List of Policies and Procedures for JCC Review 7-13-26					
Blue (Hospital-wide); Grey (Departmental)					
Status	**Dept.**	**Policy #**	**Title**	**Owner/ Reviser**	
Revised	LHHPP	23-01	Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)	**N. Zahir**	1. Added "with seven days of the completion of the comprehensive assessment" 2. Added "The comprehensive assessment shall be completed within 14-days of admission." 3. Deleted "Care problems require various professional disciplines working together in planning, implementing and evaluating goals and interventions" 4. Added "which promotes the resident's highest possible physical, mental and psychosocial well-being, which is " 5. Added "cultural preferences, is trauma-informed" and ""care goals" 6. Deleted "medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments. To promote the resident's highest possible physical, mental and psychosocial well-being" 7. Deleted "as the locus of control and" 8. Added "Food and Nutrition Services Staff (such as " 9. Replaced "his or her" with "the" 10. Replaced "must be present" with "shall be included" 11. Added "RCT members who may not be able to join" 12. Deleted "The remaining RCT members" 13. Deleted "Clinical Nurse Specialist" 14. Deleted "LHH Psychiatry providers (Psychiatrist/Psychologist/Behavioral Health Clinician/mental health or substance treatment counselor)" 15. Added "Behavioral Health and addiction medicine providers " 16. Deleted "Occupational Therapist" and "Dietary Technicians" 17. Added "Food and Nutrition Services" 18. Deleted "Peer Mentors" 19. Added "and Entrapment Risk Assessment" and "Fall Risk Assessment" and "Trauma Informed Assessment" 20. Deleted "This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident." 21. Deleted "The resident or representative shall have the opportunity to express concerns and preferences during the RCC" 22. Added "including all discipline signatures, shall be completed " and "by the end of " 23. Added "The baseline care plan shall include instructions for: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. Social services. vi. Specific health/safety needs (e.g., fall risk, elopement risk, behavioral interventions)." 24. Added RCT throughout the document. 25. Replaced "Trigger specific" with "Trauma informed" 26. Deleted "or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan" 27. Deleted "physician, other practitioner, or professional will " 28. Added "the Behavioral Emergency Response Team (BERT)"

Revised	LHHPP	24-01	Culturally Competent Care	**N. Zahir**	1. Added "Laguna Honda Hospital and Rehabilitation Center (LHH) " 2. Replaced "The facility" with "LHH" in several places 3. Replaced "The facility social worker or designee" with "A member of Social Services" 4. Added "the Resident Care Team (RCT) " 5. Replaced "facility" with "RCT" in several places 6. Replaced "facility may consider" with "mayfollowing may be considered for the resident"
Revised	LHHPP	24-02	Promoting/Maintaining Resident Dignity	**N. Zahir**	1. Added "at LHH" 2. Replaced "patient" with "resident" throughout the document
Revised	LHHPP	24-04	Trauma Informed Care	**N. Zahir**	1. Replaced "LHH" with "The Resident Care Team (RCT) " 2. Replaced "LHH" with "The RCT"
Revised	LHHPP	24-05	Advance Care Planning	**N. Zahir**	1. Replaced "medical record" with "electronic health record (EHR)" 2. Replaced "attached to the medical record" with "scanned to the EHR media files" 3. Replaced "competent resident may change his/her" with "resident with decision making capacity may change their" 4. Replaced "his/her agent or surrogate decision maker (SDM)" with "their SDM" 5. Replaced "Advance Health Care Directive (AHCD) with "AHCD" throughout the document. 6. Added "Health Care Decisions Law (AB 891Chapter 658).' 7. Added "in the EHR" 8. Replaced "electronic medical record" with "health record (EHR)"
Revised	LHHPP	24-07	Resident Visitation	**N. Zahir**	1. Added "RCT" 2. Updated references
Revised	LHHPP	24-08	Off Campus Appointments or Activities	**N. Zahir**	1. Added "Laguna Honda Hospital and Rehabilitation Cener (LHH) Escorts " 2. Replaced "Resident Care Team (RCT);" with "RCT," 3. Replaced "EVS" with "Environmental Services (EVS)" 4. Replaced "Neighborhood's" with "unit"
Revised	LHHPP	24-09	Ambulance Calls – Utilization and Access	**N. Zahir**	1. Added "from LHH"
Revised	LHHPP	24-19	The C-625 Battery Operated Ceiling Lift	**N. Zahir**	1. Added "Every department will follow their department specific procedures related to competencies, as follows, but not limited to." 2. Replaced " The Physical Therapy and Occupational Therapy staff shall" with "Rehabilitation Services staff will" 3. Replaced "Activity Therapy staff" with "Appropriate staff " 4. Added "including the" and "program" 5. Deleted "Restorative Aides assigned to" 6. Deleted "(See Attachment B)" 7. Deleted attachments.

					1. Added "shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary" 2. Added "shall be implemented 3. Deleted "It shall be documented in the EHR if the Resident is Missing Cognitively Impaired (MCI) or Absent Without Official Leave (AWOL)." 4. Added "LHH has a Resident Locator System per physician order for use with high risk for elopement individuals. Alarms shall not be a replacement for necessary supervision. Staff are to respond to alarms in a timely manner." 5. Added "“On the LHH Campus” for the purposes of this Code Green protocol is defined as within the hospital building, administration building, and surrounding enclosed outside areas such as the meadow, garden , basketball court, farm, and Serenity Park. " 6. Deleted "The facility is equipped with delayed egress door alarms which audibly alert staff when activated. The facility has a Resident Locator System per physician order for use with high risk for elopement individuals. Alarms are not a replacement for necessary supervision. Staff are to respond to alarms in a timely manner. LHH shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and

Revised	LHHPP	24-22	Code Green Protocol	**N. Zahir**	interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary." 7. Deleted "unit-to-unit" 8. Deleted "increase staff awareness of the resident's risk, modify" 9. Replaced 'behavior" with "safety" and "hazards" with "elopement" and "unit" with "nurse". 10. Added "If resident is found but is not redirectable with attempts to elope, proceed with activation of Code Green below." 11. Delete "resident attempting to elope or missing " 12. Deleted "those areas do not need to be searched. If resident" 13. Replaced "nursing operations supervisor/nurse manager" with "the Nursing Operations Supervisor or NM." 14. Added "Gift Shop/" and "First floor and second floor restrooms." 15. Added "The meadow and the farm" 16. Added "Overhead page shall not be completed from 9 PM to 9 AM to minimize disturbance while residents are sleeping." 17. Replaced "neighborhood" with "unit" throughout the document. 18. Replaced "resident attempting to elope or missing" with "the missing resident" in several places. 19. Added "Nursing Home Administrator and Chief Executive Officer" 20. Deleted "QM Mailbox in Nursing Office:" 21. Added "scanned email to Risk Management" 22. Added "If a resident who lacks capacity is located off grounds, LHH staff" and "notify Nursing Operations to confirm resident is missing from the facility. If confirmed, LHH staff shall " 23. Deleted "Confirms that the patient/resident is lost," 24. Deleted "Is unable to respond to questions, appears to be frightened, confused, and/or inappropriately dressed." 25. Removed phone numbers 26. Added "resident does not have decision making capacity for a Laguna Honda Hospital stay is not found within 24 hours." 27. Deleted "Education for staff will be provided as appropriate on the reasons for elopement and possible strategies for avoiding such behavior. " 28. Added "The RCT in collaboration with Quality Management shall review the reasons for elopement and opportunities for improvement in the resident's care plan and or systems"
Revised	LHHPP	24-25	Harm Reduction	**N. Zahir**	1. Replaced "philosophy" with "principle" 2. Replaced "public health philosophy, which promotes methods of" with "set of strategies aimed at reducing" 3. Added "framework" and "for treatment and/or health behavior changes" 4. Deleted "(sometimes you just have to live with ambivalence and accept it and move on)" 5. Replaced "must be offered a range of" with "it's best to aim for realistic treatment" 6. Replaced "in a continuum of care" with "when planning care, ranging" 7. Deleted "including the designated smoking area" 8. Deleted "Providers shall not deny services to individuals for exhibiting behaviors for which they seek or need help." 9. Deleted "Provider language shall not reflect bias toward personal behaviors, experiences, ethnicity, sexual orientation, or personal choices." 10. Deleted "Programs shall broaden their treatment philosophies in order to provide quality, comprehensive care and coordinate care with other health care service providers." 11. Added "and that" and "may" 12. Deleted "shall be measured to"

Revised	LHHPP	25-05	Hazardous Drugs Management	**N. Zahir**	1. Added "Cytotoxic/chemotherapy medications or medication contains may also be disposed of in the black RCRA bins"
					1. Moved "LHH does not allow medication to be separated from the original package and stored for administration at a later time, this is considered pre-pouring" 2. Added "RTU (ready to use)" 3. Added "on the patch" 4. Added "When medications are held based on LN clinical judgement or medications are refused by the resident, notify the provider" 5. Deleted " All other medication is disposed of in the yellow and white pharmaceutical waste bin." 6. Added "Any controlled substance/narcotic issued from the Omnicell that was not administered to the patient shall be either returned to the Omnicell if unopened or wasted in the appropriate pharmaceutical waste bin with appropriate documentation of the waste. Any partial doses pulled from the Omnicell (e.g. - one-half a tablet) that will not be administered to the patient shall be promptly wasted in pharmaceutical waste container and documented in the Omnicell. Any returns or wasting of a controlled substance shall be with the witness by a 2nd LN" 7. Added "the physical wasting of the dose prior to documenting in Omnicell. " 8. Added "may be identified in the original packaging or via drug identification lookup" 9. Deleted "still in the sealed packaging, and the actual wasting of the partial dose." 10. Added "Resources to verify if a medication is safe to be crushed may include drug information resources, pharmacy consultation, or the "Do Not Crush" list." 11. Deleted "Topical creams and ointments that are ordered "until healed" can be discontinued by the LN via an order in the EHR, and ordered "per protocol, co-sign required"." 12. Deleted "Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR." 13. Added "rescue medications such as " and "or inhalers"

					14. Deleted "All medications and herbal supplements for self-administration will be stored securely by nursing, including rescue medications, except nasal naloxone. Rescue medications, such as inhalers will be given to resident when they go out on pass with physician order and will return medication for safe storage on their return, with the exception of nasal naloxone that resident can safely store on person or at bedside." 15. Added "All medications and herbal supplements for self-administration will be stored securely by nursing, with the exception of approved, documented rescue medications such as nasal naloxone or inhalers. These rescue medications may be given to the resident when a resident may go out on pass with a physician order and will be returned to the pharmacy for review and appropriate labeling and storage upon the patient's return." 16. Added "Verify medication is not expired." 17. Deleted " Do not crush" 18. Added "Medications that should not be crushed include" 19. Added "Exceptions may be allowed if the prescriber or pharmacist can explain and justify why crushing the medication will not adversely affect the resident" 20. Replaced "with alcohol wipe at the end of the medication pass prior to returning to medication room for charging" with "after use" 21. Added "unless administration instructions indicate a mask must be worn" 22. Added "Follow manufacturer instructions for specific models in use." 23. Added "Common practice may include:" 24. Replaced "OF EYE MEDICATIONS" with "BY SPECIFIC ROUTES" 25. Deleted "Scan the arm band of resident to correctly identify resident and open their eMAR" 26. Added "Review the administration instructions doto determine if the medication order has administering parameters" 27. Added "with each administration to determine if parameter is met" 28. Added "If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician" 29. Added "Cardiovascular medications which do not have parameters ordered will have vital signs checked and provider notification per Nursing

					P&P G 1.0 The default frequency of vital signs will be a done weekly at minimum, or more frequently per NPP G1.0 Policy" 30. Deleted "Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly." 31. Deleted "Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly" 32. Deleted "If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician" 33. Added "EHR in either the specific medication order or as a nursing communication, depending on the patient-specific clinical circumstances." 34. Added "Nursing may also clarify any questions about hold parameters with physician per their scope of practice" 35. Deleted "If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days." 36. Added "Document per NPP C3.0 “Documentation of Resident Status/Care by the Licensed Nurse – SNF" 37. Deleted "VS and response to therapy once every shift for duration of therapy." 38. Added "MEDICATIONS VIA TRANSDERMAL PATCH" 39. Added "in Electronic health record (note: there is no waste documentation in" and "if a full dose was given)." 40. Added "Black bins are appropriate for disposal of both hazardous and nonhazardous medications on the resident units" 41. Deleted " Nonhazardous medications shall be disposed of in either the blue and white pharmaceutical waste bin or the yellow and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin." 42. Added "Disposal of medications in the appropriate waste bins includes" 43. Added "Any liquid, food, or power substances mixed with medications and not finished"

Revised	LHHPP	25-15	Medication Administration	**N. Zahir**	43. Added "Any liquid, food, or power substances mixed with medications and not finished 44. Added "Expired medications or discontinued treatments" 45. Deleted "should go in medication waste bin" 46. Added "Items that may go into the garbage include" 47. Deleted "Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste" 48. Added "Cups which had medication in it and the contents were consumed" and "Empty packets of powered medications can be thrown in the garbage" 49. Deleted "Cups which had medication it, and the contents were consumed can also be crushed and go in the garbage" and "Empty packets of powered medications can be thrown in the garbage." 50. Added "or it was partially administered" and "full or partial dose shall be promptly wasted in pharmaceutical waste container with witness of a 2nd LN" 51. Added "not administered to the patient back to original package to aid in identification of the medication. If the original packaging has been opened or not intact, the 2nd LN can validate the identification of the medication using the Lexicomp medication lookup tool" 52. Deleted "2nd LN can validate and ID medication for partial doses, as packaging has been opened." and "This may be done via looking up the IC medication tag through Lexicomp." and "2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident" 53. Deleted "may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed on the Physicians Order Sheet in the Medication Record" 54. Added "should contact the on-call pharmacist to identify pass medications that may be needed and provide appropriately prepared and dispensed medications" 55. Deleted "Controlled substances may not be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home" 56. Deleted "Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply" 57. Deleted "The physician will counsel the resident on proper use of his/her medications" 58. Added "All pass medications should be returned to pharmacy for inspection and determine appropriate labeling, storage, or disposition" 59. Added "to be reviewed to ensure only medications are present. The medications will be staged separately, appropriately, and securely until pickup or destruction. These will be staged separately from LHH medication inventories" 60. Added ". Exceptions may be considered after evaluation by pharmacy as noted above."

Revised	LHHPP	25-16	Safe Use of Medicinal Cannabis Products for Terminally Ill	**N. Zahir**	1. Deleted "Pure cannabidiol (CBD; Epidiolex®) means the Schedule V substance that is FDA�approved for treatment of Lennoxy-Gastaut syndrome (LGS), Dravet syndrome, or tuberous sclerosis complex (TSC) in patients 1 year of age or older" 2. Added "Deliveries of medicinal cannabis must not be dropped off or handled by Laguna HondaLHH staff and may only be brought into Laguna Hondathe facility by the patient/resident or the primary caregiver, without exception" 3. Added "Cannabis deliveries from person or delivery service who is not the patient/resident or designated primary caregiver must take place outside of Laguna Honda." 4. Added "Laguna HondaLHH cannot be responsible for any deliveries left outside and any unclaimed deliveries are not the responsibility of LHH." 5. Added "Qualifying patient/resident and/or primary caregiver will inform the unit nurse supervisor of a planned cannabis delivery at least 24 hours in advance. " 6. Added "Unit nurse supervisor will inform Nursing Operations, who will inform SFSO in advance of the delivery, per LHHPP75-10 (Security Services Standard Operating Procedures). " 7. Deleted "Qualifying patient/resident and/or primary caregiver will inform the unit nurse supervisor of a planned cannabis delivery at least 24 hours in advance." 8. Deleted "Unit nurse supervisor will inform Nursing Operations, who will inform SFSO in advance of the delivery, per LHHPP75-10 (Security Services Standard Operating Procedures). " 9. Added "SFSO willsecurity screen and then present to the ambassador to complete the check in process:" 10. Added "The ambassador will verify the identity of the primary caregiver against the list of primary caregivers," 11. Added "direct the patient/resident or primary caregiver to place and seal medicinal cannabis in a tamper-evident bag, and 12. Deleted "When the patient/resident or primary caregiver adds inventory to the lock box, the nurse will log the product and expiration date on the Medical Cannabis Resident Inventory form, which will be stored inside the lock box with the medicinal cannabis."
Revised	LHHPP	45-01	Gift Fund Management	**J. Drew**	1. Added Designee through out the document. 2. Added "Assistant Nursing Home Administrator or designee"

Revised	LHHPP	60-10	Environment of Care Program	**N. Zahir**	1. Deleted "well we meet" 2. Added "the facility meets the compliance " 3. Added "our performance " 4. Deleted "Department of Education and Training" 5. Added "c) Identify and implement improvement opportunities and process change to facilitate safety, security, and comfort of patients, staff, and visitors. d) Establish and maintain risk assessments and evaluation criteria to prioritize performance improvements and process changes. e) Work to ensure that LHH staff are trained to identify, report, and take action on environmental risks and hazards. f) Reports to LHH departments and committees to communicate progress" 6. Deleted "Identify and implement improvement opportunities and process change to facilitate safety, security, and comfort of patients, staff, and visitors. iv. Establish and maintain risk assessments and evaluation criteria to prioritize performance improvements and process changes. v. Work to ensure that LHH staff are trained to identify, report, and take action on environmental risks and hazards. vi. Reports to LHH departments and committees to communicate progress." 7. Added "Workplace Safety" and "Emergency Management" 8. Added "Management Plan owners shall present quarterly reports in their respective areas to the EOC Committee. The scope of the report shall include data metrics, priorities, goals, and objectives to ensure the ongoing effectiveness of the EOC Program" 9. Added "The following EOC Committee components shall report to the PIPS Committee on a yearly basis, separate from the EOC biannual PIPS report :Workplace Safety, Emergency Management, Environmental Health, Safety/Hazardous Materials, Environmental Services, and Infection Prevention and Control. Other areas, such as Facility Services, and Biomedical Engineering, shall report quarterly and, on a rotating/as-needed basis. Security Management shall report on a yearly basis." 10. Added "The EOC biannual report highlights all activities of the EOC Program from the current fiscal year and is written to include scope, accomplishments, program objectives, performance metrics, and goals and opportunities for improvement, and is presented to the PIPS Committee" 11. Deleted "The EOC Annual Report shall be approved by the EOC Committee prior to being presented to PIPS."
Revised	LHHPP	72-01 C17	Pediculosis Management	**M. Barajas**	1. Definitions expanded 2. Added procedures section for Pediculus capatis (head lice), Pediculus corporis (body lice), Pthirus pubic (pubic lice) to include information on: 3. Presentation and Clinical Diagnosis 4. Transmission and Susceptibility 5. Patient Management 6. Treatment 7. Notification 8. Education 9. Environmental Management 10. Transfer or Discharge 11. Visitors 12. Added Responding to Facility Outbreaks section 13. Added Staff Responsibility Section 14. Added Education Section

Revised	LHHPP	73-01	Injury and Illness Prevention Program	**W. Spaul**	1. Added "This program also includes the Workplace Violence prevention program." 2. Replaced "Workplace Safety and Emergency Management (WSEM)" with "Industrial Hygiene (DIH) " throughout the document 3. Added "The Manger of DIH is the Chairperson of the Environment of Care (EOC) subcommittee “Employee Health and Safety”, which addresses employee exposures and injury events, along with workplace violence incidents in the different departments." 4. Added "which includes conducting semiannual inventories of all chemicals in their department and forwarding a copy of that inventory to DIH, and ensuring the department’s employees know where to find the Safety Data Sheets (SDSs) for each chemical. The department manager should also inventory the list of Safety Data Sheets that are present for each chemical that is used in their department. This SDS check should be done at the same time as the semiannual chemical inventory is conducted." 5. Added "including group meetings or huddles on health, safety, and workplace violence" 6. Added "including but not limited to completing the proper forms and documentation" 7. Added "Submit the appropriate injury and illness reports to DPH Occupational Safety and health (OSH) department and send a copy to the manager of DIH. " 8. Added "Appendix B can be used as a checklist to assist Managers and supervisors during a workplace injury or illness" 9. Added "this includes the Workers’ Compensation Claim form (DWC-10 for any injury to OSH and also submit a SAFE Report to Quality Management. See the reference section for links to the forms. A copy of both forms shall be sent to DIH." 10 . Added "and complete and submit a SAFE Report (see reference section for a link; " 11. Added "Ensure the DIH has the resources for IH monitoring equipment and laboratory contracts for analyses, and fund the required professional certifications and OSHA/EPA required courses for members of the DIH" 12. Added "DIH. Hazards shall also be simultaneously reported in the SAFE Reports (see reference section for a link" 13. Deleted "Employee(s) using the Workplace Hazard Reporting Form available on the LHH intranet Occupational Safety and Health button and in hard copy in the Admin building lobby. (Appendix A)" 14. Added "and a SAFE Report will need to be submitted to QM and a copy sent to DIH. The employee either observing or involved in the unsafe act should complete the SAFE report" 15. Added "and shall complete the Workers’ Compensation Claim form (see references for a link). A list of medical facilities for WC injuries or illnesses is listed in Appendix A" 16. Added "and also submit the Workers” Compensation Form " 17. Added "and the employee and supervisor shall contact DIH. 18. Added "A SAFE Report shall be filed, in addition to the Workers” Compensation Form and required IIPP forms required in the reference list for a link"
Revised	LHHPP	73-11	Medical Waste Management Program	**D. Smith**	1. Added "or the black bin RCRA containers" 2. Added "black bins with white top on unit for any pharmaceutical waste; within pharmacy space, may use white bin with blue top for non-hazardous medications"

Revised	FNS	1.96	Contract Food and Supply Purchases	**E. Lavarreda**	1. Deleted- established and 3/84,4/84, 12/87, 1/89, 1/92, 5/97, 9/06, 7/09. Reviewed: 8/13, 8/14 2. Rephrased- The Nutrition Services Department to The Food and Nutrition Services (FNS) Department 3. Added- (LHH) 4. Deleted- only 5. Deleted- of support Services. 6. Deleted- Novation Purchasing or University Health systems Consortium. 7. Added- The department purchases from vendors which meet all city standards and requirements. 8. Deleted- Currently, Vizient Novation Purchases Group Purchasing Organization (CPO) or University Health systems Consortium may be used in place of City Purchasing as long as the CPO Novation vendor meets standard city requirements for vendors.
Revised	FNS	1.97	Food Production Performance Expectation	**E. Lavarreda**	1. Deleted- Established and 8/90,5/97, 9/06,7/09. Reviewed: 8/13, 8/14. 2. Added hyphen- computer- generated 3. Capitalized- S in supervisor through the policy 4. Corrected – it is to it's 5. Decapitalized- C in cafeteria, D in distribution 6. Deleted- duly 7. Deleted- 11/6/2015
Revised	FNS	1.98	Minimum Internal Cooking temperature of Ground Meats.	**E. Lavarreda**	1. Revised title- Proper Cooking of Ground Meats to Minimum Internal Cooking Temperatures of Ground Meat 2. Corrected- reviewed to revised. 3. Deleted- 9/06, 7/09, 8/13, 8/14 4. Expanded USDA- The United States Department of Agriculture. 5. Deleted- and others: patties held at this temperature for just 19 minutes (11 second) will usually kill all E. Coli 015:H7 in beef 6. Added- That ground meats should be cooked at the following temperatures. 7. Rephrased sentence – We must cook all ground patties to internal temperature of at least 155ºF to Ground meats are cooked to an internal temperature of at least 160ºF 8. Deleted- Consistent with proper cooking all meats with sauces will rise above 155ºF. 9. Added- Ground poultry internal temperature of at least 165ºF 10. Deleted- 11/6/2026
Revised	FNS	1.99	Unused Food Portions	**E. Lavarreda**	1. Deleted- Established and3/26, 3/81, 3/84, 1/89, 1/92, 7/00, 9/06, 7/09, 6/11. Reviewed: 8/13, 8/14 2. Replaced the department with Food and nutrition services (FNS) 3. Replaced determination to decision 4. Corrected- resident or cafeteria to residents meal services. 5. Added- cooled 6. Replaced Food Runner Charity Program to donation charity program 7. Deleted- two times per week. 8. Deleted- 11/6/2015
Revised	Nursing	B 7.0	Nursing Care of Resident with Seizures	**C. Figlietti**	1. Referenced Code Blue Policy 2. Revised documentation to reflect what is taught during Code Blue
Revised	Nursing	C 4.0	Notification and Documentation of Change in Resident Status	**C. Figlietti**	1. Moved section on "Unusual Occurrences" to Policy 2. Moved section on "resident symptoms indicating a change of condition requiring UTOX" to policy and referenced HWPP 75-05 for further details

Revised	Nursing	C 9.0	Transcription and Processing of Orders	**C. Figlietti**	1. Updated with new policy referring to DCR: "The AM shift will print a 24-hour new order report from the EHR daily at 7 AM and place orders in the applicable sections of the DCR form for the nurse manager to review (Refer to Standard Work on Laguna Honda Daily Clinical Review Form Instructions). 2. Referred verbal orders to HWPP 25-03 Verbal/Telephone Orders to remove duplication 3. Referred to Standard Work on LHH DCR Form Instructions for acknowledging physician orders 4. Added reference to Title 22 re: requirements for STAT order processing 5. Added procedure for acknowledging physician orders in the EHR
Revised	Nursing	E 2.0	Resident Mealtime Support (formerly Assisting Residents During Mealtime)	**C. Figlietti**	1. Revised Procedure B to mirror both E 1.0 Oral Management of Nutrition and 26-02 Management of Dysphagia and Aspiration Risk to state "Resident to sit as upright as possible with all meals and for at least 20 minutes after eating." 2. Revised positioning for enteral nutrition to reflect Critical Element Pathway for Tube Feeding and Enteral policy 3. Referred to HWPP 26-02 Management of Dysphagia and Aspiration Risk for resident's with aspiration risk 4. Updated references
Revised	Nursing	G 3.0	Intake and Output (I & O)	**C. Figlietti**	1. Referred to related policies for I/O measurements for residents on: - IV Therapy - TPN - Enteral - Urinary Catheter - Ostomy - Suprapubic catheter 2. Added "Intake measured for residents on fluid restriction; output measured based on clinical indication." 3. Clarified LN will document using I/O Flowsheet Activity Tab, and Nursing Assistants will document under PCA Vitals, I/O section within the Flowsheet Activity Tab 4. Updated what needs to be documented for each occurrence separately (e.g., refusals, enteral or iv therapy, alternative meals offered, percentage of intake by mouth, voided urine, unmeasured urine, stool incontinence, etc)
Revised	Nursing	G 4.0	Measuring the Resident's Height	**C. Figlietti**	1. Minor revisions (changed "PCA and CNA" to "Nursing Assistants") 2. Updated references
Revised	Nursing	K 2.0	Wound Assessment and Management	**C. Figlietti**	1. Added to RN responsibility to policy #1 "assessing each resident for presence of wound(s) on admission navigator and/or flowsheet section in the Electronic Health Record" 2. Added the following 3 policies: 3. Upon resident's intra-facility (within Laguna Honda) relocation, including Pavilion Acute, the sending and receiving registered nurses are responsible for reviewing resident's/patient's skin condition together and documenting for any presence of wound. 4. The RNs, Licensed Vocational Nurses (LVN), and Certified Nursing Assistants (CNA), within his/her/their scope of practice are responsible for observing and reporting changes in the resident's skin status. 5. For management of Pressure Injuries, refer to Nursing Policy and Procedure (NPP) K 1.0 Assessment, Prevention, and Management of Pressure Injury. 6. Removed Background section and focused on wound assessment, management and documentation/reporting. Since we already have a policy specific to pressure injury, I removed the pressure injury column from the table. 7. Added assessment data under "Wound Assessment by Licensed Nurse" section. 8. Listed the required documentation and frequency according to what is taught.

