Persons with Mumps (accessed September 2018). After onset of swelling, susceptible HCWs should not provide care if immune caregivers are available. The below note has been superseded by the above recommendation update. Note: (Recent assessment of outbreaks in healthy 18–24-year-olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high-risk resident populations remain to be clarified.)

Mycobacteria, nontuberculosis (atypical)			Not transmitted person-to-person.
Mycobacteria, nontuberculosis (atypical) Pulmonary	Standard		
Mycobacteria, nontuberculosis (atypical) Wound	Standard		
Mycoplasma pneumonia	Droplet - N95	Duration of Illness	
Necrotizing enterocolitis	Standard		Add Contact Precautions when cases clustered temporally [1080-1083].
Nocardiosis, draining lesions, or other presentations	Standard		Not transmitted person-to-person.
Norovirus (see Gastroenteritis)			
Norwalk agent Gastroenteritis (see Gastroenteritis)			
Orf	Standard		
Parainfluenza virus infection, respiratory in infants and young children	Contact + Droplet - N95	Until 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer	Viral shedding may be prolonged in immunosuppressed residents [1009, 1010]. Reliability of antigen testing to determine when to remove patients/residents with prolonged hospitalizations from Contact Precautions uncertain.
Parechovirus	Contact + Droplet – N95	Duration of illness	
Parvovirus B19 (Erythema infectiosum)	Droplet - N95	Until 7 days after illness onset or until 24 hours after the resolution of	Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised resident. For residents with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients/residents

		fever and respiratory symptoms, whichever is longer	with persistently positive PCR not defined, but transmission has occurred [929].
Pediculosis (lice)	Contact	Until 24 hours after initiation of effective therapy after treatment	
Pertussis (whooping cough)	Droplet - N95	Until 5 days after initiation of effective antibiotic therapy	Single room preferred. Cohorting an option. Postexposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Recommendations for Tdap vaccine in adults under development. Tdap Vaccine Recommendations [2018] Update: Current recommendations can be found at Tdap / Td ACIP Vaccine Recommendations (accessed September 2018).
Pinworm infection (Enterobiasis)	Standard		
Plague (Yersinia pestis) Bubonic	Standard		
Plague (Yersinia pestis) Pneumonic	Droplet - N95	Until 48 hours after initiation of effective antibiotic therapy	Antimicrobial prophylaxis for exposed HCW [207].
Pneumonia Adenovirus	Droplet – N95 + Contact	Until 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms,	Outbreaks in pediatric and institutional settings reported [376, 1084-1086]. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus. [931]

		whichever is longer	
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard		
Pneumonia B. cepacia in residents with CF, including respiratory tract colonization	Contact	IPC consultation for duration of isolation	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline. [20]
Pneumonia B. cepacia in residents without CF (see Multidrug-Resistant Organisms)			
Pneumonia Chlamydia	Standard		
Pneumonia Fungal	Standard		
Pneumonia Haemophilus influenzae, type b Adults	Standard		
Pneumonia Haemophilus influenzae, type b Infants and children	Droplet - N95	Until 24 hours after initiation of effective therapy	
Pneumonia Legionella spp.	Standard		
Pneumonia . Meningococcal	Droplet - N95	Until 24 hours after initiation of effective therapy	See Meningococcal Disease above.
Pneumonia Multidrug-resistant bacterial (see Multidrug-Resistant Organisms)			
Pneumonia	Droplet - N95	Duration of illness	

Mycoplasma (primary atypical Pneumonia)			
Pneumonia Pneumococcal (Streptococcus pneumoniae) ~~pneumonia~~	Standard		Use Droplet Precautions if evidence of transmission within a patient/resident care unit or facility. [196-198, 1087]
Pneumonia Pneumocystis jiroveci (Pneumocystis carinii)	Standard		Avoid placement in the same room with an immunocompromised patient/resident.
Pneumonia Staphylococcus aureus	Standard		For MRSA, see MDROs.
Pneumonia Streptococcus, group A ~~Adults~~	Droplet - N95	Until 24 hours after initiation of effective therapy	See Streptococcal Disease (group A Streptococcus) below Contact Precautions if skin lesions present.
~~Pneumonia Streptococcus, group A Infants and young children~~	~~Droplet~~	~~Until 24 hours after initiation of effective therapy~~	~~Add Contact Precautions if skin lesions present.~~
Pneumonia Varicella-Zoster (See Varicella-Zoster)			
Pneumonia Viral Adults	Standard		
Pneumonia Viral Infants and young children (see Respiratory Infectious Disease, acute, or specific viral agent)			
Poliomyelitis	Contact	Duration of illness	
Pressure ulcer (decubitus ulcer, pressure sore) infected Major or Minor	Contact	Until drainage can be contained	

*For SNF:	Enhanced Barrier Precautions (EBP) *1. Presence of pressure ulcer (unhealed) that can be covered and contained*		Use of gowns and gloves for specific high contact care activities. • Morning and evening care • Device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter or providing medical treatments • Wound care • Mobility assistance and preparing to transfer from the room • Any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care • Changing bed linens • Any care activity involving contact with environmental surfaces likely contaminated by the resident, including cleaning and disinfection performed by environmental services (EVS) personnel. • In multi-bed rooms, consider each bed space as a separate room and change gowns and gloves and perform hand hygiene when moving from contact with one resident to contact with another resident. • Bundle high-contact care activities whenever possible. • Dedicate daily-care equipment such as blood pressure cuffs, pulse oximeters, thermometers, and stethoscopes for use by only a single resident. Disinfect shared equipment after use on a resident and before removal from the room. • Visitors do not need to routinely wear gowns and gloves when visiting a resident on EBP; however, visitors should wear gowns and gloves if participating in high-contact care activities (e.g., assistance with bathing or toileting), especially if interacting with multiple residents.

			*Implement transmission-based precautions as necessary during an outbreak or for specific indications such as influenza or C.diff and for residents infected or colonized with an MDRO during an outbreak. In addition, public health may recommend Contact Precautions for residents infected or colonized with an MDRO not previously identified, or newly emerging in California or in the local health jurisdiction.
Prion disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) (Chlamydia psittaci)	Standard		Not transmitted from person to person.
Q fever	Standard		
Rabies	Standard		Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported [539, 1088]. If resident has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis. [1089]
Rat-bite fever (Streptobacillus moniliformis disease, Spirillum minus disease)	Standard		Not transmitted from person to person.
Relapsing fever	Standard		Not transmitted from person to person.
Resistant bacterial infection or colonization (see Multidrug-Resistant Organisms)			
Respiratory infectious disease, acute (if not covered elsewhere) Adults	~~Standard~~Contact + Droplet - N95		
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Droplet - N95	Until 7 days after illness onset or until 24 hours after the resolution of	Also see syndromes or conditions listed in Table 2.

		fever and respiratory symptoms, whichever is longer	
Respiratory syncytial virus infection	Contact + Droplet - N95	Until 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer	Wear mask according to Standard Precautions [24] CB [116, 117]. In immunocompromised patients/residents, extend the duration of Contact Precautions due to prolonged shedding [928]. Reliability of antigen testing to determine when to remove patient/residents with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	Standard		Not an infectious condition.
Rheumatic fever	Standard		Not an infectious condition.
Rhinovirus	Droplet - N95	Until 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer	Droplet most important route of transmission [104 1090]. Outbreaks have occurred in NICUs and LTCFs [413, 1091, 1092]. c (e.g., young infants) [111, 833].
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard		Not transmitted from person to person except through transfusion, rarely.
Rickettsialpox (vesicular rickettsiosis)	Standard		Not transmitted from person to person.

Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard		Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU [1093], rehabilitation hospital [1094]. Use Contact Precautions for outbreak.
Rocky Mountain spotted fever	Standard		Not transmitted from person to person except through transfusion, rarely.
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard		
Rotavirus infection (see Gastroenteritis)			
Rubella (German measles) (also see Congenital Rubella)	Droplet - N95	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant women who are not immune should not care for these patients/residents [17, 33]. Administer vaccine within 3 days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients/residents on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of postexposure vaccine.
Rubeola (see Measles)			
Salmonellosis (see Gastroenteritis)			
Scabies (not crusted)	Contact	Until 24 hours after initiation of effective therapy	
Scabies, Crusted (Norwegian)	Contact	Until skin scrapings are negative and cleared by dermatology	
Scalded skin syndrome, staphylococcal	Contact	Duration of illness	See Staphylococcal Disease, scalded skin syndrome below.
Schistosomiasis (bilharziasis)	Standard		

Severe acute respiratory syndrome (SARS)	Airborne + Droplet - N95 + Contact	Duration of illness plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	N95 or higher respiratory protection; eye protection (goggles, face shield); aerosol-generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets [93, 94, 96]. Vigilant environmental disinfection (see [This link is no longer active: www.cdc.gov/ncidod/sars. Similar information may be found at CDC Severe Acute Respiratory Syndrome (SARS) (accessed September 2018).])
Shigellosis (see Gastroenteritis)			
Shingles (See Herpes Zoster)			
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact	Duration of illness	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective [108, 129, 1038-1040].
Sporotrichosis	Standard		
Spirillum minor disease (rat-bite fever)	Standard		Not transmitted from person to person.
Staphylococcal disease (S. aureus) Skin, wound, or burn Major	Contact	Duration of illness	Until drainage stops or can be contained by dressing.
Staphylococcal disease (S. aureus) Skin, wound, or burn Minor or limited (See Wound Infection)	Standard		If dressing covers and contains drainage adequately.
Staphylococcal disease (S. aureus) Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness.
Staphylococcal disease (S. aureus) Multidrug-resistant (see Multidrug-Resistant Organisms)			
Staphylococcal disease (S. aureus) Pneumonia	Standard		

Staphylococcal disease (S. aureus) Scalded skin syndrome	Contact	Duration of illness	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (S. aureus) Toxic shock syndrome	Standard		
Streptobacillus moniliformis disease (rat-bite fever)	Standard		Not transmitted from person to person.
Streptococcal disease (group A Streptococcus) Skin, wound, or burn Major (See Wound Infection)	Contact + Droplet - N95	Until 24 hours after initiation of effective therapy	Until drainage stops or can be contained by dressing.
Streptococcal disease (group A Streptococcus) Skin, wound, or burn Minor or limited (See Wound Infection)	Standard		If dressing covers and contains drainage.
Streptococcal disease (group A Streptococcus) Endometritis (puerperal sepsis)	Standard		
Streptococcal disease (group A Streptococcus) Pharyngitis in infants and young children	Droplet - N95	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A Streptococcus) Pneumonia	Droplet - N95	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A Streptococcus) Scarlet fever in infants and young children	Droplet - N95	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A Streptococcus) Serious invasive disease	Droplet - N95	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among residents and healthcare personnel [162, 972, 1096-1098].

			Contact Precautions for draining wound as above; follow recommendations for antimicrobial prophylaxis in selected conditions [160].
Streptococcal disease (group B Streptococcus), neonatal	Standard		
Streptococcal disease (not group A or B) unless covered elsewhere. Multidrug-resistant (see Multidrug-Resistant Organisms)			
Strongyloidiasis	Standard		
Syphilis Latent (tertiary) and seropositivity without lesions	Standard		
Syphilis Skin and mucous membrane, including congenital, primary, Secondary	Standard		
Tapeworm disease Hymenolepis nana	Standard		Not transmitted from person to person.
Tapeworm disease Taenia solium (pork)	Standard		
Tapeworm disease Other	Standard		
Tetanus	Standard		Not transmitted from person to person.
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard		Rare episodes of person-to-person transmission.
Toxoplasmosis	Standard		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare.
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A Streptococcus is a likely etiology.
Trachoma, acute	Standard		

Transmissible spongiform encephalopathy (see Creutzfeld-Jacob disease, CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (M. tuberculosis) Extrapulmonary, draining lesion	Airborne + Contact		Discontinue precautions only when patient/resident is improving clinically, and drainage has ceased or there are 3 consecutive negative cultures of continued drainage [1025, 1026]. Examine for evidence of active pulmonary tuberculosis.
Tuberculosis (M. tuberculosis) Extrapulmonary, no draining lesion, Meningitis	Standard		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out. [42]
Tuberculosis (M. tuberculosis) Pulmonary or laryngeal disease, confirmed	Airborne	Once cleared via SFDPH TB Clinic~~1.~~	Discontinue precautions only when patient/resident on effective therapy is improving clinically and has 3 consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-17 Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005) (accessed September 2018) [12].
Tuberculosis (M. tuberculosis) Pulmonary or laryngeal disease, suspected	Airborne	Discontinue precautions only when the likelihood of TB disease is deemed negligible, and either 1. There is another diagnosis that explains the	~~Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either:~~ ~~1. There is another diagnosis that explains the clinical syndrome or,~~ ~~2. The results of 3 sputum spears for AFB are negative.~~ ~~Each of the 3 sputum specimens should be collected 8-24 hours apart, and at least 1 should be an early morning specimen.~~

		clinical syndrome or 2. The results of 3 sputum smears for AFB and 1 MTB PCR are negative *Each of the 3 sputum specimens should be collected 8-24 hours apart, and at least 1 early morning specimen.	
Tuberculosis (M. tuberculosis) Skin-test positive with no evidence of current active disease	Standard		
Tularemia Draining lesion	Standard		Not transmitted from person to person.
Tularemia Pulmonary	Standard		Not transmitted from person to person.
Typhoid (Salmonella typhi) fever (see Gastroenteritis)			
Typhus Rickettsia prowazekii (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact.
Typhus Rickettsia typhi	Standard		Not transmitted from person to person.

Urinary tract infection (including pyelonephritis), with or without urinary catheter	Standard		
Vaccinia			Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
Vaccinia Vaccination site care (including autoinoculated areas)	Standard		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes. [205, 221, 225].
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Progressive vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Postvaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact		Use Contact Precautions if there is copious drainage.
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		

Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infectious condition.
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., S. aureus, group A beta hemolytic Streptococcus)	Contact		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage.
Varicella Zoster (Chickenpox)	Airborne + Contact	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection (i.e., surgical mask or respirator) for susceptible HCWs. In immunocompromised host with varicella pneumonia, prolong duration of precautions for duration of illness. Varicella Post-exposure Prophylaxis Update [April 2019] Update: Postexposure prophylaxis: provide postexposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5 days before delivery or within 48 hours after delivery) provide varicella zoster immune globulin as soon as possible after exposure and within 10 days. Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received varicella zoster immune globulin, regardless of postexposure vaccination. [1036]
Variola (see Smallpox)			
Vibrio parahaemolyticus (see Gastroenteritis)			
Vincent's angina (trench mouth)	Standard		

Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Airborne + Contact + Droplet - N95	IPC consultation for duration of isolation	Ebola Virus Disease for Healthcare Workers [2014] Update: Recommendations for healthcare workers can be found at Ebola For Clinicians. (accessed September 2018). Single-resident room with the door closed with a log of all people entering the room. Emphasize: 1. use of sharps safety devices and safe work practices, 2. hand hygiene. 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles, or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected [212, 314, 740, 772]. Also see Table 3C for Ebola as a bioterrorism agent.
Viral respiratory diseases (not covered elsewhere) Adults	Standard		
Viral respiratory diseases (not covered elsewhere) Infants and young children (see Respiratory infectious disease, acute)			
Whooping cough (see Pertussis)			
Wound infections Major or Minor _____ *For SNF	Contact _____ Enhanced Barrier Precautions (EBP)	Until drainage can be contained _____	_____ Use of gowns and gloves for specific high contact care activities. • Morning and evening care

	1. Presence of a wound (unhealed) that can be covered and contained		• Device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter or providing medical treatments • Wound care • Mobility assistance and preparing to transfer from the room • Any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care • Changing bed linens • Any care activity involving contact with environmental surfaces likely contaminated by the resident, including cleaning and disinfection performed by environmental services (EVS) personnel. • In multi-bed rooms, consider each bed space as a separate room and change gowns and gloves and perform hand hygiene when moving from contact with one resident to contact with another resident. • Bundle high-contact care activities whenever possible. • Dedicate daily-care equipment such as blood pressure cuffs, pulse oximeters, thermometers, and stethoscopes for use by only a single resident. Disinfect shared equipment after use on a resident and before removal from the room. • Visitors do not need to routinely wear gowns and gloves when visiting a resident on EBP; however, visitors should wear gowns and gloves if participating in high-contact care activities (e.g., assistance with bathing or toileting), especially if interacting with multiple residents. *Implement transmission-based precautions as necessary during an outbreak or for specific indications such as influenza or C.diff and for residents infected or colonized with an MDRO during an outbreak.

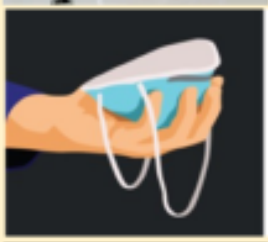
			In addition, public health may recommend Contact Precautions for residents infected or colonized with an MDRO not previously identified, or newly emerging in California or in the local health jurisdiction.
Yersinia enterocolitica Gastroenteritis (see Gastroenteritis)			
Zika	Standard		
Zoster (varicella-zoster) (see Herpes Zoster)			
Zygomycosis (phycomycosis, mucormycosis)	Standard		Not transmitted person-to-person.

Appendix B: Donning and Doffing Mask

Putting on a mask with head straps

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

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



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

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

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

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

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

Image credit: The CDC (https://blogs.cdc.gov/publichealthmatters/2019/05/using-a-respirator/)

Taking off a mask with head straps

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

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

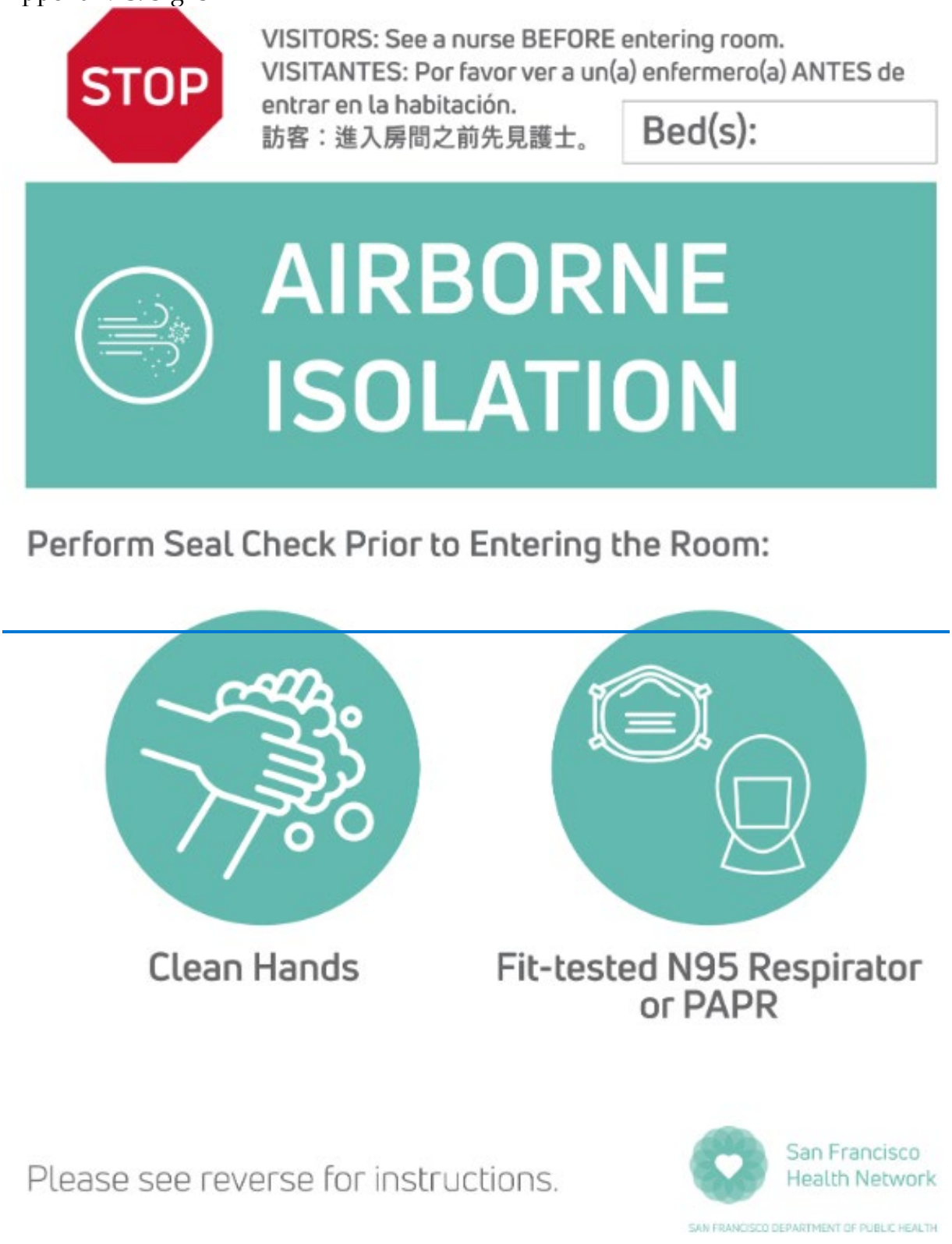
2. **Remove by pulling the bottom strap over the back of your head,** followed by the top strap. Remember, do not touch the facepiece of the mask.

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

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

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

Appendix C: Signs



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

Bed(s):

AIRBORNE ISOLATION

Perform Seal Check Prior to Entering the Room:

Clean Hands

Fit-tested N95 Respirator or PAPR

Door to Room Must Remain Closed

Please see reverse for instructions.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH


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


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

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

Bed(s):

DROPLET-N95 ISOLATION

Prior to Entering the Room:

Clean Hands

N95 Mask

Eye Protection

Please see reverse for instructions.

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH


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


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


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

STOP

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

Bed(s):

Enhanced Barrier Precautions

Prior to Entering the Room:

Perform Hand Hygiene

Anyone Participating in Any of the **6** Moments Must Also:
Don Gown and Gloves

Please see reverse for instructions.

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

~~Appendix C: Isolation Signage~~

SCABIES MANAGEMENT

POLICY:

It is the policy of Laguna Honda Hospital & Rehabilitation (LHH) to provide preventative measures for scabies transmission, and to manage a scabies outbreak by implementing measures to diagnosis, reduce spread and provide safe and effective treatment to those affected by scabies based on current best practices as outlined by the Centers of Disease Prevention and Control (CDC).

The Infection control nurse (ICN)/team will collaborate with physician~~'~~s and other interdisciplinary teams to promptly investigate and identify cases to reduce the spread of scabies outbreak.

PURPOSE:

The purpose of this policy is to provide information to Healthcare workers (HCW) to aid in the surveillance of scabies for prompt identification, and treatment thereby reducing transmission to others.

PROCEDURE:

1. Prevention through Education

a. Human scabies is caused by an infestation of the skin by the human itch mite (Sarcoptes scabiei var. hominis). The microscopic scabies mite burrows into the upper layer of the skin where it lives and lays its eggs

b. The most common symptoms of scabies includes itching and a skin rash, caused by sensitization to the proteins of the parasite.

c. Severe itching (pruritus) is the earliest and most common symptom of scabies:

   i. night shift HCW are often the first to be alerted to symptoms of nocturnal restlessness, scratching, and complaints of itching as the mite become more active at night

   ii. screening during shower is an effective method to assess between the folds of skin where the mite often burrows

d. Scabies is easily transmissible in close living conditions and HCW's must utilize Standard Precautions for all patient/resident care

e. Transmission-based precautions (TBP) should be added for suspicion of scabies until ruled out

f. Scabies is not indicative of hygiene practices or cleanliness- handwashing alone will not prevent the transmission of scabies

g. Scabies is more prevalent in congregate settings such as long-term care and suspicious rashes should be reported immediately to the physician to rule out scabies

2. Two forms of Scabies

a. Non-crusted Scabies

i. The more common, milder form of scabies

ii. Is identifiable with symptoms of itching with a rash that may represent only a few mites depending on the infestation

iii. Can affect any age group but common in congregate close living environments such as nursing homes and schools

iv. Is identifiable by the more common symptoms of itching and rash generally found on hands, feet, groin, breast areas, between fingers and toes

b. Crusted (Norwegian) Scabies

i. A more severe form of the same mite infestation that primarily affects those who are immunocompromised, elderly, disabled, or debilitated

ii. Crusted scabies present with thick crusts of skin that contain large numbers of scabies mites and eggs that resemble red or white scaly patches found on the hands, feet, knees and elbow. In a severe form, the plaques can resemble a cauliflower-like appearance on the skin, hands, feet, elbows or knees.

iii. Crusted Scabies is not associated with the severe itching or rash-like appearance of non-crusted scabies.

iv. The mites in crusted scabies are not more virulent than in non-crusted scabies; however, they are much more numerous (up to 2 million per patient) and considered highly contagious.

3. Transmission

a. Non-Crusted scabies is spread by direct, prolonged skin-to-skin contact

b. Crusted (Norwegian) scabies can be spread by indirect contact (clothes, bedding etc.) and may require a shorter period of direct contact

c. First-time infestations may take 2- 6 weeks for symptoms (pruritis and rash) to appear due to the initiation of the immune response but the individual may still spread the mite to others during this time

d. Immunocompromised patient/resident, the frail and elderly produce a less robust immune response and may not exhibit the usual symptoms of itching and rash.

e. HCW should be alert for restlessness or other behaviors not normally observed and report suspicions to ICP team and medical provider for increased surveillance and monitoring.

4. Screening

a. Skin assessments are performed upon admission or transfer from another facility

b. Signs and Symptoms to report if scabies is suspected

i. Non-crusted scabies:

- Pruritis (intense itching) with Rash is the predominant symptom
- Report suspicious rashes, particularly between fingers and toes, axilla, belt line, under breasts and perineal areas
- Rash: The scabies rash varies and may appear as small lines, red, raised bumps (papules), pustules or blisters or may appear as red or brown “tracking” where the mite burrows and moves under the skin

ii. Crusted scabies

- Presents with less or no itching
- Rash may appear as thick white or cream colored heavily crusted (dry) areas of the skin instead of the typical tracking rash

5. Treatment ~~Options~~

a. Non-crusted scabies

i. For suspected or confirmed cases, initiate Transmission-based (Contact) Precautions ~~until scabies is ruled out~~

ii. Provider will determine appropriate treatment~~Can be treated using a cream or lotion scabicide and applied as directed, usually twice per day~~

~~iii. General instructions include application of the medication over the external body from the neck down. It is important to use the medication as directed and using the amount specified over the entire external body as mites may migrate to unmedicated areas and cause re-infestation~~

~~iv.~~iii. The next day have the patient/resident shower, change bed linens and wear clean clothing

~~v.~~iv. If additional treatment ~~second application~~ is required, apply medication as directed and repeat the shower, change of bed linens and fresh clothing

~~vi.~~v. Pain and discomfort (itching) should also be considered for treatment

~~vii.~~vi. Monitor the patient/resident for secondary bacterial skin infection from scratching

~~viii.~~vii. Report increased pain, fever, increased redness, or discharge from the rash site to the physician.

b. Crusted scabies

i. For suspected or confirmed cases, initiate Transmission-based (Contact) Precautions until scabies is ruled out

ii. Large numbers of mites create a very contagious condition resulting in the potential to spread scabies through only a brief direct skin-to-skin contact.

iii. Patients/residents with crusted scabies should receive quick and aggressive medical treatment for their infestation to prevent an outbreak of scabies

~~iv. Treatment may include the use of a cream or lotion scabicide as well as oral treatments.~~

~~v.~~iv. Treatments may be prolonged until the physician has determined there is no longer any mites present.

~~vi.~~v. Nursing will confer with the ICP team and physician before discontinuing Transmission-based (Contact) Precautions TBP may be in place for extended periods (months) of time for severe cases.

~~vii.~~vi. Monitor the patient/resident for secondary bacterial skin infection from scratching Report increased pain, fever, increased redness, or discharge from the rash site to the physician.

6. Outbreak Management

a. Definition of Outbreak

   i. Two (2) or more confirmed cases OR

   ii. One (1) confirmed case and at least two (2) suspect cases occurring among patients/residents, health care workers (HCW), visitors or volunteers during a 2-week period should be considered an outbreak of scabies

b. Contact ICP team immediately with suspected cases for considerations of isolation precautions based on each individual care needs including TBP and Personal protective equipment (PPE) required

c. Contact the physician for skin testing if needed, and begin treatments- aggressive treatments should be considered for crusted scabies including comfort measures for pain and itching

d. ICP will report the scabies outbreak to the local and state health department per CDPH title 17 California Code of Regulations §2500 that requires facilities to report outbreaks

e. ICP will collaborate with nursing staff to coordinate additional skin assessment needs for others on the unit including HCW for potential contact

f. Notification of the clinical, medical, pharmaceutical and EVS leadership for potential contact tracing needs and for resources should additional cases be identified

g. Contact Precautions may be required for up to several weeks until the determination is made that the mites have been eradicated. This may require both oral and topical scabicidal medications with repeated applications and/or other antipruritic/anti-inflammatory medications for secondary infections

7. HCW/Staff Exposure or Diagnosis:

a. Staff must report any known exposure to their supervisor/ICP team such as family members living in the same home as soon as possible

b. Nurse management will refer exposed staff to Occupational Health for further diagnosis and/or treatment options

c. Staff may not return to work until cleared by Occupational Health

d. Nurse manager will report the exposure to the ICP/team

8. Patient/resident Exposure or Diagnosis

a. ICP team and medical provider will be notified immediately for a patient/resident scabies diagnosis or suspected case

b. Contact Precautions will be implemented without delay for suspected cases even without a diagnosis

c. The medical provider will determine testing needs which may include skin scrapings, but treatment should not be delayed while awaiting results

d. Rooms used by a patient/resident with crusted scabies should be thoroughly cleaned and vacuumed daily during treatment and while in Contact Precautions

e. Terminal cleaning requires thorough cleaning and vacuuming and after use but environmental disinfestation using pesticide sprays or fogs generally is unnecessary

f. Contact the local / state health department for control measures if continuous transmission or frequent outbreaks are occurring.

9. Treatment

~~a. Empirical treatment should be initiated before the lab results are available for highly suspicious rashes or crusted growths.~~

~~b.~~a. Notify pharmacy department for potential large volume medication needs

~~c.~~b. A physician's order is required for treatment following current CDC guidelines for appropriate medications

~~d.~~c. Mass treatment may be required for large exposures/outbreaks and will be managed in conjunction with the medical team and local health department

~~e.~~d. Pharmacy will provide support for bulk orders in the event of outbreak

~~f.~~e. Treatments and Contact Precautions will be discontinued on a case-by-case when there is no further evidence of transmission or active disease as determined by the physician in collaboration with ICP.

~~g.~~f. Considerations for discontinuing Contact Precautions include but are not limited to infestation type, cognitive ability of the patient/resident to effectively and consistently adhere to precautions, new infection versus re-infection, co-morbidities of the patient/resident and immune response.

10. Cleaning and Disinfection

a. Considerations for EVS cleaning and disinfection practices will include a single case of non-crusted, any crusted (Norwegian) case(s), and outbreak

b. After a diagnosis of scabies infestation is made either by suspicious rash, skin scraping or both, notify neighborhood staff, including EVS, in order to coordinate interventions.

c. If more than one case of scabies is diagnosed within 2 weeks of another case among patients/residents, staff, or visitors, then coordination among interdisciplinary department heads/ designees is warranted following A8 Outbreak/Epidemic Investigation Protocol and A9 Contact/Exposure Investigation.

d. Bedding, clothing, and towels used by infested persons ~~or their household, sexual,~~ and close contracts anytime during the 3 days before treatment should be laundered.~~decontaminated by machine washing in hot water and drying using the hot dryer cycle (or dry clean)~~.

e. Items that cannot be laundered can be treated by storing in a closed plastic bag for one week. Scabies mites generally do not survive more than 2-3 days away from human skin.

f. Change all bed linens before returning patient/resident to bed after the scabicide has been showered off 8-14 hours after application.

g. Environmental cleaning of rooms used by patients/residents with scabies includes thorough cleaning and vacuuming by personnel wearing long sleeved gown and gloves.

h. In addition to bed stripping and bedside cleaning, Nursing staff shall replace disposable personal care items such as oral hygiene equipment, water pitcher, urinal/ bedpan and personal disposable blood pressure cuff.

i. Usual disinfection is adequate for non-disposable items, such as wheelchairs, glasses. Disinfect wheelchair according to usual wheelchair cleaning procedure.

j. EVS shall clean the room and bathroom, including chairs and toilet seats, according to usual procedures and remove and replace the cubicle curtains in the room and bathroom. Request for vacuuming of upholstered surfaces that may have come in contact with infested or exposed patient(s)/resident(s). Use dedicated vacuum; empty bag and wipe down vacuum when finished vacuuming.

k. Post-treatment assessment is conducted by the Infection Control Nurse to determine if treatment was effective. The intensity of the rash and pruritus should gradually resolve over a 7-14 day period. Crusted scabies may require multimodal treatments, longer periods of contact isolation and a longer time for symptoms to resolve. If signs and symptoms persist or intensify or if new lesions are identified

within 7-14 days, treatment failure should be considered, and alternative treatments applied.

l. Document in the electronic health record procedures, medications used, description of patient's/resident's skin and reaction to treatment. Record and describe any allergic symptoms or persistent pruritis.

m. Nursing completes an Incident report. Include skin description and any medication prescribed. If this is a newly admitted patient/resident, include the name of the facility and the unit the patient/resident came from.

ATTACHMENT:
None

REFERENCE:
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 A9 Contact/ Exposure Investigation
CDC Scabies available at
https://www.cdc.gov/scabies/about/index.html
California Department of Public Health Division of Communicable Disease Control, Prevention and Control of Scabies in California Healthcare Settings, August 2020 available at
https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/PrevControlScabiesHealthcare.pdf

Revised: 01/12/16, 10/13/20, 10/2023/01, 03/25/02, 01/20/26 (Month/Day/Year)

Original adoption: 11/01/05

PEDICULOSIS (LICE) MANAGEMENT

POLICY:

1. Admission screening is performed, including observing the skin and hair for abnormalities that may including evidence of lice infestation.

2. The Infection Control Nurse is to be informed of suspected or confirmed cases of lice for room placement options. Private room with a private bathroom is preferred.

3. Contact Precautions should be implemented when lice are suspected or confirmed and continued for 24 hours post-treatment. Re-treatment may be needed 9-10 days after initial treatment.

DEFINITON:

There are three (3) distinct types of lice that are human parasites: body lice, head lice and pubic lice. Treatments will be specific to the type of lice after a diagnosis is made by a healthcare professional trained in identifying. Life cycle stages are important considerations for treatment options.

1. Live Cycle Stages:

    a. **Nits**: Nits are lice eggs. They can be hard to see and are found firmly attached to the hair shaft. They are oval-shaped and very small (about the size of a knot in thread), hard to see, and are usually yellow to white.

    b. **Nymph**: A nymph is an immature louse that hatches from the nit. A nymph looks like an adult head louse but is smaller.

    c. **Adult**~~: An adult~~: Adult hair and body louse is about the size of a sesame seed, has six legs, and is tan to grayish-white in color. An adult pubic louse resembles a miniature crab when viewed through a strong magnifying glass. Pubic lice have six legs; their two front legs are very large and look like the pincher claws of a crab. Pubic lice are tan to grayish-white in color.

2. Transmission and Disease:

    a. Head and pubic lice are not known to spread disease. The itching may lead to excessive scratching that can sometimes increase the chance of a secondary skin infection.

    b. Body lice can spread epidemic typhus, trench fever, and louse-borne relapsing fever, all which are no longer widespread.

c. Body Lice: Spread through direct physical contact with a person who has body lice or through contact with articles such as clothing, beds, bed linens, or towels that have been in contact with an infested person.

d. Head Lice: Usually spread by head-to-head contact with an already infested person. Head lice can also be spread by sharing clothing or belongings. This happens when lice crawl, or nits attached to shed hair hatch, and get on the shared clothing or belongings.

e. Pubic Lice: Usually spread through sexual contact. Pubic lice can also be spread by close personal contact or contact with articles such as clothing, bed linens, or towels that have been used by an infested person.

3. Signs and symptoms

a. **Body Lice**: Intense itching or pruritus and rash caused by an allergic reaction to the louse bites are common symptoms. When body lice infestation has been present for a long time, heavily bitten areas of the skin can become thickened and discolored, particularly around the midsection of the body (waist, groin, upper thighs);

b. **Head Lice**: Tickling feeling of something moving in the hair, itching caused by an allergic reaction to the bites of the head louse, irritability and difficulty sleeping as head lice are most active in the dark, and sores on the head caused by scratching.

c. **Pubic Lice**: Itching in the genital area and visible nits (lice eggs) or crawling lice.

PURPOSE:

To promptly identify, treat, and report lice infestations to prevent transmission to others.

PROCEDURE:

1. Head Lice:

a. Do not transmit communicable diseases.

b. Do not jump or fly; they can only crawl.

c. Prevalence of infestation is no different in individuals with long hair than in those with short hair; cutting hair is not necessary to control head lice.

d. Seldom occur on eyebrows or eyelashes

e. Infest persons from all socioeconomic levels, without regard for age, race, sex or standards of personal hygiene.

f. Do not come from animals or pets.

g. Not usually spread by contact with clothing (such as hats, scarves, coats) or other personal items (such as combs, brushes, or towels).

h. Is diagnosed best by finding a live nymph or adult louse on the scalp or hair of a person.

   i. Because nymphs and adult lice are very small, move quickly, and avoid light, they can be difficult to find.

   ii. Use of a magnifying lens and a fine-toothed comb may be helpful to find live lice.

i. Can also be diagnosed if crawling lice are not seen. Finding eggs (also called nits) firmly attached within a 1/4 inch of base of the hair shafts strongly suggests, but does not confirm, that a person is infested and should be treated.

j. Eggs that are attached more than 1/4 inch from the base of the hair shaft are almost always dead or already hatched.

k. Eggs are often confused with other things found in the hair such as dandruff, hair spray droplets, and dirt particles.

l. If no live nymphs or adult lice are seen, and the only eggs found are more than 1/4 inch from the scalp, the infestation is probably old and no longer active and does not need to be treated.

m. Diagnosis should be made by a healthcare provider, or other person trained to identify live head lice.

~~2. Treatment for HEAD LICE~~

~~a. Staff who are pregnant or nursing should not encounter topical medications containing Malathion, Check the labels for ingredients and consider non-pregnant/ non-nursing staff for treatment options.~~

~~b. Treatment for head lice is recommended for patient/residents diagnosed with an active infestation.~~

~~c. Before applying treatment, remove clothing that can become wet or stained during treatment and use a hospital gown during treatment period.~~

~~d. Do Not shampoo hair prior to treatment; Follow the directions on the label. Many treatments must be applied to dry hair.~~

~~e. Don proper PPE including gown and gloves for Contact Precautions~~

~~f. Obtain lice medicine, also called pediculicide and use as directed.~~

~~g. Review the directions contained in the box or printed on the label prior to beginning treatment; do not assume all treatments are the same as treatments vary by manufacturers.~~

~~h. Improper application may result in the medication not being effective.~~

~~i. A second bottle of pediculicide may be required for very long hair (greater than shoulder length). Obtain a second bottle before beginning treatment if indicated.~~

~~j. Follow the directions closely on the label or in the box regarding how long the medication should be left on the hair and how it should be washed out, usually after 8-12 hours.~~

~~k. Use the full amount listed on the label to treat; do not attempt to "save" or "split the dose" of the medication.~~

- ~~Not using the proper amount may lead to the treatment not completely killing the lice.~~

~~l. For liquid medications/lotions: generally, coat the hair until thoroughly wetted with the medication being particularly careful behind the ear and on the back of the head and neck.~~

~~m. The manufacturer generally recommends leaving the medication on the hair, uncovered, for 8–12 hours.~~

~~n. Allow the hair to dry naturally; do not use an electrical heat source, including a hair dryer or curling iron while the hair is wet.~~

~~o. Do not cover the head with plastic or shower caps.~~

~~p. Shoulders should be covered with a towel to prevent dripping.~~

~~Have the patient/resident put on clean clothing once the medication has been applied/dry.~~

~~Consider treating just before bedtime allowing time for the lotion/medication to dry before retiring to bed, depending on hair length.~~

~~Do not place medication / lotion on other areas of hair on the body (eyebrows, pubic area, chest, under arms)~~

~~Avoid medication near eyes~~

~~Remove and discard PPE after treatment; perform HH.~~

~~In 8-12 hours or next morning, Don PPE for Contact Precautions prior to continuing treatment including gown and gloves.~~

~~After 8–12 hours thoroughly shampoo the hair (the shower is preferred)~~

- ~~rinse well and~~
- ~~use a fine-toothed nit comb, usually included in the package, to remove dead lice and nits from the hair.~~
- ~~if a second treatment is required, the physician will need to re-order the second application, either the same or a different type and use according to manufacturer's directions~~

~~q. Have the patient/resident wear clean clothes and change the bed linens before re-entering the bed.~~

~~**3. Retreatment of head lice**~~

~~a. Is usually recommended 9-10 days after initial treatment because no approved pediculicide is completely ovicidal (able to kill unhatched nits).~~

~~b. To be most effective, retreatment should occur after all eggs have hatched but before new eggs are produced.~~

~~c. The retreatment schedule can vary depending on the pediculicide used. Follow the directions on the label/ manufacturer's directions.~~

~~4.~~2. Laundry and EVS Measures:

a. Ensure laundering of ~~Machine wash and dry~~ clothing, bed linens, and other items that the patient/resident wore or used during the 2 days before treatment ~~using the hot water laundry cycle and the high heat drying cycle.~~ .

b. Clothing and items that are not washable can be dry–cleaned OR sealed in a plastic bag and stored for 2 weeks.

c. Soak combs and brushes in hot water for 5–10 minutes. Do not share combs.

~~c.~~d. Vacuum the floor and furniture, particularly where the infested person sat or lay. However, the risk of getting infested by a louse that has fallen onto a rug or carpet or furniture is very small. Head lice survive less than 1–2 days if they fall off a person and cannot feed;

~~d.~~e. Nits cannot hatch and usually die within a week if they are not kept at the same temperature as that found close to the human scalp.

~~e.~~f. Do not use fumigant sprays; they can be toxic if inhaled or absorbed through the skin.

~~5.~~3. Document in the electronic health record procedures, medications used, description of the patient/resident's skin and reaction to treatment. Record and describe any allergic symptoms.

~~6.~~4. If the patient/resident has a reaction to treatment, nursing completes an Incident report. Include hair and skin description and any medication prescribed. If this is a newly admitted patient/resident, include the name of the facility and the unit the patient/resident came from.

~~**Body Lice Treatment**~~

~~Improved hygiene and access to regular changes of clean clothes is the only treatment needed for body lice infestations.~~

~~**Contact Precautions will be in effect until the IP nurse/ team collaborate with the physician when precautions may be discontinued. nsure laundering of those items that the infested person used during the 2–3 days before treatment.**~~

~~**Pubic Lice Treatment**~~

~~**Contact Precautions should be in effect during the treatment period; Contact the IP nurse/team to collaborate with physician when precautions may be discontinued**~~

~~**Treatments should be initiated as soon as possible after diagnosis is made**~~

~~**Don appropriate PPE for Contact Precautions including gown and gloves**~~

~~**Wash the infested area; towel dry.**~~

~~Carefully follow the instructions in the package or on the label. Thoroughly saturate the pubic hair and other infested areas with lice medication. Leave medication on hair for the time recommended in the instructions. After waiting the recommended time, remove the medication by following carefully the instructions on the label or in the box.~~

~~Following treatment, most nits will still be attached to hair shafts. Nits may be removed by using a fine-toothed comb.~~

~~Have the patient/resident put on clean underwear and clothing after treatment.~~

~~To kill any lice or nits remaining on clothing, towels, or bedding, machine-wash and machine-dry those items that the infested person used during the 2–3 days before treatment. Use hot water and the hot dryer cycle.~~

~~a. Items that cannot be laundered can be dry-cleaned or stored in a sealed plastic bag for 2 weeks.~~

~~b. All sex partners from within the previous month should be informed that they are at risk for infestation and should be treated.~~

~~c. Persons should avoid sexual contact with their sex partner(s) until both they and their partners have been successfully treated and reevaluated to rule out persistent infestation.~~

~~d. Repeat treatment in 9–10 days if live lice are still found.~~

~~e. Persons with pubic lice should be evaluated for other sexually transmitted diseases (STDs).~~

~~f. For lice or nits on the eyelashes, careful application of ophthalmic-grade petrolatum ointment to the eyelid margins 2–4 times a day for 10 days is effective. Regular petrolatum (e.g., Vaseline) * should not be used because it can irritate the eyes if applied.~~

ATTACHMENT:
None.

REFERENCE:
Centers for Disease Control and Prevention About Lice available at:
https://www.cdc.gov/lice/about/
Centers for Disease Control and Prevention Body Lice available at:
https://www.cdc.gov/lice/about/body-lice.html
Centers for Disease Control and Prevention Head Lice available at:
https://www.cdc.gov/lice/about/head-lice.html
Centers for Disease Control and Prevention Pubic Lice available at:
https://www.cdc.gov/lice/about/pubic-lice.html

Revised: 07/12/16, 03/12/19, 10/13/20, 01/10/23 09/13/2023, 01/09/24, 02/03/25, 01/20/26 (Month/Day/Year)

Original adoption: 11/01/05

CLOSTRIDIOIDES DIFFICILE GUIDELINES

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) will provide prevention measures through education to HCP to identify, report, and manage *Clostridioides difficile (C. diff)* infection in accordance with Centers for Disease Control (CDC) guidelines and in collaboration with the Infection Preventionist (IP) and medical staff.

PURPOSE:

To provide guidance for the prevention and management of outbreaks of *Clostridioides difficile* infection in accordance with evidence-based practices provided by the Centers for Disease & Control (CDC).

PROCEDURE:

1. Prevention

a. *Clostridiodes difficile (C diff*) is a highly contagious spore forming bacterium that causes severe diarrhea.

b. Risk factors include:

i. Age ≥ 65 but especially in > 85 age group

ii. Recent hospitalization (that may or may not include extensive use of antibiotics)

iii. Long term use of proton-pump inhibitors (PPIs) or H2 blockers that serve to reduce stomach acid production

iv. Weakened immune system as occurs with HIV/AIDS, cancer or organ transplant recipients and use of steroids

v. Previous C diff infection or known exposure

c. *C diff* bacteria is shed in feces and can survive on skin even when visible soiling is not evident.

d. *C diff* is spread by direct and indirect contact with spore forming bacteria

e. Education of Healthcare Providers (HCP) regarding the spread, prevention measures, personal protective equipment (PPE) use during care and management of outbreaks.

f. Education of staff to reduce transmission to others includes symptom screening, hand hygiene with soap and water for those suspected/confirmed of CDI infection,

the prompt implementation of transmission-based precautions, limiting patient/resident movement if their stool is incontinent and uncontained and frequent environmental and equipment cleaning with hospital approved EPA registered disinfectants with sporicidal kill claims (bleach based cleaners are the most common).

g. Education of patients/residents to reduce transmission to others including hand washing with soap and water before meals, after toileting, showering, and clothing changes.

h. Implement daily cleaning of high touch surfaces and terminal cleaning of rooms when patient/resident infections are cleared, or they are discharged home. This cleaning should be performed using an EPA approved disinfectant with sporicidal kill claims for *C diff*.

2. Symptoms of *C diff* Infection (CDI)

a. Staff should monitor patient/resident for loose, watery stools (typically more than three in 24-hour period of time)

b. Colitis – severe bowel inflammation often linked to diarrhea and abdominal pain

c. Fever

d. Stomach pain or tenderness

e. Loss of appetite / dehydration

f. Symptoms should be recorded in the medical record including any evidence of recent exposure and/or previous C diff infections

g. If staff identify three (3) or more loose stools in 24-hour period:

i. Contact provider without delay regarding the suspicion of CDI for further testing. ~~and begin empirical treatment before test results are known.~~

ii. Implement Contact Enteric Precautions without delay including gloving and gowning with every patient/resident care interaction (even if short), and/or contact with patient/resident items.

iii. Contact IPC for follow up. Contact EVS to clean high touch room surfaces thoroughly on a twice daily basis and upon patient/resident discharge or transfer using an EPA-approved disinfectant with sporicidal kill claims.

iv. In the event of a patient/resident transfer (such as hospital or new facility), notify the new facility if the patient/resident has a CDI.

3. **Standard Precautions**

a. During every patient/resident encounter

b. When unexpected or watery diarrhea is observed, consider CDI as a potential diagnosis and implement Contact Enteric precautions to prevent transmission of CDI until diagnosis is ruled out

c. Hand washing with soap and water (*C diff* is an anaerobic spore-forming bacteria and does not respond to alcohol based hand gels).

d. Meticulous hand washing with soap and water, glove and gown use for any patient/resident care interactions. Eye protection per standard precautions

e. Patient/Resident will need to remain in their room if patient/resident is incontinent and/or diarrhea cannot be contained. See below

4. Transmission Based Precautions Implementation

a. Contact Enteric Precautions will be implemented from the time that new or worsening diarrhea cannot be contained is noted

b. Contact Enteric Precautions shall be initiated for any unexplained or watery diarrhea and shall not be delayed pending culture results, including but not limited to:
   i. Provide a private bathroom to prevent the spread of C diff spores to environmental surfaces during showering and toileting
   ii. If a private room with a private bathroom cannot be provided then patients/residents with C diff infection may be cohorted in the same with another patient/resident infected with C diff in consultation with the Infection Prevention Department.

c. Place an isolation cart outside of the room with gowns and gloves at minimum. Add face shields if procedures that may splatter. Post Contact Enteric precautions signage at the door entrance.

d. Wash hands with soap and water only. Alcohol based hand rub is not effective against C diff spores.

e. Use an Environmental Protection Agency (EPA)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions. (Note: Only hospital surface disinfectants listed on EPA's List K are registered as effective against *C. diff* spores). Use to disinfect high touch

surfaces at least twice daily, including but not limited to call light, bed rails, door handles, and faucets.

f. Provide dedicated equipment that is disposable if possible.

g. Do not remove medical equipment from the room until the equipment is cleaned with an EPA-approved sporicidal product (e.g., vital signs equipment and ADL assistive devices).

h. Nursing staff will communicate need for Contact Enteric Precautions to patient/resident, visitors, and EVS. Educate as appropriate to the level of contact and understanding.

5. Outbreak Management

a. An outbreak of *C. diff* infection is defined as three (3) or more cases of *C. diff* infection (CDI) occurring in the same area/ unit of the facility within a period of six (6) days or less.

b. Contact the Infection Preventionist for outbreaks.

c. The IP will report to SFDPH following A8 Outbreak/Epidemic Investigation Protocol.

d. Group activities and non-essential appointments should be postponed while the patient/resident(s) has diarrhea that cannot be easily and reliably contained.

e. For essential appointments or transfer to another facility, alert the receiving staff, dress patient/resident in clean clothing and contain incontinence (e.g., with adult briefs). Alert facility about the need for Contact Enteric Precautions.

6. Disinfection

a. *C. difficile* spores can survive in the environment for months or years due to their resistance to heat, drying, and certain disinfectants.

b. Patient/resident room surface environment is frequently contaminated with *C. difficile*, including floors, commodes, toilets, bedpans, and high-touch surfaces, such as call bells and overbed tables (2018 PubMed)

c. Surfaces should be kept clean, and body substance spills should be managed promptly

d. Routine cleaning should be performed prior to disinfection.

e. EPA-registered disinfectants with a sporicidal claim have been used with success for environmental surface disinfection in those patient/resident-care areas where surveillance and epidemiology indicate ongoing transmission of *C. Diff*.

f. EPA-registered disinfectants (List K) are recommended for use in patient/resident-care areas. Follow product labels for inactivation claims, indications for use, and instructions.

7. C diff colonization (also known as c diff carriers)

a. Colonization of C diff means that the person has acquired the C diff bacteria by encountering someone with C diff. Often, these patients/residents do not have symptoms of infection. Colonization with C diff is more common than infection and patient/residents may remain colonized indefinitely. Treatment for colonization is determined on a case-by-case basis.

b. It is possible to transmit C diff to others when colonized and good hand washing with soap and water after using the bathroom is required.

c. Colonized patients/residents do test positive for the C diff organism.

d. Because there is potential of transmission with C diff colonization, the decision to implement or discontinue Contact Enteric Precautions will be made in collaboration with nursing, IPC, and medical staff care team based upon the patient's/resident's ability to comply with handwashing and other precautions.

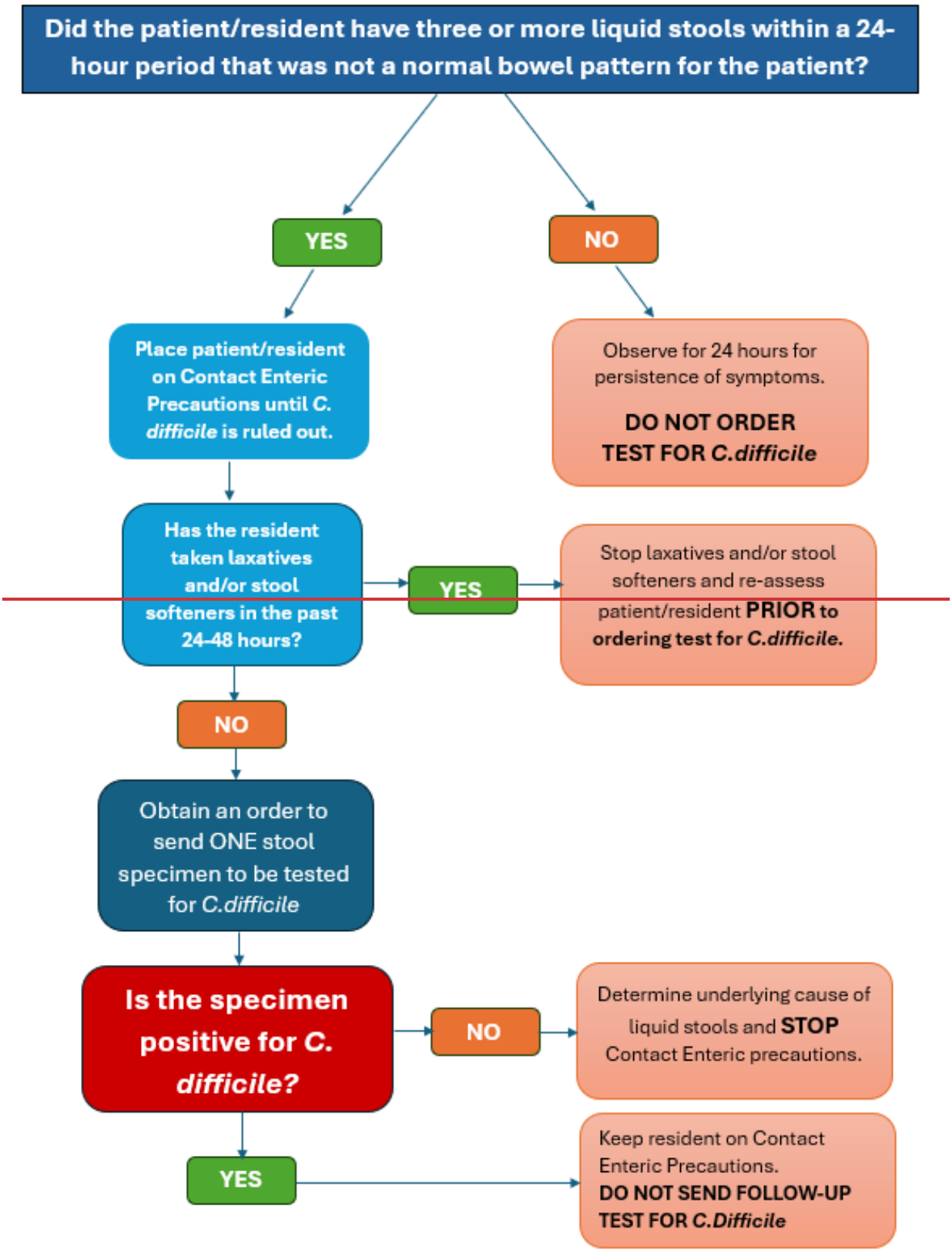
ATTACHMENT:
Appendix A: LHH ~~C. difficile Testing Algorithm~~Diarrhea Decision Tree
Appendix B: SFHN Adult Population: Clostridioides Difficile (C. Diff) Prevention Guidelines

REFERENCE:
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission Based Precautions and Patient/Resident Room Placement
APIC, 2008, Guide to the Elimination of Clostridium difficile in Healthcare Setting
CDC Advancing Excellence, *C. difficile* Infection Prevention Assessment Checklists, updated September 15, 2015
CDC (2022). FAQs for Clinicians for c.*diff*
Pubmed (2018). Crobach, M., Vernon, J. J., Loo, V. G., Kong, L. Y., Péchiné, S., Wilcox, M. H., & Kuijper, E. J. (2018). Understanding Clostridium difficile Colonization. *Clinical microbiology reviews*, *31*(2), e00021-17. https://doi.org/10.1128/CMR.00021-17