Revised	Nursing	L 1.0	Emergency Intervention for Choking	**C. Figlietti**	1. Reorganized policies 2. Removed “All nurses and PCA shall be trained and remain current in BLS.” And changed to “All nursing staff shall maintain current BLS or CPR certification as required by job description 3. Changed Definition section to Background and added definition of choking and the importance of acting quickly for person who is choking 4. Under Signs and Symptoms of Choking section, included calling Code Blue, and signs/symptoms mirroring what is taught 5. For Procedure section, added Code Blue process 6. Updated references
Deletion	Nursing	J 9.0	Insulin Subcutaneous Infusion Therapy for Patient Managed Insulin Pump	**C. Figlietti**	Delete this policy secondary to no one in nursing to manage it
Deletion	Nursing	K 2.0 Attachment 1	Two Layer Compression Bandage System	**C. Figlietti**	Deleting - added a link to the use of this product to the Wound Management section for management of arterial/diabetic/venous wounds
Deletion	Nursing	K 2.0 Attachment 2	Use of Advanced Wound Products Specifically Skin Substitutes and ECM	**C. Figlietti**	Deleting - skin substitutes info added into Wound Management section and generalized to what is relevant for nursing

Revised Hospital-wide Policies and Procedures

RESIDENT CARE PLAN (RCP), RESIDENT CARE TEAM (RCT) & RESIDENT CARE CONFERENCE (RCC)

POLICY:

1. An interdisciplinary Resident Care Team (RCT), in conjunction with the resident, resident's family, or surrogate decision-maker shall develop a Baseline Plan of Care within 48 hours of the resident's admission. It shall include instructions needed to provide effective and person-centered care of the resident and shall at a minimum include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and if applicable, Preadmission Screening and Resident Review (PASRR) recommendation(s).

2. The RCT, in conjunction with the resident or representative, shall develop a comprehensive care plan with seven days of the completion of the comprehensive assessment, based on the care team disciplines' assessments, that includes measurable objectives and a timeframe to meet the resident's medical, nursing, and psychosocial needs, if appropriate. The comprehensive assessment shall be completed within 14 days of admission.

3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter during quarterly assessments, and revised as needed during change of condition to serve as an essential resource for improved resident outcomes. Nursing will document these summaries on the Electronic Health Record (EHR).

4. The resident, family and/or representative shall be part of the development and implementation of ~~his or her~~their person-centered plan of care.

~~5. Care problems require various professional disciplines working together in planning, implementing and evaluating goals and interventions.~~

~~6.~~5. A Resident Care Conference (RCC) shall be conducted with the scheduled completion of an admission, quarterly, annually and/or with a significant change in condition.

~~7.~~6. Special Review (SR) RCC's shall be held when the review of specific care issues is clinically indicated.

~~8.~~7. Stable, ongoing resident needs, and resident preferences are addressed on the Baseline Care Plan in the ~~electronic health record (EHR).~~EHR. Unstable, alterable problems that require a more goal directed approach are addressed on the RCP in the EHR. Together they comprise the resident's care plan.

~~9.~~8. Care Area Assessment (CAA) that are triggered during completion of the comprehensive Minimum Data Set (MDS) requires evaluation and discussion from the

resident and/or representative, and RCT to develop a comprehensive care plan for the triggered care areas.

PURPOSE:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to develop and implement a comprehensive person-centered care plan for each resident, which promotes the resident's highest possible physical, mental and psychosocial well-being, which is consistent with the resident rights, cultural preferences, is trauma-informed, ~~that~~ and includes measurable objectives and timeframes to meet a resident's ~~medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments~~ care goals. ~~To promote the resident's highest possible physical, mental and psychosocial well-being.~~

DEFINITION:

Resident's goal: The resident's desired outcomes and preferences for admission, which guides decision making during care planning.

Interventions: Actions, treatments, procedures, or activities designed to meet an objective.

Measurable: The ability to be evaluated or quantified.

Objective: A statement describing the results to be achieved to meet the resident's goals.

Person-centered care: To focus on supporting the resident's autonomy, ~~as the locus of control and~~ support the resident in making their own choices, and having control over their daily lives.

"Culture" is the conceptual system that structures the way people view the world – it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

"Cultural Competency" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of ~~trauma~~traumas. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and

symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.

PROCEDURE:

1. The Resident Care Team

a. The RCT is an essential component of the care planning process. The RCT shall include members from ~~those~~ disciplines essential to the planning and delivery of care for the resident. RCT members include:

i. Nurse Manager~~s~~ (or designee)

ii. Licensed Nurse

iii. Nursing Assistant

iv. Attending Physician

v. Medical Social Worker

vi. MDS Coordinator

vii. Activity Therapist

viii. Food and Nutrition Services Staff (such as Registered Dietitian)

b. The resident, family and/or representative shall be part of the development and implementation of ~~his or her~~the person-centered plan of care, including but not limited to:

i. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

ii. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

iii. The right to be informed, in advance, of changes to the plan of care.

iv. The right to receive the services and/or items included in the plan of care.

v. The right to see the care plan.

c. In the event a special review meeting is necessary, the following disciplines ~~must be present~~ shall be included: ~~nurse~~nursing, ~~physician~~medicine, MDS coordinator, Registered Dietician, Activity Director and medical social worker. RCT members who may not be able to join ~~The remaining RCT members~~ shall be notified of any care plan changes, including the resident and/or representative.

d. Consultative ~~Members~~ members may be part of the RCT if actively involved in the care of the resident and may include as appropriate:

i. Chaplaincy

~~ii. Clinical Nurse Specialist~~

~~iii.~~ii. LHH ~~Psychiatry providers (Psychiatrist/Psychologist/Behavioral Health Clinician/mental health or substance treatment counselor)~~ Behavioral Health and addiction medicine providers

~~iv. Occupational Therapist~~

~~v.~~iii. Quality Management

~~vi.~~iv. Pharmacy

~~vii.~~v. Rehabilitation Services

~~viii.~~vi. ~~Dietary Technicians~~Food and Nutrition Services

~~ix. Peer Mentors~~

~~x.~~vii. Ombudsmen

~~xi.~~viii. Any other consultants as needed

e. The RCT shall address resident care needs and preferences through assessment of the resident and the development and implementation of the RCP.

f. The RCT shall incorporate the resident's personal and cultural preferences in developing goals of care, and address the resident's care needs through assessments such as:

i. Minimum Data Set (See LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set)

ii. Admission assessments including but not limited to:

- Physician History and Physical

- Resident Social History Assessment
- Nutrition Screening and Assessment
- Admission Nursing Assessment
- Comprehensive Pain Assessment
- Behavioral Risk Assessment
- Discharge Assessment
- Pressure Ulcer Risk Assessment
- Activity Therapy Assessment
- RCT Pre and Post Elopement Event (Cross Reference LHHPP 24-22 Code Green Protocol)
- Bed Rail Order (if appropriate) and Entrapment Risk Assessment
- Smoking Assessment and Plan of Care
- Social Services Psychosocial Assessment
- Fall Risk Assessment
- Trauma Informed Assessment

2. Resident Care Conferences

a. The RCC shall serve as the forum for interdisciplinary development and review of the care plan. Care plan review shall be done:

i. On a quarterly schedule with the MDS.

ii. With discharge planning.

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

iv. Special Review(s).

- Within seven days after completing Comprehensive MDS with –CAA including Admission MDS, Annual, and Significant Change in Status Assessment MDS.

- Significant change in resident condition such as new pressure ulcer, new behavior, and/ or a fall.

- Temporary relocations.~~, I.e., Covid unit~~

b. RCT members shall conduct their assessments and prepare prior to the RCC. ~~This will allow for efficient reporting from each discipline and provide a forum for major care problems to be discussed by the team with the resident.~~

c. The RCT shall facilitate the inclusion of the resident and/or representative~~. The resident and/or representative shall be informed of the meeting, date and time. The resident shall be invited and encouraged to attend the RCC, unless contraindicated by the resident's condition. If the resident is unable to attend, a representative is required to attend on behalf of the resident~~.

i. The social worker shall contact the representative about the meeting date and time in advance to ensure attendance. The RCC will be rescheduled based on the representative's availability. If the representative is unable to attend in person, attendance can occur via telephone or video call.

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

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

d. The nursing assistant and assigned licensed nurse shall be present, or provide information if unable to attend, at the RCC and consultants shall be invited as appropriate.

e. The Team Conference Note, including all discipline signatures, shall be completed in the EHR ~~shall be completed for~~ by the end of each RCC.

3. Baseline Care Plan

a. Shall be initiated by nursing within eight hours on the day of admission.

b. Shall be completed and implemented within 48 hours of a resident's admission.

c. The baseline care plan shall address the resident's immediate needs for safety, management of risks, and medical attention, including but not limited to the minimum healthcare information necessary to properly care for the resident as outlined in policy statement #1.

d. The baseline care plan shall reflect the resident's stated goals and objectives and include interventions that address ~~his or her~~their current needs.

i. It shall be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and/or ~~resident~~ representative, if applicable.

~~i.~~ii. The baseline care plan documents the interim approaches for meeting the resident's immediate needs, professional standards of quality care shall dictate that it shall also reflect changes to approaches, as necessary, resulting from significant changes in condition or needs occurring prior to development of the comprehensive care plan.

~~ii.~~iii. LHH staff shall implement the interventions to assist the resident to achieve care plan goals and objectives.

e. The baseline care plan shall include instructions for:

i. Initial goals based on admission orders.

ii. Physician orders.

iii. Dietary orders.

iv. Therapy services.

v. Social services.

vi. Specific health/safety needs (e.g., fall risk, elopement risk, behavioral interventions).

f. Is reviewed with the resident and/or representative, in their preferred language, no later than seven days after admission.

g. LHH shall provide the resident and/or resident representative with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary shall include:

i. Initial goals for the resident;

ii. A list of current medication and dietary instructions; and

iii. Services and treatments that shall be administered by LHH.

h. Problems identified by the Resident Assessment Instrument (RAI), shall be care planned within seven days of the completion of the comprehensive assessment.

4. Comprehensive Care Plan

a. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed.

b. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All ~~Care Assessment Areas (CAAs)~~CAAs triggered by the MDS will be considered in developing the plan of care. Other factors identified by the ~~interdisciplinary team~~RCT, or in accordance with the resident's preferences, will also be addressed in the plan of care. The ~~facility's~~ RCT's rationale to proceed with care planning will be evidenced in the ~~clinical record~~EHR. For clinical problems, care planning will be initiated with individualized interventions based on short-term or long-term goals.

c. The comprehensive care plan shall include measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, specifically in the CAA.

i. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

ii. Any services that would otherwise be furnished but are not provided due to the resident's exercise of ~~his or her~~their right to refuse treatment.

iii. Identify concerns in the CAA that may warrant interventions.

iv. Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being in the context of the resident's condition, choices, and preferences for interventions.

v. Address other important considerations, such as advance care planning and palliative care.

vi. Describe any specialized services or specialized rehabilitative services ~~t~~ LHH shall provide as a result of the PASRR recommendations.

vii. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the ~~facility~~ RCT will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate.

viii. Individualized interventions for trauma survivors that recognize the interrelation between trauma and symptoms of trauma, as indicated. ~~Trigger-specific~~ Trauma informed interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

ix. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

d. In consultation with the resident and/or representative, the comprehensive care plan shall describe:

i. The resident's goals for admission and desired outcomes.

ii. The resident's preference and potential for future discharge. ~~LHH~~ The RCT shall document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

iii. Discharge plans in the comprehensive care plan, as appropriate.

e. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to:

i. The attending physician ~~or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan~~.

ii. A registered nurse with responsibility for the resident.

iii. A nurse aide with responsibility for the resident.

iv. A member of the food and nutrition services staff.

v. The resident and the resident's representative, to the extent practicable.

vi. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to:

- The RAI Coordinator.
- Activities Director/Staff.
- Social Services Director/Social Worker.

- Licensed therapists.
- Family members, surrogate, or others desired by the resident.
- Administration.
- Discharge Coordinator.
- Mental health professional.
- Chaplain.

f. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

g. The RCT shall~~physician, other practitioner, or professional will~~ inform the resident and/or ~~resident~~ representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The ~~facility~~ RCT will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or ~~resident~~ representative.

h. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

5. Identifying and Writing the Problem Statement

a. Problems, needs, strengths, and preferences are identified by members of the RCT and the resident as a result of careful, comprehensive, and ongoing assessments.

b. Problem statements are resident focused and not staff focused.

c. The statement may, but does not require the reason for the problem, (i.e., what the problem is related to "R/T").

d. The statement may include some, but not all, of the common observable signs and be described as "As Evidenced by (AEB)".

6. Determining the Goal Statement

a. The goal statement indicates the outcome desired by the resident or representative and aims at promoting or maintaining the resident's highest practicable physical, mental, and psycho-social well-being.

b. Goals must be realistic, specific, reflect the problem, measurable, and have a target date.

7. Developing Interventions

a. Interventions can address how to minimize the risk of problem(s), address resident's preferences, and meet the resident's goals.

b. Interventions are specific, individualized and describe the team member(s)RCT members responsible for carrying it out and the frequency for conducting the interventions.

c. Interventions reflect standards of current professional practice.

8. Evaluating Effectiveness of the Care Plan

a. Evaluation of the care plan requires accurate knowledge and analysis of the resident's present status and is documented in the summary notes.

b. The progress of the goal is based on the following:

i. If there is evidence or progress towards the outcome desired by the resident or representative.

ii. If the evaluation indicates that the goal is not being met, the RCT shall determine the cause for the lack of progress and make the necessary changes.

c. Consideration by the RCT should include:

i. Identification of the problem. Is it an accurate reflection of resident's present status?

ii. Measurable and realistic goals.

iii. Appropriate interventions for each goal.

iv. Additional information as appropriate.

d. The evaluation of the effectiveness of the care plan is documented in the EHR under:

i. The Team Conference note,

ii. The Nursing Weekly Summary, and

iii. Discipline specific progress notes.

9. Behavioral Plans are a part of the Resident's Plan of Care and documented in the EHR.

a. These plans are developed by the ~~interdisciplinary~~ RCT members. Plan development may require specialized behavioral planning meetings. Planning discussion is documented by a summary special review meeting note.

b. These plans are drafted by ~~team members~~the RCT, most often ~~the~~ Nursing, in consultation with a LHH ~~Psychiatry~~ Behavioral Health provider, the Behavioral Emergency Response Team (BERT) and/or consultation with other key team members on different shifts.

c. The RCT is to discuss behavioral plans with the resident and/or the resident's surrogate decision-maker when appropriate.

d. Behavioral Plans are revised as needed and discontinued when the target behavior no longer poses a problem.

e. Behaviors identified for modification shall be clearly described, noted and tracked in the Behavior Monitoring Record (BMR).

10. Communication

a. The MDS Coordinator shall identify the scheduled RCC meeting based on the MDS assessments.

b. Nursing (i.e., MDS Coordinator, Nurse Manager or Charge Nurse) shall coordinate all Special Review RCC meeting dates and times.

c. The RCT shall communicate with one another in a timely manner using the EHR, email, and text paging, as needed.

d. The BMR shall be used by nursing to document resident behaviors and reviewed by the RCT to evaluate the resident's response to the behavioral plan.

e. Changes that affect the resident's care or daily routine shall be communicated to the resident or representative as soon as possible in the method that is most practical for the resident or representative and shall be repeated as needed or provided in writing.

ATTACHMENT:
None.

REFERENCE:
LHHPP 23-02 Completion of Resident Assessment Instrument/Minimum Data Set (RAI/MDS)
LHHPP 24-22 Code Green Protocol
MSPP D08-10 Behavioral Management Services by LHH Psychiatry
Long Term Care Survey, June 2006 Edition
42 Code of Federal Regulation (CFR) 483.21(a)(1)-(3) Comprehensive Person-Centered Care Planning, Baseline Care Plans
42 Code of Federal Regulation (CFR) 483.10(c)(2)-(3) Resident Rights – Planning and Implementing Care
Comprehensive User Manual Version 3.0 Resident Assessment Instrument. Chapter 4. CAA Process and Care Planning.

Revised: 01/10/20, 09/10/27, 10/05/25, 16/11/08, 19/03/12, 19/05/14, 19/07/09, 23/09/12, 25/05/12, 26/07/21 (Year/Month/Day)

Original adoption: 92/05/20 (Year/Month/Day)

CULTURALLY COMPETENT CARE

POLICY:

It is the policy of ~~this facility~~Laguna Honda Hospital and Rehabilitation Center (LHH) to provide culturally competent care in accordance with professional standards of practice. ~~The facility~~LHH has established a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices and cultural preference.

DEFINITIONS:

1. "**Culture**" is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

2. "**Cultural Competency**" is defined as a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

3. "**Effective communication**" describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand.

4. "**Language Assistance Services**" is defined as language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. This may include oral interpretation, written language translation, or both.

5. "**Health Equity"** is the state in which everyone has a fair and just opportunity to attain their highest level of health.

PROCEDURE:

1. ~~The facility~~LHH will use ~~the~~ its Facility Assessment to identify resident populations having unique cultural characteristics, such as language (including American Sign Language), religious or cultural practices, values, and preferences.

2. Each resident's demographic information will be assessed upon admission to identify at a minimum: race, ethnicity, religious preference, sexual orientation, and gender identity.

3. ~~The facility~~LHH will provide sufficient guidance for staff, including temporary staff, on how to communicate and deliver care for all residents. Many aspects of cultural preferences may impact the delivery of care. Once identified, these will be added to the resident's care plan. They may include, but are not limited to:

   a. Food preparation and choices.

   b. Clothing preferences such as covering hair or exposed skin.

   c. Physical contact or provision of care by a person of the opposite sex.

   d. Cultural etiquette, such as avoiding eye contact or not raising the voice.

4. ~~The facility social worker~~A member of Social Services ~~or designee~~ will meet with the resident in a calm, non-threatening, private setting to initiate a discussion/interview with the resident. If language assistance services are needed, the interpreter or translator will be present. The resident's cultural beliefs, experiences, expectations, needs, and values will be reviewed, documented, and added to the care plan so that they can be honored.

5. If the resident is non-English speaking, ~~the facility~~the Resident Care Team (RCT) will identify how on-going communication will occur with the resident. If indicated, language assistance services will be arranged for the resident. The care plan will identify the language spoken and tools used to communicate.

6. If communication systems are used, all staff interacting with the resident will know where those materials are kept, will understand how to use them, and consistently implement use of those methods. Staff will demonstrate proficiency in communicating with the resident to ~~assure~~ensure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services.

7. Resident-specific approaches will be developed and included in the resident's care plan. These interventions will be provided consistently, and supervising staff will monitor the delivery of care and staff interactions with the resident to ~~assure~~ensure they are implemented as written.

8. The ~~facility~~ RCT will involve the resident and/or his or her family in evaluating the effectiveness of cultural interventions in achieving measurable objectives and resident goals. The ~~facility~~ RCT will engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents.

9. Depending on the Facility Assessment, the ~~facility may~~ following may be considered for the resident: ~~consider:~~
   a. Offering activities that are culturally relevant to resident populations within the facility.

   b. Group activities with both sexes is often not permitted or appropriate in some cultures, or the type of programming may be in conflict with his/her cultural preferences.

   c. Providing reading materials, movies, newspapers in the resident's preferred language may help orient a resident to date, times and events.

   d. Allowing the performance of religious rites at end of life to the extent possible.

   e. Certain medications, procedures or treatments may be prohibited.

10. Residents will be informed in a language they can understand of their total health status and will be provided notice of rights and services both orally and in writing in a language that they understand. This may involve facility staff evaluating how forms, including informed consent forms, are provided in the language used by the resident.

11. Staff will be aware of resident's body language communication.

12. ~~The facility~~LHH recognizes that it is important for staff to be aware of the impact of culture and cultural preferences on the provision of care~~,~~ and have an understanding of the cultural norms and practices of the individuals they care for. Direct care staff will be trained on effective communication that reflects the needs of the resident population and needs of the staff~~,~~ and will correspond with the Facility Assessment.

13. ~~The facility~~LHH recognizes to achieve health equity, care delivery to all residents, especially those with historical and generational injustices, should be critically reviewed to ensure the avoidance of perpetuating those injustices that give rise to racial and ethnic health disparities. Equitable care supports the resident's ability to attain their highest level of health and function.

ATTACHMENT:
None.

REFERENCE:
~~What is Health Equity? | Health Equity | CDC~~
None.

Reviewed: 25/01/25, 26/07/21 (Year/Month/Day)~~01/17/25 (Month/Day/Year)~~

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

PROMOTING/MAINTAINING RESIDENT DIGNITY

POLICY:

It is the practice of Laguna Honda Hospital and Rehabilitation Center (LHH) to protect and promote resident rights and treat each resident with respect and dignity. LHH cares for each resident in a manner and in an environment that maintains or enhances the resident's quality of life by recognizing each resident's individuality.

PROCEDURE:

1. All LHH staff members who are involved in providing care to residents shall promote and maintain resident dignity and respect resident rights.

2. During interactions with residents, staff shall report, document and act upon information regarding resident preferences.

3. Assessment and interview results shall be documented; the provision of care and care plans shall be revised, if appropriate, based on information obtained from any resident assessments and interviews.

4. The resident's lifestyle choices and personal preferences shall be considered when providing care and services to meet the resident's needs.

5. When LHH staff are interacting with a resident, the resident shall be treated as a unique individual.

6. LHH responds to each request for assistance by a resident in a timely manner.

7. All staff members shall explain care and/or procedures to the resident before initiating said procedures.

8. Staff members at LHH should not talk to each other while performing a task with and for the resident as if the resident is not present. All conversation during the provision of care should be resident focused and resident centered.

9. Residents shall be dressed and groomed according to their preferences.

10. All staff at LHH shall speak respectfully to residents and shall avoid discussions about residents that may be overheard.

1. LHH respects the resident's living space and personal possessions. At no time shall staff search a resident's body or personal possessions without consent from the resident, or if applicable, the resident's surrogate decision's maker (SDM). The resident or the SDM shall understand the search is voluntary and why the search is being conducted.

11. LHH shall maintain resident privacy in all areas where care may be provided. This includes, but is not limited to, a resident's room, the great roomGreat Room, or any area where the resident is agreeable to receive care. This shall be specified in the resident's care plan as their preference.

11.12. LHH supports patient resident privacy/dignity during medication administration by pulling curtains in room or closing room door prior to administering medications or confirming with the resident that they prefer to not have the curtain pulled and/or the door closed. The resident's care plan shall specify their preferences.

12.13. All LHH staff shall assist residents to participate in activities of their own choice.

13.14. Each resident shall be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.

ATTACHMENT:
None.

REFERENCE:
None.

Revised: 23/10/10, 26/07/21 (Year/Month/Day)

Reviewed: 25/01/17 (Year/Month/Day)

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

TRAUMA INFORMED CARE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide care and services which, in addition to meeting professional standards, are delivered using approaches that are equitable, ~~culturally-competent~~culturally competent, account for experiences and preferences, and address the needs of those who have experienced trauma by minimizing triggers and/or re-traumatization.

DEFINITIONS:

1. "**Trauma**" results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to:

   a. Natural and human caused disasters

   b. Accidents

   c. War

   d. Physical, sexual, mental, and/or emotional abuse (past or present)

   e. Rape

   f. Violent crime

   g. History of imprisonment

   h. History of homelessness

   i. Traumatic life events (death of a loved one, personal illness, etc.)

2. "**Trauma-Informed Care**" is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.

3. "**Culture**" is the conceptual system that structures the way people view the world—it is the set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

4. "**Cultural competency**" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Developing cultural competence involves the on-going process of valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

5. "**Health Equity"** is the state in which everyone has a fair and just opportunity to attain their highest level of health.

PROCEDURE:

1. LHH will work to facilitate the implementation of trauma informed care based on the following trauma-informed principles:

   a. Understanding Stress and Trauma: Understanding trauma and stress allows actions with compassion and leads to well-informed steps toward wellness.

   b. Cultural Humility and Responsiveness: Understanding that all residents come from diverse social and cultural groups that may experience and react to trauma differently allows for responding sensitively so that residents may feel understood and enhance wellness.

   c. Safety and Stability: Trauma unpredictably violates our physical, social and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our residents' daily lives and having these core safety needs met can minimize their stress reactions and allow focus on resources for wellness.

   d. Compassion and Dependability: Trauma is overwhelming and can leave residents feeling isolated or betrayed, which may make it difficult to trust others and receive support. When residents experience compassionate and dependable relationships, they may reestablish trusting connections with others that foster mutual wellness.

   e. Peer support and mutual self-help: If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals.

   f. Collaboration and Empowerment: Trauma involves a loss of power and control that makes us feel helpless. When residents are prepared for and given opportunities to make choices for themselves and their care, they may feel empowered and can advocate for their own wellness. It also places an emphasis on partnering between residents and/or his/her/their representative, and all staff and disciplines involved in the resident's care in developing the plan of care.

g. Resilience and Recovery: Trauma can have a long-lasting and broad impact on residents' lives that may create a feeling of hopelessness. When residents are able to focus on their strengths and clear steps, they can take toward their wellness they are more likely to be resilient and recover.

2. ~~LHH~~ The Resident Care Team (RCT) will use a multi-pronged approach to identifying a resident's history of trauma, as well as their cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others.

3. If the resident is non-English speaking, LHH will provide staff with the tools and resources to effective communication with the resident. If indicated, language assistance services will be arranged for the resident. The care plan will identify the language spoken and tools used to communicate.

4. ~~LHH~~ The RCT will collaborate with residents who have experienced trauma, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.

5. ~~LHH~~ The RCT will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to:

   a. Experiencing a lack of privacy or confinement in a crowded or small space.

   b. Exposure to loud noises, or bright/flashing lights.

   c. Certain sights, such as objects that are associated with their abuser.

   d. Sounds, smells, and physical touch.

6. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the resident's need to be respected, informed, connected, and hopeful regarding their own recovery.

7. ~~LHH~~ The RCT will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or their family or representative will be included in

this evaluation to ensure clear and open discussion and better understand if interventions must be modified.

8. ~~LHH~~ The RCT will engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents.

9. In situations where a resident who experienced trauma is reluctant to share their history, ~~LHH~~ the RCT will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.

ATTACHMENT:
None.

REFERENCE:
~~What is Health Equity? | Health Equity | CDC~~
~~Trauma Transformed - Overview of Trauma Informed Systems~~
State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities section 483.25(m) Trauma Informed Care

Revised: 24/01/09 (Year/Month/Day)

Reviewed: 25/01/17 (Year/Month/Day)

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

ADVANCE CARE PLANNING

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing residents information about their medical condition to facilitate their involvement in medical decisions, in an ongoing process called advance care planning.

2. LHH residents are presumed to have decision-making capacity unless a determination is documented otherwise by their LHH attending physician, or a lack of decision-making capacity is documented by another LHH physician or by a court.

3. Residents are provided information about their rights to make medical decisions at the time of admission.

4. If a resident lacks capacity, decisions made by surrogate decision-makers (SDM) are honored in the same way as a decision made by the resident is honored.

5. Provision of care at LHH is not contingent upon or denied based on the presence or absence of an established Advance Health Care Directive (AHCD) that describes the resident's wishes and/or names a surrogate decision-maker.

6. Consistent with California law (CA Probate Code Section 4600-4805), ~~Advance Health Care Directives (~~AHCD~~)~~ may be oral and documented in the ~~medical record~~electronic health record (EHR) or documented in a written advance care planning document ~~attached to the medical record~~scanned to the EHR media files.

7. Consistent with California law (CA Probate Code Section 4600-4805), residents with decision-making capacity have the right to delegate medical decision making to an SDM in advance of incapacity.

8. All information related to a resident's treatment preferences, including changes, is documented in the medical record.

9. A ~~competent resident may change his/her~~resident with decision making capacity may change their AHDC at any time.

10. LHH physicians are not obligated to offer or to provide an intervention or treatment that in the physician's best judgment is determined to be non-beneficial as outline in LHHPP 29-10 Non-Beneficial Treatment.

BACKGROUND:

1. Advance Care Planning – California Law

a. California law provides individuals with the opportunity to ensure that their health care wishes are known and considered if they become unable to make these decisions themselves. By completing a form called an "Advance Health Care Directive," California law allows individuals to do either or both of two things:

   i. First, an individual may appoint another person to be a health care agent or power of attorney for health care. This person will have legal authority to make decisions about medical care if the individual ~~patient~~ becomes unable to make these decisions ~~for him/herself~~ or delegates decision making to ~~his/her agent or surrogate decision maker (SDM)~~their SDM.

   ii. Second, an individual may document in writing ~~his or her~~their health care wishes in the ~~Advance Health Care Directive (AHCD)~~AHCD form. Physicians and health care agents must follow lawful instructions set out in the ~~Advance Health Care Directive (AHCD)~~ AHCD form.

b. The ~~Advance Health Care Directive (AHCD)~~AHCD is now the legally recognized format for a living will in California. It replaces the former legislation, the Natural Death Act Declaration. It allows individuals to state wishes about refusing or accepting life-sustaining treatment in any situation, and clarifies the procedure for appointment of a health care proxy or power of attorney for health care.

   i. A power of attorney must either be acknowledged before a notary public or signed by at least two witnesses. However, in skilled nursing facilities, the signature must be witnessed by the ombudsmen.

   ii. An ~~Advance Health Care Directive~~AHCD is valid indefinitely unless specifically revoked.