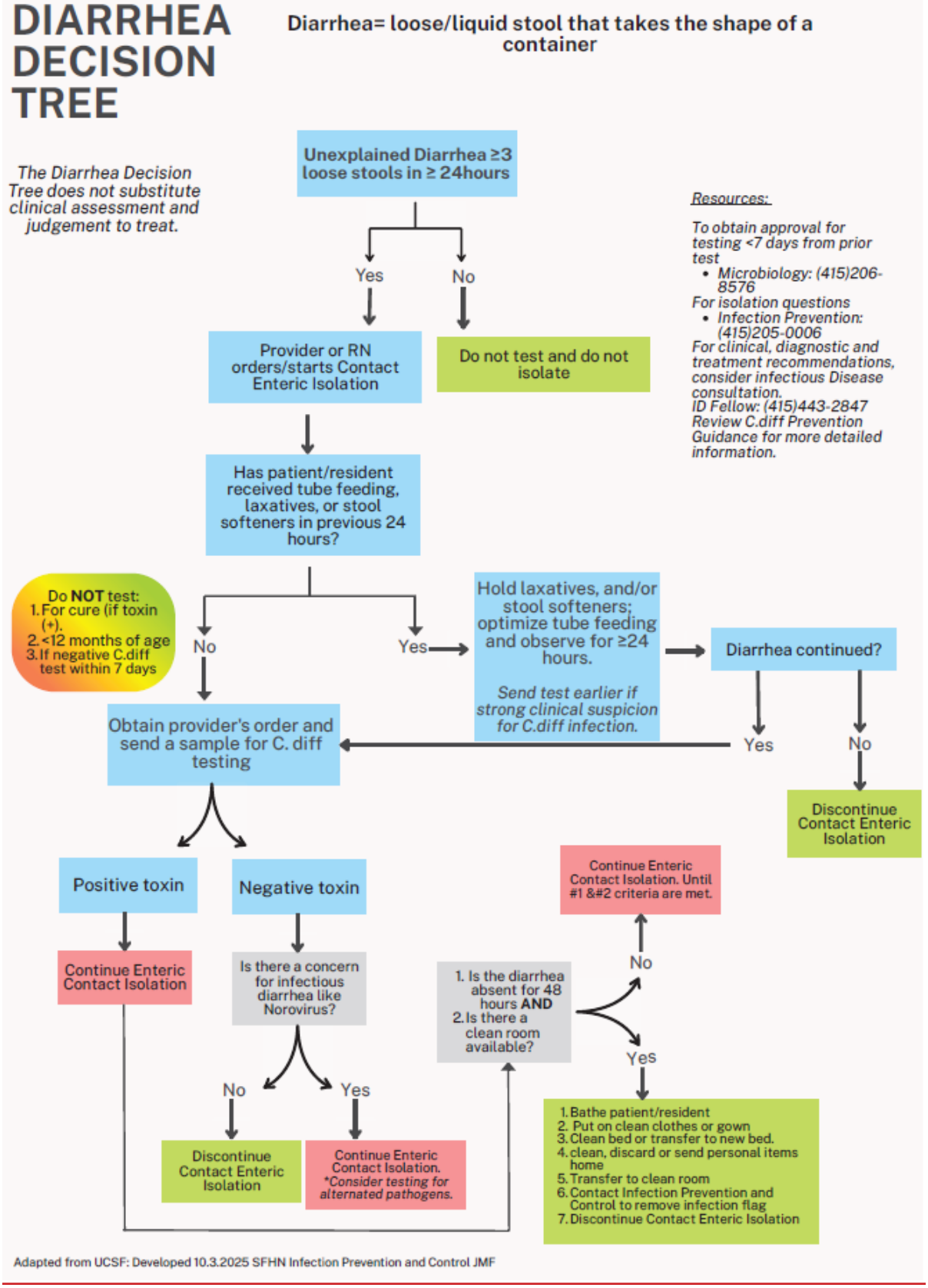
Revised: 07/12/16, 11/13/18, 10/13/20, 01/10/23, 02/03/25, 01/20/26 (Month/Day/Year)

Original adoption: 11/01/05

APPENDIX A: LHH C. difficile Testing Algorithm



Appendix A: LHH Diarrhea Decision Tree



Appendix B: SFHN Adult Population: Clostridioides Difficile (C. Diff) Prevention Guidelines

San Francisco Health Network
Quality Management

SFHN ADULT POPULATION: *CLOSTRIDIOIDES DIFFICILE* (C. DIFF) PREVENTION GUIDELINES

I. INTRODUCTION:

Clostridioides difficile (C. diff) is an anaerobic spore-forming gram-positive rod that is responsible for many healthcare-associated gastrointestinal infections nationally. C. diff is easily spread from patient to patient within the hospital setting and these infections can increase hospital lengths of stay, patient harms, and healthcare costs. The C. diff produces spores that remain viable for long periods of time and are resistant to alcohol-based hand rubs and many common disinfectants used for environmental cleaning.

C. diff is spread through the fecal-oral route when a patient ingests spores that have been shed into the environment by another actively infected patient. Healthy gut organisms can compete with C. diff and protect against infection. Treatments such as use of antibiotics disrupt the balance of healthy gut organisms and can allow C. diff to grow and produce toxins that cause diarrhea.

Consider your patient's risk of *C.diff* infection before prescribing an antibiotic	
C.diff risk factors: • Antibiotic exposure • Extended stay in healthcare settings such as hospitals and SNFs. • Previous history of *C.diff* infection • Older age • Serious underlying and immunocompromising conditions.	Higher-risk antibiotics that are more likely to predispose your patient to *C.diff* infections. • Clindamycin • Fluoroquinolones (e.g. Ciprofloxacin, Levofloxacin) • Third/fourth generation cephalosporins (e.g. Cefepime, Ceftriaxone, Cefdinir, Cefixime).
Optimize antibiotic therapy to minimize the risk of *C.diff* infection. • **Prescribe the most targeted and safe antibiotic.** o In patients with a history of *C.diff* infection, avoid the use of higher-risk antibiotics when other effective therapy is available. o If a penicillin allergy is listed in the medical record, determine whether your patient is truly allergic to decrease unnecessary use of higher-risk antibiotics • **Use the shortest effective antibiotic duration** • **Reassess antibiotic therapy based on your patient's clinical condition and relevant culture results.**	

II. ESSENTIAL PRACTICES TO PREVENT C. DIFFICILE INFECTION

There are several essential practices that you can follow to help reduce the risk of C. difficile infection. These interventions help prevent the development of new C. diff infections and also reduce its spread. Working closely with your interdisciplinary care teams – including nursing, hospitality staff, the microbiology lab, and fellow providers - can help keep infection rates low.

a. Antimicrobial Stewardship:
Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use (such as C. diff infections), and combat antibiotic resistance.

i. Optimizing antibiotic therapy to minimize risk of C. difficile infection:

Avoid unnecessary use of antibiotics and, when antibiotics are needed, prescribe the right antibiotics for right duration.

Guidelines for Empiric Therapy: Adults and Pediatrics
These recommendations are intended to assist with clinical decision-making for common situationist but, cannot replace personalized evaluation and management decisions based on individual patient factors including but not limited to history of multi drug-reistant organisms (MDRO's)

https://idmp.ucsf.edu/guidelines-for-empiric-therapy-adults

https://idmp.ucsf.edu/guidelines-for-empiric-therapy-pediatrics

b. Diagnostic Stewardship:
Only order C. diff testing when clinically appropriate.
One of the most common complaints in hospitalized patients is diarrhea.[1] Providers often screen for C. *difficile* infection reflexively when diarrhea is present. However, the majority of cases of diarrhea in the hospital are due to medications, enteral feeding or underlying illnesses. Antibiotics commonly cause diarrhea, but only 20% of cases are secondary to C. difficile colitis.[2] Many patients are tested unnecessarily when they do not have diarrhea or signs/symptoms consistent with C. *difficile* infection.

i. Use the SFHN Diarrhea Decision Tree: When taking care of a patient with diarrhea, reference the SFHN Diarrhea Decision tree for a step-by-step guide:

ii. Steps to take before ordering C. difficile testing:
1. Confirm that your patient has had at least 3 loose stools in the previous 24 hours. Diarrhea is defined as either Bristol stool type 6 or 7 on the Bristol stool scale.
    a. If your patient has not had 3 loose stools OR stools are not Bristol stool 6 or 7, continue to monitor.

2. Place patient in contact entericisolation. You should not delay placing the patient in contact enteric isolation if you are concerned for an infectious etiology of diarrhea.
3. Assess for Alternative explanations of diarrhea:
    a. If patient is receiving laxatives or stool softeners – Hold medications for 24 hours and reassess stool output.
    b. If patient is receiving enteral feeds – Work with dietary to optimize tube feeding formula to assess if this is contributing to diarrhea. Adjust tube feeds if able and reassess stools in 24 hours.
    c. If diarrhea improves after adjusting medications or tube feeds – DO NOT TEST FOR *C. difficile* and discontinue contact enteric isolation.

iii. Indications to order the C. difficile test:
    1. Patient reports >/= 3 loose stools in 24 hours, is not receiving laxatives/stool softeners or enteral feeds, then place in enteric contact Isolation and test for C. difficile.
        a. If patient is on stool softeners or enteral feeds, follow step 3
        b. Test earlier if strong clinical suspicion for C. difficile infection (ex. Severely immunocompromised patients)

iv. Do NOT order the C. difficile test IF:
    1. Patient has received laxatives/stool softeners in the last 24 hours
    2. Diarrhea has improved.
        a. If you send a formed stool (Bristol stool types 1-5) to the Microbiology lab, the lab will cancel your test
    3. C. difficile test was negative within the last 7 days unless diarrhea has substantially worsened, or the patient has developed other signs or symptoms suggesting *C. difficile* infection.
    4. Patient is receiving treatment for *C. difficile*. We do NOT recommend test for cure. The *C. difficile* PCR is highly sensitive (>90%) and can remain positive even after resolution of symptoms.
    5. Patient is less than 12 months in age. Young infants and toddlers can become asymptomatically colonized with C. difficile.

v. Understanding the ***C. difficile*** test at SFHN: At SFHN, to diagnose C. difficile infection, we use a two-tiered test approach. The first test processed is a *C. difficile* PCR, which detects the presence of C. difficile organisms that harbor the gene associated with toxin production. If the PCR result is positive, then C. difficile toxin is processed to look for the presence of the toxin. Presence of C. difficile toxins in stool supports the diagnosis of C. difficile infection. However, a positive C. difficile PCR and negative C. difficile toxin is more suggestive of colonization and should prompt you to consider alternative explanations for the patient's diarrhea.

    1. Typical C. difficile Test Interpretation:

C.diff PCR	C.diff Antigen	C.diff Toxin	Interpretation
Neg	**Not indicated	Not indicated	Negative test, not consistent with C.diff infection
Pos	Pos	Pos	Positive for C.diff
Pos	Pos	Neg	Likely C.diff colonization
Pos	Neg	Neg	Likely C.diff colonization
Pos	Neg	Pos	Likely positive C.diff toxin gene detected by PCR and toxin protein detected by immunoassay. The absence of C.diff specific protein (antigen) may represent a false negative result.*

*Correlation with clinical findings is suggested.

**Antigen and Toxin testing only completed if PCR is positive.

vi. Steps for Contact Enteric Isolation:
   1. Prior to entering the room, clean hands with the alcohol based rub outside of the room.
   2. Don a gown and gloves, which should be available in the caddy on the patient's room door.
      a. Alert the nursing staff on the unit if the caddy is empty or if no PPE is available
   3. Doff gown and gloves prior to exiting the room
   4. Wash your hands with soap and water upon exiting. Washing with soap and water is more effective at eliminating spores from hands. This is mainly due to the sheering force created by scrubbing hands vigorously with soap.

vii. When to start Contact Enteric Isolation: Place the patient in contact enteric isolation as soon as you suspect they may have an infectious source of diarrhea.
   1. Do not wait for C. difficile results to order Contact enteric isolation.

viii. Contact Enteric Isolation can be discontinued when:
   1. Diarrhea resolves with discontinuation of laxatives/stool softeners or adjustment of tube feeds and there is no suspicion for an infection.
   2. C. difficile test result is negative (gene PCR negative) and no alternative diarrheal infection is suspected.
   3. C. difficile test result is gene PCR positive/toxin protein negative AND diarrhea absent for >/= 48 hours AND a new clean room is available:
      a. In this instance, enteric contact isolation can be discontinued but the following criteria must be met:
         i. The patient must be bathed
         ii. The patient must be dressed in clean clothes
         iii. The patient bed must be cleaned OR the patient must be transferred to a new, clean bed

iv. Patient's personal items must be cleaned, discarded or sent home
v. The patient must be transferred to a clean room
vi. Provider must contact Infection Prevention & Control to discuss appropriateness of discontinuing contact enteric isolation

ix. How long to continue Contact Enteric Isolation: Duration of contact enteric isolation depends on various factors such as clinical condition, immunocompromised status, room availability, C. difficile test results and concern for alternative infectious sources of diarrhea. You must continue contact enteric isolation for all the following scenarios:
1. If your patient's C. difficile test is negative, continue enteric contact isolation IF you still suspect an alternative infectious source of diarrhea. C. difficile is not the only organism that can spread in the hospital. If you are concerned that another infection is responsible for your patient's diarrhea, then continue enteric isolation and consider diagnostic testing for other infections.
2. If your patient is C. difficile PCR positive/ toxin negative and having diarrhea, then continue contact enteric isolation. Although colonized patients may have an alternative explanation for their diarrhea, they may still transmit spores into the environment while having diarrhea, which can subsequently infect other vulnerable patients leading to C. difficile colitis.
3. If your patient is either C. difficile PCR or antigen x positive and is admitted to Oncology unit they must remain in contact enteric isolation for the duration of their admission.
4. If your patient is C. difficile PCR positive/protein negative and has persistent diarrhea, continue enteric isolation.
5. If any question around Contact Enteric Isolation, please contact Infection Prevention and Control @ (415)205-0006 or (415)806-7227.

References:

1. J Gen Intern Med. 1997 Jan; 12(1): 57–62 PMID: 9034947
2. Clin Infect Dis. 2012 Oct;55(7):982-9 PMID: 22700831

RENOVATION / CONSTRUCTION INFECTION CONTROL GUIDELINES

POLICY:

1. The Centers for Disease Control and Prevention (CDC) requires healthcare facilities to perform an Infection Control Risk Assessment (ICRA) before renovation, construction, or repair projects.

2. The completed ICRA provides for a controlled plan for the removal of building materials or construction project in healthcare facilities that does not place patient/residents at risk for transmission of pathogens in a vulnerable population.

3. The Infection Control Nurse (ICN) shall be consulted by Facility Services or project manager during preconstruction planning for facility renovation and construction projects.

4. Construction and/or remodeling on the campus will be completed by construction teams that are skilled and trained in the standards for healthcare construction.

5. Construction teams will include the ICN during the planning, pre-construction, construction, and post construction phases.

6. The ICN will provide regular surveillance and oversight of the project to ensure that project specific recommendation is in place. This information will be shared with the Infection Control Committee (ICC).

PURPOSE:

1. To provide guidance to the healthcare and construction team for containing dust, fungi (including *Aspergillus*), chemicals, bacteria (including *Legionella*), and other microbial contamination that can be transmitted via the air, plumbing, or from ground disturbance during construction that is required to be minimized during the work phases of construction/renovation projects.

    a. Soil, water, dust, and decaying organic matter can provide a source of infections when introduced to a vulnerable population that can gain entrance to the facility on construction materials, tools, and the construction workers' clothes and shoes.

2. To engage best practices and healthcare construction standards are integral in the design, demolition, and construction of patient/resident care and other areas that facilitate the desired infection control practices that is guided by completion of the ICRA.

3. To minimize infectious risks associated with internal renovation projects in patient/resident care areas, and that the necessary controls and interventions are in place.

PROCEDURE:

1. Project Planning

The ICN and Industrial Hygienist shall be advised by the Facility Services department or project manager of plans for renovation and/or new construction. The ICRA shall be a part of integrated facility planning, design, construction, and commissioning activities; and shall be conducted during the early planning phase of a project before construction begins; and continue through project construction and commissioning. Life Safety requirements must also be met.

a. A multidisciplinary team that includes the ICN, Industrial Hygienist, Facility Services, and clinical staff shall conduct a proactive ICRA during the design and planning phase for all demolition, renovation, and new construction projects. The scope of the project may require other subject matter experts to be involved.

b. After completing the ICRA, precautions shall be taken according to the matrix reflecting the risk level of the patient/resident population and the hazard level of the construction work. A complete field review of infection control implications shall be conducted before any demolition or construction begins.

c. Specific areas of consideration but are not limited to:

   i. Determination of if, where, when, the duration, and how patient/resident care area(s) closures and/or interruptions will occur

   ii. Mitigation of external air flow into the facility where there is ground disturbance or demolition of other structures external to the facility that may release air pollution that can enter windows, doors, or other ventilation mechanisms

   iii. Traffic patterns for patient/residents, staff, and visitors to minimize contamination

   iv. Patient/resident area risk assessment: criteria for emergency work interruptions (stop and start processes)

   v. Planning for air handling and water systems/plumbing as appropriate

   vi. Education (or whom and by whom)

   vii. Dust control expectations for subcontractors before start, as needed including workers clothing and shoes when entering the facility

   viii. Transport and approval for disposal of waste materials

d. ICRA expectations shall be incorporated into initial project agreements to ensure contractor accountability.

2. Contractor Dust Control Procedures

Contractor must provide dust control procedures for review and approval by the ICN and Industrial Hygienist.

a. Renovation areas must be isolated from patient/resident-occupied areas using decreased air flow barriers to eliminate airflow of particles into patient areas. Critical barriers i.e., sheetrock, plywood, or plastic, to seal areas from non-work area shall be completed before beginning any construction work. Porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) patient/residents with at least one coat of a cleanable/washable no or low volatile organic compound (VOC) paint.

b. Temporary construction barriers and closures above ceilings shall be dust tight. A ceiling-to-floor sealed plastic barrier, enclosing the ladder, shall be constructed to contain the dust whenever more than one ceiling tile is to be removed within a patient/resident care area.

c. Whenever work is performed in which dust contamination has occurred, the area is to be cleaned as soon as possible using a vacuum cleaner equipped with a High Efficiency Particulate Air (HEPA) filtration system or damp mopping procedure to prevent the “tracking” of dust throughout the facility. Sweeping and dry mopping are never appropriate in a hospital environment. Floor “tack” or “sticky” mats are to be placed in areas of construction crew egress, and replaced when they lose their ability to capture dust and debris from a user’s shoe soles.

d. If negative pressure is required (based on ICRA), negative pressure shall be established and continuously maintained to the renovation work area enclosure to contain dust generated by work activities inside the enclosure until all work is complete.

e. Negative pressure shall be monitored continuously. Recording manometers shall be used to display and record pressure differentials automatically. Pressure differential records shall be collected and reviewed by project personnel on a daily basis, as evidenced by their initials along with the date and time of the review and maintained available on site for review by infection control and health and safety personnel upon request.

f. Construction waste and demolition debris shall be covered and sealed during transport, and transport equipment cleaned prior to removal from the work area. Transport is to be done during the lowest activity periods. A schedule shall be drafted to inform contractor of times to avoid transport area. Elevators shall be avoided for debris transport. If an elevator is used, it shall be designated for construction use only. Appropriate signage postings are required

g. Removal of construction barriers and ceiling protection shall be done outside of normal working hours unless otherwise authorized in advance of activities. Areas will be wet mopped and/or HEPA vacuumed following barrier removal.

Vacuuming outside of negative pressure areas shall be performed with a HEPA-filtered vacuum which has been aerosol challenge tested prior to initial use at the LHH site.

3. Monitoring

a. The ICN will monitor construction areas for general particle (dust) levels, or other project specific contaminants or indicators in the vicinity of the project.

b. If monitoring results exceed background levels, or other infection control risk becomes apparent, the contractor shall be notified to correct the condition immediately to avoid fines and work stoppage as described below:

i. All work may be stopped on a project whenever a hazardous material/waste deficiency, infection control deficiency, or dust control complaint exists.

ii. The contractor shall take immediate action to correct the deficiencies.

4. Enforcement

a. Determination of violations shall be based on periodic rounds in collaboration with the Facility Services staff, ICN, and/or Industrial Hygienist. Findings will be reported to the ICC. Photographs may be taken to document violation(s), as feasible.

b. The contractor, project manager/coordinator, Facility Services, and others as appropriate, shall be informed in writing.

c. A record of all ICRA violations shall be maintained.

5. Documentation

a. Primary representatives shall be identified on the Infection Prevention & Control Construction Clearance Checklist (Attachment B), which contains an overview of the ICRA results and the required precautions from ICN, Industrial Hygienist, Facility Services, contractor, project manager/coordinator, and others as deemed appropriate.

b. The Clearance Checklist shall be signed by the ICN or designee and a copy shall be maintained at the work site.

ATTACHMENT:
Appendix A: Infection Control Risk Assessment (ICRA).
~~Appendix B: Infection Prevention and Control Construction Clearance Checklist~~

REFERENCE:
LHH Facility Services Policy LS-6: Life Safety Management, Building Standards
Centers for Disease Control and Prevention's *"Guidelines for Environmental Infection Control in Health-care Facilities"* (2003)
Association for Practitioners in Infection Control & Epidemiology (APIC) State-of-the-Art Report: *"The role of infection control during construction in health care facilities." (2000)*

ASHE Infection Control Risk Assessment 2.0 Matrix of Precautions for construction, Renovation and Operations (2022) Found at https://www.ashe.org/system/files/media/file/2022/08/ICRA%202.0%20Tool%20%2B%20Permit.pdf

Revised: 07/12/16, 11/13/18, 10/13/20, 01/10/23, 09/18/23, 01/09/24, 02/10/25, 01/20/26 (Month/Day/Year)

Original adoption: ~~-~~11/01/05

Appendix A: Infection Control Risk Assessment

Infection Prevention and Control Construction Clearance Checklist

Infection Prevention & Control Construction Clearance Checklist		
Name of Project:		
Contractor Performing Work:		
Location of Construction:		**Project Start Date:**
Project Coordinator/ Manager:		
Industrial Hygienist:		**Estimated Duration:**
Infection Control Nurse:		
Assessment Performed by: Project Coordinator / Manager Infection Control Nurse Industrial Hygienist Director of Facilities Services **Copy of Assessment Submitted to:** Contractor performing work (via Project Coordinator/Manager) Director of Facilities Services		

Resident Risk Level	**Construction Activity Type**			
	Type A	**Type B**	**Type C**	**Type D**
Low	I	II	II	III
Medium	I	II	III	IV
High	I	III	IV	V
Highest	III	IV	V	V

Determination: **Scope:**		
Exceptions / Additions to the permit are noted by attached memoranda:	Initials:	Date:
Updated Precautions Classification (required if any changes occur in Patient Risk Group or Construction Activity):	Initials:	Date:
Reason for Extension: **Reason for Extension:**	Initials: Initials:	Extension Date: Extension Date:
Infection Control Nurse or Designee: _____ Printed Name/ Title _____ Signature		Date:

Step One:
Using the following table, *identify* the Risk categories by construction type (Type A-D)

Type A	**Non-Invasive Activities and Inspection** Includes but is not limited to: • Removal of ceiling tiles for visual inspection (limit 1 tile per 50 square feet with limited exposure time) • Limited building system maintenance (e.g., pneumatic tube station, HVAC system, fire suppression system, electrical and carpentry work to include painting without sanding) that does not create dust or debris. • Clean plumbing activity limited in nature.
Type B	**Small scale, short duration activities that create minimal dust and debris** Includes but is not limited to: • Work conducted above the ceiling (e.g., prolonged inspection or repair of firewalls and barriers, installation of conduit and/or cabling, and access to mechanical and/or electrical chase spaces) • Fan shutdown/startup • Installation of electrical devices or new flooring that produces minimal dust and debris • The removal of drywall where minimal dust and debris is created • Controlled sanding activities (e.g., wet or dry sanding) that produce minimal dust and debris •
Type C	**Large-scale, longer duration activities that create a moderate amount of dust and debris.** Includes but is not limited to: • Removal of preexisting floor covering, walls, casework or other building components • New drywall placement • Renovation work in a single room • Non-existing cable pathway or invasive electrical work above ceilings • The removal of drywall where a moderate amount of dust and debris is created • Dry sanding where a moderate amount of dust and debris is created • Work creating significant vibration and/or noise • Any activity that cannot be completed within a single work shift
Type D	**Major demolition and construction projects** Includes but is not limited to: • Removal or replacement of building system component(s) • Removal/installation of drywall partitions • Invasive large-scale new building construction • Renovation work in two or more rooms •

Step Two:

Using the following table, *identify* the Risk categories by patient care areas that will be affected. If more than one risk group will be affected, select the higher risk group:

Low Risk **Non-patient care areas such as:**	**Medium Risk** **Patient care support areas such as:**	**High Risk** **Patient care areas such as:**	**Highest Risk** **Procedural, invasive, sterile support and highly compromised patient care areas such as:**
• Public hallways and gathering areas not on clinical units • Office Areas not on clinical units • Breakrooms not on clinical units • Bathrooms or locker rooms not on clinical units • Mechanical rooms not on clinical units • EVS closets not on clinical units	• Waiting areas • Clinical engineering • Materials management • Sterile processing department – dirty side • Kitchen, cafeteria, gift shop, coffee shop, and food kiosks •	• Patient care rooms and areas • All acute care units • Emergency department • Employee health • Pharmacy – general work zone • Medication rooms and clean utility rooms • Imaging suites: diagnostic imaging • Laboratory •	• All transplant and intensive care units • All oncology units • Or theaters and restricted areas • Procedural suites • Pharmacy compounding • Sterile processing department – clean side • Transfusion services • Dedicated isolation wards/units • Imaging suites: invasive imaging •

Step Three:

Match the Patient Risk Group (Low, Medium, High, Highest) from Step Two with the planned Construction Activity Project Type (A, B, C, D) from Step Two using the below table to find the Class of Precautions (I, II, III, IV or V) or level of infection control activities required. The activities are listed in Table 5 – Minimum Required Infection Control Precautions by Class.

Table 3 – Class of Precautions

Construction Project Type

Patient Risk Group	Type A	Type B	Type C	Type D
Low	I	II	II	III*
Medium	I	II	III*	IV
High	I	III	IV	V
Highest	III	IV	V	V

Infection control permit and approval will be required when Class of Precautions III (Type C) and all Class of Precautions IV or V are necessary.

Environmental conditions that could affect human health, such as sewage, mold, asbestos, gray water and black water will require Class of Precautions IV for LOW and MEDIUM Risk Groups and Class of Precautions V for HIGH and HIGHEST Risk Groups.

*Type C [Medium Risk groups] and Type D [Low Risk Groups] work areas [Class III precautions] that cannot be sealed and completely isolated from occupied patient care spaces should be elevated to include negative air exhaust requirements as listed in Class IV Precautions.

Step Four:

Assess potential risk to areas surrounding the project. Using the below table, identify the surrounding areas that will be affected and the type of impact that will occur. If more than one risk group will be affected, select the higher risk group using Table 2 - Patient Risk Group.

Table 4 – Surrounding Area Assessment

Unit Below:	Unit Above:	Unit Lateral:	Unit Behind:	Unit in Front:
Risk Group:	Risk Group:	Risk Group:	Risk Group:	Risk Group:
Contact:	Contact:	Contact:	Contact:	Contact:
Phone:	Phone:	Phone:	Phone:	Phone:
Additional Controls: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water

Noise & Vibration Mitigation Strategies

- ☐ Use diamond drills instead of powder-actuated fasteners.
- ☐ Schedule noise-making periods with adjacent spaces.
- ☐ Use beam clamps instead of shot.
- ☐ Prefab where possible.
- ☐ Use tin snips to cut metal studs instead of using a chop saw.
- ☐ Install metal decking with vent tabs, then use cellular floor deck hangers.
- ☐ Consider compression style fittings instead of soldering, brazing or welding.
- ☐ Wet core drill instead of dry core or percussion.
- ☐ Instead of jackhammering concrete, use wet diamond saws.
- ☐ Use HEPA vacuums instead of standard wet/dry vacuums.
- ☐ Use mechanical joining system sprinkler fittings instead of threaded.
- ☐ Where fumes are tolerated, use chemical adhesive remover (flooring glue) instead of mechanical.
- ☐ To remove flooring, consider abrasive blasting instead of using a floor scraper.
- ☐ Use electric sheers instead of reciprocating saw for ductwork cutting.
- ☐ Install exterior man/material lifts.

Ventilation & Pressurization Mitigation Strategies

- ☐ HEPA to exterior.
- ☐ Install temporary ductwork.
- ☐ Utilize temporary HVAC equipment.
- ☐ Vacate the area.
- ☐ Install temporary partitions.
- ☐ Use carbon filtration to filter odors.

Impact to Other Systems Mitigation Strategies

- ☐ Schedule outages.
- ☐ Provide temporary systems.
- ☐ Back-feed electricity or medical gases.

Table 5 - Minimum Required Infection Control Precautions by Class | Before and During Work Activity

Class of Precautions	Mitigation Activities (Performed Before and During Work Activity)
Class I	1. Perform noninvasive work activity as to not block or interrupt patient care. 2. Perform noninvasive work activities in areas that are not directly occupied with patients. 3. Perform noninvasive work activity in a manner that does not create dust. 4. Immediately replace any displaced ceiling tile before leaving the area and/or at end of noninvasive work activity.
Class II	1. Perform only limited dust work and/or activities designed for basic facilities and engineering work. 2. Perform limited dust and invasive work following standing precautions procedures approved by the organization. 3. This Class of Precautions must never be used for construction or renovation activities.
Class III	1. Provide active means to prevent airborne dust dispersion into the occupied areas. 2. Means for controlling minimal dust dispersion may include hand-held HEPA vacuum devices, polyethylene plastic containment, or isolation of work area by closing room door. 3. Remove or isolate return air diffusers to avoid dust from entering the HVAC system. 4. Remove or isolate the supply air diffusers to avoid positive pressurization of the space, 5. If work area is contained, then it must be neutrally to negatively pressurized at all times. 6. Seal all doors with tape that will not leave residue. 7. Contain all trash and debris in the work area. 8. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 9. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 10. Maintain clean surroundings when area is not contained by damp mopping or HEPA vacuuming surfaces.
Class IV	1. Construct and complete critical barriers meeting NFPA 241 requirements including: Barriers must extend to the ceiling or, if ceiling tile is removed, to the deck above, and all penetrations through the barrier shall meet the appropriate fire rating requirements. 2. All (plastic or hard) barrier construction activities must be completed in a manner that prevents dust release. Plastic barriers must be effectively affixed to ground and ceiling and secure from movement or damage. Apply tape that will not leave a residue to seal gaps between barriers, ceiling or floor. 3. Seal all penetrations in containment barriers, including floors and ceiling, using approved materials (UL schedule firestop if applicable for barrier type). 4. Containment units or environmental containment units (ECUs) approved for Class IV precautions in small areas totally contained by the unit and that has HEPA-filtered exhaust air. 5. Remove or isolate return air diffusers to avoid dust entering the HVAC system. 6. Remove or isolate the supply air diffusers to avoid positive pressurization of the space. 7. Negative airflow pattern must be maintained from the entry point to the anteroom and into the construction area. The airflow must cascade from outside to inside the construction area. The entire construction area must remain negatively pressurized. 8. Maintain negative pressurization of the entire workspace by use of HEPA exhaust air systems directed outdoors. Exhaust discharged directly to the outdoors that is 25 feet or greater from entrances, air intakes and windows does not require HEPA-filtered air. 9. If exhaust is directed indoors, then the system must be HEPA filtered. Prior to start of work, HEPA filtration must be verified by particulate measurement as no less than 99.97% efficiency and must not alter or change airflow/pressure relationships in other areas. 10. Exhaust into shared or recirculating HVAC systems, or other shared exhaust systems (e.g., bathroom exhaust) is not acceptable. 11. Install device on exterior of work containment to continually monitor negative pressurization. To assure proper pressure is continuously maintained, it is recommended that the device(s) have a visual pressure indicator. 12. Contain all trash and debris in the work area.

	13. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 14. Worker clothing must be clean and free of visible dust before leaving the work area. HEPA vacuuming of clothing or use of cover suits is acceptable. 15. Workers must wear shoe covers prior to entry into the work area. Shoe covers must be changed prior to exiting the anteroom to the occupied space (non-work area). Damaged shoe covers must be immediately changed. 16. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 17. Consider collection of particulate data during work to monitor and ensure that contaminates do not enter the occupied spaces. Routine collection of particulate samples may be used to verify HEPA filtration efficiencies.
Class V	1. Construct and complete critical barriers meeting NFPA 241 requirements including: Barriers must extend to the ceiling, or if ceiling tile is removed, to the deck above, and all penetrations through the barrier shall meet the appropriate fire rating requirements. 2. All (plastic or hard) barrier construction activities must be completed in a manner that prevents dust release. Plastic barriers must be effectively affixed to ground and ceiling and secure from movement or damage. Apply tape that will not leave a residue to seal gaps between barriers, ceiling or floor. 3. Seal all penetrations in containment barriers, anteroom barriers, including floors and ceiling using approved materials (UL schedule firestop if applicable for barrier type). 4. Construct anteroom large enough for equipment staging, cart cleaning, workers. The anteroom must be constructed adjacent to entrance of construction work area. 5. Personnel will be required to wear disposable coveralls at all times during Class V work activities. Disposable coveralls must be removed before leaving the anteroom. 6. Remove or isolate return air diffusers to avoid dust entering the HVAC system. 7. Remove or isolate the supply air diffusers to avoid positive pressurization of the space. 8. Negative airflow pattern must be maintained from the entry point to the anteroom and into the construction area. The airflow must cascade from outside to inside the construction area. The entire construction area must remain negatively pressurized. 9. Maintain negative pressurization of the entire workspace using HEPA exhaust air systems directed outdoors. Exhaust discharged directly to the outdoors that is 25 feet or greater from entrances, air intakes and windows does not require HEPA-filtered air. 10. If exhaust is directed indoors, then the system must be HEPA filtered. Prior to start of work, HEPA filtration must be verified by particulate measurement as no less than 99.97% efficiency and must not alter or change airflow/pressure relationships in other areas. 11. Exhaust into shared or recirculating HVAC systems, or other shared exhaust systems (bathroom exhaust) is not acceptable. 12. Install device on exterior of work containment to continually monitor negative pressurization. To assure proper pressure is continuously maintained, it is recommended that the device(s) have a visual pressure indicator. 13. Contain all trash and debris in the work area. 14. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 15. Worker clothing must be clean and free of visible dust before leaving the work area anteroom. 16. Workers must wear shoe covers prior to entry into the work area. Shoe covers must be changed prior to exiting the anteroom to the occupied space (non-work area). Damaged shoe covers must be immediately changed. 17. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 18. Consider collection of particulate data during work to monitor and ensure that contaminates do not enter the occupied spaces. Routine collection of particulate samples may be used to verify HEPA filtration efficiencies.

Table 6 - Minimum Required Infection Control Precautions | Upon Completion of Work Activity

Class of Precautions	Mitigation Activities (Performed upon Completion of Work Activity)
Classes I, II and III	Cleaning: 1. Clean work areas including all environmental surfaces, high horizontal surfaces and flooring materials. 2. Check all supply and return air registers for dust accumulation on upper surfaces as well as air diffuser surfaces. HVAC Systems: 1. Remove isolation of HVAC system in areas where work is being performed. Verify that HVAC systems are clean and operational. 2. Verify the HVAC systems meet original airflow and air exchange design specifications.
Classes III, IV and V	Class III (Type C Activities only), IV, and V precautions require inspection and documentation for downgraded ICRA precautions. Construction areas must be inspected by an infection preventionist or designee and engineering representative for discontinuation or downgrading of ICRA precautions. Work Area Cleaning: 1. Clean work areas including all environmental surfaces, high horizontal surfaces and flooring materials. 2. Check all supply and return air registers for dust accumulation on upper surfaces as well as air diffuser surfaces. Removal of Critical Barriers: 1. Critical barriers must remain in place during all work involving drywall removal, creation of dust and activities beyond simple touch-up work. The barrier may NOT be removed until a work area cleaning has been performed. 2. All (plastic or hard) barrier removal activities must be completed in a manner that prevents dust release. Use the following precautions when removing hard barriers: i. Carefully remove screws and painter tape. ii. If dust will be generated during screw removal, use hand-held HEPA vacuum. iii. Drywall cutting is prohibited during removal process. iv. Clean all stud tracks with HEPA vacuum before removing outer hard barrier. v. Use a plastic barrier to enclose area if dust could be generated. Negative Air Requirements: 1. The use of negative air must be designed to remove contaminates from the work area. 2. Negative air devices must remain operational at all times and in place for a period after completion of dust creating activities to remove contaminants from the work area and before removal of critical barriers. HVAC systems: 1. Upon removal of critical barriers, remove isolation of HVAC system in areas where work is being performed. 2. Verify that HVAC systems are clean and operational. 3. Verify the HVAC systems meets original airflow and air exchange design specifications.

Other Decision-Making Considerations:

1. Identify specific site of activity e.g., patient/resident rooms, medication room, etc.

2. Identify issues related to: ventilation, plumbing, electrical in terms of the occurrence of probable outages.

3. Identify containment measures, using prior assessment. What types of barriers? Will HEPA filtration be required?

4. Consider potential risk of water damage. Is there a risk due to compromising structural integrity?

5. Can or will the work be done during non-patient/resident care hours?

6. Do plans allow for adequate number of isolation/negative airflow rooms?

7. Plan to discuss containment issues with the project team regarding traffic flow, housekeeping, debris removal.

~~Appendix B: Infection Prevention and Control Construction Clearance Checklist~~

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Infection Prevention and Control Construction Clearance Checklist

Infection Prevention & Control Construction Clearance Checklist	
Contractor Performing Work:	
Location of Construction:	**Project Start Date:**
Project Coordinator/ Manager:	
Industrial Hygienist:	**Estimated Duration:**
Infection Control Nurse:	

Assessment Performed by:

Project Coordinator / Manager	Industrial Hygienist
Infection Control Committee Chair	Infection Control Nurse
Director of Quality Management	Director of Facilities Services
Chief Operations Officer	Director of Environmental Services

Copy of Assessment Submitted to:

Chief Nursing Officer	Department Managers affected by project
~~Chief Medical Officer~~	~~Contractor performing work (via Project Coordinator/Manager)~~

Resident Risk Level	Construction Activity Type			
	Type A	Type B	Type C	Type D
Low	I	II	II	III
Medium	I	II	III	IV
High	I	III	IV	V
Highest	III	IV	V	V

Determination:

Exceptions / Additions to the permit are noted by attached memoranda:	Initials:	Date:
Updated Precautions Classification (required if any changes occur in Patient Risk Group or Construction Activity):	Initials:	Date:
Infection Control Nurse or Designee: _____ Printed Name/ Title _____ Signature		Date:

MANAGEMENT OF RESIDENT'S PERSONAL CLOTHING

POLICY:

1. Clean and contaminated resident's personal clothing shall be managed in accordance with Laguna Honda Hospital's (LHH's) infection control and laundry practices to prevent or reduce the transmission of pathogens to others.

2. Residents clothing will be clean, not torn or ragged, in good working condition, and appropriate for the season and weather.

3. LHH has a process for identifying and managing lost and/or damaged personal clothing during the laundry process.

PURPOSE:

The purpose of this policy is to provide guidance to staff to provide clean and sanitized laundering management services for resident's personal clothing, reduce loss and damage to resident's personal clothing, and to reduce or prevent exposure to potentially infectious materials by following best practices that have been shown to prevent transmission of microorganism and reduce infections for disease prevention.

DEFINITION~~S~~:

Personal laundry/clothing/personal clothing (clean): Clothing belonging to the resident including but not limited to shirts, blouses, pants, shorts, skirts, socks, outerwear, gloves, undergarments, or other clothing items. Hospital provided linens refer to bed and bathing items that do not belong to the resident and are not covered in this policy.

Contaminated personal clothing (dirty): Clothing that has been worn by the resident and has become overtly soiled, wet, obvious body odors, or contaminated with blood or body fluids.

PROCEDURE:

1. Resident's personal clothing is labeled for identification with permanent ink or tags and is identified as either the facility to launder or resident's responsible party to launder. The facility will have a separate area for dirty and clean laundry.

2. Clean resident's personal clothing is stored in resident's designated clean clothing areas, such as individual resident wardrobes and drawers. Clean clothing is transported through the facility in carts designated for clean clothing only and kept covered during transportation.

3. Resident's personal clothing is not to be shared with other residents or worn by staff. Notify the resident and/or responsible party of lost or damaged items during laundering.

4. Contaminated clothing is bagged and contained at the point of collection and not carried to another area for containment. Do not sort or rinse contaminated at the point of collection.

5. No additional precautions (i.e., double bagged) or categorizing/sorting of clothing originating from transmission-based precautions room is necessary. Double bagging is recommended only if the outside bag is visibly contaminated, is observed to be wet through to the outside of the bag, of if the resident is suspected or confirmed with a pediculosis (lice) infestation.

6. Wear gloves when handling soiled or contaminated clothing. If wet or grossly contaminated, wear a fluid resistant apron or gown. Do not agitate or shake clothing, place immediately in dirty hamper.

7. Contaminated clothing shall be placed in a covered dirty hamper. The dirty hamper should not be stored inside a resident's room. Do not overfill the hamper exposing contaminated personal clothing.

8. Contaminated clothing once~~is~~ collected, is transported to an off-site facility for laundering. ~~washed, dried, folded, and placed in the resident's clothing storage area using the proper washing and drying temperatures and using appropriate facility laundry detergent following manufacturer's recommendations.~~

9. Resident's personal clothing will arrive to unit cleaned and folded then placed in resident's closet and drawers.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 C17 Pediculosis (Lice) Management
LHHPP 72-01 F4 Management of Hospital-Provided Linen
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
CMS State Operations Manual (November 2017). *Appendix PP-Guidance to Surveyors for Long Term Care Facilities*. §483.80(e) Linens.

Revised: 05/27/14, 10/13/20, 01/09/24, 01/20/26 (Month/Date/Year)

Reviewed: 11/21/24

Original adoption: 11/01/05

STAFF EDUCATION PROGRAM

PURPOSE:

The purpose of this policy is to establish a structured and standardized approach to staff education, while also delineating responsibilities related to the provision of staff education at Laguna Honda Hospital and Rehabilitation Center (LHH). The Staff Education Program ensures that all employees have the knowledge, skills, and competencies required to provide safe, high-quality, resident-centered care and to comply with regulatory, accreditation, and organizational requirements. The program is grounded in the following core learning principles:

1. **Adult Learning Theory**: Education should be relevant, practical and connected to real work experiences. Adults learn best when content directly applies to their roles, supports resident-centered care and improves bedside outcomes consistent with the hospital's mission and vision.

2. **Collaboration and Team Based Learning**: Healthcare requires interprofessional collaboration, therefore everyone learns and everyone teaches. Learning is partnership-oriented and collaborative, supporting teamwork, communication and shared accountability.

3. **Flexibility and Accessibility**: Education shall be dynamic, participatory and customized for the learners. The facilitator or instructor shall be able to apply teaching methods that the audience can relate to and find meaning which they can apply to their essential job functions and responsibilities. Training should be offered in formats to accommodate staff schedules, roles and needs (e.g. e-learning, simulation, didactic, in person, etc.)

4. **Application and Transfer of Learning**: Effective education supports all departments; clinical and non-clinical and prioritizes real situation application, and organizational focus areas so staff can integrate new knowledge directly into their daily work to support high performance and resident care.

5. **Continuous Learning**: Staff development is an ongoing process; knowledge and skills must be updated regularly to align with evolving best practices, regulatory requirements

SCOPE:

This policy applies to all facility staff, contractors, volunteers and students providing services at LHH. It encompasses:

1. Orientation and onboarding

2. Mandatory annual education and compliance training

3. Continuing education and professional development

4. Competency assessment and validation

POLICY:

~~Laguna Honda Hospital and Rehabilitation Center (~~LHH~~)~~ is committed to fostering a culture of continuous learning and professional groups. LHH shall maintain ~~an effective~~a staff training~~, orientation, and education~~ program to ~~uphold and improve~~maintain staff ~~competencies~~competency, support workforce engagement, advance health equity and ensure the highest standards of care.

~~1.~~ All employees, contractors and volunteers are required to participate in ~~the provision of person-centered, culturally respectful and inclusive interdisciplinary services.~~

1. ~~LHH~~assigned education ~~and training~~ programs.

2. The Staff Education Program shall be ~~consistent~~aligned with LHH strategic goals and regulatory requirements.

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

ROLES:

1. Department of Education ~~and~~& Training (DET~~) shall conduct~~):

a. Provides overall structure, coordination and oversight for LHH's staff education program, which is guided by Title 22, Centers for Medicare and Medicaid Services (CMS), and California Department of Public Health (CDPH) educational requirements ~~and DPH educational requirements~~.

b. Conducts a biannual review and revision of ~~the topics of its~~ in-service training ~~program per~~topics in compliance with Title 22 ~~for submission~~and submits updates to ~~California Department of Public Health (~~CDPH~~)~~.

i. Prior to submission~~ to CDPH~~, DET will engage leadership and regulatory committees to ensure relevance.

~~i.~~ii. DET will present ~~its~~ proposed ~~in-service~~ training program to the Nursing Executive Committee (NEC) for review~~. After review from NEC, the proposed in-service training program will be sent to~~ and to the Performance Improvement and Patient Safety (PIPS) Committee for a final ~~review. Thereafter it will be sent~~

~~to CDPH for approval. This process is to ensure that topics are relevant to the facility and its needs.~~approval.

c. Partners with the Controller's Office and DPH HR to maintain the learning management system (LMS), SF Learning.

d. Advises Subject Matter Experts, when requested, on curriculum development and instructional strategies, while providing consultation, instructional design expertise, learning resources and evaluation tools.

e. Leads LHH wide orientation program

f. Communicates scheduled educational in-services to staff.

g. Provides tools to assist leadership with ~~ensure~~ accountability of training completion.

2. Human Resources ~~staff shall notify the Department~~

a. Partners with DET to track employees ~~who works~~ at LHH to support the appropriate assignment of ~~Education and Training (DET)~~education.

b. Notifies DET of the names of new hires and their start dates; staff who have left and their separation dates; and staff who are on ~~an~~ extended ~~leaves~~leave and their anticipated return dates.

~~**PURPOSE:**~~

c. ~~The purpose of this policy is to delineate~~Maintains staff ~~responsibilities related to the provision of staff~~educational records.

3. Supervisors/Managers

a. Identify role-specific education and competency needs for their staff

b. Consult with DET or SMEs for guidance, training content and delivery.

c. Support staff completion of required training within designated timelines

i. Utilize compliance reports to follow up with staff who have not completed mandatory trainings.

d. Provide department and unit-based orientation for employees new to the department or to a job to address workflows, role expectations and safety protocols.

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

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

4. Subject Matter Experts (SMEs)

a. Responsible for developing and implementing education programs within their area of expertise. This includes operational leaders who oversee equipment in clinical or nonclinical areas.

b. Design, maintain and deliver educational content specific to their domain.

c. Ensure all training materials address applicable regulatory requirements and facility policies.

d. Deliver and document training for staff within their domain.

e. Consult DET for support with instructional design, adult learning methods or education delivery tools as needed.

5. Employees

~~c.~~a. Every employee shall be accountable and responsible for their own development~~ at LHH.~~, competenc~~ye~~, and compliance with educational requirements for licensure or certification. This includes, but is not limited to:

i. Be present and sign in when attending educational requirements. Employees shall not have another person represent them or sign in for them in their absence.

ii. Complete required education and competency validation by established deadlines

iii. Participate in professional development opportunities with supervisory approval as needed during paid time or continuing education leave

iv. Maintain licensure and certifications applicable to their role.

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

vi. participate in formal and informal needs assessment processes to identify learning needs.

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

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

ix. Learning and teaching are partnership-oriented and collaborative and support teamwork.

~~**CORE PRINCIPLES OF LEARNING:**~~

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

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

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

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

~~5. Education shall be dynamic, participatory and customized for the learners. The facilitator or instructor shall be able to apply teaching methods that the audience can relate to and find meaning which they can apply to their essential job functions and responsibilities.~~

~~6. Effective education supports all departments; clinical and non-clinical, and assesses interests and needs of staff and programs by identifying quality indicators in high risk, high volume, or problem-prone areas.~~

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

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

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

PROCEDURE:

4. ~~Staff Training~~Onboarding and ~~In-services~~Orientation

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

b. New employees shall receive a 3-day in-person and computer-based NEO training to the culture, strategic goals, safety and regulatory requirements of LHH.

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

d. ~~Annually,~~NEO completion is required to start work.

5. Mandatory Annual Education and Compliance Training

~~d.~~ All employees shall ~~be provided with year-round~~ complete annual mandatory ~~in-services that meet~~ education and compliance training in accordance with State, Federal, and City requirements.

~~e. A monthly calendar of~~These trainings are offered year-round through scheduled ~~educational~~ in-services ~~shall be sent electronically to LHH staff with DPH email accounts and posted on the intranet~~and other formats~~.~~

a. .

~~f.~~

~~DET shall provide in~~In~~-service education on~~will be available to ~~all shifts as required by Title 22,~~

b. Certified Nursing Assistants (CNA) and~~,~~ Patient Care Assistants (PCA~~), and Home Health Aide (HHA))~~ are provided with a minimum of 24 hours of live in-service education each year during work time.

~~g.~~c. CNA and PCA In-service education will be available to all shifts as required by Title 22.

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

~~i.~~

~~j. Live classes may also be provided for specific staff audiences.~~

~~k.~~

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

~~m.~~

~~n.~~d. ~~In-service training is provided~~Trainings will be conducted by qualified personnel (in house or outside entities) in a variety of formats (e.g., facilitated

training, computer-based training, self-directed learning, mentoring and/or coaching, etc.).

~~o. Mandatory live classes are open to staff as indicated on the monthly education calendar.~~

~~p.~~

~~q. Training content includes, at a minimum:~~

~~r.~~

~~s. Effective communication for direct care staff.~~

e. Communication about training will be provided by DET, leadership and managers and supervisors. Employees will also be notified by the SF Learning system when modules are assigned.

~~i. Resident rights and facility responsibilities for caring of residents.~~

~~ii. Elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program.~~

~~iii. Written standards, policies, and procedures for the facility's infection prevention and control program.~~

~~iv. Written standards, policies, and procedures for the facility's compliance and ethics program.~~

~~v. Behavioral health.~~

~~vi. Dementia management and care of the cognitively impaired.~~

~~vii. Abuse, neglect, and exploitation prevention.~~

~~viii. Safety and emergency procedures.~~

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

~~**5. Employee Responsibilities**~~
Continuing Education, Professional Development

~~a. Every employee shall~~

6. ~~Be accountable~~ **and** ~~responsible for their own~~ **Specialized Training**

~~b.~~a. LHH will support the learning development~~, competency, and compliance with educational~~ of staff through trainings around specialized requirements ~~for licensure or certification.~~(e.g. isolation precautions), continuing education offerings, and professional growth

~~c. Be present and sign in when attending educational requirements.~~
~~d.~~
~~e. **Employees** shall not have another person represent them or sign in for them in their absence.~~
~~f.~~
~~g. Participate in formal and informal needs assessment processes to identify learning needs.~~
~~h.~~
~~i. Participate in LHH orientation, mandatory in-services, and needs based training such as, Mandatory Plan of Correction – related trainings, unit based training, or individual training.~~
~~j.~~
~~k. Participate in professional educational activities, with supervisory approval as needed, during paid time or continuing education leave.~~
~~l.~~
~~m. Report learning needs and knowledge or skill deficiencies to their supervisor or manager during orientation, annual performance appraisal, and on an ongoing basis.~~
~~n.~~
~~o. Collaborate with their supervisor and manager in meeting identified learning needs.~~
~~p.~~
~~q. Perform duties within their respective scopes of practice, according to LHH policies and procedures in a culturally effective manner.~~
~~r.~~
~~s. Maintain adequate continuing education hours to meet the requirements of their license or certification.~~
~~t.~~
~~u. **Manager Responsibilities**~~
~~v.~~
~~w. Department leaders: including directors, supervisors, and managers may collaborate with DET educator(s) to perform the following functions:~~
~~x.~~
~~y. Provide department and unit-based orientation for employees new to the department or to a job within the department.~~
~~z.~~
~~aa. Assess, plan, develop, implement, and evaluate unit-based orientation and educational activities within their own area(s) or departments.~~
~~bb.~~
~~cc. Utilize pertinent data, including aggregate data, concerning resident satisfaction, quality indicators, competency findings and other outcome data to assist in the needs assessment process.~~
~~dd.~~
~~ee. Provide in-service education documentation including original sign-in sheets, outlines, evaluations or post-tests to DET for inclusion into the LHH education database within 2 weeks of the training.~~
~~ff.~~
~~gg. Monitor employee compliance with mandatory education by reviewing education compliance reports, following up with individual staff who have not completed their mandatory education by the designated due date and addressing timely completion of mandatory education as part of the annual performance appraisal process.~~
~~hh.~~
~~ii. Oversee that the environment is inclusive of diversity (i.e. pictures, role-modeling inclusive behavior) and supports cultural humility.~~
~~jj.~~
~~kk. Collaborate with DET if any employee was placed on administrative leave for abuse or any disciplinary issue to identify training needs prior to returning to full duty.~~
~~ll.~~
b. These trainings will be ~~led~~conducted and made available by subject matter experts.

c. Staff are encouraged to pursue professional certifications and advanced degrees.

~~6.~~7. Staff Development Steering Committee (SDSC)

a. The Staff Development Steering Committee (SDSC) ~~was developed to increase staff awareness and support~~supports LHH's core principles of learning~~.~~ and continuous improvement

b. The ~~Staff Development Steering Committee comprise of~~SDSC is an interdisciplinary ~~team of members~~committee with representatives from: Administration, Nursing, Medicine, Social Services, Clinical Nutrition, Activity Therapy, Pharmacy, ~~Rehabilitation Services~~Rehab S~~E~~ervices, Environmental Services, Human Resources~~,~~ and Quality Management.

   i. Additional members from other departments may join the Committee with approval from their ~~Division~~division ~~head~~Hhead and the Chair.

c. ~~Functions~~Role of ~~Core Team Members~~SDSC:

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

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

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

   iii. Improve communication across departments

   iv. Review and revise ~~develop~~ education related policies and procedures~~.~~

   v. ~~Cultivate a culture of compliance to support the~~Promote alignment with organization's mission ~~and~~, vision ~~of the organization.~~and compliance requirements

   vi. ~~Promote~~Support continuous Quality Assurance and Performance Improvement (QAPI) ~~approach to improve patient/resident outcomes and organizational effectiveness.~~

   ~~Evaluate the effectiveness of education programs.~~

   vii. Establish annual educational priorities based on ~~resident outcomes~~ data and ~~staff~~ performance ~~appraisal information.~~trends which may include:

viii. Establish annual hospital-wide educational priorities

d. Other Functions of Sub-groups of SDSC Members as part of their organizational roles

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

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

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

iii. Develop and maintain Certified Nurse Assistant Orientation and In-Service, Programs as required by CDPH.

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

~~7.~~8. Documentation of Formal Educational Activities

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

~~b.~~ Documentation of in-services shall include:
b.

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

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

ii. Original sign-in sheets

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

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

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

   i. Title of Program

   ii. Date(s)

   iii. CE hours

   iv. Objectives

   v. Overview

   vi. Course Outline

   vii. Method of Evaluation

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

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

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

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

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

g. NEO records are maintained in Human Resources employee personnel file. ~~for a minimum of 10 years in DET and submitted to Human Resources thereafter.~~

ATTACHMENT:
None.

REFERENCE:
None

Reviewed: 07/01/03, 08/11/25, 12/09/25, 15/03/10, 16/09/13, 19/07/09, 21/02/09, 22/12/13, 24/04/09, 25/03/10, 26/01/20 (Year/Month/Day)

Original adoption: 07/01/03

Deletion Medical Services Policies and Procedures

PSYCHOTROPIC MEDICATION MANAGEMENT

POLICY:

Laguna Honda Hospital and Rehabilitation Center provides psychotropic medications for LHH residents as clinically indicated.

PURPOSE:

To provide appropriate care to residents and to conform to State and Federal regulations relating to the use of psychotropic medications in skilled nursing facilities.