2. California law:

a. Effective July 1, 2000, the Natural Death Act and the laws governing Durable Powers of Attorney for Health Care were replaced by the new Health Care Decisions Law (AB 891Chapter 658).

3. Federal Law:

a. Patient Self-Determination Act (PSDA), 42 USCA § 1395cc(f)(3)

PURPOSE:

To comply with regulatory standards and ethical guidelines.

PROCEDURE:

1. Admission Procedures

a. Admission and Eligibility

   i. Provides written information to residents or their SDMs about their right to participate in medical decisions.

b. Medical Staff

   i. Asks resident or SDM about the existence of any advance health care directive (oral or written) at the time of admission and asks for a copy of written directive to place in the medical record.

   ii. Document~~s~~ information about the resident's treatment wishes in the electronic ~~medical record~~health record (EHR).

   iii. Document~~s~~ appropriate orders implementing the resident's treatment wishes in the EHR.

c. Social Worker

   i. Provides written information about ~~Advance Health Care Directives~~AHCD, i.e. formerly known as Durable Power of Attorney for Health Care. Information is available in Spanish, Chinese and English.

   ii. Documents in the social work assessment, if information regarding ~~advance health care directives~~AHCD was provided to resident and SDM, in the EHR.

   iii. Contacts the Ombudsmen Office if the resident would like to execute or to modify the legal document, ~~Advance Health Care Directive~~AHCD.

2. Updates or Modifications to Advance Health Care Directives

a. If a resident or SDM wishes to modify a previous directive, the attending physician is notified, and the information documented in the ~~medical record~~EHR is update and ~~is~~ communicated to the ~~RCT~~Resident Care Team (RCT).

b. The resident's treatment wishes are reviewed whenever clinically indicated.

c. To revoke the entire form, including the appointment of the agent, the resident must inform the treating health care provider personally or in writing. Completing a new ~~Advance Health Care Directive~~AHCD will revoke all previous directives.

d. For any AHCDs executed or modified at LHH, the ombudsman must serve as a witness.

ATTACHMENT:
None.

REFERENCE:
LHHPP 29-10 Non-Beneficial Treatment
Web Access to Low Literacy Advance Directive Forms in English, Spanish and Chinese: http://in-sfghweb01.in.sfdph.net/chnpolicies/sfghadmin/ZZSFGHWebForms/TOC.htm

Revision/Consolidation of:
LHHPP 24-05 Patient Self Determination Act
MSPP C02-03 Advance health care directives to Healthcare Providers

Revised: 08/3/05, 08/3/25, 19/03/12, 20/10/13, 21/09/14, 25-07-2126/07/21
(Year/Month/Day)

Reviewed: 25/01/17 (Year/Month/Day)

Original adoption: 92/05/20 (Year/Month/Day)

RESIDENT/PATIENT VISITATION

POLICY:

1. Residents'/Patients' visitors at Laguna Honda Hospital and Rehabilitation Center (LHH) shall be accommodated, without compromising the safety of the facility, residents/patients, and staff, or the care or the well-being of residents/patients at the facility.

2. Every resident/patient has the right to receive visitors of their choosing at the time of their choosing, subject to the resident's/patient's right to deny visitation when applicable and in a manner that does not impose on the rights of another resident/patient.

3. LHH shall provide access to a resident/patient by individual(s) that provides health, social, legal, or other services to the resident/patient, subject to reasonable clinical and safety restrictions and the resident's/patient's right to deny or withdraw consent at any time. This includes the following individuals:

    a. Treating physician(s);

    b. Immediate family, other relatives and friends of the resident/patient;

    c. Resident/patient representative;

    d. Representative(s) of the Health and Human Services Secretary;

    e. Representative(s) of the State;

    f. Representative(s) of the Office of the State long term care ombudsman,

        i. Any representative of the protection and advocacy systems, as designated by the state; and any representative of the agency responsible for the protection and advocacy system for the developmentally disabled individuals;

        ii. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder as established under the Protection and Advocacy for the Mentally Ill Individuals Act of 2000. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder.

4. Residents/patients, and or their representative, shall be informed of their visitation rights through review of the Resident Handbook on admission and periodically thereafter as necessary.

5. LHH will inform each resident/patient and/or resident/patient representative of their visitation rights and related facility policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner they understand.

6. LHH will inform each resident/patient of the right, subject to his or her consent, to receive the visitors whom he or she designates as well as deny visitation, including but not limited to:

    a. A spouse, including a same-sex spouse

    b. A domestic partner, including a same-sex domestic partner

    c. Another family member

    d. Adoptive/foster family members

    e. A friend

7. Visitation privileges shall not be denied based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

PURPOSE:

To encourage visitation of residents/patients while protecting resident/patient rights and health needs.

PROCEDURE:

1. LHH will provide immediate access to a resident/patient by immediate family and other relatives of the resident/patient, subject to the resident's/patient's right to deny or withdraw consent at the time. Resident's/patient's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident/patient except for reasonable clinical and safety restrictions, placed by the facility based on recommendations of the federal, state, and or local health departments.

    a. Recommended visiting hours for LHH are daily, from 10:00 a.m. to 9:00 p.m. Visits outside of the recommended visiting hours can be arranged with the Resident Care Team (RCT).

2. LHH will provide immediate access to a resident/patient by others who are visiting with the consent of the resident/patient, subject to reasonable clinical and safety restrictions and the resident's/patient's right to deny or withdraw consent at any time.

3. LHH will provide reasonable access to a resident/patient by any entity or individual that provides health, social, legal, or other services to the resident/patient, subject to the resident's/patient's right to deny or withdraw consent at any time. LHH staff will

provide space and privacy for these visits. All visitors must check in and sign in at the Pavilion Lobby and the unit upon arrival. (Cross Reference: LHHPP 75-02 Public Access and Night Security).

4. Visitors are not allowed personal items. Visitors may have a phone or wallet but cannot enter with a bag, purse, or any other personal item. Visitors are advised to leave personal belongings in their vehicles. If the visitor does not have a vehicle, staff will provide a secure locker for their belongings.

    a. If a visitor has personal medications that must be on their person, (such as blood pressure medication, allergy medication, seizure medication, etc.), they are permitted to carry this on their person.

5. All items and packages brought for residents/patients are subject to search. Searches shall be conducted by trained staff and follow standard protocol. If inappropriate items are found, they will be disposed of per facility policy.

6. If a resident's/patient's physician has determined that having visitors would not be in a resident's/patient's best interest on a given day, this shall be explained to the family. When only family visits are permitted (as determined/requested by the resident/patient), friends shall be so advised and not given entrance. (Cross Reference: LHHPP 75-03 Disorderly or Disruptive Visitors and LHHPP 75-10 Security Services Standard Operating Procedures Appendix H)

7. If isolation precautions are required in a resident's/patient's room or the care unit, visitors shall be advised of this by the unit's nursing personnel and instructed as to the necessary precautions. (Cross Reference: LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines for Infection Prevention)

8. If visitors object to any general restrictions or specific ones imposed on the resident's/patient's behalf, they should be referred to the Nursing Office for special consideration.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines for Infection Prevention
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-10 Security Services Standard Operating Procedures Appendix H: Visitors Screening Process
Appendix PP/Guidance to Surveyors for Long Term Care Facilities, F172 F563 Section 483.10 (f) (4) (vii) – (xi)
Cal. Code Regs. Tit. 22, § 70707 - Patients' Rights 70707 (b)(17)

Revised: 92/05/20, 12/09/25, 16/11/08, 17/09/12, 22/06/14, 22/12/13, 24/01/09, 25/04/14, 26/07/21 (Year/Month/Day)

Original adoption: 88/01/22

OFF CAMPUS APPOINTMENTS OR ACTIVITIES

POLICY:

1. Laguna Honda Hospital and Rehabilitation Cener (LHH) escortsEscorts shall be provided with the necessary training and or information for resident safety.

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

PURPOSE:

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

PROCEDURE:

1. Assessment and Documentation

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

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

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

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

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

2. Transportation

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

b. The Unit Clerk or designee shall:

i. fax the Transportation Prescription Form to EVS Environmental Services (EVS) to arrange transportation with a contracted transportation service.

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

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

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

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

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

f. Use of Taxi Service:

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

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

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

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

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

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

3. Request for Nursing Staff Escort

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

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

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

ii. The Weekend prior to the appointment:

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

iii. The Day before the appointment:

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

iv. The Day of the appointment:

The Charge Nurse or designee will:

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

The Escort shall:

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

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

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

4. Medical Record Information Needed for Off Campus Appointment

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

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

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

5. Non-staff Escort

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

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

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

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

b. Volunteer Escorts (when available)

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

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

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

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

c. Peer Mentor Escorts (when available)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT:
Attachment A: Transportation and Appointment Ticket

REFERENCE:
LHHPP 21-02 Transmission of Confidential Medical Information via Facsimile
LHHPP 24-10 Coach Use for Close Observation
MR908 Transportation Prescription

Revised: 99/01/12, 12/07/31, 13/05/28, 13/09/24, 15/09/08, 19/03/12, 19/07/09, 20/01/14, 24/03/12, 26/07/21 (Year/Month/Day)

Reviewed: 25/01/17 (Year/Month/Day)

Original adoption: 96/07/15 (Year/Month/Day)

AMBULANCE CALLS – UTILIZATION AND ACCESS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall utilize routine and emergency transportation in accordance with agreed-upon Emergency Medical Services (EMS) and LHH standards.

LHH Contracted Ambulance Providers

Name of Ambulance Provider/ Contact #	Type of Service
Primary: Pro Transport Telephone #: 1-800-650-4003	• Basic Life Support (BLS) Non-Emergent • BLS Emergent • Advanced Life Support (ALS) Non-Emergent • ALS Emergent • Specialty Care Transport (SCT) • Urgent and Non-Urgent Routine and Bariatric Transport • Wheel Chair Van
Secondary: King American Telephone #: 1-415-931-1400 Fax #: 1-415-621-2100	• ALS Non-urgent • ALS Emergent • BLS Non Emergent
Tertiary: American Medical Response Telephone #: 1-800-540-3066 or 1-800-913-9197	• ALS • BLS

PURPOSE:

To assure safe and timely transfer of residents from LHH to acute care or medical appointments in the community utilizing the appropriate service level of care.

DEFINITION:

1. Basic Life Support (BLS): Emergency first aid and cardiopulmonary resuscitation procedures which, at a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the resident can be safely transported or until ALS is available.

2. Advanced Life Support (ALS): Means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specific drugs and other medicinal preparations, and other specified techniques and procedures administered by certified personnel under the direct supervision of a base hospital

3. Specialty Care Transportation (SCT): Ground medical transportation services that exceed the normal scope of paramedic services and require a higher trained level of personnel and additional equipment.

   Note: Special transport situations include but are not limited to the following conditions:

   a. Obesity (>250 lbs.)

   b. Cervical immobilization

   c. BiPAP or CPAP support required

PROCEDURE:

1. **Transfers of residents outside of LHH**

   a. Transfers outside of LHH include non-urgent (i.e., scheduled routine transport) and emergent medical transfers.

   b. Non-urgent, routine transfers are generally pre-arranged, however circumstances may arise requiring request for services by telephone.

   c. The Physician Certification Statement~~,~~ (PCS) form shall be reviewed and signed by the physician, and includes the resident's diagnosis relating to the purpose of the transfer/medical appointment, as required by the payer. The details of the appointment and patient information on the form shall be completed by a Licensed Nurse or Unit Clerk.

   d. During off-hours, weekends/holidays, and same day transportation is arranged directly with the ambulance company by the licensed nurse.

   e. During regular business hours, 8:00am – 4:00pm the PCS form is faxed to 415-682-5689 or hand-delivered or via inter-office mail to Admissions & Eligibility (A&E) at Pavilion Ground (PG123). When transportation is arranged after hours, a copy of the completed PCS form is faxed to the A&E

   f. A&E shall fax the PCS form to the ambulance provider.

g. A&E shall provide and confirm the transportation arrangement to the licensed nurse or unit clerk.

h. Inquiries and concerns are to be addressed with A&E (located at PG123) at extension 4-5680 or 4-5681.

i. Do not call A&E for STAT or 911 transfers, as this is the responsibility of the health care team members, charge nurse or nursing operations nurse manager/supervisor.

2. Bariatric Transports (Non-Urgent)

a. Pro Transport can accommodate bariatric transportation with a bariatric gurney.

   i. Arrangement shall be made with as much advance notice as possible to ensure that the gurney is available.

   ii. Pro Transport shall provide the gurney for the resident going to the appointment.

3. Urgent Bariatric Transports

a. Pro Transport also provides urgent bariatric transportation services.

   i. The bariatric gurney is not stored on site, so allow time for the transportation service to pick up their gurney before coming to LHH.

4. Emergent acute medical transfers

a. **Code 1 transfers**: For residents who are medically stable but require BLS ambulance, staff can anticipate a response time of approximately 1 hour or less subject to the availability of resources:

   i. Call the primary contracted ambulance company,

   ii. The LHH physician, nursing operations nurse manager/supervisor or charge nurse shall be asked to :

      - Provide information regarding the resident's status and needs related to transport.
      - state whether basic EMT or ALS Paramedic Ambulance is needed; and
      - provide other information as requested by the ambulance dispatcher. Based on standardized criteria, the dispatcher shall determine whether an

appropriate ambulance team is available and state an estimated time of arrival.

iii. If the primary contracted ambulance service is not able to arrive within an hour, call the secondary or tertiary ambulance company and request for transportation services to transfer the resident. If the alternate ambulance company cannot arrive in time; and it is urgent that the resident be transported, call 911.

Note: If you have called a private ambulance company and subsequently need to call 911 because of the resident's condition is deteriorating, be sure to call the private ambulance back and tell them not to come.

b. **Code 2 transfers**: For medically unstable residents who require ALS ambulance response within 20 minutes or less:

i. Call the primary ambulance company, or 911 and request a paramedic unit.

ii. The LHH physician, nursing operations nurse manager/supervisor or charge nurse shall:

- state this call is for a Code 2 transfer for a deteriorating or acute patient; but the condition is not immediately life-threatening (i.e., not Code 3); and

- provide other requested by the ambulance dispatcher. The dispatcher shall use standardized criteria to triage the call and dispatch an appropriate unit. Lights and sirens shall not be used.

c. **Code 3 transfers**: Immediately life-threatening situations (lights/sirens; ambulance response time 8-10 minutes or less with ALS paramedic transfer):

i. Call 9-1-1 directly from the neighborhood.

ii. LHH physician, nursing operations nurse manager/supervisor, or charge nurse:

- Shall state that this is a Code 3 transfer for a life-threatening medical emergency and

- describe the resident's condition and the immediacy of response needs.

iii. After 911 is called, alert the LHH Sheriff's Department regarding the exact location where arriving emergency personnel is needed.

5. Communication with hospital to which patient is referred to

a. When 911 is called regarding immediate life-threatening situations (Code 3):

i. the paramedics shall determine which hospital the resident shall be transported to; and in most instances the resident shall be transported to UCSF Moffett/Long Hospital, because it is geographically closest to LHH;

ii. the LHH physician shall call the designated receiving ER to provide necessary medical information.

iii. For 911 calls, a staff member is sent to wait at the Pavilion entrance to escort EMS to the neighborhood.

b. When residents are transferred for acute medical problems (other than Code 3):

i. The LHH physician shall communicate with the emergency room attending physician at the receiving hospital before sending the resident, or as the resident is being transported.

ii. In general, residents shall be sent to Zuckerberg San Francisco General Hospital (ZSFG) (after calling the E. R.) unless ZSFG is on diversion or the resident has a health plan which determines where acute care shall be provided (e.g., Kaiser). Also, if the resident or family requests transfer to another hospital, that request shall be honored, if possible.

iii. A copy of the resident's Advance Directives shall be included in the resident transfer packet.

ATTACHMENT:
None.

REFERENCE:
LHHPP 24-16 Code Blue
NPP C1.3 Discharge to Acute

Revised: 00/03/09, 11/09/27, 12/03/27, 15/09/08, 19/03/12, 26/07/21 (Year/Month/Day)

Reviewed: 25/01/17 (Year/Month/Day)

Original adoption: 98/11/16 (Year/Month/Day)

THE C-625 BATTERY OPERATED CEILING LIFT

POLICY:

1. Two trained staff members are required for operating and transferring residents using the C-625 battery operated ceiling lift.

2. The Nursing pPolicy and Pprocedure (NPP) D6 1.41 Battery Operated Ceiling Lift Battery Operated Lift Transfer (C-625 Ceiling Lift and EZ Way Smart Lift) is the guideline to be used by both nursing and non-nursing staff for the safe transfer of residents using the ceiling lift.

3. Individual resident slings are not required for use in the rehab gym and pool areas.

PURPOSE:

To provide residents weighing up to 625 lbs.pounds (lbs.) with safe and dignified transfers.

PROCEDURES:

1. Staff Training

a. Prior to operating the ceiling lift, staff that are required to use the lift during their duties shall be trained upon hire and annually thereafter. Every department will follow their department specific procedures related to competencies, as follows, but not limited to.

i. Rehabilitation Services staff willT the Physical Therapy and Occupational Therapy staff shall be trained and demonstrate competency to use the walking slings.

ii. Activity Therapy staff Appropriate staff assigned to the Wellness Center including the and Restorative Aides assigned to Aquatic Therapy program shall be trained on theusethe use of of the aquatic ceiling lift and aquatic slings.

b. A competency checklist shall be used to validate competency on use of the ceiling lift (See Attachment B) for Aquatics.

b.c. Competency checklist for nursing is located inis in NPP D6 1.4the Laguna Honda Hospital (LHH) Department of Education and Training (DET) SharePoint.

c.d. Staff training shall comprise of topics on:

i. Evaluating the resident for lift transfers

ii. Procedure for transferring the resident using the C-625 battery operated ceiling lift

iii. Understanding the different types of slings and when to apply them

~~iii.~~iv. Charging the lift battery

~~iv.~~v. Operating the emergency lowering/stopping function

~~v.~~vi. Care, maintenance and infection control of the ceiling lift and slings

2. Resident Assessments

a. Respective members of the Resident Care Team are responsible for assessing the resident for tolerance and appropriateness of lift transfers for the activity planned.

b. The resident is also to be assessed for the appropriate type and size of sling by the respective discipline performing the transfer [~~(~~see NPP ~~D6 1.4~~D6 1.1 Battery Operated Lift Transfer (C-625 Ceiling Lift & EZ Way Smart Lift)~~)~~]

c. Walking slings are one size fits all with multiple straps for adjustment to the individual based on manufacturer's instructions. Walking slings are used as aides for standing and mobility and are cleaned every 30 days and/or when visibly dirty/soiled.

d. Transfer sling~~s come in multiple sizes based on weight and height. Slings are also available with and without a head support. The sling's stripe must ultimately be aligned against the resident's spine from the top of the spine to the coccyx. The stripe and label shall face the outside. If the sling has no head support, the top of the sling starts at the shoulders and the bottom/ toileting accessends at the coccyx. If the sling has a head support, the neck and head shall rest onthe head support.~~ selection is based on resident's condition (i.e., their ability, need for support and comfort, and type of transfer needed). After sling model is chosen, sling size is based on the resident's height and weight. Use judgement for body shape and patient comfort when selecting between sizes. Assessment continues during the lifting process. Evaluating the resident's safety, comfort and position. When a resident's condition or size changes, a re-assessment of appropriate sling may be needed [Refer to Nursing Policy and Procedure D6 ~~1.4 Battery Operated Ceiling Lift (C-625)~~1.1 Battery Operated Lift Transfer (C-625 Ceiling Lift & EZ Way Smart Lift) for more information about sling use.]~~.~~

3. Documenting Use of the Ceiling Lift

a. Members of the Resident Care Team are responsible for documenting the plan on transferring the resident using the ceiling lift for the specified planned activity in the resident care plan.

b. When the resident is no longer performing the activity, or no longer require the use of the ceiling lift for transfers, the care plan shall be discontinued or revised as appropriate.

4. Care and Maintenance of the Ceiling Lift and Sling

~~Care and maintenance procedures of the ceiling lift and slings are to be followed according to the manufacturer's guidelines located in the Wellness Center.~~

a. Manufacturer recommends slings are to be replaced every 6 months, or if damaged. Damaged slings must be discarded and replaced with a new sling.

b. Each staff using the sling must inspect sling' seams, loops, straps, and fabric for any loose threads, fraying, and holes prior to use and after laundry~~The ceiling lift, lifting strap, and slings are to be inspected prior to use by residents~~ to ensure that they are in a safe and operable condition.

ATTACHMENT:
~~NONE~~None.
~~Attachment A: C-625 Battery Operated Ceiling Lift Post-Test for Aquatic Staff Members~~
~~Attachment B: Competency Check for C-625 Battery Operated Ceiling Lift for Aquatics~~

REFERENCE:

~~C450/C625 Ceiling Lift Owner's Manual, Waverley Glen~~EZ Way Smart Lift Operating Instructions [Manufacturers Manual]. (2023). Clarinda, IA: EZ Way, Inc. Medline: Safe Patient Handling Slings

Medline: Safe Patient Handling Slings

Swim-Lift Series Model Gallatin, Chair Lift Owner's Manual, Spectrum Aquatics

CROSS-REFERENCES:

Nursing Policy and Procedure
D6 ~~1.4 Battery-Operated Ceiling Lift (C-625)~~ 1.1 Battery Operated Lift Transfer (C-625 Ceiling Lift & EZ Way Smart Lift)
- Appendix 1: Sling Sizing Guide
- Appendix 2: Sling Application
- Appendix 3: Operating the Battery-Operated Lifts (Ceiling & EZ)

~~Sling Instruction Sheet, Waverley Glen Universal Sling~~

~~Sling Specification Sheet Standing Sling~~
~~Swim-Lift Series Model Gallatin, Chair Lift Owner's Manual, Spectrum Aquatics~~

Revised: 22/02/08 18/03/13 (Year/Month/Day), 25/0~~1~~7/2~~3~~1
Original adoption: 11/03/24

~~Attachment A~~

~~C-625 BATTERY OPERATED CEILING LIFT~~

~~**Post-Test for Aquatic Staff Members**~~

~~**Trainer:**~~ ____ ~~**Date:**~~ _

~~**Safe Transfers:**~~

~~**What type of resident would use the ceiling lift to access the pool?**~~

____
____
____

~~**What type of sling is appropriate for use in the pool? (check one)**~~

~~**mesh sling**~~ ☐ ~~**hammock sling**~~ ☐ ~~**walking sling**~~ ☐ ~~**positioning sling**~~ ☐ ~~**standing sling**~~ ☐

~~**Where should the carry bar be when placing straps? (check one)**~~

~~**head level**~~ ☐ ~~**chest level**~~ ☐ ~~**behind the head**~~ ☐

☐ ~~**any of the above locations at least 12 inches away from resident**~~

~~**When lifting a person, all the straps used should be the same (color and/or position)on all four points on the sling. (Circle one) T F**~~

~~**When using the remote the lift is able to go front to back and side to side.(Circle one) T F**~~

~~**Explain why it is required to have 2 people when using the ceiling lifts:**~~

~~**Explain:**~~ ____

____
____

~~**When would you use the emergency stop and lower on the ceiling lifts? (check one)**~~

~~**resident is screaming**~~ ☐ ~~**battery doesn't work**~~ ☐ ~~**wheelchair is broken**~~ ☐ ~~**Power or battery failure**~~ ☐ ~~**power failure**~~ ☐

~~**Equipment Monitoring:**~~

~~**When would you wash the mesh sling?**~~

~~**visibly dirty**~~ ☐ ~~**weekly**~~ ☐ ~~**monthly**~~ ☐

~~**daily**~~ ☐ ~~**visibly dirty and weekly**~~ ☐

~~**When wouldn't you replace a universal sling?**~~

~~**see fraying**~~ ☐ ~~**torn mesh**~~ ☐ ~~**strap is loose**~~ ☐

~~**faded**~~ ☐ ~~**stitching is missing**~~ ☐

~~**What is the maximum load the lift can transfer?**~~

~~**300 lbs.**~~ ☐ ~~**450 lbs.**~~ ☐ ~~**625 lbs**~~ ☐ ~~**800 lbs**~~ ☐

~~**How do you know the lift is charging?**~~
~~**Explain:**~~____

____
____
____

~~**What would you do if the lift would not move in any direction while your patientwas in the lift?**~~
~~**Explain:**~~____

____
____
____

Attachment B

COMPETENCY CHECK FOR C-625 BATTERY OPERATED CEILING LIFT

(for Aquatics)

EMPLOYEE NAME:_____POSITION:_____DATE: _

S = Satisfactory and competent to perform procedure safely **U** = Unsatisfactory and indicates need for follow-up			
INDICATOR	**S**	**U**	**COMMENTS**
1) Policies			
• Employee states a second staff will assist with the transfer of residents			
• Employee states action to do when using unfamiliar equipment / procedures (i.e.asks for assistance and ensures needed assistance is provided before proceeding)			
Employee states action to take when new staff person works on pool deck who isnot familiar with equipment (i.e. notifies supervisor to ensure employee receives training)			
• Employee is able to verbalize the most appropriate size of sling for resident prior to initial use of lift transfer			
• Employee is able to verbalize resident's other conditions that must be taken into account when choosing a sling in addition to resident's shoulder width,trunk length, & weight. Able to refer to Lift Sling Assessment Form			
2) Selecting the sling			
• Checks sling type and size in the resident care plan			
• States how the length of the back is measured			
• Demonstrates proper use of the size chart			
• Inspects sling for fraying or damage and can verbalize removing a defective sling from use and reporting it to supervisor			
3) Knowing Lift			
• Demonstrates how to position the lift over locked wheelchair			
• Identifies the method to raise and lower the resident using the button on the panel			
• Locates the emergency red pull strap and describes its purpose			
• Able to reset the system after the emergency pull is engaged			
4) Demonstrating the transfer lift procedure from pool to wheelchair			
• Positions the sling under the resident trunk and shoulders			
• Positions the sling so that the handles face down into the water			
• Centers the sling so that it covers the shoulders and comes to 2 inches below thebase of the tail bone.			
• Lifts the resident's left thigh, pulls the left wing under the thigh and places it on thetop of the thigh. Does the same with the right leg (does not matter which leg is done first).			
• Moves the lift over the resident so that the lift is over the resident's stomach.			

~~• Attaches the shortest sling loops at the shoulder to the hooks on the spreader bars.~~			

• Takes the wing that is over the right thigh and attaches it to the left hook usingthe longest loop. Does the same for the other leg (does not matter which leg is first).			
• When using mesh sling, crosses wings over and threads the wingsthrough each other.			
• Pushes "up" button and raises the resident an inch above the water. Checks loops and hooks, ensures that resident's arms are in the sling and checks that the shouldersare covered and that sling is 2 inches below tail bone.			
• Continues to lift resident over wheelchair			
• Employee stands behind the chair, using the handles on the sling to position andlower the resident into the chair.			
• Unhooks the sling and carefully glides lift away.			
5) Demonstrating the lift procedure from a wheelchair to a water			
• Assists the resident to lean forward and places the sling in the chair with the handles away from the body and the crotch of the sling touching the back of theseat.			
• Arranges the sling underneath the resident placing the wings over the thighs and checking to see that the resident's weight is evenly distributed in the sling.			
• Positions the lift so that the separator bar is 12 inches in front of the residents head.			
• Attaches the straps at the shoulders using the shortest loops.			
• Takes the wing that is over the right thigh and attaches it to the left hook using the longest loop. Does the same for the other leg (does not matter which leg isfirst).			
• When using mesh sling, crosses wings over and threads the wings through each other.			
• Raises the resident 1-2 inches above the chair, ensures that the resident's arms areinside the sling and that the sling covers the shoulders and extends 2 inches belowthe tail bone; and there is no bunching.			
• Raises the resident and moves the resident to the pool deck and lowers the residentgently into the water.			
6) Other Considerations			
• States that all residents requiring lift transfers will have accurate weight, to sizesling.			
• States how to apply sling to resident whose legs are extremely rigid.			

Name (PRINT):_Signature:_____Title/Job Class: ________

☐ **Demonstrates competency to use the Lift**

Signature of Observer _ **Title: __**

☐ **Does not demonstrate competency to use the Lift**

Signature of Observer _

Title: __

Follow up action plan:

____

____

CODE GREEN PROTOCOL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. ~~ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision &/or i~~Interventions shall be implemented to prevent accidents and receive care in accordance with their person-centered plan of care ~~addressing~~ to address the unique factors contributing to wandering or elopement risk.