DEFINITION:

1. Psychotropic medications are drugs that affect brain activities associated with mental processes and behavior. They are divided into four broad categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic medications ("Psychotropic Drug Use in Nursing Homes," Department of Health and Human Services, Office of Inspector General, November 2001 OEI-02-00-00490). For the purpose of this policy, psychotropic medications also include any other drugs used for the purpose of effecting mental status or behavior.

2. LHH providers of psychotropic medications include all LHH Medical Staff members with prescribing authority as defined by the State of California.

PROCEDURE:

1. ASSESSMENT PRIOR TO PRESCRIBING

a. The resident shall receive proper clinical assessment prior to being prescribed psychotropic medications.

b. The assessment may be performed by the Primary Care Physician or by a LHH consulting psychiatrist. For initiating services by a LHH consulting psychiatrist, please refer to MSPP D08-03, Access to LH Psychiatry Services.

c. The assessment shall include documentation of the medical indication for prescription of psychotropic medications.

d. If the assessment is performed by a LHH consulting psychiatrist, the psychiatrist will discuss the findings of the assessment with the referring physician including diagnosis, medical necessity (Specialty Mental Health, Non-specialty Mental Health, Substance Treatment And Recovery Services, Primary Care Behavioral Health - see MSPP D08-02 Attachment 1, Behavioral Health Medical Necessity) and the suggested treatment plan. The referring physician and the consulting psychiatrist will determine whether the referring physician or the psychiatrist will assume responsibility for prescription of psychotropic medication, but for residents whose mental health conditions meet medical necessity for Specialty Mental

Health, psychotropic medication management shall be assumed by the psychiatrist, with the consent of the resident or surrogate decision maker. This is to ensure that the resident's clinical needs can be met by direct psychiatrist services and other mental health services under the Specialty Mental Health program. In the case of urgent situations, or if a psychiatrist is unavailable, psychotropic medication management may be provided by a covering member of the medical staff until a psychiatrist is available.

2. RESPONSIBILITIES RELATED TO PSYCHOTROPIC PRESCRIBING

a. The LHH prescriber of psychotropic medications, whether primary care provider or psychiatrist, will follow all LHH documentation practices related to psychotropic medications including, but not limited to, review and use of:
   i. LHH psychiatric/psychotropic medication consent form and procedures
   ii. Physician Quarterly Psychotropic and Sedative/Hypnotic Regimen Review
   iii. Behavioral monitoring procedure
   iv. Licensed Nurse Weekly Behavior Summary
   v. Gradual dose reduction implementation and documentation
   vi. Perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications
   vii. Regulatory guidelines regarding the use of psychotropic medications in skilled nursing facilities

b. LHH psychiatrist prescribers of psychotropic medications will also follow documentation guidelines of San Francisco Health Network Behavioral Health Services (SFHN BHS) and instructions for relevant electronic health record (EHR). LHH psychiatrists will document in the designated EHR.

c. For psychotropic medications the prescriber shall ensure that the use of the medication is clinically appropriate and only after inadequate response to non-pharmacologic interventions. Use of antipsychotic medications for dementia-related behaviors should be avoided unless there is a strong clinical indication, and in those instances, should be used at the lowest possible doses, for the shortest possible period of time, and with clearly documented discussion of risk versus benefit.

3. INFORMED CONSENT

(Refer to MSPP C02-01 Patient's Consent for Treatment and Operation. HWPP 25-10 Use of Psychotropic Medications.)

a. Resident with decision making capacity or resident without decision making capacity but with a surrogate decision maker (SDM):

   i. The resident or SDM will be informed by the prescribing physician about the reasons for the medication, the goals of therapy, the probable and potential side effects and the reasonable alternative treatments. The resident or SDM

will be informed about the right to accept or refuse the proposed treatment and informed that consent may be withdrawn at any time. The resident or SDM may state their desire to withdraw consent to any member of the treating staff.

ii. The type of medication, frequency of administration, dosage amount, method of administration, and duration of taking the medication will be described.

iii. The resident or SDM and the physician will sign the informed consent form for psychotropic medications.

iv. Informed consent may be obtained from the SDM over the phone, in which case "telephone consent" should be noted on the informed consent form.

v. Informed consent is required for sedative hypnotics used to aid sleep.

vi. A written copy of the consent form will be maintained in the medical record. If a resident verbally consents to the medication but does not wish to sign the form, the unsigned form will be placed in the medical record with a note indicating that the resident understands the nature & effect of the medication, consents to the administration of the medication, but does not wish to sign.

vii. Any time a psychotropic medication is increased beyond the limit set in the consent, a new consent must be obtained.

viii. Informed consent must be obtained by the prescriber prior to the administration of the first dose for all new orders, except in an emergency situation as described in Section 5.

b. Resident without decision making capacity, without a surrogate decision maker, and unable to understand the proposed treatment. Per California Health and Safety Code Section 1418.8:

i. Prior to the initiation of psychotropic medications, attempts should be made by the Resident Care Team to identify a person with legal authority to make health care decisions for the patient.

ii. If no SDM can be identified, the attending physician will convene a meeting of the RCT prior to the administration of the medication, except in an emergency situation as describe din Section 5. The RCT shall include the attending physician, the nurse responsible for the resident and other appropriate staff as determined by the resident's needs. A patient representative must be included on the RCT, where practicable. This patient representative may be a family member or friend who is unable to assume decision-making responsibility, or another person authorized by law such as the public guardian or ombudsman. The RCT must:

- review the resident's medical condition;

- discuss the reason for use of a psychotropic agent;
- discuss the resident's desires, if known;
- discuss the type of psychotropic medication planned, including the probable impact on the resident's condition with and without the medication, and the probable frequency and duration; and
- discuss reasonable alternative interventions considered or utilized and reasons for their discontinuance or inappropriateness.

The prescribing physician will note in the resident's medical record, which may include on the informed consent form itself, that the resident does not have capacity to make decisions concerning his or her health care, that there is no person with legal authority to make those decisions on behalf of the resident, and that resident's interdisciplinary team reviewed the prescribed medication intervention.

iii. The resident may seek judicial review of the RCT decision to provide the resident with such psychotropic medication(s).

.

iv. The RCT will evaluate the use of the psychotropic drug at least quarterly or upon a significant change in the resident's medical condition.

v. The determinations required to be made pursuant to this section 3(b), as required under California Health & Safety Code Section 1418.8 (l), and the basis for those determinations shall be documented in the patient's medical record and shall be made available to the patient's representative for review

4. Family Notification Regarding Antipsychotic Medications for Residents with Decision Making Capacity

The prescribing physician shall seek the consent of the resident to notify the resident's interested family member, as designated in the medical record. If the resident consents to the notice, the physician or psychiatrist shall make reasonable attempts, either personally or through a designee, to notify the interested family member, as designated in the medical record, within 48 hours of the prescription, order, or increase of an order. Notification of an interested family member is not required if any of the following circumstances exist:

- There is no interested family member designated in the medical record.
- The resident has not consented to the notification.

As used in this section, the following definitions shall apply:

- "Resident" means a patient of a skilled nursing facility who has the capacity to consent to make decisions concerning his or her health care, including medications.
- "Designee" means a person who has agreed with the physician or psychiatrist to provide the notice required by this section.

- "Antipsychotic medication" means a medication approved by the United States Food and Drug Administration for the treatment of psychosis.
- "Increase of an order" means an increase of the dosage of the medication above the dosage range stated in a prior consent from the resident.

5. EMERGENCY USE OF PSYCHOTROPIC MEDICATIONS

a. In an emergency situation, psychotropic medications may be ordered by the physician electronically or in writing when necessary to ensure the physical safety of the resident, other residents, or members of the staff. This shall be done in accordance with all applicable state and federal regulations.

b. There should be appropriate documentation in the EHR of the specific circumstances for which the medication is prescribed.

c. The resident will be monitored by the nursing staff for the effectiveness of the medications and any adverse reactions.

d. Emergency orders will be continued only as required to treat the emergency condition.

e. Before continuing psychotropic medications which were initiated on an emergency basis, informed consent must be obtained.

f. When psychotropic medications have been used in an emergency situation and the resident is unable to consent and there is no surrogate, informed consent must be obtained through the RCT.

g. The form, Nursing Assessment and Progress Note: Potential Emergent/Unplanned Psychotropic Drug Use, will be completed by nursing and signed by the prescribing physician when psychotropic medications are used in emergency situations.

6. ONGOING MONITORING

a. The prescribing physician will review the psychotropic medications quarterly and document in the EHR the review of psychotropic medications, noting efficacy and possible side effects.

b. In accordance with regulatory guidelines, an attempt shall be made for gradual dose reduction of all psychotropic medications. Tapering shall be attempted in conjunction with the RCT quarterly meeting and documentation shall be placed in the chart quarterly when there are strong clinical indications for not tapering.

c. The prescribing physician will perform the Abnormal Involuntary Movement Scale (AIMS) for residents on antipsychotic medications:
   - Within the first 30 days of admission (if new to LHH) or within the first 30 days of starting or discontinuing an antipsychotic medication at LHH.
   - Every 6 months while on an antipsychotic.
   - When clinically indicated.

d. For all residents on psychotropic medications, the nursing staff shall monitor resident behavior, observe for drug side effects according to nursing procedure and notify the primary physician as indicated.

e. The electronic copy of the written consent form must be kept in the resident's EHR. A new consent form for the same medication need not be completed when a resident is discharged and re-admitted; however, changes in medication dosing should be discussed with the resident or SDM.

REFERENCES:

1. Psychotropic Drug Use in Nursing Homes, Department of Health and Human Services, Office of Inspector General, November 2001 OEI-02-00-00490
2. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilitie §483.45(d) Unnecessary drugs and §§483.45(c)(3) and (e) Psychotropic Drugs
3. MSPP C02-01 Patient's Consent for Treatment and Operation
4. MSPP D08-02 Attachment 1, Behavioral Health Medical Necessity
5. MSPP D08-03 Access to LH Psychiatry Services
6. California Health and Safety Code Section 1418.9
7. HWPP 25-10 Use of Psychotropic Medications

Most recent review: 19/10/03; 22/08/04; 23/06/30
Revised: 19/10/03; 22/08/04; 23/06/30
Original adoption: 12/03/27

New Nursing
Policies and Procedures

Non- Invasive Ventilation Support: Continuous Positive Airway Pressure (CPAP)/Biphasic Positive Airway Pressure (BiPAP)

POLICY:

1. Only non-intubated residents/patients in stable respiratory status with CPAP/BiPAP may be admitted to and cared for at Laguna Honda Hospital (LHH).

2. Screening for the appropriateness of the resident/patient prior to admission is per Hospital Wide Policy and Procedure (HWPP) #20-01: Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units. In situations when appropriateness is in question, the Chief Medical Officer and Respiratory Therapy (RT) will be consulted.

3. A physician's order specifying inspiratory pressure, expiratory pressure (if applicable), back up rate (if applicable), CPAP/BiPAP mask type and size or pillow circuit, frequency and duration of treatment, and indications are required.

4. The Respiratory Care Practitioner (RCP) and physician are responsible for the overall airway management.
~~4.~~5. Registered Nurses (RNs) and/or RCPs can manipulate and operate non-invasive ventilator (CPAP/BiPAP). Licensed Vocational Nurses (LVNs) cannot as this is outside the LVN scope of practice.

~~5.~~6. Residents/patients with tracheostomies who require BIPAP support will not be accepted to Laguna Honda for admission.

PURPOSE:

To ensure that residents benefit from the safe and effective use of Continuous Positive Airway (CPAP) and Biphasic Positive Airway devices (BiPAP).

DEFINITIONS:

BiPAP devices deliver pressure during both inspiration and expiration, with a higher pressure during inspiration.

CPAP devices deliver continuous airway pressure at a constant inspiration and exhalation phase.

CHARACTERISTICS:

CPAP/BiPAP devices are used for residents/patients who breathe spontaneously, but whose efforts do not meet total respiratory requirements.

PROCEDURE:

A. A Laguna Honda Hospital admission screening team member will notify Laguna Honda Respiratory Therapy in the event that CPAP/BiPAP is warranted.

B. Assessment by Registered Nurse upon admission

1. Determine that the physician's order is reflected for the device according to policy.

2. Determine resident's/patient's ability to use CPAP/BiPAP independently and correctly. Consult RCP as needed.

3. Assess for impaired airway clearance during treatment as exhibited by signs and symptoms of respiratory distress.

4. Observe facial skin for irritation related to mask, elastic straps or headgear.

C. Interventions

1. Prior to use, check that pressure settings are as ordered.

2. Advise resident/patient to immediately report headaches, chest pain, nasal, sinus or ear pain, increased sleepiness and gastric upset.

3. Check to ensure that air is not leaking around the mask.

D. Care of the Equipment

1. Replacement equipment may be requested through the Respiratory Therapy Department

2. Weekly and as needed, detach and clean the equipment:
   a. Wipe down the device, tubing, and mask with an alcohol wipe and allow to dry thoroughly.

3. Check filter monthly
   a. RT will check, clean or change as needed the filter monthly and document that this is done on the Integrated Progress Notes.

E. Documentation

1. Resident Care Plan:
   a. Address reasons for use of the CPAP/BiPAP
   b. Individualized interventions include the monitoring for activity level, coughing, daytime hyper somnolence, condition of the facial skin, etc.

2. Worklist based on Physician's Order for the type of device, settings, mask size and nightly use

3. Weekly Nursing Notes:

   Address the outcome of the Resident Care Plan goals and monitoring.

ATTACHMENTS/APPENDICES:

None

REFERENCES:

Elsevier (2024) Ventilation: CPAP, BIPAP and HFNC https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on May 6, 2025

Heuer, A.J., Hilse, A.M. (2021). Chapter 42: Medical gas therapy. In R.M. Kacmarek, J.K. Stoller, A.J. Heuer (Eds.), *Egan's fundamentals of respiratory care* (12th ed., pp. 906-935). St. Louis: Elsevier.

Respiratory Care ZFGH 500 – Continuous Ventilation Procedures (Last Approved 01/2023)
Continuous Ventilation Procedure
Modes of Mechanical Ventilation
Non-Invasive Ventilatory Support Protocol

California Board of Vocation Nursing and Psychiatric Technicians
Website:
Board of Vocational Nursing & Psychiatric Technicians

CROSS REFERENCES:

Hospitalwide Policy and Procedure
#27-04 Special Respiratory Therapy Equipment.
#20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units

Originated: 2007/03

Revised: 10/2010, 03/2016, 09/12/2017; 10/11/2022; 05/15/2025

Reviewed: 08/19/2025

Approved: 08/19/2025

Revised Nursing Policies and Procedures

NURSING CLINICAL AFFILIATIONS (Student Placements)

POLICY:

1. Laguna Honda Hospital (LHH) supports the clinical training and education of nursing professions, including Nursing Assistants, Unit Clerks, ~~Home Health Aides,~~ Paramedic Students, Licensed Vocational Nurses, Registered Nurses, Advanced Practice Nurses and those enrolled in doctoral programs.

2. Each ~~c~~Clinical ~~i~~Instructor will not exceed eight (8) students per clinical shift. Clinical Iinstructor will provide supervision on-site to all their students.

3. All nursing students or ~~preceptees~~trainees, whether pre-certification, pre-licensure, or in a post-licensure course of education must:

   a. Be enrolled in an educational institution approved by the California Department of Public Health, Board of Registered Nurses, and/or Board of Vocational Nursing and Psychiatric Technicians,
   b. Be enrolled in an educational program that has a current contract with the San Francisco Department of Public Health. The contract stipulates responsibilities of faculty and of LHH staff consistent with legal and ethical standards of practice,
   ~~c. Adhere to the following procedures.~~

4. The ~~c~~Clinical ~~i~~Instructor must ~~communicate all planned treatments and medications~~ communicate resident care prior to implementation for approval to ~~-~~the Charge Nurse.

5. The ~~c~~Clinical instructor will ~~complete~~sign in and out on the *Clinical Instructor's Sign-in Sheet* in the Nursing Office each day that they are on-site with the students. The Clinical Instructor will provide a copy of students' daily sign-in sheets to Department of Education and Training (DET).

6. Department of Education and Training (DET) is responsible for ~~monitoring current affiliations' agreements and~~ following up on clinical or educational concerns that occur as a result of student placements and will provide a regular update to the Director of DET and/or ~~Chief Nursing Officer~~Directors of Nursing (DONs).

7. To avoid conflicts of interests:

   - LHH nursing staff are not permitted to be paid or unpaid ~~c~~Clinical ~~i~~Instructors of educational programs and supervise students at their place of employment.
   - LHH nursing staff are not permitted to be placed into a student placement at LHH.
   - LHH nursing staff are not permitted to serve as a nursing student ~~preceptor~~ trainer for other LHH nursing staff.

PURPOSE:

1. To outline guidelines to ensure a safe and educationally sound clinical experience.

2. To clarify the roles and responsibilities of the school and the nursing staff of LHH.

PROCEDURE:

A. ~~One Two~~ne ~~months~~ 6 weeks prior to the ~~practicum~~start of the clinical rotation.

1. The ~~c~~Clinical ~~i~~Instructor/Affiliate Student Placement Coordinator will send a request via email for student placement to the Student Affiliation Coordinator in the Department of Education and Training Department.

2. The C~~c~~linical ~~i~~Instructor/Affiliate Student Placement Coordinator will electronically send ~~a clinical syllabus~~all required documents to the Student Affiliation Coordinator prior to the start of the clinical rotation~~.~~

3. All schools who utilize LHH as a clinical site must have an approved school affiliation contract with the City and County of San Francisco.

~~3.~~4. If the school has not had a recent affiliation with LHH (~~i.e.~~e.g. within the past school year), the Student Affiliation Coordinator will verify with the San Francisco Department of Public Health (SFDPH) Contracts Office ~~at (415) 554-2839~~ to determine if a current contract exists between the school and SFDPH.

~~4.~~5. The C~~c~~linical ~~i~~Instructor and the Student Affiliation Coordinator, in collaboration with the Nurse Manager, when applicable, shall determine the practicum dates, days, hours and the resident care units where students will be placed.

~~1. A written agreement is reached describing the clinical experience among the faculty, Affiliation Coordinator, and Nurse Manager. This agreement will specify the days and hours the student will be on the neighborhood, the skills the student will be practicing, services the students will be providing and programs the students will be developing. The written agreement will specify in writing the faculty's responsibility related to supervising pre-licensure students' administration of medication or treatments.~~

~~5.~~6. Students will receive orientation prior to the first day of their clinical rotation via SF Learning ELM and EHR (Epic) training as appropriate.

~~6.~~7. The Clinical ~~i~~instructor/Affiliate Student Placement Coordinator will send the list of students with complete demographics for pre-boarding and onboarding, and to obtain POI numbers for each student. Student Affiliation Coordinator will conduct~~i~~ pre-boarding and communicates with the Clinical Instructors/Affiliate Student Placement Coordinator all instructions to disseminate instructions to the students.

~~7.~~8. ~~For~~ All ~~c~~Clinical ~~i~~Instructors/Affiliate Student Placement Coordinator will need to inform the Student Affiliations Coordinator and provide complete demographics in order to start the pre-boarding and onboarding process. Orientation of ~~c~~Clinical ~~i~~instructors will be conducted via SF Learning ELM, complete required EHR (Epic) training, and attend ~~in-person nursing orientation~~ initial tour of the facility. Scheduling of ~~orientation~~ tour can be arranged with the Student Affiliation Coordinator and/or the New Employee Orientation Coordinator via email or phone call.

~~8.~~9. Once request for clinical rotation is confirmed, the Student Affiliation Coordinator will electronically send Clinical Instructor/Affiliate Student Placement Coordinator required compliance documents and orientation education requirements ~~Student/Instructor Health Screening Verification Form, and Student/Instructor Roster/Clinical Schedule~~, preboarding and onboarding, and orientation instructions.

B. Orientation to Clinical Instructor

1. Clinical Instructor orientation will be coordinated by the Affiliation Coordinator, New Employee Orientation Coordinator, and/or Nursing Orientation Coordinator.

1.2. Clinical Instructor orientation education will be provided via SF Learning ELM to cover regulatory and compliance topics.

2. The following orientation content will be covered during the clinical instructor orientation via SF Learning ELM:

   a. Welcome and Overview
   b. Hospital and Nursing Organization
   c. Resident Rights and Civil Rights
   d. Abuse Video: Film on "Iit's Your Legal Duty" and Mandated Reporting Law
   e. Abuse Post Test, Attestation,
   f. Code of Conduct
   g. Confidentiality Agreement
   h. Privacy and Compliance
   i. Infection Control
   j. Fire Safety,
   k. Disaster Preparedness
   l. Cardiopulmonary Emergencies
   m. Prevention of Workplace Violence
   n. Injury Illness Prevention Program
   o. Quality Assurance Performance Improvement (QAPI)
   p. Cultural Humility
   q. Dementia and Behavior
   r. Trauma Informed Care
   s. Resident Color Codes, Code Green
   t. Individualized Precautions to Prevent Aspiration
   u. Therapeutic Communication
   v. Facility tour by the Clinical Instructor

C. Clinical Instructor Responsibilities

1. The ~~c~~Clinical ~~i~~instructor shall collaborate with the Charge Nurse and/or Nurse Manager to determine students' resident assignments.

2. The ~~c~~Clinical ~~i~~Instructor will ensure that students receive hand-off report from the Charge Nurse or designee before providing care.

2.3. The Clinical Instructor will be present and available for students during their clinical assignment in any of the care areas at LHH.

3. The ~~c~~Clinical ~~i~~Instructor will provide direct/line of sight supervision for each ~~student during medication administration, and each student will be supervised during treatments by either the clinical instructor or the LHH licensed nurse. Students will **not** administer controlled substances. The clinical instructor will co-sign the student in the EHR for each medication administered, and t~~The ~~c~~Clinical ~~i~~Instructor ~~or LHH licensed nurse will co-sign in the EHR for the treatment administered.~~

4. ~~The c~~Clinical ~~i~~Instructor will co-sign all EHR documentation completed by student.

D. Student Responsibilities

1. Each student must wear a visible school identification (ID) badge so that it can be easily identified.

2. Each student must obtain a hand-off report from the Charge Nurse or designee before providing care. When leaving the neighborhood, students will provide appropriate hand-off report to the Charge Nurse or designee, and Cclinical linstructor.

~~3. Students needing to review medical records prior to clinical rotation must check in with the Charge Nurse and adhere to LHH policy on confidentiality (LHH 21-01 Medical Record Information: Confidentiality and Release).~~

~~4.~~3. Students may s~~S~~eek guidance from their Clinical Instructor ~~faculty member~~ or Student Affiliations Coordinator regarding activities and student role.

E. Student Affiliation Coordinator Responsibilities

1. Ensure students completion of required forms and required information for pre- and onboarding prior to orientation.

2. Request for POI access and coordinate SF Learning ELM orientation and EHR (Epic) training for Cclinical linstructor and student orientation prior to start of clinical rotation.

3. Keep records of clinical instructors and students' orientation and training documents.

4. Maintain communication with the school affiliation.

5. Maintain communication with the school affiliation and report any problems related to the student.

6. Keep records of student roster and neighborhood assignments including assigned Cclinical linstructors.

ATTACHMENT:

NONE

CROSS REFERENCE:

Hospitalwide Policy and Procedure
~~Laguna Honda HHPP~~ 84-01 Student Affiliation
~~LHH 22~~1-01 Medical Record Information: Confidentiality and Release

Adopted: 1/2005

Revised: ~~2007/~~10/2007; ~~2011/~~09/27/2011; ~~2015/~~09/08/2015; ~~2019/~~07/09/2019; ~~2022/~~12/13/2022; 10/06/2025

Reviewed: ~~2022/~~12/13/2022

Approved: ~~2022/~~12/13/2022

NURSE AND RESIDENT CALL SYSTEM

POLICY:

1. The Laguna Honda Hospital (LHH) Executive Committee must grant authorization prior to turning off the NurseCall system or before modifying any system settings that may impact resident safety.

2. Group Assignments Worksheets must be entered accurately in the Master Station by charge nurse or designee. If any changes are made in either the resident grouping or wireless phone assignment, the Group Assignment Worksheet must be updated first then in the Master Station by the same designated staff.

3. Any changes or updates related to a resident's demographic information that can be seen in the Master Station are done by an authorized staff member from Admission & Eligibility (A&E).

4. Residents with limited hand mobility, aphasia, and/or hard of hearing will be evaluated by a licensed nurse using adaptive devices guidelines for the correct adaptive device. Complex situations will be referred to appropriate rehabilitation staff for evaluation.

5. Unit clerks can answer the routine calls and forward the call/request to the assigned nursing staff.

6. Nursing staff assigned to a resident will respond to the nurse call system by going to the location of the calling resident. However, routine calls can also be answered directly through the Nurse Call Master Station or via the Wireless phone. All license nurses are not assigned to receive Routine Calls, except PM Acute. Calls made from any emergency pull cord station (i.e., bathroom/toilet and shower/tub room), bed exit alerts, code blue alerts, and staff emergency calls must be answered immediately by going to that location.

7. Fire alerts in residents' rooms are triggered automatedly by the system and are not manually activated by any residents.

8. Any call where the listener is unable to determine the resident's need requires the responder to physically go to the resident/location.

~~9. Designated HHA may respond to routine calls and bath calls as requested by the LN (Licensed Nurse) and within the scope of HHA responsibilities.~~

~~10.~~9. Daily checking of all bedside call lights and weekly checking for shower and bathroom call lights for proper function are part of the nursing assistant's work list in the Electronic Health Record (EHR).

PURPOSE:

To be able to communicate with residents and staff in order to meet the resident's need in a timely and prompt manner.

CHARACTERISTICS:

Each neighborhood has two master call stations, one for each nursing station in the South Residence Building (SRB) and the North Resident Building (NRB); Pavilion Mezzanine (PM) will have three master stations (PM-SNF; PR- Acute Rehab, PA- Acute Medical).

The Master Station allows staff to answer the resident's routine call, view new calls/alerts, monitor the active calls and alerts, make calls directly to resident's room, and monitor requests that have been dispatched to staff members and schedule/send text messages to the staff.

Each neighborhood has their own template for the Group Assignment Worksheet. This is printed out daily by each shift. Charge nurses or designee changes the worksheet details if there staffing shortage or a change in the assigned staff or there is a broken Wireless Phone. Any changes in the Group Assignment Worksheet should be duplicated in the Master Station. This Group Assignment Worksheet needs to be kept by charge nurse or designee for three (3) years in case an unusual occurrence may occur.

A. Types of Nurse and Resident's Call Stations

1. Master Call Station - comes with a computer with the vendor's software, a touch-screen monitor, mouse, keyboard, and connected telephone handset that is used to talk to the resident when answering a routine call. The touch screen has a floor map displaying all resident rooms and beds in the neighborhood. Group and Wireless Phone assignments are added and edited in the Master Stations. Pens or other sharp objects other than fingers should not be used to operate the master station.

2. Patient's Station - located in each room next to the resident's bed. All calls activated in patient station, pillow speakers, and other adaptive nurse call devices will show in the Master station screen and are routed to the assigned caregiver's Wireless Phone

3. Patient Pillow Speaker -connected to every patient call station. The pillow speaker is also used as remote control and speaker for the television. Pillow speakers or adaptive nurse call devices must be within the resident's reach.

4. Emergency Pull Cord Station -located in every bathroom, toilet, shower or tub room in every neighborhood.

5. Staff Call Stations and Staff Duty Stations – are located in commonly used areas by staff and residents. These include the living rooms at the end of each household, the great rooms and the staff lounge rooms.

B. Group Assignment Worksheet

See Attachment 3–A for a sample of Group Assignment Worksheet

C. Hallway Light Illumination Patterns

For each type of call, a corresponding light illumination pattern is displayed on the ceiling light at the end of the hallway (zone light) and outside each resident's door (dome light). These lights will provide visual cues to the staff signaling the location where a call has been made.

See Attachment 3-B for list of identified Light Illuminating patterns and the type of calls it identifies.

1. Zone lights – located at the end of each household in the living room area, and in between nurses' stations, and great rooms. The zone light remains lit if there is an active call in the neighborhood.

2. Dome lights –located outside each resident room, above the door. The dome light remains on if there is an active call/alert inside the room

PROCEDURES:

A. Receiving and Responding to Calls

When calls and alerts are activated, it will be sent to both NurseCall Master Station and displayed according to their priority ranking, and also auto paged to the wireless phone.
Listed below are the available calls and alerts in order of highest priority.