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

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

   ~~4. It shall be documented in the EHR if the Resident has or does not havedoes not have decision making capacity for a Laguna Honda Hospital stayis Missing Cognitively Impaired (MCI) or Absent Without Official Leave (AWOL).~~

4. ~~The facility~~LHH has a Resident Locator System per physician order for use with high risk for elopement individuals. Alarms shall not be a replacement for necessary supervision. Staff are to respond to alarms in a timely manner.

Definitions:

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

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

~~2.~~3. **"On the LHH Campus"** *for the purposes of this Code Green protocol is defined* ~~includes~~ as within the hospital building, administration building, and surrounding enclosed outside areas such as the meadow, garden, basketball court, farm, and Serenity Park.

PURPOSE:

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

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

PROCEDURE:

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

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

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

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

1. Initial Elopement Assessment

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

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

2. On-going Elopement Assessment

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

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

b. Interventions to ~~increase staff awareness of the resident's risk, modify~~support the resident's ~~behavior~~safety, or to enhance safety and minimize risks

associated with ~~hazards~~ elopement will be added to the resident's care plan and communicated to appropriate staff.

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

3. Resident Elopement While On Campus

a. Code Green

i. If a resident is missing the ~~resident's neighborhood~~unit-unit staff shall conduct a search within or off the ~~neighborhood~~unit-unit if needed where the resident had potential to go ~~to~~, such as all ~~neighborhood~~unit-unit households, rooms or offices (that would be accessible to the resident), activity areas off the unit such as Serenity Park, Pavilion E~~e~~splanade, the farm and meadow area, ~~;~~ or as indicated from the Resident Locator ~~program~~system.

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

- If the resident is found on the LHH campus but is not redirectable with attempts to elope, proceed with activation of Code ~~Green~~ Home~~below~~.

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

b. Activation Of Code Green

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

ii. Charge nurse (CN) or designee to call ~~x~~4-2319 to inform ~~SFSO~~ San Francisco Sheriff Office (SFSO) of the CODE GREEN (Unit) "__", name of resident and description of what the resident looks like.

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

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

- Resident rooms and bathrooms in each household.
- Living rooms in each household.
- Stairwells in each household.
- Medication Rooms.
- Galley, Great Room/Dining Rooms, Charting and Report Room.
- Offices (MDS, Nurse Manager (NM), AT, Conference Room, Staff Lounge, Staff Bathroom).
  - If areas were locked during the period ~~that~~the resident was not seen, ~~those areas do not need to be searched. If resident~~and had the potential or was suspected to enter these areas, unit should coordinate access with ~~and staff do not have access to enter, contact~~the owner/department of office or troubleshoot with ~~nursing operations supervisor/nurse manager~~the Nursing Operations Supervisor or NM.
- Spa Rooms, Linen Rooms, Storage Rooms, Biohazard Rooms, EVS Room, Laundry Room and Physician Office.
- Garden and Patio (if any).

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

- Barber Shop and Beauty Salon.
- Library.
- Gift Shop/Vending/ATM Room.
- Cafeteria.
- Art Studio.
- First floor and second floor restrooms.
- John Kanaley Center.
- Chapel and Simon Auditorium.
- Rehabilitation Area.

- Wellness Center.
- Clinic.
- The meadow and the farm.

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

- Obtain the following information from the caller:
  - Location of neighborhoodunit unit where the missing resident or resident attempting to elope resides.
  - Full name of the resident.
  - Full name of staff activating Code Green.

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

viii. NURSING OFFICE Overhead Page:

- Initial Page – CODE GREEN (Unit) "___" (number) (specify neighborhoodunit) X3.
- Ongoing Page for Code Green – continue to overhead page every 30 minutes until a thorough and complete search has been performed by all neighborhoodunits, SFSOSFSO, and Security or when the resident has been found.
  - Overhead page shall not be completed from 9 PM to 9 AM to minimize disturbance while residents are sleeping.

ix. NURSING OFFICE Send Text Page – 415-327-8124.

- Initially – CODE GREEN (Unit) "___" (number), specify neighborhoodunit, followed by first name and last name of resident attempting to elopethe or missing resident.
- Ongoing Page for CODE GREEN - continue to text page every 30 minutes until a thorough and complete search has been performed by all neighborhoodunitsunits, SFSO, and Security or when the resident has been found.
- End of day – shall send group page CODE GREEN (Unit) "___" (specify

neighborhoodunit) remains active at 9PM if resident continues to be missing or Code Green is not cleared yet.

c. Code Green Inin Progress – Once Code Green is activated the following shall be conducted:

i. Other NeighborhoodUnits – Charge NurseCN shall receive a CODE GREEN Stage (Unit) "__" (number) text page with neighborhoodunit and full name of resident attempting to elope or missingthe missing resident.

ii. For Code Green - search within the neighborhoodunit is initiated as follows:

- Charge nurseCN or designee shall obtain picture of resident attempting to elope or missingthe missing resident (e.g. print from EHR, online, binder).
- Charge NurseCN or designee shall call for a huddle with neighborhoodunit staff to show the picture of the resident attempting to elope or missing resident and assign staff for designated search areas:
  - All households' resident rooms, bathrooms, living rooms.
  - All stairwells
  - Medication Rooms.
  - Galley, Great Room/Dining Rooms, Charting, Report Room
  - Offices (MDS, Nurse ManagerNM, AT, Conference Room, Staff Lounge, Staff Bathroom, Directors of Nursing). If areas were locked during the period that resident was not seen, those areas do not need to be searched. If resident had potential or suspected to enter these areas and staff do not have access to enter, contact owner/department of office or troubleshoot with nursing operations supervisor/nurse managerthe Nursing Operations Supervisor or NM.
  - Spa Rooms, other neighborhoodunit Bathrooms, Linen Rooms, Storage Rooms, Biohazard Utility Rooms, EVS Room, Laundry Room and Physician Office.
  - Garden and Patio (if any).
- For Code Green: Charge NurseCN or designee shall call Nursing Office 415-682-1500 to report that search is completed, and if resident is found or not found.
  - If resident is found, Charge nurseCN-Nurse or designee shall also call

the ~~neighborhood~~unit of the missing resident to inform that the resident is found and arrange pick up.

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

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

- Code Green search shall be conducted as follows:
  - Forest Hill Station;
  - LHH Grounds (including offices/rooms that maybe locked John Kanaley Center, Library, Patios, Pool, Wellness Center, etc.)
  - LHH Administration building, including all stairwells.
    - Officer on duty or designee shall call Nursing Office 4-1500 to report that search is completed, and if resident is found or not found.
    - Officer on duty or designee shall include in their change of shift report the status of CODE GREEN (Unit) "___" that was last heard from the overhead announcement, a picture of the missing resident ~~or resident attempting to elope~~ to incoming shift until CODE GREEN is clear.

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

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

d. Termination Of Code Green

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

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

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

iv. ~~Neighborhood~~Units and Departments to discard Resident Photo or return to original area per standard work after CODE GREEN is terminated.

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

e. Notification ~~And~~ and Documentation

i. ~~Neighborhood~~Unit where missing resident resides

- ~~Charge Nurse~~CN or ~~Nurse Manager~~NM shall notify the following once CODE GREEN is **activated ~~and~~ or terminated:**
    - Nursing Home Administrator and Chief Executive Officer
    - Nursing Office
    - ~~Nurse Manager~~NM or Nursing ~~Ops~~Operations Supervisor
    - Unit Physician or On-Duty physician
    - SFSO
    - Directors of Nursing (DON) &/or (if acute patient) Chief Nursing Officer
    - Risk Management ~~Staff~~staff
    - Appropriate Resident Care Team Members – to assist in locating/calling resident/family
    - Family or responsible party
- Shall document events and notifications made in EHR:
    - Notification of family, surrogate decision-makers and/or conservators
    - Circumstances of the elopement, interventions, and the resident status until resolution of search
    - Progress Notes.

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

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

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

  - Incident Report (even if resident is found)

  - Care Plan – Upon resident's return, initiate elopement Care Plan or update if there's an existing Care Plan.

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

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

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

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

  - ~~Additional document when resident is Code Green~~

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

  Additional documentation when resident is determined missing:

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

ii. Other ~~Neighborhood~~Units and Departments:

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

  And Complete the **MISSING RESIDENT INCIDENT ~~NEIGHBORHOOD~~UNIT CHECKLIST** and Fax to Nursing Office ~~at 415-~~

682-1510 once search is completed within their assigned area.

iii. SFSO Officers:

For Code Green:

- Notifies Nursing Office that search is completed and whether resident is found or not found.
- Completes the **SFSO SEARCH CHECKLIST** and Fax fax to Nursing Office at 415-682-1510 once search is completed within their assigned area.

For a resident who was/is determined as missing:

- Completes the SFSO Missing Person report form.

iv. Nursing Office staff

For Code Green:

- Completes MISSING RESIDENT INCIDENT NURSING OFFICE CHECKLIST and NURSING OFFICE AT RISK MISSING RESIDENT REPORT CALL LOG.
- Send completed forms to Quality Management via QM Mailbox scanned email -to Risk Managementin Nursing Office:
  - MISSING RESIDENT INCIDENT NEIGHBORHOODUNIT CHECKLIST from all 13 or 14 neighborhoodunits.
  - MISSING RESIDENT INCIDENT NURSING OFFICE CHECKLIST.
  - NURSING OFFICE AT RISK MISSING RESIDENT REPORT CALL LOG.

v. Nursing Operations:

For Code Green:

- Faxes Resident's photo and "Emergency Notification of Missing Resident" completed by charge nurseCN to the following:
  - Local emergency rooms.
  - SFSO at LHH.

- Other agencies listed on Table 1 as appropriate.

~~For Code Green after~~After the Code Green incident has been cleared or within 4 hours of the Code Green activation:

- Nursing ~~o~~Operations, ~~Nurse Manager~~NM of ~~Neighborhood~~Unit or designee conducts debriefing with ~~neighborhood~~unit staff, SFSO Staff, security staff, and other appropriate staff to identify what went well and what areas needed improvement.

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

  Administrator, Assistant Nursing Home Administrators (ANHA), Medical Director, Directors of Nursing (DONs), (if acute patient - Chief Nursing Officer), DPH Security Representative, ~~Chief Operations Officer,~~ and Chief Quality Officer.

4. Resident Elopement While Off Campus

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

i. Initiate a search of the immediate area;

ii. Inform the ~~nurse manager~~NM/~~charge nurse~~CN ~~&/or nursing operations supervisor~~and Nursing Operations Supervisor, who will notify SFSO and others listed above; and

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

iv. complete an incident report ~~UO~~ by the end of the shift.

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

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

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

- local emergency rooms;
- SFSO at LHH; and
- Other agencies listed on Table 1 as appropriate.

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

5. **Resident Found Off-Grounds**

a. If a resident who lacks capacity is located off grounds, LHH staff~~Employees or volunteers~~ shall notify Nursing Operations to confirm resident is missing from the facility. If confirmed, LHH staff shall attempt to return the resident to ~~the Hospital if the resident~~ the facility.~~:~~

~~i. Confirms that the patient/resident is lost,~~

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

b. If resident appears to need medical attention, call 911 for resident to be transferred to the emergency department for further evaluation.

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

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

6. **Downtime Procedure**

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

b. EHR System – if ~~neighborhood~~units cannot print resident photo from EHR:

i. Nursing Office Staffer shall fax the received photo to all ~~neighborhood~~units

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

7. **Reporting**

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

~~i.~~ Within 24 hours of the elopement event if a resident does not have decision making capacity for a Laguna Honda Hospital stay is not found within 24 hours.~~cognitively impaired resident is not found within 24 hours.~~

~~ii.~~i. Within 5 days of the elopement event if a resident who has decision making capacity for a Laguna Honda Hospital stay is not located in 5 days.

b. Informational updates about the resident shall be communicated to the RCT, Administration/Administrator on Duty (AOD) ~~and Regulatory Affairs~~the Director of Regulatory Affairs, and the NHA/CEO or their designee. ~~.~~

8. Procedure Post-Elopement and Resident Returns to LHH

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

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

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

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

e. The RCT in collaboration with Quality Management shall review the reasons for elopement and opportunities for improvement in the resident's care plan and or systems~~Education for staff will be provided as appropriate on the reasons for elopement and possible strategies for avoiding such behavior~~.

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

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

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

REFERENCE:
SFSO Checklist
Standard Work: Notifying Central Office of Code Green Occurrences

Revised: 16/07/12, 19/07/09, 22/06/14, 25/01/14 (Year/Month/Day)

Original adoption: 14/11/25

Table 1: List of Emergency Room Facsimile (Fax) Numbers
Most recently confirmed on: ~~February 28, 2022~~February 3, 2025

All numbers are 24/7 except where specifically noted.

ER Telephone	Hospital	ER Facsimile
(415) 353-1037 (415) 353-1743	UCSF	
(415-) 668-1000	St. Mary	(415) 750-~~4886~~8121
(415) 353-6300	St. Francis	~~931-7357~~(415) 750-4886
(415) 600-3333	CPMC – Pacific Campus	~~(4600-3124~~(415) 447-7308
(415) 600-0600	CPMC – Davies Campus	~~436-9159~~(415) 600-2985
(628) 206-8111	~~SF General~~ZSFG	(628)- 206-9176 ~~206-4719~~
(628) 206-8125	~~SFGH~~ ZSFG – PES	(628) 206-5733
(415) 677-2300	Chinese Hospital	(415) 677-2443
(415) 833-3304	Kaiser Hospital	(415) 833-~~2582~~3071

Missing Persons	SF Police	Missing Persons Facsimile
415- 734- 3070 415 553-0123 (non-Emergency)	Police (~~0900-1700~~24/7)	415-558-5531 ~~/ 5522~~
415 553-1071	Police (OPS Night Spvr.)	(handled only dayshift)

Telephone	Men's Shelters
415 749-2110	Central City Hospitality House for Men
415 861-8688	City TEAM Work Start Shelter
415 282-6209	Dolores Street Community Services
~~597-7960~~415-255-3525	Multi-Service Center: South of Market
~~487-3300~~415-776-7715	Next Door

Telephone	Women's Shelters
415 487-2140	A Woman's Place
415-255-3525	~~597-7960~~Multi-Service Center: South of Market
~~487-3300~~415-776-7715	Next Door
415 751-7110	Asian Women's Shelter (battered, address anonymous)
415 503-0500	La Casa de las Madres (battered, address anonymous)
415 255-0165	Rosalie House (battered, address anonymous)

Telephone	Other Agencies
~~355-7445~~628-652-8000	SF Homeless Outreach Team

EMERGENCY NOTIFICATION OF MISSING RESIDENT

<table>
<tr>
<td>
DATE:______________________________

TO:________________________________

FROM: LAGUNA HONDA HOSPITAL
AND REHABILITATION CENTER
375 Laguna Honda Blvd.
San Francisco, CA 94116-1411

RESIDENT'S CARE UNIT:______________

RESIDENT INFORMATION:

Last Name ______________________________

First Name ______________________________

Nickname _______________________________
</td>
<td>
This space is 3 1/4"- X -3 1/4"

Resident Photograph
</td>
</tr>
</table>

Height________ **Weight**________ **Hair Color**__________ **Eye Color** __________

Race/Ethnicity _____________________ **Date of Birth** ________________________

Language Spoken

____

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

____

____

____

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

____

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

____

____

____

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

Thank you for assisting us.

HARM REDUCTION

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) that provision of services is consistent with the San Francisco Department of Public Health's harm reduction principle~~philosophy~~, and state and federal standards for the provision of person-centered care.

PURPOSE:

To provide strategies that promote healthy behavior and decrease the short/long-term adverse consequences of risk behavior, even for those residents who continue to engage in unsafe practices.

SCOPE:

Harm reduction methods and treatment goals shall be used by LHH providers (including contractors), who deliver substance use treatment, mental health treatment, sexually transmitted disease (STD), and HIV/AIDS treatment and prevention services, and/or who serve residents who use drugs or alcohol.

DEFINITION:

1. **Harm Reduction**: It is a set of strategies aimed at ~~public health philosophy, which promotes methods of~~ reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals, their family and community. The Harm Reduction model is person-centered and attempts to reach residents "where they are at," to assist them in making choices that lead toward better health. Harm reduction methods and treatment goals are free of judgment or blame and directly involve the resident in setting their own goals. There is growing evidence in literature to indicate that harm reduction approaches greatly reduce morbidity and mortality associated with risky health behaviors.

2. **Unhealthy practices**: Habits or practices that negatively impact one's health. Some examples include: 1) A resident continues to eat an excessive amount of sweets despite having unstable diabetes; 2) A resident continues to smoke despite having a history of stroke but is doing so off campus; 3) A resident continues to drink alcohol despite having liver failure but is not disturbing others.

3. **Unsafe practices**: Behaviors that negatively impact the healing environment and recovery of self or others but are not imminently dangerous. Some examples include: 1) A resident who is HIV positive brings used needles to the unit, increasing the risk

of needle stick to others around them; 2) A resident attempts to smoke inside their room; 3) A resident (who is not aggressive) brings alcohol/drugs or other contraband to the unit and secretly provides to other residents.

4. **Imminently dangerous behavior**: Behaviors that if not intervened upon immediately, would cause immediate harm to self or others. For example: 1) A resident attempts to smoke, or use lighters, matches, e-cigarettes, and/or other devices that ignite or fuel a flame, in the presence of or near devices that deliver oxygen to persons; 2) a resident is agitated and waving around a broken bottle while intoxicated~~)~~.

5. **Trauma informed System:** A service system in which all parties involved recognize the widespread impact of trauma on the clients they serve and make an effort to avoid re-traumatization while providing services. This approach includes the principals of safety, choice, collaboration, trustworthiness and empowerment. Ensuring that the physical and emotional safety of an individual is addressed is the first important step to providing Trauma-Informed Care.

6. **Motivational Interviewing:** A counseling technique that uses the stages of change framework to determine readiness for treatment and/or health behavior changes, focuses on exploring and resolving ambivalence ~~(sometimes you just have to live with ambivalence and accept it and move on)~~, and centers on motivational processes within the individual that facilitate change.

7. **Stages of Change:** The transtheoretical model that posits that health behavior change involves progress through six stages of change: ~~—~~precontemplation, contemplation, preparation, action, maintenance, and relapse.

RATIONALE:

Harm reduction is a public health strategy that was developed initially for adults with substance use problems for whom abstinence was not feasible. People are more responsive to culturally competent, non-judgmental services, delivered in a manner that demonstrates respect for individual dignity, personal strengths, and self-determination.

Service providers are responsible to the wider community for delivering interventions, which attempt to reduce the economic, social, and physical consequences of drug and alcohol related harm and harms associated with other behaviors or practices that put individuals at risk.

Those engaged in unhealthy or unsafe practices are often difficult to reach by offering 'traditional services'~~,~~ (e.g. abstinence-oriented treatment), therefore, the service continuum must seek creative opportunities and develop new strategies to ~~engage~~, motivate, and intervene with those individuals who are unable or not yet willing to engage in treatment services. At LHH, this means that comprehensive treatments need to include

strategies that reduce harm for residents who come for medical treatment but may be unable or not yet willing to modify their unsafe practices.

Relapse or periods of return to unsafe health practices are an expected ~~-~~part in the stages of change and shall not be equated with or conceptualized as "failure of treatment", nor as "failure of resident."

Each service area within the system of comprehensive services at LHH can be strengthened by working collaboratively with other areas in the system. Harm Reduction methods are most effective when applied consistently across all services and providers.

People change in incremental ways and it's best to aim for realistic~~must be offered a range of~~ treatment outcomes when planning care, ranging ~~in a continuum of care~~ from reducing unsafe practices (including but not limited to: changes in routes of administration, decrease in frequency of practices, use of alternative substances, or reduction of medical risks from practices) to the ultimate goal of abstaining from unsafe practices.

PROCEDURE:

1. Provision of Services

a. Service goals shall be determined through collaboration between the resident and resident representatives, the staff, and the program, establishing realistic measurements of success, for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care[42 CFR § 483.40].

b. Providers shall expand service options within existing programs or collaborate with other service agencies to be able to respond to residents and their individualized needs.

c. As LHH is part of the San Francisco Health Network and a safety net institution, access to LHH services is allowed even for residents who are unable or not yet willing to abstain from unsafe practices on the LHH campus ~~including the designated smoking area~~, provided that LHH can provide safe and adequate care for the resident.

~~d. Providers shall not deny services to individuals for exhibiting behaviors for which they seek or need help.~~

~~e.~~d. Residents shall not be denied access to, restricted from participation in, or terminated from, services solely on the basis of their use of illicit substances.

~~f. Provider language shall not reflect bias toward personal behaviors, experiences, ethnicity, sexual orientation, or personal choices.~~

~~g.~~e. ~~Programs shall broaden their treatment philosophies in order to provide quality, comprehensive care and coordinate care with other health care service providers.~~

2. Interventions

a. Initiation and Resident Education

i. Clinical interventions shall be individualized based on the safety risk assessment, differentiating approaches for unhealthy practices and unsafe practices.

ii. The provider shall:

- Meet with the resident to acknowledge and address the resident's unsafe practice(s), assess where the resident is in relation to the stages of change, as well as how their current behavior relates to their recovery goal(s) and goal(s) for that session in particular.

- Provide and document resident education regarding risk of unsafe practice(s) to increase resident awareness, reduce the risk of negative consequences, and help resident in making an informed decision regarding unhealthy and unsafe habits. Education and training opportunities shall include reference to LHH's harm reduction policy ~~philosophy~~ as appropriate to the education and training content/topic. Education provided shall be documented in electronic health record by the discipline providing the education.

- Utilize the principles in Trauma Informed System through mindfulness and awareness, and recognize personal trauma and triggers, and its impact to present behavior and coping skills. Use a "What has happened to you?" rather than, "What's wrong with you?", perspective in developing plan of care to our residents.

- Include motivational strategies (e.g. motivational interviewing) to explore residents' ambivalence regarding their willingness to change, meanwhile reducing the harm for those residents who are unable to or not yet willing to stop unsafe practices.

- Along with the Resident Care Team (RCT), ensure that clinical interventions and initiated care plans are person-centered and shall take the resident's own goals and values into consideration.

b. Monitoring and Follow Up

i. Providers shall make a reasonable attempt, within the context of their programs, to follow-up with residents who demonstrate an inability or unwillingness to participate in treatment, and prior to discharge, make a reasonable attempt to find additional or alternative treatment.

~~ii.~~ Providers shall recognize relapse, or a return to unsafe practices as part of the recovery process, not as a "failure of treatment" or "failure of resident~~.~~" but an anticipated stage in the stages of change; and that ~~.~~

~~iii.~~ii. Successes may ~~shall be measured to~~ include incremental improvement in housing, physical and mental health, finance, employment and family and social support system.

~~iv.~~iii. In the event that a resident is so impaired and/or uncooperative to present imminent danger to self or others, the provider shall follow LHHPP 22-10 Management of Resident Aggression in managing the situation.

~~v.~~iv. The RCT will conduct a regular evaluation of the resident risk factors and discuss with the resident or representative during the Resident Care Conference.

ATTACHMENT:
None.

REFERENCE:
42 CFR Section 483.40 Behavioral Health Services

San Francisco Health Commission Resolution No. 10-00: Adopting a Harm Reduction Policy for Substance Abuse, STD and HIV
https://www.sf.gov/information--harm-reduction-training-institute-hrti
~~https://www.sfdph.org/dph/files/hc/HCRes/Resolutions/2000Res/HCRes10-00.shtml~~
LHHPP 01-00 Value, Mission and Vision Statement

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.
https://www.samhsa.gov/sites/default/files/programs_campaigns/IECMHC/iecmhc-cog1.pdf.

LHHPP 20-01 Admission to Laguna Honda Acute and SNF Services and Relocation Between Laguna Honda SNF Units

LHHPP 22-03 Resident Rights

LHHPP 22-10 Management of Resident Aggression

Revised: 19/03/12, 19/07/09, 26/07/21 (Year/Month/Day)
Original adoption: 18/01/09

HAZARDOUS DRUGS MANAGEMENT

POLICY:

1. Hazardous Drugs (HDs) shall be managed according to established safe procedures to mitigate the risk to resident, employee and environmental safety.

2. Intravenous cytotoxic/chemotherapy drugs shall not be initiated or administered at Laguna Honda Hospital and Rehabilitation Center (LHH).

3. The management of intravenous cytotoxic/chemotherapy drugs initiated elsewhere via an ambulatory computerized drug delivery (CADD) pump shall be restricted to the Pavilion Mezzanine Acute (PMA).

4. Staff who are trying to conceive (male or female), or are pregnant or breast-feeding, shall not administer cytotoxic or Hazardous Drugs or handle excreta of residents on chemo precautions. Staff who fit into these categories should inform their immediate supervisor for work reassignment.

5. Nurses preparing medications shall never crush or cut tablets, or open capsules labeled as “hazardous” by the Pharmacy.

6. Clinical staff responsible for the ordering, dispensing, administering and monitoring of hazardous drugs shall be provided with training on hazardous drugs.

PURPOSE:

To safely handle, administer, and dispose of Hazardous Drugs (HDs). This policy has procedures relating to three areas of care:

1. Prescribing Cytotoxic Drugs

2. Preparing, Administering and Disposing of Hazardous Drugs

3. Exposure and Spill Management of Hazardous Drugs

DEFINITION:

1. Hazardous Drug (HD): Any drug which poses significant risk to a healthcare worker by virtue of its teratogenic, mutagenic, carcinogenic, reproductive toxicity potential, or which can cause serious organ or other toxic manifestation at low doses. Drug classes listed as HD include: cytotoxic/chemotherapy agents, hormonal agents, immunosuppressants, some antiviral agents, some antibiotics and some biological response modifiers.

2. Cytotoxic Drug: A type of hazardous drug that destroys cells or inhibits or prevents their function. Cytotoxic drugs include drugs used for cancer (chemotherapy) and in some cases those drugs are used to treat other conditions (e.g., psoriasis, arthritis, transplant rejection). Not all drugs used to treat cancer are cytotoxic.

3. Chemo Precautions for cytotoxic medications: Precautions required when handling and disposing of excreta from residents who are currently receiving or have recently received cytotoxic drugs or cytotoxic chemotherapy. The duration of chemo precautions after the administration of any cytotoxic drug is 7 days unless otherwise identified and documented on the medication administration record by pharmacist that verified the original order.

PROCEDURE:

1. Procedure for Prescribing Cytotoxic Drugs

a. Consulting medical specialists (oncologist, rheumatologist, and dermatologist) may prescribe cytotoxic drugs, in consultation with a LHH physician responsible for the resident's care.

i. A LHH physician may order cytotoxic drugs in consultation with a clinical pharmacist.

ii. Cytotoxic/Chemotherapy IV infusions initiated at another healthcare facility and continued at LHH (for example, CADD pump continuous infusion of fluorouracil) shall be ordered by a LHH physician. The ordering healthcare facility that originally ordered the continuous cytotoxic/chemotherapy infusion shall furnish and dispense these medications.

iii. "Off-label" prescribing of cytotoxic drugs is prohibited, unless the provider documents the rationale for use and supporting evidence

2. Preparing and Administering Hazardous Drugs (HDs)

a. General Principles for HD Medication Administration

i. Hazardous Drugs shall be identified by a label on the medication from the pharmacy and will also be identified as hazardous on the medication administration record in the electronic health record. A list of common hazardous drugs prescribed at the hospital is located on the nursing and pharmacy intranet.

ii. Procedures for oral, enteral, subcutaneous and topical routes of administration shall comply with Nursing policies and procedures.

iii. Appropriate personal protective equipment (PPE) shall be used according to the likelihood of particular exposure:

- Wear chemotherapy gloves when handling HDs and medication administration equipment or supplies. The standard hospital supply of exam gloves are rated for chemotherapy. Wear one or two pairs of chemotherapy gloves depending on the dosage form being handled:
    - Solid intact tablet/capsule – 1 pair of gloves
    - Parenteral – 2 pairs of gloves
    - Liquid oral solution – 2 pairs of gloves
    - Transdermal patch – 2 pairs of gloves
    - Suppository – 2 pairs of gloves
    - Topical – 2 pairs of gloves
- When wearing 2 pairs of gloves the outer glove shall be changed every 30 minutes when working continuously with HDs or immediately if gloves are torn, punctured, or contaminated
- Wear a splash-resistant chemo gown and eye protection if risk of spillage or splashing is possible. Yellow gowns used for contact precautions do not provide adequate protection.
- Before leaving the immediate area where a cytotoxic drug was administered or prepared, remove PPE and dispose in a yellow cytotoxic waste container.

b. Oral/Enteral Hazardous Drugs (HDs): Handling and Administration

i. Never crush or cut tablets, or open capsules labeled as “hazardous” by the Pharmacy.

ii. If a resident is unable to swallow intact tablets or capsules, contact Pharmacy to provide an alternative dosage form. Contact Pharmacy for liquid dosage form immediately if tablets/capsules are dispensed for an enteral feeding resident.

iii. If a HD is to be administered enterally via GT/JT, a liquid preparation must be obtained from pharmacy.

iv. After a hazardous drug has been administered, discard administration equipment such as medication cups, PPE, and enteral feeding syringes, into the yellow cytotoxic waste container.

c. Intravenous Administration of Hazardous Drugs (HDs)

   i. Intravenous cytotoxic drugs shall not be administered except via CADD pump as stated in policy statements 2 and 3.

      - Prior to administration of intravenous HDs nursing shall obtain a yellow cytotoxic waste container from EVS. In addition, an intravenous medication infusion pump shell be obtained.

      - Wear a splash resistant chemotherapy gown and two pairs of gloves when starting or discontinuing intravenous HDs or changing I.V. tubing.

      - Face shields or goggles shall be used when there is a splash hazard.

      - Place an absorbent pad with impermeable plastic backing underneath the infusion site to contain any leakage of solution which may occur during handling of I.V.

      - All PPE and equipment used for administration of intravenous HDs shall be disposed of in a yellow cytotoxic waste container.

d. Subcutaneous or intramuscular hazardous drugs including cytotoxic chemotherapy may be administered at LHH and shall be administered using the same processes described in Nursing Medication Administration Policy. The Pharmacy shall dispense the medication in a pre-filled syringe for administration.

e. Topical HDs including cytotoxic chemotherapy may be administered at LHH according to Nursing Medication Administration Policy using two pairs of gloves and a chemo gown. Chemo precautions for handling patient excreta are not required for residents receiving only topical HDs.

f. Disposal of Hazardous Drug Waste from Medication Administration

   i. Unused, unopened or expired drugs shall be returned to the pharmacy for disposal.

   ii. Any contaminated containers or materials used in the preparation or administration of HDs including cytotoxic/chemotherapy, shall be disposed of in a yellow, cytotoxic waste container. Cytotoxic/chemotherapy medications or ~~medication~~medications contains may also be disposed of in the black RCRA bins.

   iii. Do not pour hazardous drugs/solutions down drains or into toilets.

g. Chemo Precautions for cytotoxic drugs

i. Residents may excrete active drug and/or hazardous metabolites for a limited time after administration of a cytotoxic drug. The duration of chemo precautions after the administration of any cytotoxic drug is 7 days unless otherwise identified and documented on the medication administration record by the pharmacist that verified the original order.

   Note: Follow standard infection control precautions whenever contact with body fluids is possible (regardless of medication regimen).

ii. A chemo precautions cart shall be ordered from Central Processing Department and a yellow, cytotoxic waste bin shall be ordered from EVS. The chemo precautions cart contains appropriate PPE, a spill kit, and a yellow sign for the door.

iii. Place yellow sign on resident room door to inform all staff that all waste generated in the room must be disposed of in the yellow, cytotoxic waste bin.

iv. Use double gloves and splash-resistant chemo gown available on the cart when handling blood or excreta. A face shield shall be worn if splashing is possible.

v. Linen that is contaminated with cytotoxic drugs or excreta from patients who are on chemo precautions shall be separated from regular dirty linen and placed in a yellow laundry bag from the cytotoxic medication cart.

vi. Linens used by patients who have received cytotoxic drugs, which are not contaminated with body fluids shall be handled as other linen.

vii. Staff Laundering Practices for residents on Chemo precautions:

   - Staff laundering residents' personal clothing soiled with urine or feces shall wear double gloves and a splash-resistant chemo gown. If splashing is possible, face shield shall be used.
   - Personal clothing soiled with urine or feces for a patient on chemo precautions shall be:
   - Washed separately from other residents' clothing if resident is incontinent.
   - Placed in a yellow laundry bag for transport to washing machine.
   - Sent through two cycles of washing (first a pre-wash, followed by a second wash) with regular detergent.
   - Personal clothing that is not soiled with urine or feces shall be handled according to standard laundry procedure.

3. Hazardous Drug Exposure Response

a. If an exposure to hazardous drugs occurs, immediately remove the contaminated PPE and dispose in the yellow cytotoxic waste container.

b. Provide first aid as outlined below:

i. If there is skin or mucous membrane contact: wash contact area thoroughly with soap and water. Avoid iodine preparations or chlorhexidine.

ii. If there is eye exposure, immediately flood affected eye with a gentle stream of water for at least 15 minutes using the emergency eye wash. Make sure the eye is open and the individual blinks and rotates eye in all directions.

iii. If there is a needle stick injury or sharp exposure, immediately rinse any sharps injury with soap and water. Report the exposure to the Needle stick hotline for expert assessment and advice regarding immediate treatment.

c. Report the exposure to your supervisor, who shall complete an injury report according to the LHH 73-01 IIPP.

d. Complete an Incident Report for residents or other exposed individuals.

e. If exposure involves a resident, provide immediate first aid as outlined above and immediately notify the physician and nursing supervisor.

4. Hazardous Drug Spill Management

a. Spills of hazardous drugs or body fluids contaminated with cytotoxic/chemotherapy drugs shall be contained by the person who caused the spill with help from another staff person on the scene using a Chemo Spill Kit.

b. Chemo Spill Kits are available on PMA, and on Chemo carts that are provided to resident rooms where there are chemo precautions in effect.

c. Procedures for cleanup are provided in the Spill Kit and in Appendix B.

ATTACHMENT:
Appendix A: Procedures for Cleanup of Chemotherapy and Hazardous Drug Spills

REFERENCE:
LHHPP 73-01 Injury and Illness Prevention Program
LHHPP 73-10 Medical Waste Management Program
LHHPP 73-14 Personal Protective Equipment
NPP J 1.0 Medication Administration

NPP J 6.0 Intravenous Therapy Maintenance
PPP 07.02.00 Preparation, Handling, and Disposal of Hazardous Drugs

Medical Waste Management Act, California Health and Safety Code (Section 117690). January 2007.
http://www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/MedicalWasteManagementAct.pdf
CDC NIOSH (National Institute for Occupational Safety and Health). 2004- 165. Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings
U.S. Department of Labor Occupational Safety & Health Administration. 2008. Controlling Occupational Exposure to Hazardous Drugs; Section VI: Chapter 2; www.osha.gov
American Society of Health System Pharmacists. 1/12/2006. ASHP Guidelines on Handling Hazardous Drugs.

Revised: 13/11/21, 17/07/11, 17/09/12, 19/07/09, 20/01/14, 25/02/03, 26/07/21 (Year/Month/Day)

Original Adoption: 08/09/30
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Replaces NPP J10.0 Antineoplastic/Cytotoxic Medications (rev. 00/08/03)

Appendix A: Procedures for Cleanup of Chemotherapy and Hazardous Drug Spills

Procedure for Cleanup of Chemotherapy and Hazardous Drug Spills
Laguna Honda Hospital and Rehabilitation Center
July 29, 2016

This procedure is designed to for the cleanup of hazardous drug spills, and spills of body fluids containing cytotoxic drugs, including collection and disposal of spilled materials, cleaning of surfaces, and decontamination to remove any residual contamination.

Cleanup Requires 2 Persons

- Respondent 1 (R1) – Performs Hands-on cleanup (generally the person involved in or closest to the spill).
- Respondent 2 (R2) – Controls access to the area. Provides “Situational Awareness” for R1. Prepares and passes supplies and equipment so R1 never needs to leave the area.

Note: Persons who have had skin, body or clothing contamination should not be assigned to cleanup unless they have thoroughly decontaminated and changed into clean clothing.

Personal Protection Needed

- Safety Glasses
- Shoe covers
- Inner gloves (long cuff)
- Outer gloves (shorter cuff)
- Chemo Gown
- Face shield
- Fitted N95 respirator

Procedures

1. Block off spill area using “Do Not Enter” signs in the spill kit (Use the tape provided in the box). Notify area supervisor of the spill.
   R2 shall read off and use the checklist on the back of the “OK to Enter” sign to keep track of the cleanup progress, initialing steps as they are completed.

2. R1 dons all PPE in the following sequence
    - Safety Glasses
    - Chemo Gown
    - Shoe covers
    - Fitted N95 Respirator
    - Face shield
    - Long cuff inner gloves
    - Short cuff outer gloves

   R2 dons short cuff gloves (or any available) and readies supplies. R2 prevents people from entering the spill area and watches R1, warning them about dragging clothing or possible contact with contaminated surfaces, and passing materials and supplies to R1 so they never need to step away from the spill.

3. R1 uses scoop/scraper to collect broken glass and gently place them in a yellow chemo waste bag. DO NOT use your gloved hands. Place the waste bag in a rigid yellow chemotherapy contaminated waste container immediately.

   For liquid spills:

   Taking care not to step or come in contact with spilled materials, R1 uses sorbent supplies in the spill kit to soak up the spilled materials. Use:

    - Spill pads if there are puddles
    - “Green Z” sorbent powder if there is spattered liquid or lots of droplets

   Use scoop/scrapers to collect used green-Z. Place used Green Z, scoops/scrappers, and/or spill pads into yellow chemo waste bags.

   For dry material spills:

   Avoiding contact with dry material, R1 uses the dampened sponge to push spilled material into the scoop.
    - Avoid using scraper from orange scoop/scraper; use the sponge
    - Do NOT over wet the sponge
    - Do NOT use sponge to clean surfaces.

4. After all the spilled materials are collected, R1 removes outer pair of gloves and dons a fresh set.

5. R1 uses detergent solution in a wash bottle to gently wet down the area (try to go 1 foot beyond known spill area). Gently agitate/wipe detergent on surfaces with paper towels. Use spill pads or clean sponge if lots of detergent solution is left over. Repeat detergent wipe down a second time.

   R2 adds water to detergent wash bottle (labelled Alconox 5 gm) up to the fill line and gently agitates it. Place the detergent back into the plastic bag before handing it to R1.

6. R1 removes outer pair of gloves and dons a fresh set.

7. When area has dried, R1 uses step 1 - (Blue Label) of Surface Safe Wipes to wipe the spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag. Wait for two minutes.

8. R1 removes outer pair of gloves and dons a fresh set.

9. R1 uses step 2 - (Red Label) of surface safe wipes to re-wipe the entire spill area. Use as many packets/wipes as needed to completely wet all surfaces. Discard used wipes in a waste bag.

10. R1 removes all PPE in following sequence:

    a. Shoe Covers

    b. Outer Gloves

    c. Chemo gown

    d. Face shields

    e. Inner Gloves

    f. Safety glasses

    Place the used PPE in a chemotherapy waste bag for disposal.

11. R2 places the chemotherapy waste bags in a chemotherapy waste bin and removes and disposes off their gloves as conventional trash.

12. R1 and R2 immediately wash their hands and arms with soap and water.

13. Post green “OK TO Enter” sign showing cleanup has been completed.

14. Contact EVS and request a “disinfection” (i.e. wet-cleaning) of the area. Ask EVS to check the floor and spot wax as necessary.

15. Complete and submit the Incident Report.

MEDICATION ADMINISTRATION

POLICY:

1. Registered Nurses (RN) and Licensed Vocational Nurses (LVN) must demonstrate safe medication administration competency and are responsible for administering, monitoring, and documenting medications consistent with their scope of practice.

   a. Only an RN may administer intravenous (IV) medications, whether by IV piggyback or IV push.

   b. The LVN may administer medications per LVN scope of practice, except for IV medications.

   c. The Certified Nursing Assistant/Patient Care Assistant (CNA/PCA) may, under the supervision of Licensed Nurses (LN), administer the following: medicinal shampoos and baths, non-prescription topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.

   d. Exception: –Moisture barrier cream to macerated areas is acceptable for the CNA/PCA to apply.

2. All medications and herbal supplements, require a physician's order which includes:

   a. Medication name/agent

   b. Dose

   c. Frequency

   d. Route of administration

   e. Indication for use.

      i. If indication for use is not on order, consult with ordering physician.

3. Personal medications will not be obtained, stored or used by residents unless they have been ordered by a Laguna Honda Hospital and Rehabilitation Center (LHH) physician, and shall not be kept at bedside.

4. LN will follow the "6 Rights" of medication administration:

5. Right resident

~~5.~~6. Right drug (including checking expiration date) ~~(including checking expiration date)~~

a. Right dose

b. Right time

c. Right route

d. Right documentation

~~6.~~7. Bar Code Medication Administration (BCMA) is not a substitute for the LN performing an independent check of the 6 Rights of medication administration.

~~7.~~8. Resident arm bands should only be scanned if the arm band is secured on the resident. Arm bands should be replaced if worn, torn, or do not scan.

~~8.~~9. Select residents can use identification (ID) cards in lieu of ID wristbands. The ID cards will be used by staff to correctly identify residents for the purpose of BCMA and point of care testing (POCT). (See appendix II)

~~9.~~10. The LN will prepare medications at the resident's side (i.e., If resident is in bed, preparation will be at bedside, if resident is in great room, they may receive at chair side).

~~10.~~11. LHH does not allow medication to be separated from the original package and stored for administration at a later time, this is considered pre-pouring. The LN will prepare medication(s) at the time just prior to administration. ~~–~~Do not prepare medications prior to administration or store out of the package.

~~11. LHH does not allow medication to be separated from the original package and stored for administration at later time, this is considered pre-pouring.~~

12. IV RTU (ready to use) medications are only prepared by RN for emergency situations and must be labeled with resident name, date and time of preparation, medication name, strength, amount, and name of the person preparing.

13. Medication delivered via transdermal route must have date, time, and LN's initials on the patch. Before application of new patch, old transdermal patch must be removed.

~~13.~~14. When medications are held based on LN clinical judgement or medications are refused by the resident, notify the provider.

~~14.~~15. Medication times are standardized in the Electronic Health Record (EHR). Medication administration times may be modified to accommodate clinical need or resident's preferences. The LN will notify pharmacy via the EHR with medication administration time change request.

~~15.~~16. The safe administration of psychotropic, hazardous, high risk/high alert medications, and reporting of Adverse Drug Reactions (ADR) will be followed as outlined in other LHH policies and procedures.

~~16.~~17. Medications may not be added to any food or liquid for the purpose of disguising the medication, except in the following limited circumstances:

a. a resident who has capacity to make their own health care decisions and provides written consent; or

b. a resident who is LPS-conserved and has a current, valid court order that determines the resident does not have the right to refuse the type of medication in question (i.e., "Affidavit B" for psychiatric medications); or

c. a resident who is conserved under the Probate Code and has a current, valid court order that explicitly grants the conservator authority to consent to health care, whether or not the conservatee objects, and the conservator consents in writing; or

d. a resident who has been found by a court or their physician to lack capacity to make their own health care decisions and has in place a current, valid, signed durable power of attorney or advanced directive form which explicitly authorizes the legal decisionmaker to consent to all medications or the type of medication in question and the decisionmaker consents in writing.

~~17.~~18. Any medications that are opened but not administered shall be disposed of in the appropriate pharmaceutical waste container, including crushed, dissolved, or disguised medications. Controlled substances shall be disposed of in the Rx Destroyer located in the medication rooms. ~~All other medication is disposed of in the yellow and white pharmaceutical waste bin.~~

~~18.~~19. Any controlled substance/narcotic issued from the Omnicell that was not administered to the patient shall be either returned to the Omnicell if unopened or wasted in the appropriate pharmaceutical waste bin with appropriate documentation of the waste. Any partial doses pulled from the Omnicell (e.g. - one-half a tablet) that will not be administered to the patient shall be promptly wasted ~~Partial doses of controlled substances being pulled from Omnicell must be pulled at time of administration with witness and immediately wasted~~in pharmaceutical waste container and documented in the Omnicell. Any returns or wasting of a controlled substance shall be with the witness by a 2nd LN~~with co-signer/other LN at the time of retrieval from Omnicell~~.

a. A 2nd LN shall directly observe ~~witness~~ the physical wasting of the dose prior to documenting in Omnicell. T~~when t~~he medication may be identified in the original

packaging or via drug identification lookup. ~~is still in the sealed packaging, and the actual wasting of the partial dose.~~

b. Partial doses should not be placed in medication cart for administration at later time.

~~19.~~20. Each powdered medication administered via enteral tube should be diluted with at least 30 mL of water. Highly viscous suspensions should be diluted in a volume of at least 1:1 with water.

~~20.~~21. Each medication needing to be crushed for administration via enteral tube must be administered individually (do not mix medications together).

~~21.~~Oral medications that are safe to be crushed can be crushed at the discretion of the LN. Resources to verify if a medication is safe to be crushed may include drug information resources, pharmacy consultation, or the “Do Not Crush” list., ~~.~~

22. Each crushed medication must be given individually unless approved by the physician via an order to crush and combine medications for oral administration (medications may not be combined for enteral tube administration as noted above), and after pharmacy review for compatibility of mixed medications which is documented in the EHR.

23. A provider order must be obtained for medications to be mixed with pudding.

24. Medications mixed with food mediums (e.g., apple sauce, pudding) must have the food medium dated, timed and discarded at the end of each medication pass.

25. It is the legal and ethical responsibility of the LN to prevent and report medication errors.

~~26. Topical creams and ointments that are ordered “until healed” can be discontinued by the LN via an order in the EHR, and ordered “per protocol, co-sign required”.~~

~~27. Nursing students may administer medication under the direct supervision of their clinical LN instructor or the LHH LN. The supervising LN or clinical instructor must co-sign in the eMAR.~~

~~28.~~26. Medications and ordered herbal supplements are not to be stored at the bedside, with the exception of rescue medications such as nasal naloxone or inhalers, if ordered.

~~29.~~27. Residents who request to self-administer medications and/or herbal supplements must be assessed by Resident Care Team (RCT) and determined to be able to safely self-administer medications.

~~30.~~28. Herbal supplements are not considered medications. The contents and purity of herbal supplements are not regulated and may contain undeclared contaminants. A limited number of herbal supplements are on the hospital formulary. Non-formulary herbal supplements are limited to USP verified supplements or those evaluated by the pharmacy department.

~~31.~~29. ~~All medications and herbal supplements for self-administration will be stored securely by nursing, including rescue medications, except nasal naloxone. Rescue medications, such as inhalers will be given to resident when they go out on pass with physician order and will return medication for safe storage on their return, with the exception of nasal naloxone that resident can safely store on person or at bedside.~~All medications and herbal supplements for self-administration will be ~~store~~stored securely by nursing, with the exception of approved, documented rescue medications such as nasal naloxone or inhalers. ~~-~~These rescue medications may be given to the resident when a resident may go out on pass with a physician order and will be returned to the pharmacy for review and appropriate labeling and storage upon the patient's return.

DEFINITIONS:

1. BCMA: Bar Code Medication Administration

2. eMAR: Electronic Medication Administration Record

~~2.~~3. MAR: Medication Administration Record

~~3.~~4. EHR: Electronic Health Record

~~4.~~5. WOW: Workstation on Wheels

PURPOSE:

Medications will be competently and safely administered.

1. Critical Points

Six Rights of Medication Administration

a. Right Resident

i. Two forms of identification are mandatory.

ii. Verify identity of resident using any of the following two methods:

iii. Successful scan of identification band, only if arm band is on the resident, or successful scan of identification card for the resident who meets criteria (See appendix II)

iv. Resident is able to state his/her first and last name (Ask for first and last name without prompting)

v. Resident Medication Profile Photograph matches the resident image in the EHR.

vi. Resident is able to state date of birth (Ask without prompting.)

vii. In situations where the LN can positively identify the resident, visual identification is acceptable as a second form of identification.

viii. Family member or fellow caregiver identifies resident by standing next to or touching the resident (caregiver should not point from a distance).

b. Right Drug

i. Review eMAR for drug/medication ordered

ii. Review resident allergies to medications or any other contraindication

iii. Check medication label and verify with the eMAR for accuracy. Check with physician when there is a question.

- Checks or verifies information about medication using one or more of the following references, when needed:

c. Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

d. Black Box Warnings via Online Lexi-comp reference http://www.crlonline.com/crlsql/servlet/crlonline

~~d.~~e. Verify medication is not expired.

~~e.~~f. Right Dose

i. Review eMAR for dose of drug/medication ordered

ii. Check medication label and confirm accuracy of dose with eMAR

~~f.~~g. Right Time

i. Review eMAR for medication administration time.

- Medications will be administered one hour before or one hour after the scheduled time with the exception of short acting insulin, and any medication ordered more often than every 4 hours will be administered within 30 minutes before or after schedule time.

- All medications scheduled for administration at midnight (0000) will be given by A.M. (night) shift.

- See Appendix I for routine medication times and abbreviations.

- Medications requiring special timing to maximize bioavailability or to prevent adverse effects are included in Appendix A.

~~g.~~h. Right Route

~~h.~~i. Review routes of administration

~~i.~~j. Enteral Tube Drug Administration: Refer to NPP E 5.0

i. IV Push and IV Piggyback - Medications that an RN may give as I.V. push, without a physician at the bedside, are specified in the following link: ~~Laguna Honda Hospital IV Push Guidelines~~Laguna Honda Hospital IV Push Guidelines.docx

~~j.~~k. Right Documentation

i. Document the administration of medication in eMAR at the time medication is given utilizing bar code scanning.

ii. If resident is not wearing an armband, or refuses to allow scanning of their arm band, document reason in override section.

iii. If product/medication is not scanned, document the reason in override section.

2. Override of medication administration

a. If a resident requires urgent attention, use clinical judgment when deciding to override BCMA in order to provide care.

b. Document override reason.

3. **Two LN independent check of medications**

a. Two LN independent check of medication is the process by which 2 LNs perform an independent review of the medication to be administered, without prompting or cueing for other LN prior to medication being administered:

b. Each LN reviews the Right resident, Right medication, Right dose, Right route and Right time.

c. Each LN will complete their own documentation in EHR.

4. **Crushing medications for oral administration**

a. Crushing medications is based on nursing judgement and resident care plan.

5. Medications that should not be crushed include ~~Do not crush~~ hazardous, enteric, sustained release or medications with “do not crush” in the admin instructions of the eMAR. Exceptions may be allowed if the prescriber or pharmacist can explain and justify why crushing the medication will not adversely affect the resident.

6. Each resident shall have their own pill cutter, which is cleaned with alcohol wipes between uses.

7. Pill crushers will be cleaned ~~with alcohol wipe at the end of the medication pass prior to returning to medication room for charging~~after use, and PRN.

8. Staff may choose to wear mask when crushing or cutting pills, unless administration instructions ~~indicate~~indicate a mask ~~to~~ must ~~be~~ be worn.

9. Enteral ~~M~~medications which are to be crushed for administration, ~~must~~ should be given individually.

10. Combining crushed oral medications

a. LHH staff will work with resident and appropriate clinicians to determine the most appropriate method of crushed medications for patient safety.

b. A physician order shall be placed for crushing and combining oral medications. ~~and should not be combined with other crushed, uncrushed or liquid medications (e.g. in pudding or other similar food), unless pharmacy has reviewed the medications for safety and efficacy, and pharmacy has documented that it is safe to mix crushed medications together and the physician has placed an order for crushing and combining the medications.~~

c. When using a food medium (e.g., apple sauce or pudding) to administer medications, the LN will:

i. Date and time the food medium container at time of opening. Food medium container should remain on the medication cart if the food medium will be used for multiple residents. Use hand hygiene per protocol between each resident.

ii. For each individual resident, use a new, clean spoon to remove a portion of the food medium and place it in a different container (e.g., medicine cup or pill crusher cups.)

d. If using supplemental pudding as the food medium to administer medications, a physician order is required for the supplemental pudding.

iii. The opened food medium must be kept covered throughout the duration of the medication pass and discarded at the end of medication pass. Food medium cannot be stored in or on the medication cart beyond your medication pass time.

11. **HAZARDOUS MEDICATIONS**

a. Special precautions need to be applied when preparing and handling and disposing of hazardous medication. (Refer to LHHPP 25-05 Hazardous Drugs Management).

b. Instructions for administering the medication can be found in administration instructions on the MAR.

12. **PHYSICIAN ORDER – SPECIAL CIRCUMSTANCES**

13. Verbal orders are not indicated when the prescriber is present or available, except in an emergency, in which case a repeat-back is acceptable. ~~LNs may accept telephone orders from an authorized prescriber~~ (Refer to LHHPP 25-03) a~~nd will confirm resident's medication allergies with prescriber and read back the order entered into the EHR for accuracy with the physician. Verbal orders should only be taken during emergent situations when provider is unable to enter the order due to care being provided to resident~~.

14. ~~STAT medication orders are processed immediately and administered no later than four hours after the order was written.~~(A) Drugs ordered "Stat" that are not available in the facility emergency drug supply shall be available and administered within one hour of the time ordered during normal pharmacy hours. For those hours during which the pharmacy is closed, drugs ordered "Stat" shall be available and administered within two hours of the time ordered. Drugs ordered "Stat" which are available in the emergency drug supply shall be administered immediately.

a. (B) Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

~~15. All other medication orders are administered as soon as the medication is available, unless clinical needs warrant more immediate action.~~

PROCEDURE:

1. Once determined medications are due, and eMAR has been reviewed, minimize distractions or interruptions from preparation to documentation.

2. Determine which resident(s) need medication(s) pulled from Omnicell for this medication pass time only. Do not pull for future med pass times.

   a. Pull those resident's cassettes from the medication cart and place them on top of the WOW or bring the medication cart inside med room if space permits.

      i. Ensure each cassette is labeled with the correct resident name.

      ii. Do not overcrowd the WOW with too many cassettes.

   b. Bring WOW with the resident(s) medication cassette(s) into the medication room.

      ~~a. If using medication cart with computer screen attached, bring the entire cart into the medication room.~~

   c. Use resident's order in EHR to retrieve medication from Omnicell for 1 resident at a time.

   d. Physically count the medication found in the Omnicell bin and confirm it matches the Omnicell screen count prior to removing the medication.

      i. If the count is off, immediately notify your charge nurse and/or nursing supervisor.

   e. Once confirmed medication is correct, immediately put the medication(s) into the appropriate resident cassette.

   f. Repeat this for each resident that need medication(s) removed if needed.

   g. Return to medication cart with WOW and cassettes and put cassettes in medication cart.

      i. Do not place any medication(s) in pockets, cups or other containers. Medications must be placed in appropriate resident cassette and immediately followed by placing cassettes in the medication cart.

3. Log into the EHR and review the medications which will be administered. Remove those medications from resident's cassette and place on top of WOW. Bring the WOW with only the medications to be administered and needed supplies to the resident's side.
4. Confirm with the resident that they are ready to receive their medications in the location they are located if they are not in their room, such as the great room.

    a. Support patient privacy/dignity by pulling the curtain in the room or closing the room door prior to administering medications or confirm with the resident that they prefer not to have the curtain pulled and/or the door closed and has a care plan specifying this preference.

    b. If administering medication(s) in community or common area, such as the great room, confirm with resident they would like to receive medications in that area and resident has care plan specifying preference/acceptance of receiving medications in the common area.

5. Scan the arm band of resident to correctly identify resident and open their MAR.

    a. If the resident is wearing their arm band, this will serve as is one form of identification. Then, use a second form of identification to confirm you are administering to the Right Resident.

    b. If the resident is not wearing arm band, navigate to the MAR of the resident who will receive the medications.

    c. Use two forms of identification to confirm the Right Resident. Document an override, and then select the reason why bar code scanning of the resident is not used.

15. Scan medication(s) barcode(s) at bedside/chairside.

16. Compare each medication package to the medication prescribed in the MAR according to first 5 Rights and verify medication has not expired.

17. Immediately prepare medication(s), ~~if~~ as appropriate~~.~~ (e.g., crush)~~,~~ and administer medication(s).

    ~~a. If this is the first dose being given, document that the "1st dose" resident education has been performed as appropriate.~~

18. Remain with the resident until all medications have been taken.

    a. Never leave medications at the bedside/chairside.

19. Document in real time in the EHR medication(s) given, not given, self-administered, etc.

20. Log out of the EHR. If medication cassette was brought to bedside, disinfect it and return the cassette to the medication cart.