1. Fire Alert – this highest priority call is always activated by the fire alert system. It is only triggered when there is fire within the resident's room. The alert is displayed in the NurseCall Master Station and will send alerts to all staff Wireless Phones. It will not trigger if the fire is detected in any other area of the neighborhood (but will trigger the fire alert system). Smoke Detectors are connected directly to the Patient Stations.

2. Code Blue Call – this highest priority call is intended only for life-threatening medical emergencies. This call overrides any routine call, bath call, or staff emergency call. This call must be responded to by any LN and/or nursing staff by going directly to the resident's location where the call was activated. A Code Blue Call can only be initiated at the patient station where medical emergency assistance is needed. This call can only be cancelled from the originating patient station after the Code Blue has been cleared by the Code Blue Team. Refer to LHHPP 24-16 (Code Blue). NOTE: There are also code blue in the clinic, rehab and wellness.

3. Staff Emergency Call – high priority calls activated by pressing the "STAFF" button in the patient's station, or NurseCall master call station. This call will override any routine call. Available staff working in the neighborhood should respond and check the resident's status immediately. This call can only be cancelled in the originating patient station.

   Examples of staff emergency calls, but not limited to:
   a. Resident found on the floor
   b. Resident with unsafe behavior needing staff interventions
   c. Any emergent situation that may require a second nursing staff for assistance

4. Bath Call – a high priority call activated from the pull cord stations located in every resident's bathroom or toilet room, tub room, or tub room in every neighborhood. When activated, a "Bath" call appears on the Master Station and the wireless phone of assigned staff. However, due to the hospital building's wiring and sharing of bathroom, the room or bed number that is closest to the bathroom is displayed in the alert message. The assigned staff or any available staff should respond and check the resident's status or condition immediately. This call can only be cancelled in the originating toilet station. Each shower pull cord station will state "Cancel at Toilet" (station).
   a. Bath Calls activated from the toilets on the ground and first floors – Pavilion Building go to the nursing office Master Station

5. Routine Call – regular call initiated from pillow speaker, patient's station, or other adaptive nurse call devices.
   a. For some simple requests, a pre-programmed "Send Request" button from the Master Station will send a text message to the assigned staff's Wireless Phone indicating the request, room number and resident's name. Alternatively, a designated staff member answering the call from the Master Station can type a specific request, which is then sent to the assigned staff's Wireless Phone. Once a request is sent to a Wireless Phone, the

request must be cleared by pressing the *cancel* button on the patient station. If the request is not cleared in a pre-determined time, the request will re-appear on the Master Station and will be resent to the Wireless Phone.

b. See attachment 3-C for Table of Wait time

6. Cord-out Call - activated when certain devices (i.e. pillow speaker, adaptive nurse call device, smart bed cord and the beds power cord.) are accidentally pulled out from the patient station, disengaged from a connector, or unplugged from the electric outlet. These calls can only be cancelled from the resident's room by reconnecting items that were pulled out, disengaged or unplugged.

B. Checking Function of Resident Call System

1. Testing the Patient Station: a call initiated from the resident's pillow speaker or adaptive device should appear as a routine call in the Master Station as well as on the assigned (CNA or PCA staff's Wireless Phone). The call should be answerable both at the Master Station and by a Wireless phone, with both parties able to hear each other talking. Both dome light outside of the resident's room and the zone light at the end of each hallway should turn on.

2. Testing the Bath Call: when the bathroom pull cord is activated, the call should appear as a bath call in the Master Station as well as the assigned staff's Wireless Phone with the room number. Both dome light outside of the resident's room and the zone light at the end of each hallway should turn on.

    a. For the bath calls made from the spa rooms and public toilets within the neighborhood, a designated group of nursing staff are assigned to respond when the pull cord is pulled. The same steps should be followed as stated above when testing pull cords from the spa room and public toilets within the neighborhood.

3. Acknowledged in the Work List in EHR of the assigned Nurse Assistant upon completion of checking:

    a. Daily for the bedside call lights
    b. Weekly on bed stripping days for shower and bathroom call lights

4. Reporting of Non-Working Resident Call System

    a. Report to Facility Services
        i. if the nursing staff is unable to hear a call to or from the Master Station, Patient Station, Pillow Speaker, Adaptive Nurse Call Devices, or from Wireless Phone.
        ii. If nursing staff is unable to receive a bath call message on the Wireless Phone or in the Master Station, or if the pull cord needs repair.
        iii. If the dome or zone light is not working.
    b. Open a ServiceDesk ticket
        i. If the name of the resident displayed was incorrect
    c. Contact Central Supply
        i. To replace a pillow speaker.

C. Downtime Procedures

During a planned downtime, email notification will be sent to all users.

During unplanned downtime, email notification, communication tree and/or text page is used for communication.

ATTACHMENTS:

Attachment 1: Nurse Call System User Guidelines
Attachment 2: Wireless Phone Operating Guidelines
Attachment 3: Nurse and Resident Call System
3A: Sample of Group Assignment Work Sheet
3B: Light Illumination Patterns
3C: Table of Wait Time

REFERENCES:

West-Com Nurse Call Systems, Inc., West-Call® FocusCare® User's Interface Software, Installation and Configuration Version 1.1.8 October 2014
Cisco Wireless IP Phone 8821 and 8821-EX User Guide

CROSS REFERENCES:

Hospitalwide Policy and Procedure
24-16 Code Blue

Nursing Policy and Procedure
D9 3.0 Bed Stripping and Terminal Cleaning
M 12.0 Adaptive/Assistive Devices Management

Original: 2010/10

Revised: ~~2011/~~07/26/2011; ~~2013/~~09/24/2013; ~~2015/~~03/10/2015; ~~2015/~~10/16/2015; ~~2016/~~07/12/2016; ~~2021/~~04/13/2021; ~~2023/~~01/10/2023; ~~2025/~~01/08/2025; 10/06/2025

Reviewed: ~~2025/~~03/10/2025

Approved: ~~2025/~~03/10/2025

Attachment 1: Nurse Call System User Guidelines and Procedures in Responding to Calls

A. Definition:

A Nurse Call System is a method for hospital staff to communicate with residents/patients. Different call stations (i.e., Master Station, Patient Station, Staff Station) allow staff to respond to resident's/patient's call, make calls directly to resident's/patient's room, and monitor any requests that have been dispatched to staff members. The call system will also alert staff to respond during emergencies (i.e., Code Blue, staff emergency, or bath calls).

Master Station

- A Nurse Call Ssystem monitor, that is in each nurse's station, ~~and~~ is used to:
  - Answer and cancel a routine call from the resident's/patient's room.
  - Call a resident's/patient's room.
  - Send Requests and/or messages to staff.
  - Assign residents/patients to a group template.
  - Assign a staff member's Wireless Phone to a group (e.g., Licensed Nurse, CNA, ~~HHA,~~ etc.
- A Request that is a pre-set or manually entered will ONLY send a reminder notification (when not addressed) to the sending master station. All calls, alerts, and duration of calls are time stamped and recorded in the log bin of the Nurse Call Master Station.
- This is a touch-screen device with an attached mouse. Pens, markers, or other objects other than fingers should not be used when operating this device.

Patient Station

- When a resident/patient presses the routine call using the pillow speaker, adaptive device or the button on the patient station, tone sounds are emitted with LED illuminations for notifications. The call is also displayed on the nurse call master station. When a call is answered, two-way communication is established between the patient room and nurse master station. Audio is disconnected when a call is canceled or put on hold,

Staff Station

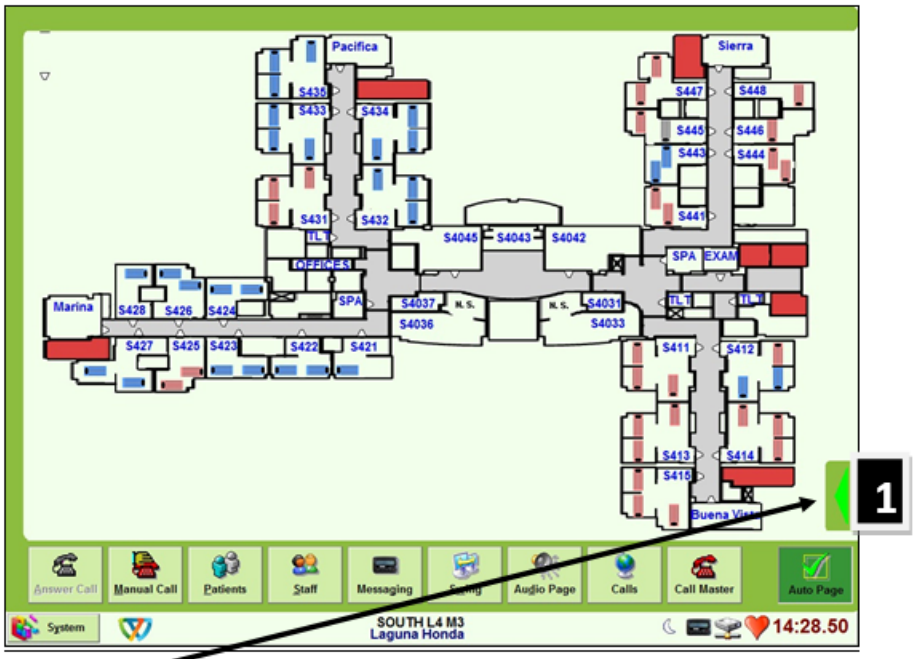
- For voice communication between the nurse station and non-patient occupied areas such as staff break rooms, conference room, chart room, dining room, solarium, etc.

Group Assignment Worksheet

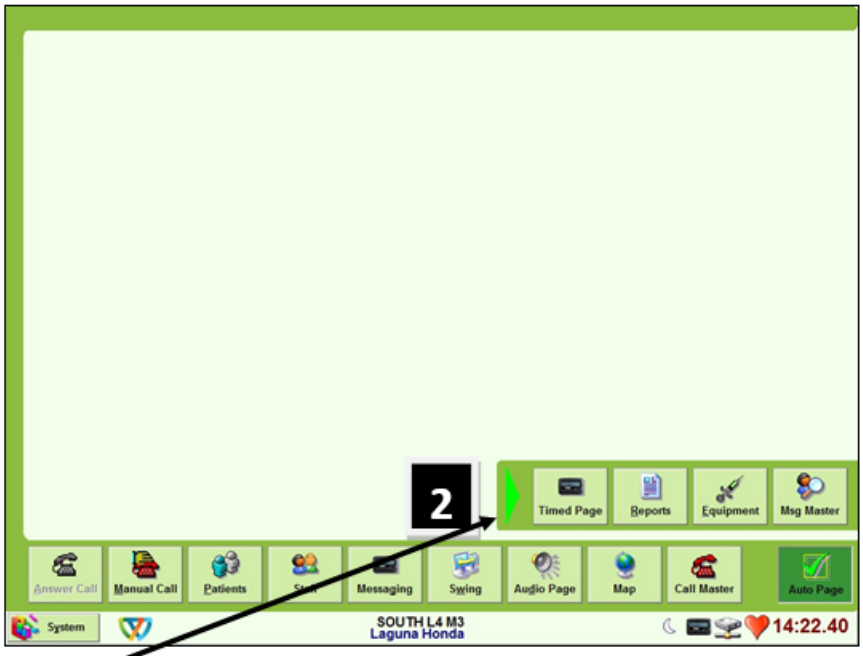
- This should be completed before performing any changes in the master station. Group templates of resident/patient assignments and staff Wireless Phone extensions are listed and recorded on this worksheet. Group Assignment Worksheets should also be retained for a minimum of 3 years for record keeping and documentation purposes.
- Charge nurses or designee(s) can change the worksheet details if there is a staffing shortage or a broken Wireless Phone. If a regular assigned staff is off or sick, the replacement staff and assigned phone extension should also be updated in the Worksheet. Any changes to the worksheet should be reflected in the Master Station.
- Assignment of Support Staff is made according to each neighborhood's preference. Support Staff is an additional recipient of a call or a request in case the assigned staff does not answer after 3 attempt calls (Attachment 3 – C).
- All master stations use TEMPLATE Names based on the neighborhood (e.g., Marina, Redwood, Sierra, and Pacifica). Examples of Group Templates: S4 License 1 AM, N2 License 2 PM, N6 Charge Nurse Day.

II. PROCEDURES

A. Viewing the Hidden Icons in the Master Station



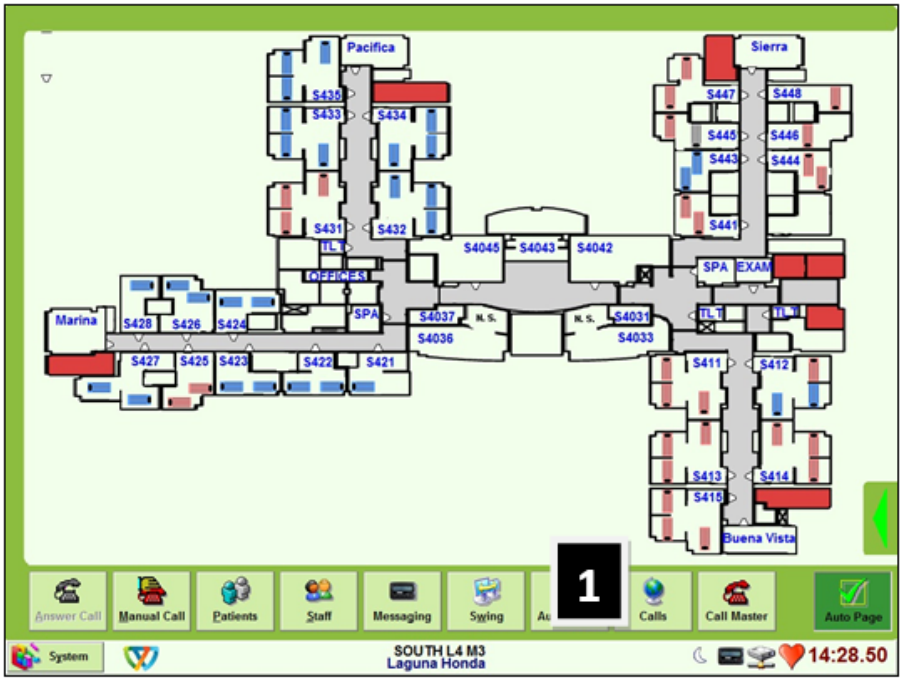
1. Click or touch ◀ to display more option tabs



2. Click or touch ▶ to hide the option tabs

B. Two view options of the master station

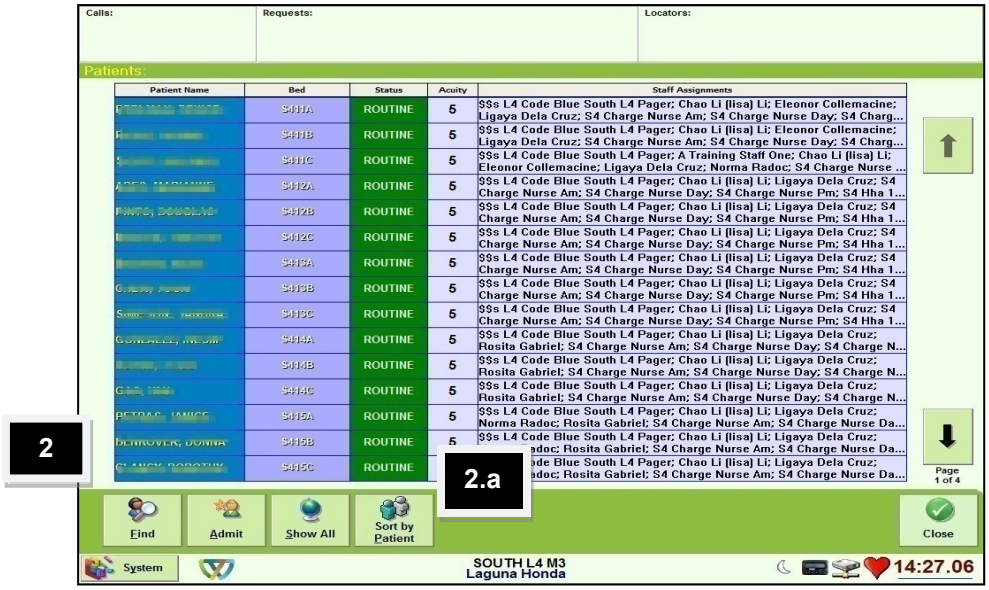
1. Click or touch the **Calls** button to view a list of calls.



2. Click or touch the **Map** button to view the neighborhood's room layout.

C. Viewing the Resident's/Patient's List

1. Click or touch the **Patients** button to view the list of residents/patients on that neighborhood.
2. Use the **Find** button to search for a resident/patient by name. Or you can click on the down arrow button & scroll down through the list of residents'patients' names. The names can be sorted by:
    a. Resident's/Patient's Last Name
    b. Resident's/Patient's Room Number



D. Calling a Resident's/Patient's Room

1. Lift the NurseCall handset.
2. Click or touch the **Manual Call** button.
3. A window containing the resident/patient room numbers and names will appear.

4. Click or Touch the **bed number/resident's name** to call that resident/patient.
   a. Use the **right arrow** to move to the next page of resident/patient room numbers and names.
   b. Once connected, address the resident/patient, and introduce yourself.

5. Click or Touch the **Cancel** button to end the call.

E. **Assigning/Re-assigning a resident/patient and/or a Wireless Phone to a group template**
Always refer to the neighborhood's group assignment worksheet when assigning a resident/patient or a Wireless Phone to a group template. DO NOT change the master station assignment unless changes were made in the group assignment worksheet. If this is a temporary change (ex: pick up assignments), the assignments must be change back at the end of the shift.

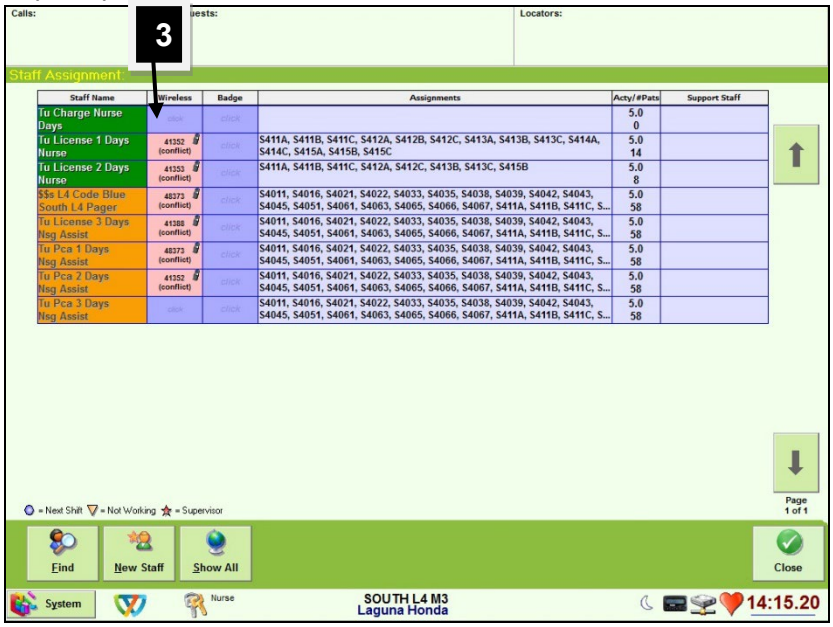
Charge Nurse: Derek - 41242 **Date**: September 14, 2012
Neighborhood: Test Unit **Shift:** Day

1

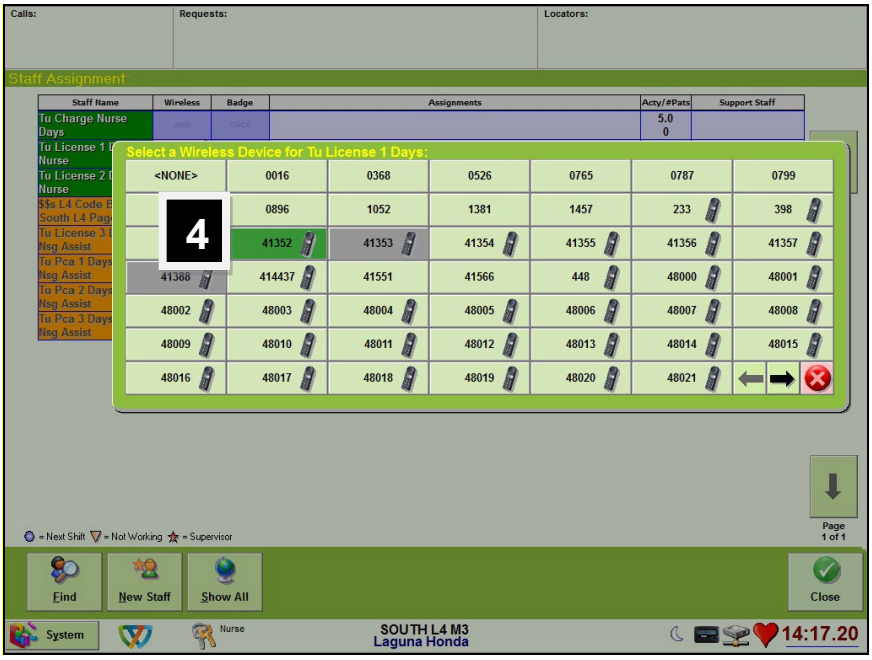
TU License 1 Day						
Meredith		11 ABC	13 ABC	15 ABC	42AB	**Support**
41352		12 ABC	14 ABC	41AB	47A	Christina
TU License 2 Day						
Christina		21 AB	24 AB	27 AB	44 AB	**Support**
41353		22 AB	25 AB	28	47 B	Alex
		23 AB	26 AB	43 AB		
TU License 3 Day						
Alex		31 ABC	33 ABC	35 ABC	46AB	**Support**
41354		32 ABC	34 ABC	45AB	48	Meredith

1. Review, confirm and mark the changes made in the **Group Assignment Worksheet**.
2. Click or touch the **Staff** button to view or assign/re-assign a resident/patient and/or a Wireless Phone.

3. To assign a Wireless Phone extension, click or touch the box under the **Wireless** column of the group template.



4. A window containing of all the Wireless Phone extensions assigned to a neighborhood will appear. Referring to the worksheet, click or touch the Wireless Phone extension that needs to be assigned to the group template.


Calls:
Requests:
Locators:
Staff Assignment:
Staff Name
Wireless
Badge
Assignments
Acty/#Pats
Support Staff
Tu Charge Nurse Days
5.0
0
Select a Wireless Device for Tu License 1 Days:
<NONE>
0016
0368
0526
0765
0787
0799
4
0896
1052
1381
1457
233
398
41352
41353
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414437
41551
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448
48000
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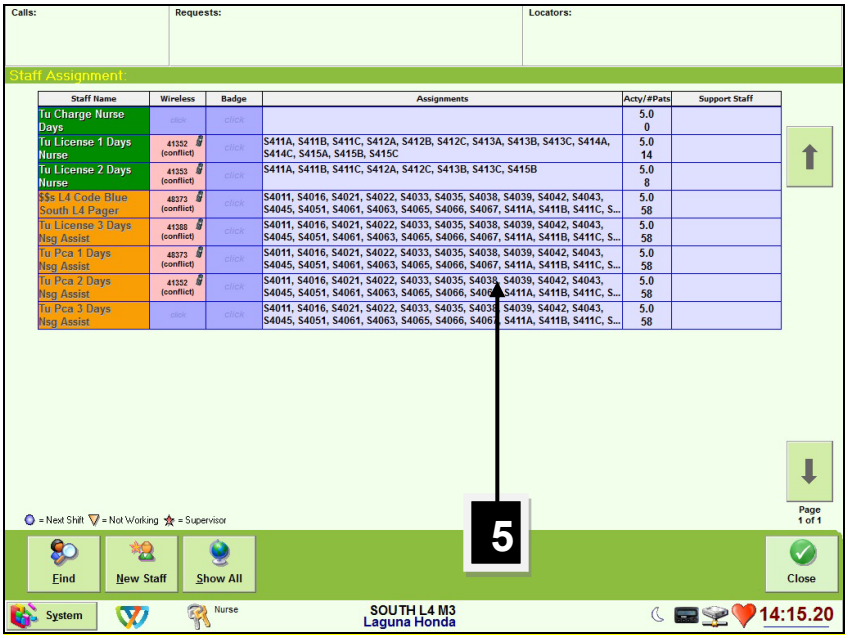
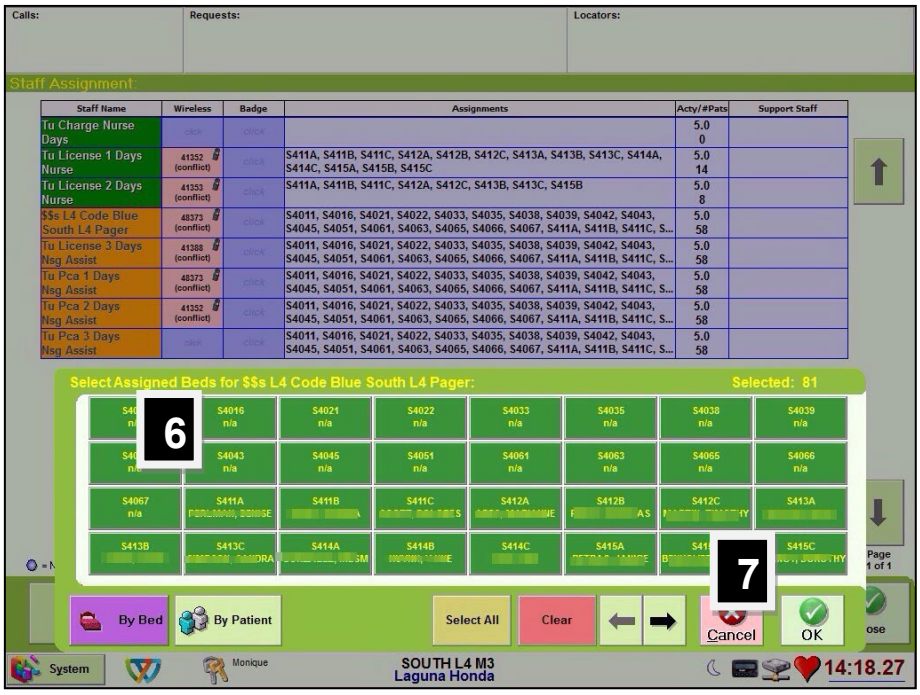
48009
48010
48011
48012
48013
48014
48015
48016
48017
48018
48019
48020
48021
= Next Shift = Not Working = Supervisor
Page 1 of 1
Find
New Staff
Show All
Close
System
Nurse
SOUTH L4 M3
Laguna Honda
14:17.20

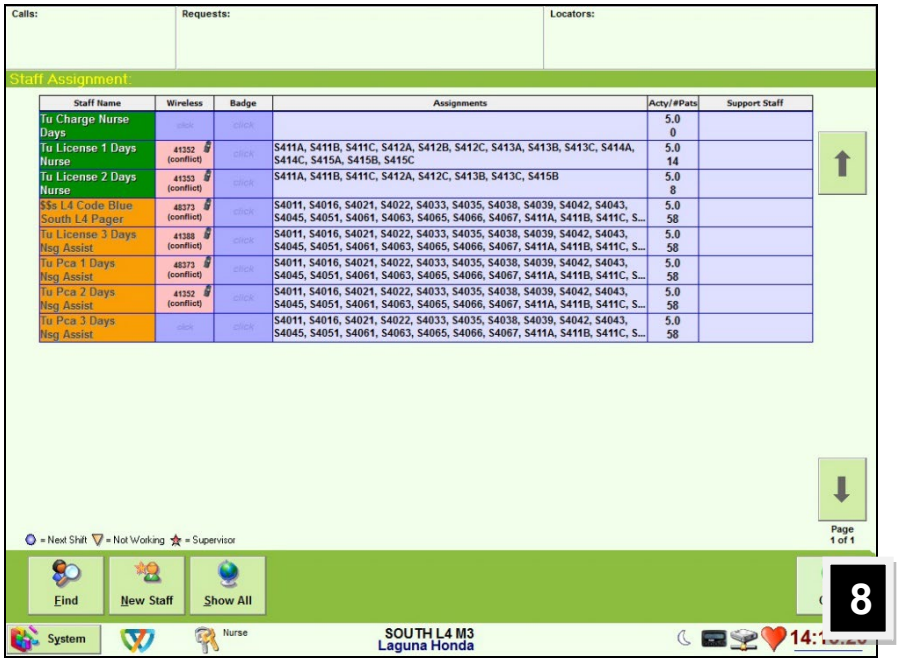
5. To assign/re-assign a resident/patient, click or touch box under the **Assignment** column of the work group template.