ADMINISTRATION OF MEDICATION(S) THROUGH ENTERAL TUBE

1. Request medications be in liquid form whenever possible. If liquid form is not available from the Pharmacy, and a tablet form must be used, crush the tablets (except for enteric coated, hazardous or sustained release medications).

2. **Do not add medication directly to an enteral feeding formula.**

~~20.~~3. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).

~~21.~~4. Prior to administering the medication, stop the feeding and flush the tube with at least 15 mL of water.

5. Dissolve the tablets or dilute the medication in at least 30 mL of water, to sufficiently allow for medication to pass through the tube.

6. Each medication should be administered separately. After each medication flush the tube with 15 mL of water.

7. Administer diluted medications or fluids through enteral tubes by gravity or gentle flush using a 60 mL catheter-tip syringe.

8. Give medication at the appropriate time in relation to feeding.

    a. Some medications should be given with food, while some should be given on an empty stomach with tube feeding stopped for a prescribed interval before and after medication is given (e.g., Dilantin suspension).

    b. For proper action, some medications must be delivered into the stomach rather than into the duodenum or jejunum.

    c. Consult with pharmacist about administration and drug-drug or drug-nutrient compatibility.

9. Elevate the resident's head of the bed to a minimum of 30 degrees unless otherwise ordered by the physician before administering medication, and for 30 minutes after administration of medication to decrease risk of gastroesophageal reflux and/or aspiration.

~~22. Confirm correct placement of enteral tube (refer to NPP E 5.0 Enteral Tube Management).~~

10. Nutritional formula may be given before medications. To flush formula from the tube prior to instilling medication, flush the tube with approximately 15 mL of water using gravity or gentle flush with the syringe.

11. After all medication(s) is administered, instill approximately 15 mL of water to flush medication.

12. If a resident is on fluid restriction~~regulation~~, and requires a different flushing schedule, a physician must place order which includes the amount of water to be used for the flushing between each crushed medication.

13. Document the amount of the flush used for medication administration in the flowsheet.

ADMINISTRATION OF NARCOTIC (OPIATE) MEDICATIONS

1. As needed, and for newly admitted residents, the LN will explain to resident that due to hospital safety reasons, confirmation of swallowing is required after administering medication:

   a. After performing the six rights of medication administration and administering the narcotic medication, LNs will confirm resident has swallowed the medication by:

      i. Visually inspecting the mouth by requesting the resident opens their mouth and lifts their tongue to view entire mouth.

      ii. Request the resident to repeat a sentence such as “no, ifs, ands, or buts,” to ensure the oral medication have been swallowed.

   b. If resident declines to allow confirmation, notify the resident the narcotic medication will be held and notify provider for further guidance.

      i. Notify the physician of refusal to follow protocol and request for follow-up such as change of order to liquid opioids or crushed medications.

      ii. If resident initially agrees to new procedure but then refuses to open mouth for inspection, stay with resident and ask 2nd LN to notify charge nurse to call physician.

      iii. Notify resident care team of refusal for discussion of alternatives and interventions.

      iv. Document occurrence in a nursing note and update care plan.

2. Administration of buprenorphine-naloxone.

   a. Buprenorphine-naloxone should not be swallowed and must be allowed to dissolve in the mouth; therefore, verification of swallow per standard narcotic administration should not be performed.

   b. Buprenorphine administration is as follows:

      i. Place the sublingual tablet or film under the tongue and keep in place until fully dissolved.

         - 5-10 minutes for sublingual tablet

         - 3-8 minutes for film

      ii. Resident should not eat, drink, smoke or talk until the film/tablet is completely dissolved.

      iii. If other medications are needed at the same time, give these medications prior to buprenorphine-naloxone administration.

   c. For buprenorphine induction, physician may order clinical opiate withdrawal scale (COWS).

      i. If ordered, document COWS in EHR COWS nursing flowsheet.

ADMINISTRATION OF AEROSOL/NEBULIZER MEDICATIONS

1. Monitor resident

   a. Before administering the initial treatment, monitor the resident's ability to participate in the medication administration process, and to ascertain the most appropriate gas delivery device (e.g., mouthpiece, mask, etc.).

   b. Whenever the resident's condition warrants, and/or per physician's order, monitor heart rate and auscultate lung sounds before and after treatment administration, especially when giving a new medication or when there has been a change in the treatment.

   c. **Residents who are unable to self-manage the delivery system safely and effectively require frequent or continuous monitoring to ensure proper medication delivery.**

2. Administration

d. Refer to Medication Administration: Nebulized -CE Elsevier Clinical Skills, follow Manufacturer's Instructions, and/or consult with Pharmacy or Nursing Education for clarification for appropriate use of inhaled medication devices.

e. When using multiple puffs of the same medication, allow at least 1 minute to elapse between each puff.

f. When using multiple inhaled medications, wait 5 to 10 minutes between drugs to get maximum benefit. NOTE: If both bronchodilator and a steroid inhaler are prescribed, use the bronchodilator first.

g. When using a steroid inhaler, rinse the mouth afterwards to help reduce dry mouth, hoarseness, and to prevent fungal growth.

3. Compressor/ Nebulizer ~~(brand name Misty-Fast)~~

a. Follow manufacturer instructions for specific models in use.
b. Common practice may include:
~~a.~~c. Use with nebulizer face mask, which has medication cup and lid.

d. Pour medication into the cup. Connect the blue end of the tubing to the cup, and the green end of the tubing to the air source.

~~b.~~e. Air source

~~c.~~f. Nebulizer machine: Do not place machine on soft surfaces. Turn on the machine until mist is no longer produced

~~d.~~g. Compressed wall air: Turn on the flow rate at 8 liters per minute for 3-4 minutes or until mist is no longer produced.

h. For residents with a physician's order for oxygen and the resident is not a known carbon dioxide (CO_2) retainer: Oxygen may be used as a delivery method. If using oxygen, set the liter flow at 8 liters per minute for 3-4 minutes, or until mist is no longer produced. Thereafter, set the oxygen at the flow rate prescribed by the physician.

~~e.~~i. For residents able to follow instructions, encourage resident to breathe as calmly, deeply, and evenly as tolerated until the nebulizer stops producing mist.

2. Assessing Resident during treatment and for the effectiveness of treatment.

a. Briefly stop the treatment if rest is needed. Provide assisted coughing and expectoration as needed and suction as clinically indicated.

b. Assess the resident's response to treatment.

ADMINISTRATION ~~OF EYE MEDICATIONS~~BY SPECIFIC ROUTES

1. Eye Drops

   a. Using your finger, pull lower lid down gently to form a small pocket (cul-de-sac).

   b. Instruct the resident to tilt head back and look upward.

   c. Gently squeeze a drop into the center of the lower lid (cul-de-sac). If more than one drop is prescribed wait at least one minute between drops of the same medication.

   d. Do not touch the dropper tip to eye, or any surface, in order to avoid contamination of the solution.

   e. Apply pressure to the nasolacrimal duct (inner canthus) after each prescription eye medication for 30 seconds to prevent possible systemic effects.

   f. Do not wipe the dropper or rinse under water

   g. Instruct the resident to close both his eyes and to keep them closed for a full minute without squeezing.

   h. To blot excess eye drops from the eyes, use a clean, separate tissue or gauze for each eye.

   i. If a resident has an order for more than one eye medication, wait about five minutes between drugs to prevent one medication from washing the previous medication away

2. Eye Ointments

3. To administer eye ointments, apply a small strip of ointment into the cul-de-sac pocket.

4. Avoid contacting the tube tip with the eye.

5. Administration of Medications in ear.

   a. Have resident lie on side or sit with his/her head tilted and hand supporting the head on the unaffected side.

   b. Use medication at room temperature.

   c. Clean external orifice gently with cotton swab.

d. Gently pull the pinna upward and outward to straighten the auditory canal

e. Drop the prescribed amount of medication against the side of the ear canal and hold the ear in position for a moment to enable the drop to spread down the canal.

f. Have the resident maintain his position for a few moments.

g. Place a tissue or gauze loosely at canal opening to protect the canal and catch any outflow.

~~5.~~6. Administration of Medications in the Nose

~~5. Nose Drops~~

~~6.~~7. Nasal Drops

a. Have resident lie flat with his head slightly lower than the shoulders.

b. Steady resident's head. Holding the dropper in a vertical position near the nasal opening, instill the number of drops ordered.

c. Keep the resident in position for at least two minutes. During this time, instruct the resident to sniff three or four times and not to blow his nose.

Nasal Spray

a. Resident may be in a sitting position during this procedure.

b. Place the tip of the bottle in resident's nostril.

c. Instruct resident to sniff up as you simultaneously squeeze the lower portion of the bottle.

d. Instruct the resident to continue sniffing 3-4 times and ask that they do not blow their nose for at least two minutes.

SPECIAL CONSIDERATIONS

1. If the resident does not wish to take medication(s) at the prescribed time, you may attempt to return and administer later if medication is still unopened and in the original packaging.

2. If medication(s) is not given within the time schedule, review “Appendix B: Specific Medication Administration Times and Abbreviations” to avoid giving time sensitive medications outside acceptable timeframe and according to special considerations.

3. Other medications should be reviewed for modification of times (see Policy Statement #9.

4. If non-time-sensitive medications are given outside of the time schedule, document the rationale in the override section of eMAR.

5. If medications have been prepared/removed from packaging, and resident does not take the medication(s), the medication must be wasted and documented in eMAR.

6. Request from pharmacy any missing doses and/or need for replacement.

PREPARATION FOR INJECTABLE AND PARENTERAL MEDICATIONS AND IV FLUID

1. IV medication prepared by pharmacy and IV fluid bags will have a medication label which includes a bar code for administration.

2. In urgent situations, if RN needs to prepare IV drip, it must be labeled with resident name, date and time of preparation, medication name, strength and amount, and name of person preparing.

3. Prepare parenteral medication and fluids in a clean workspace away from distractions.

4. Prepare the IV as close as possible to administration time and administer no more than 1 hour after reconstitution, such as spiking IV fluid bag, spiking prepared IV antibiotic bag, or reconstituting antibiotic.

5. Exception: Insulin and IM injections should be drawn into syringe at time of administration.

SHAKING MEDICATIONS OR MIXING A SUSPENSION

1. Medications labeled “shake well” must be shaken vigorously to evenly distribute the dose, immediately before administration.

2. Medications which require mixing, but are not to be shaken, should instead be “rolled.”
3. Any rolling motion used is acceptable ~~as long as the suspension appears milky~~, ~~and~~ as long as the rolling action has not created bubbles.

CARDIOVASCULAR DRUG PARAMETERS NURSING PROTOCOL

1. ~~Scan the arm band of resident to correctly identify resident and open their eMAR and~~ R~~r~~eview the administration instructions ~~do~~to determine if the medication order has administering parameters.

2. ~~Every c~~Cardiovascular drugs which have an ordered hold parameter require~~s~~ vital sign monitoring with each administration to determine if parameter is met. ~~as outlined below:~~

   a. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.

3. Cardiovascular medications which do not have parameters ordered will have vital signs checked and provider notification per Nursing P&P G 1.0 The default frequency of vital signs will be ~~a~~ done weekly at minimum, or more frequently per NPP G1.0 Policy

4. Default parameters

   ~~b. Frequency of monitoring:~~

      ~~i. Monitor and document in flowsheet the heart rate for antiarrhythmic medications or combined antiarrhythmic/antihypertensive medications before each dose, for 7 days, then weekly.~~

      ~~ii. Monitor and document in flowsheet the blood pressure for antihypertensive and combined antiarrhythmic/antihypertensive medications before each dose for 7 days, then weekly.~~

   ~~c.~~a. Hold medication for SBP < 105 and/or hold for HR < 55 and notify physician.

      ~~i. If the systolic BP or heart rate is below the specified parameter, hold medication and notify physician. The nurse will document medication held in the eMAR and notify physician.~~

   ~~d.~~b. If the physician desires more frequent monitoring, they will specify parameters ~~which will be~~ in the EHR in either the specific medication order or as a nursing communication, depending on the patient-specific clinical circumstances.

~~Cardiovascular medications which do not have parameters ordered will have vital signs checked and provider notification per Nursing P&P G 1.0, Vital Signs.~~

5. Whenever the nurse believes per their~~his/he~~r judgement that ~~more frequent~~ monitoring is warranted, they may check vital signs per their scope of practice. Nursing may also clarify any questions about hold parameters with physician per their scope of practice.

~~e. If a resident is on weekly cardiovascular monitoring schedule, and a medication is held, the LN will monitor and record cardiovascular monitoring before each dose, for a minimum of 3 additional days, to assist in the evaluation of therapy. The medication will continue to be administered as scheduled unless outside of specified parameters. Weekly monitoring may be resumed without written physician orders only after physician has been notified of outcome of monitoring, and the resident's vital signs have been outside of the hold parameters for 3 consecutive days.~~

~~3.~~6. PRN Cardiovascular Medication Orders

a. When a PRN cardiac medication is ordered to be administered for blood pressure above a specified parameter, the blood pressure is to be re-checked within 30-60 minutes of the time the medication was administered. If the blood pressure continues to remain above the parameter, the physician is to be called for further orders.

SPECIAL MONITORING REQUIREMENTS

1. Antibiotics

   a. Document per NPP C3.0 "Documentation of Resident Status/Care by the Licensed Nurse – SNF~~.~~." ~~VS and response to therapy once every shift for duration of therapy.~~

2. Pain

   a. Document pain scores per pain management policy. (Refer to HWPP 25-06**)**

3. Psychoactive Drugs (Refer to HWPP 25-10 and NPP J2.5)

4. High Alert Drugs (Refer to HWPP 25-01)

5. Hazardous Medications (Refer to HWPP 25-05)

6. Controlled Substance Medications (Refer to Pharmacy P&P 09.01.00)

SHIFT-TO SHIFT LN REPORTING

1. During change of shift, hand-off and when reporting to team lead or charge nurse, report:

   a. Any new medications started, indication and monitoring required.

   b. Any suspected Adverse Drug Reactions (ADRs).

c. If receiving medication that requires monitoring, report clinically relevant data including abnormal VS or laboratory results.

d. Time or food sensitive medications to be given on incoming shift.

e. PRNs given at end of shift requiring evaluation of effect.

f. Refusal of medication.

MEDICATIONS VIA TRANSDERMAL PATCH

1. Document application and location of patch in the eMAR.

2. Verification of patch placement and monitoring

   a. Inspect site of application every shift to verify that the patch remains in place.

   b. Document verification in the eMAR.

   c. If the patch has come off, attempt to locate the patch and dispose of it. If the patch is not recovered, complete an Incident Report. Reapply a new patch and document per application procedure above.

   d. Do not apply heat source to the patch as it may enhance absorption and result in bolus administration. Note: high fever can result in bolus effect as well.

   e. If resident is diaphoretic, the patch may come off. In some instances, applying a transparent dressing covering the patch may help to keep it in place.

   f. The resident may shower, wash and bathe with the patch in place, as long as not scrubbing over the patch area which will disturb the adhesive.

3. Disposal

   a. Fentanyl patch disposal requires a two LN independent check of medication disposal and will be documented in Omnicell.

   b. After removing the patch, fold the old patch in half so that the adhesive sides are in contact, request 2nd license nurse to witness the disposal in medication room disposal container and ~~both~~ LN~~'s~~ will complete documentation of the waste in Electronic health record (note: there is no waste documentation in Omnicell if a full dose was given).

SELF-ADMINISTRATION

The resident must be assessed by the Resident Care Team (RCT) and determined to

be able to safely self-administer medications and re-assessed quarterly and as needed thereafter. The assessment of the residents' ability to self-administer medications and/or herbal supplements will be documented in the RCT note and include input from the resident during this process.

1. Self-Administration

a. The RCT and other disciplines as indicated, will collaborate to assess the residents' ability to participate in medication and/or herbal supplement self-administration. This assessment must include:

   i. The medications appropriate and safe for self-administration.

   ii. The resident's physical capacity to swallow without difficulty and to open medication bottles;

   iii. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;

   iv. The resident's capability to follow directions and tell time to know when medications need to be taken;

   v. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.

   vi. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.

   vii. The resident's ability to ensure that medication is stored safely and securely. Appropriate notation of these determinations must be documented in the resident's medical record and care plan.

b. If the resident assessment or re-assessment has determined that a resident cannot safely self-administer medication this will be communicated to the physician and to the resident.

c. A resident may only self-administer medications and/or herbal supplements after the appropriate orders have been placed and the assessment is complete.

d. Orders will be entered in the EHR for medications and herbal supplements.

e. The LN will observe the resident self-administer prescribed medications and herbal supplements and will follow the 6 Rights of medication administration including scanning of resident and the medications and/or herbal supplements the resident is self-administering.

f. The resident will prepare and take their own prescribed medications and/or prescribed herbal supplements, which are kept in the medication cart, under the supervision of the LN. The LN will observe self-administration preparation at each medication time and answer the resident’s questions, or reinforce the teaching as indicated.

g. If the nurse notices the resident is about to make an error, the nurse will intervene to stop the preparation. The nurse will also discuss and clarify with the resident the accurate manner of self-administration. The RCT will be kept informed of any change in the residents’ ability to safely self-administer, or the need to re-evaluate the resident for self-administration of medications and/or herbal supplements.

h. The LN observing the resident taking the appropriate prescribed medications and/or herbal supplements via self-administration will document in MAR as ‘~~given’ and~~ “self-administered”

i. For self-administration of a rescue medication stored at bedside that was not observed, the resident will report to the LN who will document in the MAR as ~~given and~~ “self-administered” and include a comment of ‘patient reported’ in the MAR.

   i. If a resident fails to report self-administration of a medication despite on-going education, the RCT will re-assess if self-administration is appropriate

j. Education and training skills will be documented, and care planned in the EHR.

k. The storage of all medications and/or supplements for self-administration will follow Pharmacy Policy 02.01.03: Bedside Storage of Medications

2. Bedside Medication (Refer to Pharmacy Policy 02.01.03: Bedside Storage of Medications)

WASTING MEDICATION

1. Medications that are not administered must be disposed of in the appropriate medical waste container (See LHHPP 73-11 Medical Waste Management Program & LHHPP 25-05 Hazardous Drugs management).

   a. Any opened unused medications, and containers that may contain residual medications, shall be disposed of in the appropriate pharmaceutical waste container (including crushed, dissolved or disguised medications). Black bins are appropriate for disposal of both hazardous and nonhazardous medications on the resident units. ~~Nonhazardous medications shall be disposed of in either the blue and white pharmaceutical waste bin or the yellow and white pharmaceutical waste bin. Hazardous drugs shall be disposed of in the yellow and white pharmaceutical waste bin.~~

~~a.~~b. Disposal of medications in the appropriate waste bins includes:

i. Any liquid, food, or power substances mixed with medications and not finished

ii. Whole pills out of the package, such as those refused by resident, dropped on floor, or opened in error~~,~~

iii. Expired medications or discontinued treatments~~should go in medication waste bin~~.

iv. Items that may go into the garbage include:

- Empty medication cups go in the garbage.

~~i. Crushed, whole pills or liquid medications that are mixed with liquid or food that is not entirely consumed go in the med waste.~~

- The empty spoon can go in the garbage.

- If resident consumes the entire amount of apple sauce or pudding or liquid the medication was in, the empty container it was in can be crushed and put the garbage.

- Cups which had medication in it and the contents were consumed.

- Empty packets of powered medications can be thrown in the garbage.

~~ii.~~v. For residents who are at risk for digging through the garbage, care plan ~~your~~ interventions to attempt to minimize and avoid this behavior.

~~iii. Cups which had medication in it, and the contents were consumed can also be crushed and go in the garbage.~~

~~iv.~~vi. ~~Empty packets of powered medications can be thrown in the garbage.~~

2. The LN must secure narcotics/controlled substances from time of receipt/removal from Omnicell to administration by having it in physical possession or securely locked in medication cart.

3. Partial doses of a ~~Narcotics/~~controlled substances that are removed from the ~~omnicell~~Omnicell~~and not administered and/or are only partially administered,~~ shall be ~~immediately~~ promptly wasted in pharmaceutical waste container and documented in the Omnicell with witness of a 2nd LN.

   a. The need for partial wasting shall be identified prior to leaving the medication room.

b. ~~A~~ 2nd LN witness ~~shall be present to initiate controlled substance waste.~~will observe the medication in its original packaging and observe the physical wasting of the partial dose prior to leaving the med room.

~~c. The 2nd LN shall witness both when the medication is still in the sealed packaging and the wasting of the partial does.~~

~~d.~~c. Both LNs shall document the waste in Omnicell.

4. If resident refuses medication or it was partially administered, the full or partial dose shall be promptly wasted in pharmaceutical waste container with witness of a 2nd LN.

   a. LN shall ~~return~~place any remaining dose of the medication not administered to the patient back to original package to aid in identification of the medication. If the original packaging has been opened or not intact, the 2nd LN can validate the identification of the medication using the Lexicomp medication lookup tool.

   ~~b.~~ 2nd LN will ~~also~~ observe the physical wasting of the controlled substance and serve as a witness ~~the waste of the controlled substance~~ in the Omnicell.

   ~~c. 2nd LN can validate and ID medication for partial doses, as packaging has been opened.~~

   ~~This may be done via looking up the IC medication tag through Lexicomp.~~

   ~~d. 2nd LN shall witness actual wasting of controlled substance medication that was refused by the resident.~~

   ~~e.~~b. Both LNs shall document waste in Omnicell.

EMERGENCY MEDICATIONS – CODE BLUE AND EMERGENCY BOX

Emergency Box and Crash Cart store medications that are used for emergency situations and during CODE BLUE. Locks are checked and documented on the Emergency Equipment / Refrigeration Monitoring Sheet.

THERAPEUTIC LEAVE/OUT ON PASS MEDICATIONS

1. For planned trips away from the hospital, the attending physician will place an order in the EHR for each out on pass medication, including controlled substance medications. The order shall include the name of the medication, strength, directions for use, and the number of days needed.

   a. The nurse will have the order filled at the hospital Pharmacy.

b. The pharmacist will dispense the medications in properly labeled child-proof containers.

c. The nurse will review the directions and check the number and appearance of the drug with the resident or responsible person.

2. When the Pharmacy is closed, the physician should contact the on-call pharmacist to identify pass medications that may be needed and provide appropriately prepared and dispensed medications ~~may dispense only the amount of medications for the duration of the pass from the resident's own medication supply and will record the drugs and quantity dispensed~~ in the EHR~~on the Physicians Order Sheet in the Medication Record~~.

~~a. Controlled substances may not be dispensed by the physician from the neighborhood's supply. When the Pharmacy is closed, the Nursing Supervisor will contact a pharmacist at home.~~

~~b. Blank prescription labels and empty child-proof containers will be available in the Supplemental Drug Supply Room for the physician to properly label the pass medications taken from the resident's own supply.~~

~~c. The physician will counsel the resident on proper use of his/her medications.~~

3. When Resident is on therapeutic leave/out on pass, the MAR will be on hold status.

~~3.~~4. All pass medications should be returned to pharmacy for inspection and determine appropriate labeling, storage, or disposition.

PERSONAL MEDICATION

1. Medications brought into LHH with the resident at admission:

a. Will be given to family or guardian to take home.

b. If medications are not returned to family or guardian, they may be ~~are to be~~ taken to Pharmacy ~~or placed in the pharmacy pickup tray~~ to be reviewed to ensure only medications are present. The medications will be staged separately, appropriately, and securely until pickup or destruction. These will be staged separately from LHH medication inventories.

c. Pharmacy manages the medications and may dispose of as necessary.

d. Personal medications are permitted only to assure continuous therapy while awaiting replacement by LHH Pharmacy. Such medications are not to be used unless the physician enters an order to use them.

e. If the physician orders use of the medication, the medications are verified, relabeled, and reissued according to Pharmacy department policies. The nurse is not to administer the medication unless it has been relabeled by the LHH Pharmacy.

2. Personal medications will not be obtained, stored or used by residents. Exceptions may be considered after evaluation by pharmacy as noted above.

3. If a resident or family member requests that medication(s) be filled by other than the Laguna Honda Hospital Pharmacy, refer the request to the Pharmacy Director.

MISSING MEDICATIONS

1. After confirming a medication that is due is missing, document on the MAR the med is not available, and actions taken to secure a supply.

2. Notify pharmacy via MAR message of need for dose

3. Administer when dose is available

4. If dose is grossly overdue, confer with physician and/or pharmacy on administering vs waiting till next dose is due

5. If not administered on shift it is due, a brief note should be entered in EHR indicating plan and follow up

EXCESS MEDICATIONS

If resident is refusing medications and there is an excess of medications, return excess medications to the Pharmacy.

ATTACHMENT:
Appendix I Specific Medication Administration Times
Appendix II Use of Identification Cards for Resident Identification for Bar Code Medication Administration

REFERENCE:
Lexicomp Online website:
Institute for Safe Medication Practices Link. Oral dosage forms that should not be crushed. Institute for Safe Medication Practices. Retrieved from:
~~http://www.ismp.org/tools/donotcrush.pdf or https://onlinelibrary.wiley.com/doi/epdf/10.1177/0148607116673053~~Oral Medications That Should Not Be Crushed or Altered (Lexi-Drugs) - UpToDate® Lexidrug™ - electronic access on April 1, 2026

AeroChamber Plus® Flow-Vu® Cleaning Instructions
DeWit, Susan, Fundamental Concepts and Skills for Nursing, 3rd edition, 2009

Mosby's Skills – Elsevier: Medication Administration: Nebulized – CE: https://point-of-care.elsevierperformancemanager.com/skills/372/quick-sheet?skillId=GN_20_9&virtualname=sanfrangeneralhospital-casanfrancisco

Mosby's Skills - Elsevier: Medication Administration: Nasal Instillation – CE: https://point-of-care.elsevierperformancemanager.com/skills/370/quick-sheet?skillId=GN_20_7&virtualname=sanfrangeneralhospital-casanfrancisco

Mosby's Skills – Elsevier: Medication Administration: Eye – CE: https://point-of-care.elsevierperformancemanager.com/skills/367/quick-sheet?skillId=GN_20_4&virtualname=sanfrangeneralhospital-casanfrancisco

LHHPP ~~File~~: 25-01 High Risk – High Alert Medications
LHHPP ~~File~~: 25-02 Safe Medication Orders
LHHPP ~~File~~: 25-03 Verbal/Telephone Orders
LHHPP ~~File~~: 25-04 Adverse Drug Reaction Reporting Program
LHHPP ~~File~~: 25-05 Hazardous Drugs Management
LHHPP ~~File~~: 25-06 Pain Assessment and Management
LHHPP ~~File~~: 25-08 Management of Parental Nutrition
LHHPP ~~File~~: 25-10 Use of Psychoactive Medications
LHHPP ~~File~~: 25-11 Medication Errors and Incompatibility
LHHPP ~~File~~: 25-13 Herbal Supplements
LHHPP ~~File~~: 73-11 Medical Waste Management Program
LHH Pharmacy P&P: 01.02.02 Automatic Stop Orders
LHH Pharmacy P&P: 02.01.02 Disposition of Medications
LHH Pharmacy P&P: 02.01.03: Bedside Storage of Medications
LHH Pharmacy P&P: 02.02.02 Fentanyl Transdermal Patches
LHH Pharmacy P&P: 02.02.00 Controlled Substances

LHH Pharmacy P&P: 02.02.00b Distribution of Medications and Medication Order Processing
LHH Pharmacy P&P: 09.01.00 Automated Medication Dispensing Cabinets
Nursing P&P: C 3.0 Documentation of Resident Care by Licensed Nurse
Nursing P&P: C 9.0 Transcription and Processing Orders
Nursing P&P: E 5.0 Enteral Tube Feeding Management System
Nursing P&P: G 1.0 Vital Signs
Nursing P&P: I 5.0 Oxygen Administration
Nursing P&P: J 2.5 Monitoring Behaviors and Effects of Psychoactive Meds
Nursing P&P: J 7.0 Central Venous Access Device Management
Standard Work - LN Wasting Controlled Substance (Partial Dose and Resident Refuse Meds)

Revised: 23/11/14, 25/05/12 (Year/Month/Day)
Hospital Wide Adoption: 23/06/13 as 25-15 Medication Administration (Year/Month/Day)
Original adoption (as NPP J 1.0): 23/06/13 (Year/Month/Day)

SAFE USE OF MEDICINAL CANNABIS PRODUCTS FOR TERMINALLY ILL OR CHRONICALLY ILL RESIDENTS OVER 65

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to adhere to California state law requiring healthcare facilities to allow the use of medicinal cannabis on premises for patients who 1) are terminally ill, and/or 2) are over the age of 65 and living with a chronic disease declared by a physician assessment as a serious medical condition, and a physician's assessment states that the use of medicinal cannabis is appropriate.

In compliance with California state law, patients should not be denied admission to LHH, in whole or in part, because of their use of medicinal cannabis.

Except for the provisions of this policy, cannabis is prohibited and subject to Policy No. 75-07: Illicit ~~Or~~or Diverted Drugs And/or Paraphernalia Possession/Use By Residents Or Visitors and other applicable policies.

PURPOSE:

California state law (Cal. Health & Safety Code § 1649-1649.6 requires skilled nursing facilities (SNFs) and general acute care hospitals to allow patients to use medicinal cannabis who are either terminally ill or—for SNFs but not general acute care hospitals—are over the age of 65 with a chronic disease meeting specific criteria. CDPH has issued All Facilities Letters on this law, including AFL 22-04, AFL 23-07, and AFL 24-06.

DEFINITION:

1. **Cannabis** means substances derived from the *Cannabis sativa* plant. The medicinal properties of cannabis derive partially from two of the primary components: THC (delta—9-tetrahydrocannabinol) and CBD (cannabidiol). THC and CBD can be found in varying proportions in cannabis products. THC is the primary psychoactive component of cannabis or marijuana. The California Department of Cannabis Control (DCC) ensures the safety of commercially available cannabis products.

2. **Medical cannabis or Medicinal cannabis** means cannabis or a cannabis product used in compliance with the Compassionate Use Act of 1996 and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the California Health and Safety Code.

3. **Medical Marijuana Identification Card (MMIC)** means a valid identification card authorized by section 11362.715 of the California Health and Safety Code.

4. **Primary caregiver** means, as defined in California Health and Safety Code section 11362.7(d), the individual at least 18 years of age, designated by a qualified patient, who has consistently assumed responsibility for the housing, health, or safety of that patient.

~~5. **Pure cannabidiol (CBD; Epidiolex®)** means the Schedule V substance that is FDA-approved for treatment of Lennoxy-Gastaut syndrome (LGS), Dravet syndrome, or tuberous sclerosis complex (TSC) in patients 1 year of age or older.~~

~~6.~~5. **Qualifying patient** means an LHH SNF patient who meets one or both of the following criteria: (1) is terminally ill, or (2) over the age of 65 with a chronic disease declared by a physician assessment as a serious medical condition and that the use of medicinal cannabis is appropriate.

~~7.~~6. **Qualifying patient** also means general acute care hospital patients who are terminally ill but does not include patients over the age of 65 with a chronic disease that is a serious medical condition.

~~8.~~7. **Serious medical condition** means each of the following conditions, as defined by California Health and Safety Code Section 11362.7(h): Acquired immune deficiency syndrome (AIDS); anorexia; arthritis; cachexia; cancer; chronic pain; glaucoma; migraine; persistent muscle spasms; including, but not limited to, spasms associated with multiple sclerosis; seizures, including, but not limited to, seizures associated with epilepsy; severe nausea; and any other chronic or persistent medical symptom that either substantially limits the ability of the person to conduct one or more major life activities as defined in the federal Americans with Disabilities Act of 1990, or, if not alleviated, may cause serious harm to the patient's safety or physical or mental health.

~~9.~~8. **Terminally ill** means a medical condition resulting in a prognosis of one year or less to live, if a disease follows its natural course.

PROCEDURE:

1. Use of medicinal cannabis may not be used as a reason to deny admission.

2. **Qualifying for use.**
   a. The person must be a qualifying patient as defined above.

   b. Qualifying patients must provide the health care facility a copy of their medical marijuana identification card (MMIC) or written documentation from a provider outside of Laguna Honda which includes an assessment and recommendation in order to qualify to use medicinal cannabis under this policy.

      i. Copy will be provided to HIM for entry into the electronic medical record.

c. For a patient at LHH that has decision-making capacity and has expressed an interest in medicinal cannabis and does not already have a valid MMIC, the person should be referred to a medical provider who does not work at or is affiliated with LHH for evaluation of whether the patient qualifies for medicinal cannabis.

d. The patient or responsible party shall understand that California law allows access to medicinal cannabis products, but not through smoked or inhalational use (including vaping) at healthcare facilities.

e. The patient shall provide a copy of their physician's assessment (may use the medicinal cannabis authorization form CDPH 9044), or a photocopy of a valid, unexpired MMIC to be added to their medical record.

i. MMIC will be verified on CDPH's registry: https://mmic.cdph.ca.gov/MMIC_Search.aspx

f. The patient shall be informed that failure to safely store cannabis products, sharing of cannabis products, smoking or vaping cannabis products, or development of a use disorder are reasons that access to cannabis may be discontinued (signature of an informed consent document is advised).

3. **LHH Physician Documentation**

a. If the LHH primary care physician deems medical cannabis to be contra-indicated, this will be discussed with the patient and primary caregiver, and the following steps will not ensue. The rationale will be documented in the medical record.

b. For patients ~~that~~ who qualify, the LHH primary care physician shall enter "Cannabis use" onto the problem list (ICD-10 F12) and indicate if the person has terminal illness or age over 65 with identified chronic disease in order for to be a qualifying patient.

c. The patient should have listed on their problem list the terminal illness and/or chronic disease for which they qualify.

4. **Procuring Medicinal Cannabis**

a. The patient/resident must obtain the non-smoked cannabis product themselves, either through an authorized out on pass trip, directly accepting a delivery outside of ~~Laguna Honda~~LHH, or from a primary caregiver.

b. Deliveries of medicinal cannabis must not be dropped off or handled by ~~Laguna Honda~~LHH staff and may only be brought into ~~Laguna Honda~~the facility by the patient/resident or the primary caregiver, without exception.

c. Cannabis deliveries from person or delivery service who is not the patient/resident or designated primary caregiver **must** take place outside of Laguna HondaHH.

d. Laguna HondaLHH cannot be responsible for any deliveries left outside and any unclaimed deliveries are not the responsibility of LHH.

e. Qualifying patient/resident and/or primary caregiver will inform the unit nurse supervisor of a planned cannabis delivery at least 24 hours in advance.

f. Unit nurse supervisor will inform Nursing Operations, who will inform SFSO in advance of the delivery, per LHHPP75-10 (Security Services Standard Operating Procedures).

f.g. If a designated primary caregiver will be the courier of the cannabis products, the following protocol must be followed:

i. One-time primary caregiver pre-registration with LHH shall be completed:

- Qualifying patient/resident must first request registration for the primary caregiver through the resident care team (RCT)
- The RCT will escalate to the CEO/NHA, ANHA, CMO, and CQO.
- LHH Administration will maintain a list of primary caregivers and send updates to the Nursing Operations office, Ambassadors, and the San Francisco Sheriff's Office (SFSO) whenever updated.

g. Qualifying patient/resident and/or primary caregiver will inform the unit nurse supervisor of a planned cannabis delivery at least 24 hours in advance.

h. Unit nurse supervisor will inform Nursing Operations, who will inform SFSO in advance of the delivery, per LHHPP75-10 (Security Services Standard Operating Procedures).

i.**h.** e. Upon patient/resident or primary caregiver arrival they will undergo the usual , **SFSO willsecurity screen and then present to the ambassador to complete the check in process: :**

- **The ambassador will verify the identity of the primary caregiver against the list of primary caregivers,**
- notify nursing,

- **direct the patient/resident or primary caregiver to place and seal medicinal cannabis in a tamper-evident bag, and**

- ~~inform~~ notify the ~~the nurs~~unit charge nurse~~e~~ that the patient/resident or primary caregiver has arrived and is en-route to the floor.

5. **Storage and Handling**

   a. Medicinal cannabis will be stored on the patient/resident unit using two levels of security to prevent theft or diversion of medicinal cannabis:

      i. a lockbox or locked bag that a patient/resident or primary caregiver can access that is secured in a locked storage area that charge nurses can access.

         - The patient/resident will hold the key to this lockbox.

         - The charge nurse will have the key to the storage area and provide the patient/resident or primary caregiver access to their own lockbox upon request.

      ii. Cannabis must be stored in the lockbox provided by the facility and the lockbox must be stored in the locked storage area at all times between use.

      ~~When the patient/resident or primary caregiver adds inventory to the lock box, the nurse will log the product and expiration date on the Medical Cannabis Resident Inventory form, which will be stored inside the lock box with the medicinal cannabis.~~

   b. Only the patient/resident, or their primary caregiver, should remove the cannabis product for use.

      i. The patient/resident may request access to their cannabis, and the charge nurse will unlock the locked storage area so that the patient may access their own lockbox

      ii. If the patient/resident is physically unable to retrieve the lockbox, the charge nurse may bring the lockbox to the patient.

      iii. The patient/resident or primary caregiver must retrieve the desired amount of medicinal cannabis and lock the lockbox before returning the lockbox to the secured storage area

c. Healthcare staff must not handle the cannabis except as outlined by LHH medication disposal policy. This means staff are prohibited from administering the cannabis to the patient and may not retrieve it from lockbox, even by patient request.

d. If the patient/resident or primary caregiver is unable to safely secure the cannabis products and prevent loss or diversion, the team should convene an RCC to discuss and document the situation and apply the medication disposal policy.

6. **Administration**

a. The patient/resident will self-administer the cannabis product at a ~~3~~dose they feel is necessary to control their symptoms.

7. **Clinical Monitoring**

a. If the patient/resident has a change in clinical status, including any of the symptoms listed below (c), the LHH physician should be notified. In contrast, there are normal physiologic effects from cannabis use that may be observed include: increases in heart rate, decrease in blood pressure, dry eyes/mouth, decreased urination, increased appetite, and decreased attention.

b. If the LHH physician or RCT is concerned that the patient is developing unhealthy use of cannabis and may have a cannabis use disorder, consultation from addiction medicine or psychiatry should be sought (MSPP D-16).

c. Excessive use of cannabis does not stop respiration or cause an overdose syndrome with apnea (no breathing) and cyanosis (turning blue). Excess cannabis may lead to the following symptoms, and if present, should be reason to inform the primary care provider:

i. Changes in resident behavior

ii. Increased, unexplained drowsiness

iii. Lack of coordination

iv. Slurred speech

v. Mood changes

vi. Loss of consciousness

vii. Hyperemesis

viii. Paranoia or hallucinations

8. **Patient Education, Policy Violations and Diversion**

   a. Patients and primary caregivers desiring to participate in this policy must be educated on reporting if they are being asked, pressured, or forced to share or violate this policy.

   b. Patients found to be sharing their medicinal cannabis product(s) violation of this policy will automatically forfeit the right to medicinal cannabis within LHH.

   c. Sharing with a patient that does not have capacity to consent to use of the cannabis product must be reported as a patient abuse case following abuse reporting policies and follow Diversion policies (25-12 and 75-05).

   d. If the patient is found to be sharing their cannabis product(s) with a patient that does have capacity to consent to use, then the primary care provider should be contacted to evaluate the patient with whom the cannabis was shared, and staff should follow the policy and procedure for Diversion (25-12 and 75-05).

   e. If a primary caregiver is found to be sharing medicinal cannabis with someone other than a person who is using medicinal cannabis in accordance with this policy, then this person will be subject to all applicable laws and policies including but not limited to Diversion policy 75-05.

9. **Staff Training**

   a. LHH shall train staff on the use and disposal of medicinal cannabis.

10. **Disposal**

   a. Upon discharge, policy violation, other reasons for stopping use, medicinal cannabis will be disposed of by patients or primary caregivers. However, if they do not remove the medicinal cannabis, the product must be disposed of according to the LHH policies and procedures.

11. **Suspension of Policy**

   a. If a federal regulatory agency, the United States Department of Justice (US DOJ), or the federal Centers for Medicare and Medicaid Services (CMS) takes one of the following actions, or makes an inquiry about LHH's activities under this Policy, staff may suspend compliance with this Policy until the regulatory agency, the US DOJ, or CMS notifies the health care facility that it may resume permitting the use of medicinal cannabis within the facility:

i. A federal regulatory agency or the US DOJ initiates enforcement action, including a notice to suspend funding, against LHH related to the facility's compliance with a state-regulated medical marijuana program.

ii. A federal regulatory agency, the US DOJ, or CMS issues a rule, guidance, or otherwise provides notification to LHH that expressly prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with a state-regulated medical marijuana program.

b. LHH hospital administration and/or quality management will issue guidance to all staff, including when the Policy has been suspended, in the event that either of these situations exists.

ATTACHMENT:
Attachment A: Laguna Honda Medicinal Cannabis Policy Acknowledgement

REFERENCE:
AFL 22-04: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-04.aspx
AFL 24-06: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-24-06.aspx
Proposal for Rescheduling of Cannabis. https://www.dea.gov/sites/default/files/2024-05/Scheduling%20NPRM%20508.pdf Additional information here: https://www.justice.gov/opa/pr/justice-department-submits-proposed-regulation-reschedule-marijuana
LHHPP 75-95 Illicit or Prohibited Drugs and Paraphernalia Possession/Use By Residents or Visitors
Laguna Honda House Rules and Responsibilities
LHHPP 22-12 Clinical Search Protocol
LHHPP 75-10 Security Service Standard Operating Procedures
Standard Work: Contraband Items Handling, Storage & Disposal
MSPP D-16 Clinical Services For Residents With Substance Use Disorders
DEA Rescheduling of pure cannabidiol: https://www.dea.gov/press-releases/2018/09/27/fda-approved-drug-epidiolex-placed-schedule-v-controlled-substance-act

~~Most recent review: (Month/Day/Year)~~
Revised: 26/07/21 (Month/Day/Year)
Original adoption: 10/20/05(Month/Day/Year)

GIFT FUND MANAGEMENT

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation Center (LHH) to maintain a gift fund for the purpose of receiving all gifts, donations and contributions of money, stocks and/or other financial donations made for the general benefit and comfort of LHH residents/patients in accordance with the San Francisco Administrative Code (Section 10.100-201 Public Health Gift Funds).

All expenditures from the Gift Fund shall be made for the purposes for which the gift or donation was originally made.

PURPOSE:

The purpose of this policy is to provide guidance to effectively manage the Gift Fund and to ensure oversight and accurate disbursements.

PROCEDURE:

1. Donations and Gifts:

a. Project codes for cash gifts have been established for the general benefit and comfort of patients. The project code list is managed by the Chief Financial Officer and Gift Fund program coordinator.

b. In the event a donation is made for a purpose/intent outside of the existing established project codes, a new project code may be established with the authorization of LHH's Chief Financial Officer (CFO). At the discretion of the Gift Fund Committee, a new project code in the name of a donor may also be created in honor of the donor.

c. The process for donation(s) or gift(s) made to LHH is as follows:

   i. If a donation is made by cash or check, the staff person who receives the donation shall deliver it to the LHH's CFO/designee for deposit.

   ii. If the donation is in another form (e.g., property, stocks, bonds), the recipient will inform the CFO, who will take steps to secure and receive the donation.

   iii. The Accounting staff notifies the Director of Public Health/designee of each donation over $100, and the Director of Public Health/designee will send an acknowledgement of appreciation to the donor.

iv. The donation is deposited in the project code that is specific to the donor's purpose/intent.

v. If the donor's intent/purpose is nonspecific, the donation will be deposited in the Miscellaneous Gift Fund for the general benefit and comfort of the residents/patients.

vi. Donations exceeding $25,000 require Health Commission and Board of Supervisors' approval.

vii. Names of individuals or organizations making donations of $100 or more to the Gift Fund are posted on the ~~LHH~~ SFDPH.org website on an annual basis in accordance with the San Francisco Administrative Code (Section 67.29-6 Sunshine Ordinance).

2. Fund Oversight and Reporting:

a. Program Monitor
Each project code will have an assigned Program Monitor to assist in budget planning and supervising the budgeted expenses/expenditures for the assigned project code(s).

b. Gift Fund Management Committee
The Gift Fund Management Committee shall consist of the following: Chief Financial Officer, Chief Nursing Officer, Chief Quality Officer, Assistant ~~Hospital~~ Nursing Home Administrator, ~~Director~~ Administrator ~~of~~ for SFDPH Rehabilitation Services, Director of Social Service, and Ombudsman. The Gift Fund Management Committee will meet at least quarterly to review and make recommendations for budget planning and expenditures.

c. Executive Committee
The CFO, on behalf of the Gift Fund Management Committee, will provide quarterly reports of Gift Fund activities, i.e., donations and expenditures, to the Executive Committee. The Executive Committee provides additional and overall supervision of Gift Fund management.

d. Health Commission
The CFO/designee and Executive Administrator/designee, through the Health Director, will provide updates as needed to the Health Commission of Gift Fund activities, including but not limited to donations, expenditures, and Gift Fund related policy and procedure revisions.

LHH will work with the Department of Public Health to provide a report on an annual basis, in writing to the Health Commission and the Board of Supervisors a listing of all gifts, donations and contributions of money or personal property related to the Gift Fund.

e. The City Controller's Office has the right to conduct final review and approval of all expenses.

3. Budgetary Planning:

a. Each fiscal year, no later than July 1, the CFO will provide to the Executive Administrator and the Gift Fund Management Committee Members the expenditure budget for the upcoming fiscal year. The CFO/designee and Executive Administrator/designee will then present the annual budget recommendations to the Joint Conference Committee each year for approval.

b. An out-of-budget funding request during the fiscal year shall be brought to the Joint Conference Committee for approval before the expenditures can be made for any proposed expenditures from the Gift Fund not already included in the fiscal year budget approved by the Health Commission, or that do not fall under the miscellaneous category of the Gift Fund budget,

4. Stock Management:

Each fiscal year, no later than August 1, the CFO will provide the Office of the Treasurer and Tax Collector (Treasurer's Office) the project codes that contain donated stocks so that the department can actively manage the portfolio of stock bequests in the Gift Fund in accordance with the Treasurer's Office's investment policy. Any recommendations to change status of any stocks will be reviewed by the Gift Fund Management Committee prior to the Health Commission approval.

5. Interest:

Interest generated from all Gift Fund project codes is distributed to the Miscellaneous Gift Fund project code.

6. Expense Incurred:

a. Before expenses are incurred, all expenses must be reviewed and authorized by the assigned Program Monitor. Purchases must be made consistent with City policies and procedures for contracting and purchasing, i.e., purchases from City-approved vendors, encumbrances in place prior to ordering the item(s).

b. All catering expenditures must be additionally pre-approved by the ~~Chief Operations Officer~~Assistant Nursing Home Administrator or designee.

7. Reimbursement Process:

a. Except for professional services (e.g., catering services), employees may purchase nominal (up to $200) and singular items, but pre-approval for the purchase must be obtained from the applicable Program Monitor. The employee

who incurs an expense shall follow the reimbursement policy to submit reimbursement requests to the LHH Accounting Department. Accounting staff will review documentation for appropriateness, validity, completeness and mathematical accuracy and will submit the documents to the CFO for approval. Accounting staff will process approved requests through the City Controller's Office who provide final review and approval. Estimated time for reimbursement to the employee is about seven days from the date approval is obtained from the Accounting Department.

8. Revolving Funds:

a. A number of resident programs funded through the Gift Fund require the regular availability of cash or purchasing flexibility outside of the hospital's routine purchasing mechanisms. For these programs revolving funds have been established.

   i. Community Outings

   ii. Community Reintegration

   iii. Hospital-Wide Programs

   iv. ~~Substance Treatment and Recovery Services (STARS)~~Substance Use and Treatment programs

   v. Social Services Petty Cash

b. The appropriate Program Monitor or designee shall complete and submit a Gift Fund Revolving Fund Reimbursement form, Appendix A, with original receipts to replenish the Revolving Fund on regular basis.

c. Procurement Cards (P-Cards) are used in conjunction with these programs as deemed appropriate by the Chief Financial Officer

ATTACHMENT:
Attachment A: Gift Fund – Revolving Fund Reimbursement Form

REFERENCE:
LHHPP 50-06 Employee Reimbursement Request Guideline
LHHPP 50-11 Procurement Card
LHHPP 90-05 Catering Services
Materials Management Purchasing Policy
San Francisco Administrative Code (Section 10.100-201 Public Health Gift Funds)
San Francisco Administrative Code (Section 67.29-6 Sunshine Ordinance)

Revised: 98/11/16, 00/05/25, 04/12/02, 10/04/15, 11/01/25, 16/11/08, 18/06/12, 22/07/12, 23/06/13, 26/07/21 (Year/Month/Day)
Original adoption: 93/09/01

Attachment A:

Gift Fund – Revolving Fund Reimbursement Form

LAGUNA HONDA HOSPITAL
CITY AND COUNTY OF SAN FRANCISCO
GIFT FUND – REVOLVING FUND REIMBURSEMENT

To: Accounting Department **Date:** ______________________ ☐ P-Card ☐ Cash

From: ______________________ **Telephone No.**______________________
Print Name

Fund: 22150 **Department** 251865 **Project/Activity** __________ **Program** P0066

Authority 10001

Account:

546990 $__________ (Food)
549610 $__________ (Recreation supplies)
549990 $__________ (Other materials & supplies)
535710 $__________ (Subscriptions)
527030 $__________ (Transportation services)
535990 $__________ (Other current expenses)

Total Requested Amount: $ ______________________ **Date(s) of expense:** ____________

Reason for Expenditure:

☐ Social Services Petty Cash ☐ STARS ☐ Community Outings
☐ Community Reintegration ☐ Hospital-Wide Programs ☐ Neighborhood Money

Resident's Name (if applicable):

1. ______________ 4. ______________ 7. ______________
2. ______________ 5. ______________ 8. ______________
3. ______________ 6. ______________ 9. ______________

Staff and/or Volunteer's Name (if applicable):

1. ______________ 3. ______________ 5. ______________
2. ______________ 4. ______________ 6. ______________

Requested by: ______________________ ______________________ Date: ____________
Employee: Print Name Signature

Pre-approved by: ______________________ ______________________ Date: ____________
Program Monitor/Division Head: Print Name Signature
(or)
Pre-approved by: ______________________________________ Date: ____________
Mivic Hirose, CEO or authorized designee

Approved by: ______________________________________ Date: ____________
ChiaYu Ma, CFO or authorized designee

Note: Original receipts/invoices must be attached when submitting to Accounting. Revised: May 4, 2017

ENVIRONMENT OF CARE PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to providing a safe and healthy environment for patients, visitors, staff, and volunteers through the administration of an Environment of Care (EOC) Program.

2. The effectiveness of the EOC Program shall be measured by how ~~well we meet~~the facility meets the ~~standards~~ compliance standards and meeting program objectives by evaluating our performance improvement from established baseline performance metrics.

PURPOSE:

To provide a comprehensive description of the components that comprise the EOC Program.

PROCEDURE:

1. Management Plans

a. Management Plans are essential to the environment of care for supporting strong performance, demonstrating that there are processes in place to provide a safe environment, and minimizing or responding to risk. EOC professionals develop and maintain Management Plans in their respective disciplines. The EOC Program encompasses the following seven areas:

   i. Safety Management

   ii. Security Management

   iii. Hazardous Materials and Waste Management

   iv. Medical Equipment Management

   v. Utility Systems Management

   vi. Fire Life Safety Management, and

   vii. Emergency Management (Note: This program is integrated into the EOC Program and all patient care services, ensuring LHH's overall preparedness for emergencies and disaster response).

b. Management Plans shall include risk assessment, staff development, emergency response and procedures, inspection, testing, and maintenance, information collection and evaluation, performance monitoring, and annual evaluation.

c. Management Plans shall be reviewed annually but may be revised more frequently as needed to ensure that information is consistent with current health care industry standards. Management Plans shall be reviewed and approved by the EOC Committee prior to final presentation to the Performance Improvement and Patient Safety Committee (PIPS).

3. Environment of Care Committee

a. The EOC Committee is a multi-disciplinary group which is focused on the continuous improvement of the Environment of Care and takes a collaborative approach to providing a safe, secure and comfortable environment to facilitate patient care. Committee members represent the following areas:

i. Nursing

ii. Clinical Labs

iii. Security Management

iv. Infection Control and Prevention

v. Pharmacy Services

vi. Facility Services

vii. Quality Management

viii. Environmental Services

~~ix. Department of Education and Training~~

~~x.~~ix. Workplace Safety

~~xi.~~x. Emergency Management

b. Activities of the Environment of Care Committee include:

i. Plan, direct, implement, and improve the organization's performance of EOC activities.

ii. Evaluate and assess existing conditions, operations, and practices to determine impact and general regulatory compliance.

iii. Identify and implement improvement opportunities and process change to facilitate safety, security, and comfort of patients, staff, and visitors.

iv. Establish and maintain risk assessments and evaluation criteria to prioritize performance improvements and process changes.

v. Work to ensure that LHH staff are trained to identify, report, and take action on environmental risks and hazards.

vi. Reports to LHH departments and committees to communicate progress.

4. Environment of Care Rounds

a. The EOC Committee shall conduct scheduled EOC rounds throughout LHH on a continuous basis to identify potential risks and test EOC-related staff knowledge and skills. Rounds are scheduled to cover all patient care areas on a quarterly basis. The EOC rounds team includes representatives from:

i. Nursing

ii. Clinical Labs

iii. Security Management

iv. Infection Prevention and Control

v. Pharmacy Services

vi. Facility Services

vii. Quality Management

viii. Environmental Services

~~ix. Department of Education and Training~~

~~x.~~ix. Workplace Safety

~~xi.~~x. Emergency Management

5. Data and Reporting

a. Information ~~Data~~ obtained from the EOC Rounds checklists shall be collected and analyzed to determine improvement and/or identify trends and other challenges. Results shall be reported to the EOC Committee on a quarterly basis.

b. Management Plan owners shall present quarterly reports in their respective areas to the EOC Committee. The scope of the report shall include data metrics, priorities, goals, and objectives to ensure the ongoing effectiveness of the EOC Program.

c. The following EOC Committee components shall report to the PIPS Committee on a yearly basis: Workplace Safety, Emergency Management, Environmental Health, Safety/Hazardous Materials, Environmental Services, and Infection Prevention and Control. Other areas, such as Facility Services, and Biomedical Engineering shall report quarterly and, on a rotating/as-needed basis. Security Management shall report on a quarterly basis.

d. The EOC ~~Annual~~ biannual r~~R~~eport highlights all activities of the EOC Program from the current fiscal year and is written to include scope, accomplishments, program objectives, performance metrics, and goals and opportunities for improvement, and is presented to the organization.

~~e. The EOC Annual Report shall be approved by the EOC Committee prior to being presented to PIPS.~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 60-11 Environment of Care Committee

Revised: 24/05/14, 25/06/09 (Year/Month/Day)

Original adoption: 20/11/10 (Year/Month/Day)

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 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.~~

iii. ~~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.~~

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

v. ~~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.~~

vi. ~~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.~~

vii. ~~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.~~

viii. ~~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.~~

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

x. ~~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.~~

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

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

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

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

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

xv. Avoid medication near eyes

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

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

xviii. 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

h. 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. 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.
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;~~

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.~~

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

5. ~~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. ~~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.~~

7. **~~Body Lice Treatment~~**

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

   b. ~~Contact Precautions will be in effect until the IP nurse/ team collaborate with the physician when precautions may be discontinued.~~

8. **~~Pubic Lice Treatment~~**

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

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

   c. ~~Don appropriate PPE for Contact Precautions including gown and gloves~~

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

   e. ~~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.~~

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

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

h. ~~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.~~

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

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

k. ~~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.~~

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

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

n. ~~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.~~

~~PURPOSE~~

~~The purpose of this policy is to define the specific measures that must be taken to prevent and control the spread of lice at Laguna Honda Hospital and Rehabilitation. This policy will establish a standard for the prevention and control of lice, outlining evidence-based practices that have been proven to reduce the transmission of lice in healthcare facilities. By ensuring strict compliance with this policy, we help ensure the safety of our patients, personnel, and visitors by protecting against the spread of lice.~~

~~RATIONALE~~

~~Pediculosis (lice infestation) is caused by wingless parasites that feed on human blood. Although there are 3000 different species of lice, only 3 species are known to infect humans: *Pediculus humanus* capitis (head louse), *Pediculus humanus corporis* (body louse), and *Pthirus pubis* (crab or pubic louse). Body lice can transmit diseases, including epidemic typhus, relapsing fever, and trench fever. Lice can spread when contact is made with contaminated clothing, linen, and the head, eyebrows, eyelashes, and pubic hair of infected persons. Hospital transmission is most commonly seen in pediatric settings. Early identification, management, and treatment is important to prevent spread between patients and personnel.~~

DEFINITIONS

Lice: Parasitic insects that feed on human blood and can be found on the head, body, or clothing and linens. The plural form of "louse."