6. A window containing the list of residents/patietns will appear. Referring to the worksheet, click, or touch the **Room Number** assigned to the resident's/patient's name that you want to re-assign or remove from the group template.

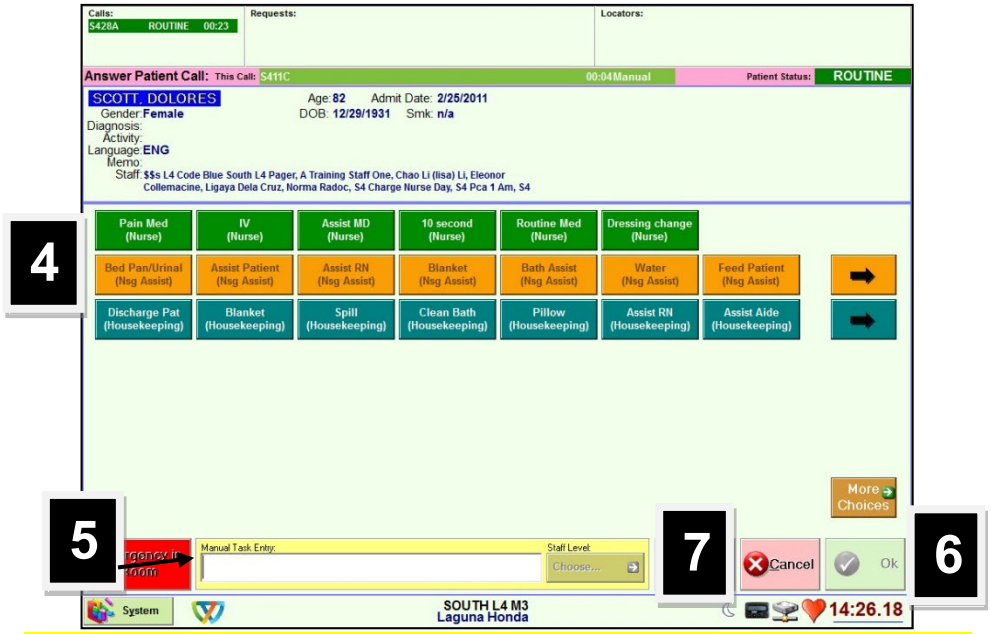


7. Click or touch the **OK** button.
8. Verify that the data in the master station matches the details of the Group Assignment Worksheet. Then click or touch the **Close** button.



F. Receiving and Responding to a Routine Call

1. Lift the NurseCall handset. ONLY Routine Calls can be answered and/or cancelled using the Master Station
2. Click or touch the **Answer Call** button to speak to the resident/patient.
3. Once connected, address the resident/patient and introduce yourself.



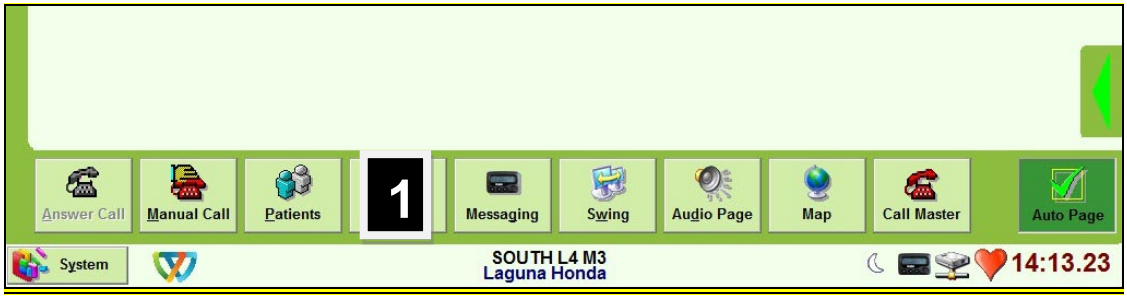
4. The Request screen will appear. Select the pre-programmed **request** button according to the resident's/patient's need.
5. If a resident/patient has a specific request, a message can be entered manually in the **Manual Task Entry** box. This allows you to submit a customized request and select the staff level required by the resident/patient.
6. Click or touch the **OK** button to send the request.
7. To end a call without a sending request, click or touch the **Cancel** button. Do not cancel a call without first determining the resident's/patient's need.

NOTE:

If the request of the resident/patent is not answered within 3 minutes, another routine call (Patient Recall Screen) will be sent to the wireless phone to remind the staff. However, this call will ONLY be sent to the master station where the request was made.

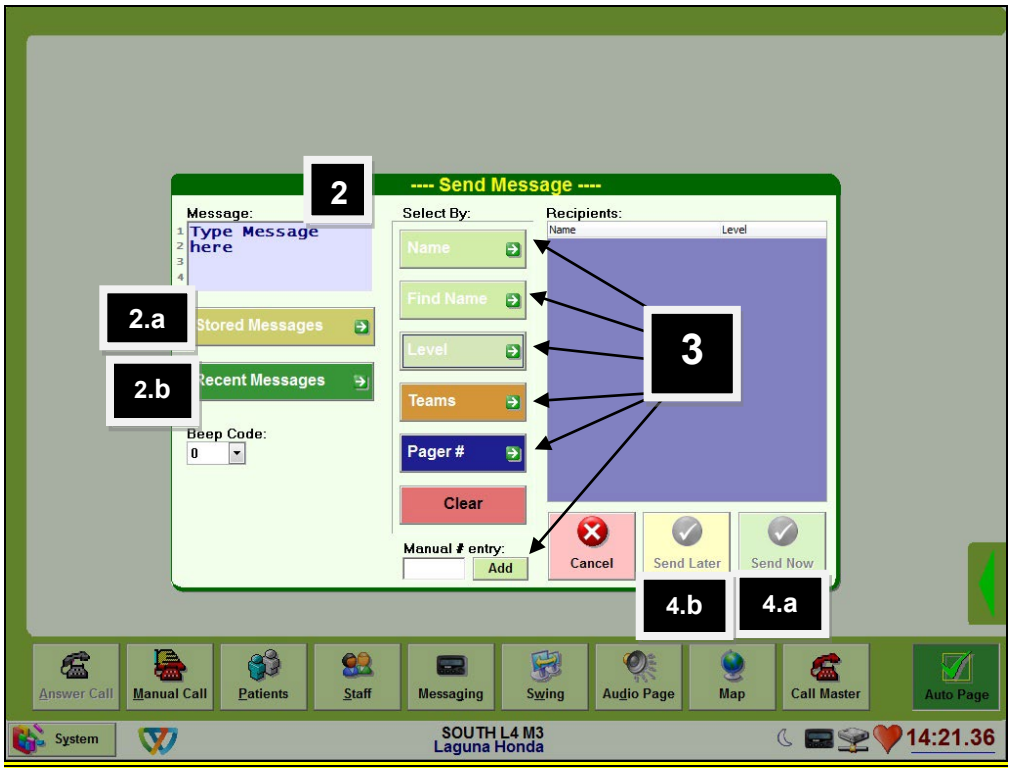
G. **Sending NOTE**: **a message or text page**

1. Click or touch the Messaging button.



2. When the **Send Message** window appears, type in your message in the **Message** box or select a message that was previously sent or was stored:
   a. **Stored Messages** button

b. Recent Messages button



3. Select the recipient by any of the following options:
   a. **Name** - specific group assignment
   b. **Level** - all nurses, all nurse assistants~~, or all home health aides~~
   c. **Team** - Code Blue, Lift Team
   d. **Pager** - Wireless Phone extensions
   e. **Manual # entry** - type in the Wireless Phone extension (then click or touch the **Add** button)
4. To send, click or touch one of the following buttons:
   a. **Send Now** - when your message is completed and ready to be sent
   b. **Send Later** - to choose a specific day or time when the message will be sent

REFERENCE:

West-Call FocusCare® Nurse Call System Manual Operating Instructions

New Document: 2010/11/21

Reviewed: 2010/12; 2011/01/31; 2021/04/13; 2023/01/10; 2025/03/10

Approved: 2025/03/10

Attachment 2: Wireless Phone Operating Guidelines

A. Definition:

1. The wireless phone is a means of communication between residents/patients, staff, neighborhoods, and outside callers.

2. The wireless phone uses wi-fi connection to place or receive calls from another Wireless Phone, Desk phone, and outside call. The wireless phone can receive alerts and messages when used in conjunction with the nurse call system to:

    a. Receive calls alerts coming from a resident's/patient's room, resident's/patient's bathroom and/or spa room.
    b. Receive alert messages from third-party applications (e.g., Johnson Controls Inc (JCI), Resident Tracking Locator System, etc.).
    c. Receive text messages sent from the NurseCall master station.

3. The wireless phone cannot make a direct call to the Master Call Station or to a resident's/patient's room.

B. Operating the Wireless Phone

Turning on the phone	1. Press and hold the red Power/End Call button until the LED light on the top left corner of the phone turns on. 2. Verify the Wi-Fi signal  on top right-hand corner is present. 3. Verify the phone's 11-digit (**ex: +16285555555**) telephone number on top left-hand side of the screen is present.
Nurse Call System/Patient Room	**Answering Calls:** 1. Press the Answer/Send button and press the softkey  button to select "Connect" to talk to the patient. 2. To end or cancel the call and/or remove the call from the Nurse Call Master Station: Press "3". 3. To end a call but keep the call on in the Nurse Call Master Station: Press any number or the Power/End Call button. **Checking Missed Calls/Messages:** 1. Use the Navigation ring and the Select button to open "Apps". 2. Select "LHH Nurse Call". 3. Scroll down through the messages to review them (the most recent messages are displayed at the top of the list).
Non-Nurse Call	**Making and Answering Calls:** 1. Making a call: To call other wireless phones, enter the desired 5-digit extension number. For outside calls, dial 9, 1, area code, then the outside number and press the Answer/Send button. (To redial the last call, press the Answer/Send button twice.) 2. To answer a call: Press the Answer/Send button. 3. To end a call: Press the red Power/End Call button. *****To dial 911, dial 911 directly or 9-911***** **Checking Missed Calls:** 1. Use the Navigation ring and the Select button to open "Recents". 2. Scroll down using the Navigation ring and use the Select button to select the desired entry. 3. Press the Answer/Send button. *****Voicemails cannot be left on the wireless phones*****
Turning off the Phone	1. Press and hold the red Power/End Call button for 4 seconds. 2. Press the softkey  button to select "Power off".

C. Staff's Responsibilities

1. The nurse manager, charge nurse or designee will use the Group Assignment Worksheet Template to assign the residents/patients to a designated phone number. Changes in a resident's/patient's group, assigned staff, or assigned phone number must be updated in the Group Assignment Worksheet and master station by the nurse manager, charge nurse or designee.
    a. Prior to their shift, each staff member must sign-out or initial their name in the Wireless Phone's Inventory sheet acknowledging receipt of their assigned Wireless Phone. All staff will be held accountable for the Wireless Phone that has been assigned to them during their shift.
    b. Receiving Phones:
        i. Staff must turn on their phone
        ii. Check the phone's battery level (change the battery if needed)
        iii. Check that the phone is functioning appropriately
        iv. Check that the phone's ringer is not turned off or on vibrate only.

v. Clean their assigned wireless phone at the start of the shift. Wipe the wireless phone with facility-approved disinfectant wipes. Remove excess fluid from the wipe to ensure the wipe is damp, but not soaking before wiping down the phone. Allow to air dry. (Excess liquid can damage screen and buttons).

2. At the end of the shift, each staff member:
    a. Must turn off their assigned Wireless Phone
    b. Must clean the wireless phone with facility-approved disinfectant wipes and allow them to dry before returning them to the charging doc.
    c. Must handoff their phone to the incoming charge nurse or designee who will initial their name in the Wireless Phone Receipt log to acknowledge the phone's return.
    d. The outgoing shift's charge nurse/designated person must perform an inventory count of all the Wireless Phones with the incoming charge nurse/designated person.

3. Each shift has their own designated set of phones. Phones that are not being used will be stored in the designated Wireless Phone cabinet behind nursing station two except for the Pavilion (in Conference Room P025) and South 4 (behind nurse station 1) neighborhoods which have alternative locations for storing the wireless phone cabinets.
    a. There are a minimum of four (4) wireless phone multi-chargers in each Wireless Phone cabinet.
    b. The wireless phone cabinet must be locked when it is not in use.
    c. A total of three keys have been distributed to each unit.
        a. The Nurse Manager will keep the master copy and the spare key will be locked in his/her office.
    d. At the start of the shift, the outgoing shift charge nurse or designated staff will hand over the third key to the incoming shift's charge nurse.
    e. Do NOT place anything on top of the wireless phone cabinet as this will block the circulation vents.

4. To avoid overloading the system with phone calls, staff must keep the conversations to a minimum.

5. Broken/Lost phone:
    a. Nursing staff should inform their charge nurse if the designated phone is lost, damaged, or not functioning.
    b. Refer to the standard work on Request Repair or Replacement for Broken Cisco Phones
    c. The charge nurse must reassign the loaned phone in their NurseCall Master Station to replace the previously assigned broken wireless phone.
    d. Do NOT borrow a phone from another staffer on a different shift.
    e. Complete an incident report if a phone is:
        i. Lost
        ii. Broken due to:
            1. A cracked or damaged screen
            2. Water damage
            3. Physical damage (beyond normal wear and tear)

6. Downtime procedure: In the event of a Wireless Phone downtime:
    a. Refer to the red system downtime manual binder located in nursing stations 1 & 2 or refer to the System Manual on the LHH Intranet Nursing Department
    b. Network Downtime - The wireless phone call features and alert messages will be inactive. Staff must regularly round on the residents/patients during the downtime.
    c. NurseCall Liaison Downtime - Staff will not receive any alert messages. During this time, a staff member must be assigned to monitor the Master Call Station when the nurse call system is activated.

D. Cleaning Wireless Phones and pagers:

1. Wipe phones with facility-approved disinfectant wipes. Squeeze excess fluid from the wipe to ensure it is damp, but not saturated before wiping down the phone.

2. The phone should not be cleaned with harsh and/or caustic chemicals (i.e., Sani-cloth® Plus wipes) because the chemicals in the wipes may seep into the keypads and damage the phone.
3. Alcohol wipes or alcohol-based cleansers also cannot be used to clean the phone.

REFERENCES:

Cisco Wireless IP Phone 8821 and 8821-EX User Guide

New Document: ~~2010/~~11/23/2010

Revised: ~~2010/~~12/2010; ~~2011/~~01/31/2011; ~~2021/~~04/13/2021; ~~2023/~~01/10/2023; ~~2025/~~01/08/2025; 10/06/2025

Reviewed: ~~2010/~~12/2010; ~~2011/~~01/31/2011; ~~2021/~~04/13/2021; ~~2023/~~01/10/2023; ~~2025/~~03/10/2025

Approval: ~~2025/~~03/10/2025

Attachment 3 - A: Sample of Group Assignment Work Sheet

Charge Nurse: Derek - 41242 **Date**: September 14, 2012

Neighborhood: Test Unit **Shift:** Day

TU License 1 Day

Meredith		11 ABC	13 ABC	15 ABC	42AB	**Support**
41352		12 ABC	14 ABC	41AB	47A	Christina

TU License 2 Day

Christina		21 AB	24 AB	27 AB	44 AB	**Support**
41353		22 AB	25 AB	28	47 B	Alex
		23 AB	26 AB	43 AB		

TU License 3 Day

Alex		31 ABC	33 ABC	35 ABC	46AB	**Support**
41354		32 ABC	34 ABC	45AB	48	Meredith

TU PCA 1 Day

Izzy		11 ABC	13 ABC	15 ABC		**Support**
41355		12 ABC	14 ABC			George

TU PCA 2 Day

George		21 AB	23 AB	25 AB	27 AB	**Support**
41356		22 AB	24 AB	26 AB	28	Izzy

TU PCA 3 Day

Bailey		31 ABC	33 ABC	35 ABC		**Support**
48373		32 ABC	34 ABC			Callie

TU PCA 4 Day

Callie		41 AB	43 AB	45 AB	47 AB	**Support**
48374		42 AB	44 AB	46 AB	48	Bailey

HHA 1 :	**41388**	Richard
HHA 2 :		
Coach #1 :		
Coach #2 :		

Attachment 3 – B: Light Illumination Patterns

Types of Calls	Light Illumination Patterns	
	Dome light	**Zone light**
Fire Alert	Solid red	All lights alternately blinking
Code Blue Call	Flashing strobe lights (all colors)	Flashing strobe lights (all colors)
Staff Emergency Call	Flashing white light with solid green light	Flashing red light
Bath Call	Flashing white light	Flashing red light
Routine Call	Solid white light	Flashing white light

Attachment 3 - C: Table of Wait time

Order of Call	Recipient and Duration
First Call/ Request	goes to the assigned Nurse Asst. - after 3 min
First Recall	goes to the assigned Nurse Asst - after 3 min
Second Recall	goes to the assigned Nurse Asst - after 3 min
Third Recall	goes to the assigned Nurse Asst and the support staff - after 3 min
Fourth Recall	goes to the assigned Nurse Asst and the support staff and the charge nurse

Original: 03/10/2015

Revised: ~~2015/~~03/10/2015; ~~2021/~~04/13/2021; ~~2023~~/01/10/2023; ~~2025/~~01/08/2025

Reviewed: ~~2025/~~03/10 -/2025, 10/06/2025

Approved: ~~2025/~~03/10/2025

MAINTAINING TEMPERATURE OF MEDICATION and NOURISHMENT REFRIGERATORS/FREEZERS VIA TEMPTRAK & CLEANLINESS OF REFRIGERATORS

POLICY:

1. The types of refrigerators in the neighborhoods are medication, nourishment, and employee's refrigerators.

~~2. Temperature Ranges:~~
- ~~Medication refrigerator: between 36 and 46 degrees Fahrenheit.~~
- ~~Nourishment refrigerator: between 33 and 41 degrees Fahrenheit.~~
- ~~Galley freezer: between -10 and 0 degrees Fahrenheit.~~

2. Licensed Nurse (LN) will ~~is to~~ check the temperature of nourishment refrigerators, medication refrigerators and galley freezers twice a day, on the AM and PM shifts, by logging ~~on~~ into TempTrak~~.~~ (Refer to Standard Work on Checking Temperature of Medication and Nourishment Refrigerators via TempTrak).
   Acceptable Temperature Ranges:
   - Medication refrigerator: between 36 and 46 degrees Fahrenheit.
   - Nourishment refrigerator: between 33 and 41 degrees Fahrenheit.
   - Galley freezer: between -15 and 0.1 degrees Fahrenheit.

3. If the nourishment refrigerators and galley freezers are continuously out of range for 2 hours, the charge nurse will receive an alert via pager:
   a. Licensed nurse needs to check the refrigerator/freezer and close door if opened or do other corrective action as needed.
   b. The LN will log into TempTrak database to document action taken.
   c. Licensed nurse shall check the refrigerator after an hour to ensure temperature has been corrected. If still NOT within range, call Facility Services and create a work order.

~~If equipment goes out of range continuously over 2 hours, an additional online check via TempTrak must be done.~~

4. If the temperature of a refrigerator containing medications is out of range, the licensed nurse is to contact the Pharmacy for instructions on what to do with the refrigerated medications.

~~3. Licensed Nurse is to clean medication refrigerator weekly with facility approved disinfectant.~~
~~4.~~
~~5. If equipment goes out of range continuously over 2 hours, an additional online check via TempTrak must be done.~~

~~6. If the nourishment refrigerators and galley freezers are out of range:~~
   ~~a. Licensed nurse needs to check the refrigerator/freezer and close door if opened or do other corrective action as needed.~~
   ~~b. The licensed nurse will log into TempTrak database to document action taken.~~
   ~~c. Licensed nurse shall check the refrigerator after an hour to ensure temperature has been corrected. If still NOT within range, call Facilities and create a work order.~~

~~7.~~5. Medication refrigerators are **only** used for medication requiring refrigeration. The medication refrigerators are located in the medication rooms and must be kept locked at all times.

~~8. If the temperature of a refrigerator containing medications is out of range, the licensed nurse is to contact the pharmacy for instructions on what to do with the refrigerated medications.~~

6. Nourishment refrigerators are **only** used for storage of resident's/patient's nourishments / supplements~~.~~ provided by the facility. The nourishment refrigerators are in the Galley in each neighborhood.

~~9.~~7. ~~Any additional food~~Food brought into the facility by residents/patients ~~or~~ for residents'/patients' consumption is stored in the resident//patient refrigerator located in the Great Room. Resident/patient refrigerators in the Great Room must ~~be kept~~ always be kept locked. The key is kept in the nursing station. (Refer to Standard Work on Safe Handling of Residents Food Brought from Outside LHH)

~~10.~~8. All food in refrigerators should be stored in covered containers. Food not in original container is to be clearly labeled and dated.

~~11.~~9. Licensed Nurses (LNs), Certified Nursing Assistants (CNAs), and Patient Care Assistants (PCAs) ~~, and Home Health Aides (HHAs)~~ must check the dates of refrigerated foods before serving and discard immediately if outdated.

~~12.~~10. Employees must store their food in the designated refrigerator in the staff lounge.

~~13.~~

PURPOSE:

To store substances that require refrigeration in a hygienic refrigerator environment at the correct temperature.

BACKGROUND:

Temperature readings are displayed in the monitor located at the bottom of the refrigerator doors. Temperatures are also displayed online in real time on TempTrak.

PROCEDURE:

A. Equipment

Obtain from ward supply: clean basin, mild soap, clean cloths.

B. Cleaning of the Refrigerator

1. Remove food containers and medications prior to cleaning the refrigerators. Using warm water and mild soap, wash inside refrigerator with clean cloth.
2. ~~Wipe d~~Dry with clean cloth.
3. Racks or shelves must be thoroughly washed and dried.
4. After cleaning and drying inside of refrigerator, return contents.

5. Wipe ~~off the~~ outside of refrigerator.

C. Maintenance of the Refrigerator {Refer to Hospitalwide Policy and Procedure (HWPP) 31-01 Wireless Refrigeration and Warming Temperature Monitoring System}

~~1. It is the responsibilities of the A.M. and P.M. shift Licensed Nurses to check for correct temperature.~~

~~2.~~1. It is the responsibility of the ~~A.M .~~PM shift Licensed Nurses to check for any outdated food or medications in the medication and nourishment refrigerators. The ~~A.M.~~PM Nursing Supervisors and Nurse Managers will monitor for ongoing compliance ~~for~~ of timely removal of outdated ~~foods~~items.

~~3.~~2. The ~~A.M.~~PM shift assigned ~~C.N.A.~~CNA or ~~P.C.A.~~PCA is responsible for cleaning the nourishment and employee~~'s~~ refrigerators. Cleaning of these refrigerators is neighborhood based as scheduled by the Nurse Manager or Charge Nurse.

~~4.~~3. All nursing staff are responsible for discarding any unlabeled or expired foods found during their shift.

D. Food Storage

1. ~~_____~~For food brought from outside LHH, refer to Standard Work on Safe Handling of Residents Food Brought from Outside LHH.

2. Food sent by Food and Nutrition Services (FNS) for ~~nourishments are~~nourishment is stored only in Galley refrigerators. All containers must be labeled with expiration dates. Outdated and unmarked foods are to be discarded immediately. DO NOT store food from residents/patients meal trays (opened or unopened) in the nourishment refrigerators

E. Reporting and/or Documentation (Refer to Standard Work on Checking Temperature of Medication/Nourishment Refrigerators and Freezers via Temptrak)

1. On the Emergency Checklist, the AM and the PM shifts will initial TempTrak to signify that they logged on to TempTrak.

2. Report any malfunctions or incorrect temperature settings to Facility Services~~,~~. Licensed Nurse to complete a Facility Services ~~n online w~~Work Order ~~requisition~~request ~~for repair~~.

REFERENCES:

Standard Work on Checking Temperature of Medication/Nourishment Refrigerators and Freezers via Temptrak

Standard Work on Safe Handling of Residents Food Brought from Outside LHH

TempTrak ~~Reference~~ Basic Training Guide
https://www.in.gov/fssa/thehub/files/TempTrak_Basic_Training_Guide.pdf (Revision ~~H~~A, ~~January 2010~~August 2014) © ~~2003-2010~~2014 Cooper-Atkins Corporation. – electronically accessed on October 8, 2025

CROSS REFERENCES:

Food and Nutrition Services Policies and Procedures
File #: 1.1 Food from Home or Outside Sources Served Directly to Residents

Hospital Policies and Procedures
31-01 Wireless Refrigerator and Freezer Temperature Monitoring System
~~72-01 F5 Standard for Refrigeration Equipment~~

ATTACHMENTS:

None
~~Attachment 1: Emergency Equipment / Wireless Temperature Monitoring System Checklist~~
~~Attachment 2: TempTrak: Quick Reference Guide for Nurses~~

Revised: ~~2003/~~04/2003; ~~2006/~~03/2006; ~~2006/~~12/2006; ~~2009/~~03/2009; ~~2010/~~11/2010; ~~2011/~~11/29/2011; ~~2015/~~01/13/2015; ~~2017/~~01/10/2017; ~~2020/~~03/17/2020; ~~2024/~~03/08/2024; 10/08/2025

Reviewed: 2024/05/14

Approved: 2024/05/14

TRACHEOSTOMY CARE

POLICY:

1. Physician's order is required for all tracheostomy care.

2. The **first tracheostomy tube** change will be performed by Ear, Nose, & Throat (ENT) Physician.

3. Cuffed tracheostomy tubes: Cuffed tracheostomies are **only** changed by ENT.

4. Upon admission, the attending physician may refer any resident/patient with a tracheostomy to the ENT and/or other specialists for review and evaluation. If the primary physician determines the referral is not indicated, the reason will be documented in the medical record. Referral to the ENT, Speech Language Pathologist (SLP) and/or Respiratory Therapists (RT) shall be made via e-referral.

5. Residents/patients admitted with a speaking valve will also be referred to Speech pathology per HWPP 27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passy-Muir.

6. Emergency respiratory equipment shall always be available at the bed-side:
    a. Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/saline
    b. Tracheostomy of the same type, size (including inner cannula)- for emergency replacement
    c. Ambu bag ~~if ordered by physician~~

7. The disposable inner cannula (DIC) should never be cleaned and reused. It is intended for a one-time use only and is changed at least **twice daily** and as needed. Discard the used cannula and insert a new one, touching only the external portion. Lock it securely in place.

8. Tracheostomy site care should be performed daily, unless ordered otherwise, and PRN. Site assessment/observation should be performed and documented QShift to determine status of dressing.

9. Subsequent replacements of the outer cannula standard tracheostomy tubes will be carried out by a registered nurse (RN) or respiratory therapist/respiratory care practitioners (RT) ~~nursing~~ at least **once per month**. If an urgent appointment is needed, phone the Surgical Clinic and mark "urgent" on the ENT e-referral. (Note: if an ENT appointment cannot be obtained in a timely manner, consult with Respiratory Therapy).

10. With the exception of those residents/patients requiring specialized tracheostomy tubes, trained ~~registered nurses (~~RNs~~)~~ ~~or licensed vocational nurses (LVN)~~ or RTs will change the cuffless tracheostomy outer cannula for residents/patients who have had a tracheostomy for more than three weeks old, and who have been seen by ENT for initial change. The type, tube size, and day of change are to be ordered by the physician.

11. Non-standard Tracheostomy Tubes for Special Needs (e.g., extra-long tracheostomy tubes): If a resident/patient has a non-standard tracheostomy tube, the resident/patient shall be referred to ENT for all tracheostomy tube changes. A spare non-standard tracheostomy tube will be kept at the bedside to be used only in an emergency (e.g., tracheostomy tube falls out).

~~11.~~12. LVNs may perform basic respiratory tasks within their scope of practice per the Board of Vocational Nursing and Psychiatric Technicians. (see Appendix)

PURPOSE:

To maintain a patent airway and to prevent infection.

PROCEDURE:

A. Emergency Care for Dislodged or Removed Tracheostomy Tube:

1. If the tracheostomy tube of a fresh tracheostomy becomes dislodged or pulled out, the licensed nurse is to have another staff person call code blue (Ext. 42999) while the LN stays with the resident/patient and attempts to ~~open the~~ maintain a patent airway.

2. In a **new** tracheostomy (less than 7 days) do not attempt to reinsert another tracheostomy tube. Keep the wound open with a clamp (Mayo or Kelly) or use the stay sutures if they are present.

3. In a **fresh** tracheostomy (less than 21 days), a smaller size or a size below the existing tracheostomy tube should be at the bedside to keep the stoma open until the physician arrives.

4. In a more chronic, well-established tracheostomy, attempt to ~~may~~ keep tracheostomy open with a tracheostomy set, one size smaller, kept in treatment room.

5. During an emergency the physician may choose to immediately insert an endotracheal tube by mouth whether or not the tracheostomy is new or has an established tract.

6. The physician may transfer the resident/patient with a fresh tracheostomy to an emergency room for acute surgical consultation.

B. Emergency Care Using the Resuscitation Bag:

1. Hyperextend the resident's/patient's neck, UNLESS the resident/patient has had a recent cervical injury, has a cervical brace, or is on cervical precautions.

2. If the tracheostomy tube has been accidentally removed and the resident/patient does not have a complete upper airway obstruction, a gaping stoma, or a laryngectomy, a Bag Valve Mask (BVM) resuscitation device may be used to ventilate the resident/patient by mouth while covering the stoma.

3. Squeeze the bag once every 5 seconds while it is connected to oxygen set at 15 L/min until the physician arrives.

4. **Nursing Alert:**

   a. New tracheostomy
      i. Manipulation of tracheostomy tube holder and face plate should be minimized.
      ii. Residents/patients who are likely to remove or manipulate the tracheostomy tube may need ~~assessed~~to be assessed by the physician and Resident Care Team to determine if mitten(s) or restraints are appropriate.
      iii. A suction machine is to be readily available.
      iv. A sterile clamp (Kelly or Mayo) and a sterile endotracheal tube and tracheostomy tube set matching the type of tube, but one size smaller than the tube the resident/patient has in place, are to be kept in a plastic bag in the top drawer of the bedside stand.

   b. Tracheostomy emergency replacements sets should be kept in the bedside stand, sterile replacement tube sets and clamps may be kept in the treatment room. Keep one set for each

size and type tracheostomy tube in use on the unit.

c. Aspiration: If food or liquid is noted during suctioning, inform the resident's/patient's physician immediately. Consider referral to speech therapy for urgent swallowing evaluation

C. Resident/Patient Considerations:

1. Assess resident/patient: there may be apprehension about choking, inability to communicate verbally, inability to remove secretions, and difficulty in breathing.

2. Explain the function of the equipment. Inform the resident/patient and significant others that speaking with a tracheostomy is difficult.

3. Provide resident/patient the best method of communication, for example: letter boards, paper and pencil, dry erase board.

4. The resident/patient with a tracheostomy will be positioned at approximately 45 degrees or sitting upright when possible with position changes about every 2 hours to ensure ventilation to all lung segments and to prevent secretion accumulation around the tracheostomy tube.

5. The licensed nurse is to ~~assess~~ ausculate breath sounds as needed for evidence of crackles, rhonchi, or diminished breath sounds. Secretions are to be observed for amount, consistency, color, and odor.

6. The resident/patient may be provided with tracheostomy protector during bathing to protect his/her airway. Tracheostomy protectors are obtained in LHH Central Supply Room.

D. Equipment:

Disposable sterile tracheostomy care kit for suctioning, cleaning, additional sterile gloves.
Tracheostomy tube holder
Suction equipment
Sterile connecting tubing and catheter plug
Mask, goggles and plastic apron
Sterile clamps (Mayo, Kelly, or Magill)
Water soluble lubricant
Sterile saline solution
Bedside waste bag
10 mL Luer syringe to inflate/deflate cuffed tubes
Bag Valve Mask
Oxygen source

E. Routine Tracheostomy Site Care: Changing Inner Cannula of Cuffed or Cuffless Tracheostomy - Done BID and PRN: (Site Care can be performed by LVN, RN or RT). Inner cannula change can be performed by RN or RT.)

1. Preparations:

a. Only an RN or RT may p~~P~~erform suctioning of the trachea and pharynx as necessary before changing inner cannula. (Refer to Skills: (elsevierperformancemanager.com) for procedures on Tracheostomy Tube: Care and Suctioning)
b. Wash hands thoroughly before and after performing this procedure.
c. Put on a mask, goggles, and/or plastic apron if resident/patient has copious secretions.
d. Stand at the resident's/patient's side while suctioning or cleaning the tracheostomy tube.

e. Sterile saline solution is single use only and should be discarded after procedure is completed.

f. Remove the soiled dressing from around the stoma and discard.
g. Observe the skin surrounding the tracheostomy for evidence of irritation or infection.
h. Wash hands.
i. Prepare the sterile field on the bedside table.
j. Open the tracheostomy care set on sterile field and prepare the equipment
k. Put on the sterile gloves. Keep dominant hand sterile throughout the procedure. Use the other hand as clean hand to handle unsterile items.
l. Use your sterile-gloved hand to remove the remaining contents of the set onto the sterile field and separate the basins.
m. Use your clean gloved hand to pour the solution.

2. Tracheostomy site skin care:

a. Cleanse the skin around the stoma site. If crusts are present, soften them with sterile 4" x 4" gauze slightly moistened with sterile saline.
b. Rinse with a sterile saline-soaked 4" x 4" gauze and pat dry. Avoid snagging loose threads on the tracheostomy tube because they could be inhaled.
c. Cleanse external areas of tracheostomy tube with sterile cotton-tipped applicators **moistened in the saline**. Rinse areas with sterile saline-dipped applicators and d iscard.
d. Place a dry drain sponge under and around the tracheostomy tube. Reserve the extra tracheostomy dressings as needed for changes in between tracheostomy care.
e. Replace the tracheostomy tube holder if soiled.
f. Discard used equipment. Remove and discard gloves and wash hands.

F. Changing Tracheostomy Tube (Outer Cannula) of a Cuffless Tracheostomy - Done Monthly and PRN (Performed by RN or RT)

1. Prepare equipment:

a. Refer to Section E1 above to set up equipment for cleaning solutions and suctioning catheter.
b. Open the packages containing the replacement tracheostomy tube and sterile 4" x 4" gauze.
c. Squeeze a small amount of water soluble lubricant on the sterile 4" x 4" gauze
d. Suction the resident/patient if necessary.
e. Insert obturator into the outer cannula of the new tracheostomy tube.
f. Lubricate the tracheostomy tube well.

2. If difficulty occurs:

If the resident/patient goes into a laryngeal spasm, or the resident/patient has difficulty breathing, or you cannot get the tracheostomy tube in place, as an emergency measure, quickly insert the mayo clamp into the stoma opening and spread the clamp. This is to be done only in case of emergency. Call a code blue.

3. Changing the cuffless tracheostomy tube monthly and as needed:

a. Use clean-gloved hand to cut the tracheostomy tape attached to the tracheostomy tube that you are going to change.
b. Remove old tracheostomy tube.
c. With sterile-gloved hand, insert the new tracheostomy tube into the stoma, using a downward motion.
d. Quickly remove the obturator.

e. Using sterile-gloved hand, insert the inner cannula and lock in place according to the type of tracheostomy tube in use. That is, a Shiley tube twists into place and a Portex tube snaps in place.
f. Velcro/fasten the tracheostomy tube holder.
g. Apply a sterile drain sponge around the tracheostomy tube.

G. Cuffed Tracheostomy Tubes: **Only Changed by ENT physician**

If an emergency occurs during the day shift, notify the physician. (MSPP #D06-01 Tracheostomy Management.) If an emergency occurs with a cuffed tracheostomy tube during am or pm shift, follow emergency procedures on page 1, part A.

1. The attending physician will document in the medical record if a resident/patient is admitted with a cuffed tracheostomy tube and will write specific orders regarding cuff inflation/deflation.

2. If cuff inflation/deflation is ordered by the physician, Respiratory Therapy shall be consulted to review inflation/deflation procedure/precautions with Licensed Nurse.

H. Speech with a Tracheostomy Tube:

Consult with Speech Language Pathologist and/or Respiratory Therapists for information on the care and use of speaking devices.

I. Documentation:

1. The licensed nurse is to document pertinent information, including the type and size of the tracheostomy in the electronic health record.

2. Tracheostomy care during routine care or tube changes:

   For Acute care, residents/patients with tracheostomies under 6 weeks in progress notes:

   a. Resident/patient tolerance of tracheostomy care procedure such as cyanosis or respiratory distress.
   b. Appearance of the tracheostomy skin site
   c. Characteristics of secretions

   For chronic care residents/patients with stable tracheostomies, document above on weekly, monthly summaries.

3. Tracheal Cuff care:

   a. Tracheal cuff release time.
   b. Amount of air used for cuff inflation.
   c. Any changes in respiratory status during deflation/inflation.
   d. Amount, color and consistency of secretions

4. Inform physician and document if the resident/patient develops a cough, chest pain, fever, rales, dullness of the chest on percussion, or stoma site develops signs of infection.

REFERENCES:

Basic Respiratory Tasks and Services (Respiratory Care Board of California website)

Elkin, M. K., Perry, A. G., & Potter, P. A., (2012). *Nursing interventions & clinical skills*, (5th ed), St. Louis, MO: Elsevier

Elsevier (2025) Oxygen Therapy for Patients with an Artificial Airway (Respiratory Therapy) https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on June 12, 2025

Elsevier (2025) Tracheostomy Tube: Care and Suctioning https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on June 12, 2025

Lippincott, Williams, and Wilkins Staff; (2007) *Best practices: evidence-based nursing procedures*, (2nd ed), Philadelphia, PA: Lippincott Williams & Wilkins

Mosby's Clinical Skills, Tracheostomy Tube: Care and Suctioning

Nettina, S., (2010). *Lippincott manual of nursing practice*, (9th ed), Philadephia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

Hospitalwide Policies and Procedures
27-01 Tracheostomy Speaking Valve: Interdisciplinary Protocol for Use of the Passey- Muir.
27-05 Tracheostomy Management

Nursing Policy & Procedure
I 5.0 Oxygen Administration

ATTACHMENTS/APPENDICES

Appendix ~~None~~

Revised: 09/2000, 08/2008, 09/13/2016, 03/12/2019; 05/14/2019; 07/12/2022; 10/10/2023; 06/12/2025

Reviewed:08/19/2025

Approved: 08/19/2025

APPENDIX

California Code of Regulation, title 16, section 1399.365

Regulatory Language

1399.365. Basic Respiratory Tasks and Services

(a) For purposes of this section, "assessment" means making an analysis or judgment and making recommendations concerning the management, diagnosis, treatment, or care of a patient or as a means to perform any task in regard to the care of a patient. Assessment as used in this section is beyond documenting observations, and gathering and reporting data to a licensed respiratory care practitioner, registered nurse, or physician.

(b) For purposes of subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services do not require a respiratory assessment and include the following:

Patient data collection.
Application and monitoring of a pulse oximeter.
Medication administration by aerosol that does not require manipulation of an invasive or non-invasive mechanical ventilator.
Heat moisture exchanger (HME) and oxygen tank replacement for patients who are using non-invasive mechanical ventilation.
Hygiene care including replacement of tracheostomy ties and gauze and cleaning of the stoma sites.
Use of a manual resuscitation device and other cardio-pulmonary resuscitation technical skills (basic life support level) in the event of an emergency.
Documentation of care provided, which includes data retrieved from performing a breath count or transcribing data from an invasive or non-invasive ventilator interface.
Observing and gathering data from chest auscultation, palpation, and percussion.

(c) For purposes of subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services do not include the following:

Manipulation of an invasive or non-invasive ventilator.
Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion.
Pre-treatment or post-treatment assessment.
Use of medical gas mixtures other than oxygen.
Preoxygenation, or endotracheal or nasal suctioning.
Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration.
Tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula.

LARYNGECTOMY TUBE CARE

POLICY:

1. Physician's order is required for all laryngectomy care.

2. Upon admission, the attending physician may refer any resident with a laryngectomy to ENT/RT and/or other specialists for review and evaluation.

3. Trained registered nurses (RN) or Respiratory Therapist/Respiratory Care Practitioner (RCP) ~~licensed vocational nurses (LVN)~~ will change the laryngectomy (LaryTube) of residents who have had been stable post laryngectomy and LaryTube placement.

4. Emergency respiratory equipment shall always be available at the bedside:
    a. Airway suction supplies including complete suction equipment set-up, unopened suction kit, and unopened sterile water/saline
    b. Lary Tube of the same type, size - for emergency replacement
    c. Ambu bag with pediatric mask ~~(ordered by physician to keep at bedside)~~

5. If resident is to use a Heat Moisture Exchanger (HME) valve, an order and RT referral is required.

PURPOSE:

To maintain a patent airway and to prevent infection.

DEFINITIONS:

Laryngectomy: A surgery to remove part or all of your larynx (voice box). After a total laryngectomy, the trachea is brought to the skin as a stoma and is called a tracheostoma, which no longer has any anatomical connection with the oropharyngeal cavity and digestive tract

Laryngectomy tube (LaryTube): A hollow, pliable silicone tube that is inserted into the tracheostoma designed to maintain an airway. It has a curvature consistent with the curvature of the trachea following a laryngectomy.

Heat Moisture Exchanger (HME): a device that you use in-line with a breathing tube to keep moisture in your airway.

PROCEDURE:

A. Emergency Airway Care for Resident with LaryTube:
    a. If LaryTube becomes dislodged and stoma is not patent, the licensed nurse is to have another staff person call code blue (Ext. 42999) while the LN stays with the resident and attempts to ~~open the~~ maintain patent airway.
    b. If the resident requires bag valve mask ventilation with an ambu bag for respiratory distress, respiratory failure or cardiac arrest, use a pediatric sized mask with an adult ambu bag for rescue breathing, and mask should be placed over the stoma.
        i. Squeeze the bag once every 5 seconds while it is connected to oxygen set at 15L/min until the physician arrives.
    c. During an emergency the physician may choose to immediately insert an endotracheal tube into the stoma, not into the oral airway.

B. Resident Considerations:

a. Assess resident: there may be apprehension about choking, inability to communicate verbally, inability to remove secretions, and difficulty in breathing.
b. Explain the function of the equipment
c. Provide resident the best method of communication, for example: letter boards, paper and pencil, dry erase board.
d. The licensed nurse is to ~~assess~~ auscultate breath sounds as needed for evidence of crackles, rhonchi, or diminished breath sounds. Secretions are to be observed for amount, consistency, color, and odor.
e. The resident is provided with tracheostomy protector during bathing to protect their stoma and airway. Tracheostomy protectors are obtained in LHH Central Supply Room.

C. Equipment:

- Mask and/or plastic apron; goggles, face mask, if needed
- Sterile water
- Sterile gauze 4" x 4"
- Sterile cotton-tipped applicators
- Trach Kit, and LaryTube supplies (Tube Brush, Tube Holder or tracheostomy tie)
- Replacement/Clean Lary Tube
- Water soluble lubricant (KY Jelly, SurgiLube, Xylocaine)
- Sterile clamp (Mayo, Kelly, or Magill) for emergency

D. Routine LaryTube Change (performed by RN or RT)

Note: The LaryTube disinfection requires a dwell time, so cleaning the current LaryTube requires swapping a clean tube to insert while the old tube is being cleaned. Do NOT throw away the removed tube. It needs to be cleaned and stored, so it can be swapped if necessary.

a. Perform suctioning of the trachea as necessary before changing LaryTube. (Refer to Skills: (elsevierperformancemanager.com)
b. Perform laryngectomy stoma care (refer to Nursing Policy & Procedure I 3.0 Tracheostomy Care)
c. Wash hands thoroughly before and after performing this procedure.
d. Put on a mask, goggles, and/or plastic apron if resident has copious secretions.
e. Stand at the resident's side while suctioning or cleaning the Larytube.
f. Remove the soiled dressing from around the stoma and discard.
g. Observe the skin surrounding the stoma for evidence of irritation or infection.
h. Wash hands.
i. Prepare the sterile field on the bedside table.
j. Open the tracheostomy care set on sterile field and prepare the equipment including replacement LaryTube.
k. Place the paper drape across the resident's chest.
l. As needed, remove tracheostomy mask.
m. Hold the LaryTube in place and remove the HME system component from the tube as needed.
n. Release one side of the TubeHolder (trach tie) and remove the LaryTube from the stoma using a slow, gentle motion.
o. Place the removed LaryTube in the sterile water basin.
p. Remove gloves, perform hand hygiene and don sterile gloves.
q. Rinse an already clean LaryTube with sterile water to remove any disinfectant residues. Gently shake off excess water or dry with gauze.
r. Verify the new or cleaned LaryTube is the correct size.

s. Carefully inspect the Larytube before each use (i.e., before insertion). Do not use the product if damaged (e.g., tears, cracks, or crusts) and obtain a replacement.
t. If needed, lightly lubricate the LaryTube with water soluble lubricant.
u. Gently inserts the LaryTube into the tracheostoma and attaches with TubeHolder or tracheostomy tie.
v. Discard used equipment. Remove and discard gloves and wash hands.

E. Cleaning of LaryTube and Storing for Next Use

a. Rinse the used LaryTube with sterile water
b. Clean the inside of the tube with Tube Brush.
c. Clean the holes of a fenestrated tube (if resident has this type of tube) with a Provox Brush
d. In a clean basin, place the LaryTube in disinfectant with one of the following methods: (obtain solution from pharmacy)
    i. Ethanol 70% for 10 minutes
    ii. Isopropyl alcohol 70% for 10 minutes
    iii. Hydrogen peroxide 3% for 60 minutes
e. Rinse the Brush after use (reusable for single patient use, replace after 4 weeks or PRN)
f. After dwell time, rinse the LaryTube in sterile water and allow to dry.
g. When not in use, store the cleaned/disinfected LaryTube in a clean and dry container (i.e. denture cup) at room temperature. Protect from direct sunlight.
h. Do not use the device until it is completely dry. Inhalation of disinfection fumes can cause severe coughing or airway irritation
i. If the LaryTube looks dirty or has air dried in an area with a risk of contamination, the device should be cleaned and disinfected before use.
j. The LaryTube may be used for a maximum of 6 months. Replace earlier if damaged or as needed.
k. If resident is using HME, do not lubricate the HME holder, HME cassette or any accessory that is held by the LaryTube because it may lead to accidental detachment.

F. Suctioning: Refer to Skills: (elsevierperformancemanager.com)

G. Documentation

a. The licensed nurse is to document pertinent information, including the type and size of the LaryTube ~~tracheostomy~~ in the electronic health record.

REFERENCES:

Elsevier (2025) Tracheostomy Tube: Care and Suctioning https://point-of-care.elsevierperformancemanager.com/skills?virtualname=lhh – electronic access on July 10, 2025

PROVOX LaryTube Manufacturer Instructions for Use https://www.atosmedical.us/wp-content/uploads/sites/2/2022/12/90734_provox-larytube-manual_2022-03-14_web.pdf

CROSS REFERENCE:

Hospitalwide Policy and Procedure
27-05 Tracheostomy Management/Laryngectomy Care

Nursing Policy & Procedure
I 3.0 Tracheostomy Care
I 5.0 Oxygen Administration

Revised: 10/10/2023, 07/10/2025

Reviewed: 09/16/2025

Approved: 09/16/2025

OXYGEN ADMINISTRATION

POLICY:

1. Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) will follow their California licensing boards scope of practice for respiratory care and management.

2. An RN ~~licensed nurse~~ may administer oxygen during an urgent situation pending the physician's evaluation.
    a. LVN can use a manual resuscitation device and other cardio-pulmonary resuscitation technical skills (basic life support level) in the event of an emergency.

3. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.
    ~~b.~~a. LVN cannot perform initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration.

~~2.~~4. Oxygen tanks shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.

~~3.~~5. Disposable oxygen tubing administration devices shall be labelled with the date and initials according to the following schedule: Routine weekly changes shall be documented by the AM shift nursing staff.

a. Daily and PRN: sterile water for humidifier, tracheostomy collar, tracheostomy tubing and tracheostomy mask.
b. Weekly and PRN: Nasal cannula oxygen tubing, suction tubing, suction cannister, Yankauer, nebulizer set (mask and tubing) and reusable humidifier bottles.

PURPOSE:

To safely administer oxygen therapy and compressed air.

BACKGROUND:

Disposable oxygen devices may include but are not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula, mask or tracheostomy mask.

PROCEDURE:

A. Equipment:

1. Obtain oxygen delivery system supplies from neighborhood storage room or central supply.

2. Obtain from Central Supply, as needed:
    a. For rooms without oxygen:
        i. Small “E” tank oxygen cylinder with valve protection device attached. (Each Neighborhood will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)

ii. Compressed Air Connector if no humidification required (only available in PMA, PMS and south tower.)

b. Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm for rooms without wall oxygen
   i. Flow meter for oxygen or compressed air based on physician order.

- "NO SMOKING" sign(s)

B. <u>Safety measures</u> for oxygen are to be followed.

1. Residents and visitors are to be informed of the risks of smoking when oxygen in use, as needed.

2. “OXYGEN IN USE” signs are to be <u>clearly visible</u>:

   a. around the neck of the wall mounted oxygen flow regulators
   b. on oxygen or compressed air tanks in carriers or on wheelchairs
   c. outside the door of resident’s room when oxygen or compressed air is in use in the room

3. “OXYGEN STORAGE. NO SMOKING. NO OPEN FLAME” signs visible where oxygen is stored

4. **No alcohol or tincture, oil, glycerin, Vaseline or petroleum** product is to be used on or near residents receiving oxygen.

5. When oxygen tubing is not in use, make sure oxygen is turned off and tubing is stored in bags by the resident’s bedside

6. Do not connect or disconnect electrical devices such as suction machines, electric razors and cell phones or any heat producing device during oxygen treatment,

7. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.

8. If fire breaks out on the neighborhood, turn off all oxygen sources. If a resident cannot survive without oxygen therapy, move resident/bed to a safe area before resuming oxygen.

9. If oxygen cylinders are required:

   a. Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
   b. Always look at the cylinder gauge to determine contents before administering any.
   c. Oxygen cylinders in storage shall be equipped with valve protection devices and stored in oxygen cabinet.
   d. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.
   e. Cylinder valves shall be closed before moving cylinder on all tanks including empty cylinders.

C. Setting up and monitoring oxygen cylinders:

1. Remove cap and plastic cover.
2. Open and close valve quickly to remove dust from valve.
3. Place proper diameter-indexed regulator, with adapter attached, on the tank and position so that regulator is perpendicular to tank for easy reading.

4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
5. No smoking sign will be posted on front of tank. A no smoking tag, plastic bag with oxygen tubing, cannula, mask and compressed air connector will be hung on tank.
6. Always check the amount of oxygen in cylinder before dispensing.
7. Unless in use, the oxygen regulator is closed.
8. Cylinders are to be stored on unit in appropriate cylinder holder. Cylinders stored in the open are protected from weather.
9. Empty cylinders are segregated from full cylinders.
10. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply

D. When oxygen cylinders are no longer needed, or are empty:

1. Nursing will disinfect the oxygen cylinder (avoiding valve stem) with the facility-approved disinfectant.
2. Nursing will put "empty tag" on the oxygen cylinder and place the disinfected cylinder in the oxygen storage cabinet in the clean utility room in the designated location for empty cylinders.
3. Central Supply will pick up used/empty cylinders.

E. Procedure

1. Refer to Elsevier Clinical Skills titled "Oxygen Therapy: Nasal Cannula or Oxygen Mask."

F. Documentation in EHR

1. Physician will order the individualized oxygen therapy needed for the resident
2. Licensed nurses will document:
   a. Every shift for continuous order or during the shift when administered intermittently and PRN
   b. Delivery method (e.g., nasal cannula, etc)
   c. Oxygen Flow Rate
   c. Other information based on each individualized order and/or care provided (e.g., if tubing changed, with humidifier)

REFERENCES:

Elsevier Clinical Skills: Oxygen Therapy: Nasal Cannula or Oxygen Mask, Adapted from Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills & techniques* (10th ed.). St. Louis: Elsevier. Published: September 2021

https://point-of-care.elsevierperformancemanager.com/skills/380/quick-sheet?skillId=GN_22_1&virtualname=sanfrangeneralhospital-casanfrancisco

Board of Vocational Nursing and Psychiatric Technicians – Changes to Respiratory Care Scope of Practice Effective 10/1/2025
Board of Vocational Nursing & Psychiatric Technicians

CROSS REFERENCES:

Respiratory Services Policies & Procedures:

A 2. Safety Regulations for Oxygen Therapy
A 6. Oxygen Administration: Nasal Cannula
A 7. Oxygen Administration: Simple- Oxygen Mask
A 8. Oxygen Administration: Non-Rebreather Mask
A 9. Oxygen Administration: Venturi Mask

Revised: 2006/03, 2006/04, 2009/08, 2017/01/10; 2019/03/12; 2022/01/11; 2022/07/12; 2022/12/13; 2023/03/14, 2024/02/13; 2024/10/31

Reviewed: 2025/01/13

Approved: 2025/01/13

Appendix

What LVNs May Perform in their Scope of Practice:

- LVNs may perform defined basic respiratory tasks that do not require a respiratory assessment, such as pulse oximetry, medication administration by aerosol, and hygiene care related to respiratory devices.
- The regulation excludes advanced respiratory assessments and invasive procedures (e.g., tracheal suctioning, ventilator management) from the LVN scope of practice.
- LVNs must continue to work under the supervision of a registered nurse, or physician, depending on the care setting.
- Delegation of basic respiratory tasks should be consistent with the LVN's competency, employer policies, and applicable laws and regulations.

What Respiratory Tasks LVNs may not perform:

- Manipulation of an invasive or non-invasive ventilator.
- Assessment or evaluation of observed and gathered data from chest auscultation, palpation, and percussion.
- Pre-treatment or post-treatment assessment.
- Use of medical gas mixtures other than oxygen.
- Preoxygenation or endotracheal or nasal suctioning.
- Initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration.
- Tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve, or removal and replacement of the tracheostomy tube or inner cannula.

Deletion Nursing
Policies and Procedures

revised: 4/23/2021

EMERGENCY EQUIPMENT / WIRELESS TEMPERATURE MONITORING SYSTEMS

MONTH_____ YEAR 20_____ Neighborhood_____

DESCRIPTION	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
A.M. SHIFT																															
Blood Glucose Quality Ctrl																															
Emergency Drug Box "Red Lock" intact (1st station)																															
Emergency Drug Box "Red Lock" intact (2nd station)																															
TempTrak																															
Humidifiers Changed																															
Flashlights Working																															
Expiration of Bulk Meds (IVs & Supplies)																															
Expiration of Meds and TX Carts																															
AM Nurse Initials																															
DAY SHIFT																															
Emergency Drug Box "Red Lock" intact (1st station)																															
Emergency Drug Box "Red Lock" intact (2nd station)																															
DAY Nurse Initials																															
P. M SHIFT																															
Emergency Drug Box "Red Lock" intact (1st station)																															
Emergency Drug Box "Red Lock" intact (2nd station)																															
TempTrak																															
PM Nurse Initials																															

CRASH CART CHECK	Crash Cart to be checked daily and sheet to be kept on clipboard with Crash Cart

Licensed Nurse is to check the items as indicated above. Completed forms are to be checked by the Nurse Manager and kept on the neighborhood for one year.

(Revised 4/23/2021) **NM Signature:** _____

Attachment 2: Refrigerator – TempTrak: Brief Reference Guide

INSTRUCTIONS:

1. From the left column of the LHH Intranet homepage, click TempTrak.

2. Enter Login ID and password. These are the same as your unit's Aeroscout Instant Notifier username and password.

   Ex. N2 login ID is nursingn2, password is nursingn2123.

3. For the North and South neighborhoods, there are ten temperature displays. For P.M. shift, there are eight.

4. If the temperature readings are:

   a. green (normal), no action is required.
   b. red (above normal) or blue (below normal), initiate basic corrective actions.
      The 2 most common causes are doors not fully closed and equipment is unplugged. The corrective actions therefore are to make sure the doors are shut tight and/or plug equipment into an electrical outlet

5. If logging on in response to a pager alert, document on TempTrak the corrective action(s) taken by completing the following steps:

   a. Point to **Alerts.**
   b. Point to **TempTrak.**
   c. Click **Sensor Readings.**
   d. Click the **gray square** under Acknowledge/Clear Alert.
   e. Select and click appropriate **Standard Actions** and/or type additional action(s) under Corrective Action/Notes if necessary.
   f. Click **Clear Alert**.
   g. Log off TempTrak.

REFERENCES:

TempTrak Reference Guide (Revision H, January 2010) © 2003-2010 Cooper-Atkins Corporation.

New: 11/29/2011

Reviewed: 11/29/2011

Approved: 11/29/2011