Louse: The singular form of "lice." Often used to specifically refer to head lice that have reached maturity with the ability to lay eggs.

Nits: Small and oval shaped, they are lice eggs or a young form of head lice; often seen attached to human hair.

Pediculosis: Any type of louse infestation (i.e., head, body, or pubic).

Pediculus humanus capitis: Species of lice found in head hair, eyebrows, and lashes.

Pediculus humanus corporis: Species of lice found on clothing and linens, which intermittently moves from clothing or linens to the human body for feeding.

Pthirus pubis: Species of lice found in pubic hair.

POLICY

The infection prevention and control department is tasked with overseeing the prevention and control of infectious diseases in the hospital setting, including the development of policies and procedures that will aid in the prevention and control of infection. This policy addresses measures taken to prevent and control the spread of lice at the facility. All personnel are expected to comply with this policy, including all assigned responsibilities herein and relevant to their individual roles at the facility. As additional scientific knowledge is made available, this policy will be updated accordingly, and personnel will be expected to comply with the updated expectations in procedures and responsibilities.

PROCEDURES

Pediculus capitis (Head Lice)

Presentation and Clinical Diagnosis

Infestation occurs on head hair, eyebrows, and eyelashes.

Head lice is diagnosed when mature lice or nits can be seen with the naked eye.

Adult lice can crawl fast, making them difficult to see. Wetting the hair with water, oil, or conditioner can slow lice down, making them easier to identify.

~~Signs and symptoms:~~

~~Itching, sometimes intense, in the infested area.~~

~~There may also be a crawling sensation, sores on the head from scratching; irritability and difficulty sleeping in young children.~~

~~Transmission and Susceptibility~~

~~Transmission occurs most commonly through direct head-to-head contact with an infected person.~~

~~Transmission may also occur objects used by an infected person, including combs, hats, hair bands, head gear. This method of transmission is less common.~~

~~Lice cannot jump or fly.~~

~~Transmission may occur long as lice or eggs remain alive on an infested person. The life cycle of a louse extends over 18 days, with 6 to 9 days between the laying of eggs to hatching.~~

~~Any person may become infested under suitable conditions of exposure.~~

~~Patient Management~~

~~Immediately place patients with suspected/confirmed head lice on Contact Precautions.~~

~~Place hair covering (such as a bouffant cap) on the patient's head until treatment can be initiated.~~

~~Single room placement is preferred, but the facility may cohort cases of the same type of lice infestation together in the same room if single rooms are not available.~~

~~Place a Contact Precautions sign at the door until Contact Precautions are discontinued or the patient is discharged, and the room is terminally cleaned.~~

~~Continue Contact Precautions for lice until 24 hours after initiating treatment.~~

~~Reevaluate the need for Contact Precautions 24 hours after appropriate treatment has been provided.~~

~~Always maintain best practices in infection prevention and control, such as strict compliance with Standard Precautions, correct use of personal protective equipment (PPE), and hand hygiene.~~

~~Treatment~~

~~The recommended treatment for head lice is an over-the-counter or prescription pediculicide.~~

~~Follow the instructions on the box or label to ensure effective treatment is provided.~~

~~Do not wash hair for two days after removal of the lice medicine.~~

~~Use a fine-toothed nit comb to comb nits and dead lice from the hair shaft out.~~

~~Notification~~

~~Notify the patient's provider, if they are not already aware.~~

~~Contact infection prevention and control for any patient questions about preventing and controlling the transmission of lice.~~

~~If the patient was transferred within the previous 6 weeks from another institution (e.g., nursing home, homeless shelter, prison, school, day care, or other congregate setting), notify that facility.~~

~~Education~~

~~Educate facility personnel and patients on lice, including signs and symptoms of infection.~~

~~Environmental Management~~

~~Ensure appropriate environmental cleaning and disinfection.~~

~~Wash all of the patient's clothing and linens in hot water (at least 130°F) and dry them using a hot dryer cycle.~~

~~Place any items unable to be washed (e.g., stuffed animal) in a sealed plastic bag for 2 weeks.~~

~~If possible, the facility may consider sending the patient's personal items home with family for laundering.~~

~~Clean and vacuum the room thoroughly to remove any fallen hairs with nits attached.~~

~~Transfers or Discharge~~

Limit in-house transfers to those that are medically necessary for the first 24 hours of treatment. Place a hair cap on the patient's head for necessary transfers outside of the room.

Upon discharge, notify any receiving facility of isolation and infection status, making that facility's personnel aware of lice diagnosis, treatment plan, and any current Transmission-Based Precautions.

Visitors

Ask visitors to wear personal protective equipment, including a hair cap.

Counsel visitors with previous close contact with the patient to seek evaluation and possible treatment for head lice.

Pediculus corporis (Body Lice)

Presentation and Clinical Diagnosis

Body lice is diagnosed when eggs and crawling lice are seen.

The primary symptom is Itching, which is sometimes intense, in the infested area.

Transmission and Susceptibility

Transmission occurs via direct contact with an infested individual or contact with their personal belongings, especially linens, clothing, and personal belongings.

Body lice remain communicable as long as lice or eggs remain alive on the infested person, their clothing, or bedding. (Body lice live and lay eggs on clothing and periodically move to the skin to feed.)

The average life cycle of body lice extends over a period of 18 days, with 1 to 2 weeks between laying of eggs to hatching.

Body lice can survive 7 days without a human food source and eggs can remain viable for a month.

Individuals who live in crowded settings can be at increased risk for body lice.

Individuals who lack access to personal hygiene resources, or live in circumstances in which changing clothing is difficult (e.g., refugee camp, homeless shelter, and other congregate living settings where access to clothing changes is unlikely), are also at elevated risk.

Management

~~Use Standard Precautions in the care of patients with suspected/confirmed body lice.~~

~~Personnel should wear PPE (gowns and gloves) when handling potentially contaminated linens or clothing.~~

~~Assist the patient with bathing/showering.~~

~~Wash all of the patient's clothing and linens in hot water (at least 130°F) and dry them using a hot dryer cycle.~~

~~Place items that cannot be laundered in a sealed plastic bag for 1 week.~~

~~Treatment~~

~~The recommended treatment for body lice is improved hygiene and laundering all linens and clothing as described in "Management."~~

~~Pediculicides are not generally recommended, but they may be prescribed at the discretion of the patient's healthcare provider.~~

~~Notification~~

~~Notify the patient's provider, if they are not already aware.~~

~~If the patient was transferred within the previous 6 weeks from another institution (e.g., homeless shelter, nursing home, prison, school, day care, or other congregate setting), notify that facility.~~

~~Education~~

~~Educate patients and personnel on lice, including signs and symptoms of infection.~~

~~Contact infection prevention and control for guidance about any patient questions about preventing and controlling the transmission of lice.~~

~~Environmental Management~~

~~Perform standard cleaning and disinfection of all rooms of patients with suspected/confirmed body lice.~~

~~Transfers or Discharge~~

~~Limit in-house transfers to those that are medically necessary until the patient is bathed, their linens and clothing are changed, and soiled linens and clothing are placed in a sealed bag.~~

~~Upon discharge, notify any receiving facility of the lice diagnosis and treatment plan.~~

~~Pthirus pubis (Pubic Lice [Crabs])~~

~~Presentation and Clinical Diagnosis~~

~~Pubic lice or crabs is diagnosed when eggs and lice are seen on in the pubic area.~~

~~With heavy infestation, lice and eggs can also be found on facial or axillary hair.~~

~~Individuals may experience severe itching in the infested area.~~

~~Transmission~~

~~Transmission occurs via sexual contact with an infested partner or contact with infested clothing or linens (e.g., towels, bed linens).~~

~~Pubic lice can be transmitted as long as nits or eggs remain alive on the infested person. The average life cycle of pubic lice extends over a period of 30 days with 6-10 days between laying of eggs to hatching.~~

~~Management~~

~~Use Standard Precautions in the care of patients with suspected/confirmed body lice.~~

~~Personnel should wear PPE (gowns and gloves) when handling potentially contaminated linens or clothing.~~

~~Machine wash and dry all clothing, towels, or bedding used by the patient within the three days prior to treatment. Wash in hot water (at least 130°F) and dry them using a hot dryer cycle.~~

~~Place items that cannot be laundered in a sealed plastic bag for two weeks.~~

~~Treatment~~

~~Wash the infested area and towel dry.~~

~~The recommended treatment for pubic lice is an over-the-counter or prescription pediculicide.~~

~~Treatment must be initiated by the patient's provider.~~

~~Follow the instructions on the box or label to ensure effective treatment is provided.~~

~~Caution: Be sure to follow any special instructions for treatment of lice or nits on eyebrows or eyelashes.~~

~~Nits may be removed by using a fine-toothed comb.~~

~~Notification~~

~~Notify the patient's provider, if they are not already aware.~~

~~Encourage the patient to notify all people with whom they have had sexual contact in the previous month.~~

~~Education~~

~~Educate the patient and personnel that pubic lice are typically spread through sexual contact.~~

~~Encourage the patient to be evaluated for other sexually transmitted infections.~~

~~Instruct the patient to avoid all sexual contact until both they and their partner(s) have been successfully treated.~~

~~Advise the patient to monitor and retreat in 9 to 10 days if live lice are found.~~

~~Contact infection prevention and control for guidance on any patient questions about preventing and controlling the transmission of lice.~~

~~Responding to Facility Outbreaks of Lice~~

~~Outbreak Definition~~

~~Two or more diagnosed cases of new onset head or body lice, in patients or staff members of the same unit/area within a 2-week time frame.~~

~~Surveillance~~

~~Implement heightened surveillance procedures to identify additional cases of lice in patients or unit personnel.~~

~~Conduct daily hair/skin assessments for all at-risk/exposed patients.~~

~~Instruct personnel to report any signs or symptoms of lice.~~

~~Continue increased surveillance of all exposed patients and personnel for at least 2 weeks after identification of the last identified case.~~

~~Notification~~

~~Notify patient providers, if they are not already aware, of the outbreak.~~

~~Notify infection prevention and control immediately whenever an outbreak of lice in patients or healthcare personnel is suspected.~~

~~Notify public health as required by local outbreak reporting requirements.~~

~~Responsibilities~~

~~All Staff~~

~~Will comply with all procedures in this policy as they relate to their individual roles within the institution.~~

~~Will report noncompliant behavior to help ensure the safety of patients, visitors, and other personnel.~~

~~Infection Prevention and Control~~

~~Will assist with the implementation of this policy.~~

~~Will assist in the response to cases of suspected/confirmed lice.~~

~~Will educate clinical teams on the identification and response to lice, including assuming responsibilities for updates to this policy.~~

~~Will coordinate with the infectious disease and occupational health teams in the response to suspected/confirmed cases of lice in patients or personnel.~~

~~Infectious Disease and/or Hospital Epidemiologist~~

~~Will oversee the evaluation, diagnosis, and treatment of patients with suspected lice.~~

~~Will assist in the institutional response to cases and outbreaks of lice with infection control and prevention, occupational health, and the clinical team.~~

~~Will assist in the creation, updates, and implementation of this policy.~~

~~Occupational Health~~

Will oversee the evaluation, diagnosis, and treatment of employees with suspected lice.

Will oversee the treatment of employees exposed to lice.

Will oversee the return-to-work policies and procedures for employees with lice.

Assist in the creation, updates, and implementation of this policy.

Education

Education Frequency

All staff must be educated on the components of this policy at the following frequency:

As needed

When cases or outbreaks of lice are suspected/identified

Policy Communication

Changes to this policy must be communicated and appropriate education provided to all relevant staff members immediately following published changes.

Communication should be accomplished by:

Email

Unit or area management

Other methods as determined.

ATTACHMENT

None

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~~**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 (Month/Day/Year)~~

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

INJURY AND ILLNESS PREVENTION PROGRAM (IIPP)

POLICY:

The Laguna Honda Hospital and Rehabilitation Center (LHH) injury and Illness Prevention Program (IIPP) was established to provide a safe and healthy work environment for all LHH employees. This program also includes the Workplace Violence prevention program.

This document is intended to be ever-~~evolvingp~~evolving and shall reflect our progress toward the continuous improvement of the health, safety, and welfare of our employees.

PURPOSE:

The purpose of the IIPP is to implement and maintain effective procedures for preventing workplace injury and illness in accordance with California Occupational Safety and Health Standards, California Code of Regulations (CCR) Title 8, Section 3203, Section 1509, and Section ~~1509~~3342.

PROCEDURE:

1. **Responsibilities**

   a. The Manager of the LHH Department of ~~Workplace Safety and Emergency Management (WSEM)~~Industrial Hygiene (DIH) shall be the IIPP administrator and have the authority and responsibility for administering and maintaining the overall program and for updating the program annually. (~~WSEM~~DIH) shall also be responsible for the following:

      i. Providing initial and ongoing health and safety training to employees during hospital-wide orientation and periodic in-services.

      ii. Providing assistance to Department Managers as requested in implementing the IIPP. This might include assessing hazards, training employees, and investigating accidents.

      iii. Reviewing all incident reports, investigating when necessary, and recommending controls up the command chain.

      iv. Analyzing and summarizing injury/illness data. Reports shall be provided to PIPS twice per year and to the Executive Team once per year.

      v. Making recommendations for injury/illness prevention based on hazards and injury/illness data.

      vi. The Manager of DIH is the Chairperson of the Environment of Care (EOC) subcommittee "Employee Health and Safety", which addresses employee

exposures and injury events, along with workplace violence incidents in the different departments.

b. Department Managers shall be responsible for implementing the components of the IIPP, including the workplace violence requirements, within their work areas. This shall include the following:

   i. Identifying risks and informing workers of risks and how to minimize them, which includes conducting semiannual inventories of all chemicals in their department and forwarding a copy of that inventory to DIH, and ensuring the department's employees know where to find the Safety Data Sheets (SDSs) for each chemical. The department manager should also inventory the list of Safety Data Sheets that are present for each chemical that is used in their department. This SDS check should be done at the same time as the semiannual chemical inventory is conducted.

   ii. Providing job-specific health and safety training, including group meetings or huddles on health, safety, and workplace violence.

   iii. Promoting a positive atmosphere of open communication regarding safety and health that is free from harassment, discrimination, and fear of reprisal.

   iv. Making sure that employees follow safety procedures.

   v. Conducting incident investigations and identifying corrective actions and preventative actions.

   vi. Take appropriate disciplinary action when employees do not comply with LHH health and safety policies and procedures, including but not limited to completing the proper forms and documentation.

   vii. Submit the appropriate injury and illness reports to DPH Occupational Safety and health (OSH) department and send a copy to the manager of DIH.

   viii. Appendix B can be used as a checklist to assist Managers and supervisors during a workplace injury or illness.

c. All employees shall:

   i. Comply with LHH health and safety policies and procedures;

   ii. Use and maintain required personal protective equipment (PPE), including respirators;, when required to wear respirators;

   iii. Promote and facilitate a safe and healthy environment for themselves and their co-workers;

iv. Report injuries, illnesses, and incidents involving a risk to health and safety immediately to their supervisor; this includes the Workers' Compensation Claim form (DWC-10 for any injury to OSH and also submit a SAFE Report to Quality Management. See the reference section for links to the forms. A copy of both forms shall be sent to DIH.

v. Report any potential safety or health risk immediately to their supervisor, including perceived physical or emotional risk~~;~~, and complete and submit a SAFE Report (see reference section for a link;

vi. Abate risks immediately when possible and safe to do so;

vii. Not undertake a task or operate equipment unless authorized and trained to do so safely and to ask for assistance when they do not understand how to complete a task safely;

viii. Attend required health and safety training and medical surveillance examinations.

d. The LHH Executive Team shall:

i. Provide the necessary resources to implement and maintain an effective IIPP.

ii. Assign Department Managers responsibilities for implementing the IIPP in their areas of responsibility.

iii. Calendar at least annually a review of a report from the LHH Department of ~~Workplace Safety and Emergency Management~~Industrial Hygiene including analyses of injury and illness data.

iv. Review recommendations from the Department of ~~Workplace Safety and Emergency Management~~Industrial Hygiene.

v. Take action as appropriate to minimize health and safety risks.

vi. Ensure the DIH has the resources for IH monitoring equipment and laboratory contracts for analyses and fund the required professional certifications and OSHA/EPA required courses for members of the DIH.

2. **Communication**

a. LHH promotes a system of open communication between management and staff in which staff are encouraged to report hazardous conditions and near-misses without fear of reprisal. Employees are encouraged to report any hazards immediately to their supervisors, who are expected to investigate and mitigate the hazards.

b. Employees may also choose to report health and safety hazards directly to ~~WSEM or through a hazard reporting form, which is available in hard copy outside WSEM offices located in A401 as well as online. The hazard reporting form may be submitted anonymously.~~DIH. Hazards shall also be simultaneously reported in the SAFE Reports (see reference section for a link).

c. All LHH employees shall receive an introduction to ~~WSEM~~worker safety and the DIH department and an overview of this IIPP and workplace violence during new employee orientation.

d. All LHH employees shall receive health and safety training specific to their jobs on initial hire and periodic in-service trainings by their departments as arranged with DET throughout the year.

e. Department Managers shall be instructed on the hazards in their work areas either during Leadership Forum or individually by ~~WSEM staff~~requests to DIH.

f. Employees shall receive task-specific health and safety training within their departments on initial assignment and additionally when:

  i. Assigned to a new job or task for which they have not been trained previously;

  ii. New substances, processes, procedures, or equipment are introduced and pose a new hazard;

  iii. A previously unrecognized hazard is brought to the attention of the Supervisor.

g. Departmental/neighborhood employee safety meetings shall be held periodically and/or time shall be allocated in regular staff meetings to discuss health and safety issues. Department Managers are encouraged to invite ~~WSEM~~DIH staff as technical experts to safety meetings as appropriate.

h. A health and safety bulletin board on the first floor of the main Administration building shall be maintained by ~~WSEM~~DIH with information about the LHH IIPP, and the most recent Cal/OSHA Form 300A. This log should be updated when new notices are received (at least annually).

i. The main page of the LHH Intranet site is accessible to all employees and has a ~~WSEM~~WS icon (for worker safety) linking users to safety and health resources including injury reporting procedures, safety data sheets, and the online hazard reporting form.

3. **Hazard Identification and Evaluation**

a. Hazards shall be identified primarily by Department Managers, but may also be identified in any of the following ways:

i. Health and safety surveys conducted by the LHH ~~Industrial Hygienist~~DIH either randomly or at the request of an employee or Manager.

ii. Supervisors introducing new tasks, substances, or equipment into their area.

iii. Employee(s) bringing the hazard to the attention of the Supervisor, Department Manager, or ~~WSEM~~DIH.

~~iv. Employee(s) using the Workplace Hazard Reporting Form available on the LHH intranet Occupational Safety and Health button and in hard copy in the Admin building lobby. (Appendix A)~~

~~v.~~iv. Aggregated incident report/injury information.

v. Periodic EOC inspections

New hazards shall be evaluated by the supervisor, the LHH ~~Industrial Hygienist~~DIH, or the LHH ~~OSH Committee~~EHS subcommittee (Employee Health and Safety) as appropriate to determine necessary safety procedures and training.

4. **Reporting and Investigation of Occupational Injuries and Illnesses**

a. Notification

i. All incidents involving health and safety hazards shall be reported immediately to the supervisor of the employee involved~~.~~, and a SAFE Report will need to be submitted to QM and a copy sent to DIH. The employee either observing or involved in the unsafe act should complete the SAFE report.

ii. In the case of injuries that do not require immediate emergency treatment, the employee shall report the injury to his/her supervisor prior to seeking medical treatment~~.~~, and shall complete the Workers' Compensation Claim form (see references for a link). A list of medical facilities for WC injuries or illnesses is listed in Appendix A.

iii. In the case of injuries that do require immediate emergency medical treatment, the employee must inform the supervisor and also submit the Workers" Compensation Form as soon as possible. Unless they are medically unable to do so, employees must inform their supervisors on the same day/shift of the injury.

iv. In the case of occupational illnesses, it may be difficult to associate a specific event or exposure. The employee shall report the illness to the supervisor as soon as there is a suspicion of diagnosis of an occupational illness~~.~~, and the employee and supervisor shall contact DIH.

v. In the case of needle sticks and blood borne pathogen exposures, after washing/flushing the affected area, the incident should be reported to the supervisor in the same manner as other occupational injuries and illnesses. In addition, there is a 24-hour phone hotline which allows employees to obtain more specific information on follow-up for this type of exposure. A SAFE Report shall be filed, in addition to the Workers" Compensation Form and required IIPP forms required in the reference list for a link.

b. Medical Treatment

i. The supervisor shall assist the employee in obtaining prompt medical treatment of occupational injuries and illnesses, as necessary. The employee may proceed to any one of the twelve approved service sites for San Francisco City and County employees. A list of these service sites can be found in Appendix B.

- An ambulance shall be called for transport if the employee's condition is serious or medically unstable.

ii. If the employee's condition is not serious or medically unstable, the supervisor shall arrange for safe and appropriate transportation to designated treatment facilities.

- Incident forms do not have to be completed prior to the employee seeking medical treatment but should be completed within the timeframes detailed below.

c. Documentation

i. On the same day/shift of an employee reporting or a supervisor having knowledge of an occupational injury or illness, the Supervisor **(not the employee)** shall complete the following forms found in ~~Appendix C~~the references for a link. These forms are available as fillable pdf forms on the LHH intranet ~~WSEM~~Forms site:

- Supervisor's Incident Investigation Form (SIIR)
- Employer's Report of Occupational Injury or Illness (Form 5020)
- Employee's Claim for Worker's Compensation Benefits form (Form DWC-1).

ii. If the employee loses work time or seeks medical treatment, the employee must complete and sign their section of Form DWC-1.

iii. Fax ~~all completed~~or electronically email forms to DPH OSH or call ~~at~~ 415-554~~-~~2562 as soon as possible~~ and then send~~. Email a copy to DIH. Send a hard copy in interoffice mail to OSH.

iv. If all the details of the incident cannot be obtained quickly or are not known due to the employee's unavailability, submit the form with as much information as possible and submit a written supplement to the form as soon as possible when you have more detail.

d. Fatality / Serious Injury

i. In the event of a fatality or a serious occupational injury or illness requiring hospitalization: the attending supervisor shall complete the LHH Supervisor Serious Injury/Fatality Tool.

ii. The supervisor shall contact the Senior Industrial Hygienist, ~~Industrial Hygienist,~~ Administrator on Duty, or the Nursing Supervisor as indicated on the LHH Supervisor Serious Injury/Fatality Tool.

iii. The Senior Industrial Hygienist, ~~Industrial Hygienist,~~ Administrator on Duty, or the Nursing Supervisor shall notify the nearest Cal OSHA office immediately at 415-972-8670.

ATTACHMENT:

~~Appendix A: Workplace HazardSAFE Reporting Formprocedure~~
Appendix ~~A~~A: List of Workers' Compensation Designated Clinics
Appendix ~~C~~B: Injury Reporting Checklist and Paperwork
~~Appendix D: State and SF DPH required forms for incidents and injuries, and Worker's Compensation~~
~~1. Supervisors Incident Investigation Report (DPH SIIR)~~
~~2. DPH OSH Form 5020~~
~~3. DPH DWC-1 (Worker's Compensation Form)~~

REFERENCE:

SAFE Reporting Standard Work
State and SF DPH required forms for incidents and injuries, and Worker's Compensation:

- Supervisors' Incident Investigation Report (DPH SIIR)
- DPH OSH Form 5020
- DPH DWC-1 (Worker's Compensation Form)

California Occupational Safety and Health (OSH) Standards, Title 8, *California Code of Regulations (CCR),* section 3203

CCR Title 8, Section 3342. Workplace Violence Prevention in Health Care

Revised: 95/05/01, 98/12/24, 99/11/22, 00/03/02, 08/04/29, 14/03/25, 14/05/27, 16/07/12, 17/03/14, 23/09/12 (Year/Month/Day)
Original adoption: 92/05/20

Appendix A:
Workers' Compensation Designated Clinics

When an employee has an occupational injury or illness, the first concern is to ensure that the employee receives timely medical care. If the employee needs medical care, the supervisor should direct the employee to a Workers' Compensation Designated Clinic.

For Injuries Occurring During Normal Business Hours:

St. Francis Treatment Room
1199 Bush Street, Suite 160
Hours: 7:30 a.m. to 5:30 p.m., Monday through Friday
Telephone: (415) 353-6305

AT&T Clinic – St. Francis Health Center (at the Ballpark)
24 Willie Mays Plaza
Hours: 7:30 a.m. to 5:00 p.m., Monday through Friday
Telephone: (415) 972-2249

Kaiser Occupational Health Clinic (Opera Plaza)
601 Van Ness Avenue, Suite 2008
(Inside the Opera Plaza building, 2nd floor)
Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday
Telephone: (415) 674-7000

California Pacific Medical Center – Davies Campus
Castro & Duboce Streets
Hours: 7:00 a.m. to 11:00 a.m. and 1:00 p.m. to 5:00 p.m., Monday through Friday
Telephone: (415) 600-6600

San Francisco International Airport Medical Clinic
International Terminal, Level 3, "A" Side
(Departures Level, Pre-Security)
Hours: 8:30 a.m. to 5:00 p.m., Monday through Friday and
9:00 a.m. to 1 p.m., Saturday
Telephone: (650) 821-5600

US Healthworks
1893 Monterey Road, Suite 200
San Jose, CA
Hours: 7:00 a.m. to 7:00 p.m., Monday through Friday
Telephone: (408) 288-3800

Valley Care Occupational Health Clinic
5565 W. Los Positas Blvd. Suite 150
Pleasanton, CA
Hours: 8:00 a.m. to 5:00 p.m., Monday through Friday
Telephone: (925) 416-3562

For Injuries Occurring After Normal Business Hours:

San Francisco General Hospital Emergency Department
1001 Potrero Ave
San Francisco, CA
Telephone: (415) 206-8111

California Pacific Medical Center – Davies Campus Emergency Department
Castro and Duboce Streets
Telephone: (415) 600-0600

Kaiser Permanente Medical Center – San Francisco
Urgent Care Clinic
2238 Geary Blvd., 8th Floor S.E.
Hours: 5:00 p.m. to 9:00 p.m.

Kaiser Permanente Medical Center – San Francisco
Emergency Department
2200 O'Farrell Street at Baker
Hours: 9:00 p.m. to 8:00 a.m.
Telephone: (415) 202-2000

Saint Francis Memorial Hospital Emergency Department
1100 Bush Street, between Hyde and Leavenworth Streets
Telephone: (415) 353-6300

Appendix ~~C~~B: Injury Reporting Checklist and Paperwork for Supervisors

Laguna Honda Supervisor's Injury Reporting Checklist

1. **Whenever a Laguna Honda employee reports a workplace injury or near miss incident, the supervisor must do the following before the end of the shift:) (See Appendix D)**

   Complete the Supervisor's Incident Investigation Report (DPH SIIR).

   Complete the State of California Employer's Report of Occupational Injury or Illness (DPH OSH Form 5020).

   Give the employee a blank Workers' Compensation Claim Form (DWC-1) and Notice of Potential Eligibility.

2. **If the employee is going to seek medical treatment for an injury or illness:**

   Have the employee complete and sign the top section of the DWC-1. You must complete the Employer section (bottom half).

   Send all three forms (SIIR, 5020, and DWC-1) to DPH OSH at ~~DPH-Workcomp@sfdph.org~~DPH-Workcomp@sfdph.org, or fax to 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail. Copies are to be sent to the Senior Industrial Hygienist at LHH.

   Provide the employee with the list of workers' compensation designated clinics. The employee must seek treatment at one of these facilities unless they have submitted a pre-designation form to HR to see their personal physician.

3. **If the employee does not intend to seek medical treatment:**

   Send the SIIR and 5020 ~~**ONLY**~~ to DPH OSH at ~~DPH-Workcomp@sfdph.org~~DPH-Workcomp@sfdph.org, or fax to 415-554-2570 or 415-554-2562, then send the originals to DPH OSH at 101 Grove via interoffice mail. And email a copy to the LHH Senior Industrial Hygienist.

   If they change their mind and turn in a completed DWC-1, follow the instructions in section 2.

4. If the reported incident involves exposure to blood, body fluids, or other infectious material:

Complete section 1 and the first two steps in section 2 above.

Instruct the employee to call the Needlestick Hotline at 415-469-4411.

Send the employee for follow up care to SFGH Occupational Health Services.

5. If the reported incident involves exposure to an aerosol transmissible disease (ATD), such as TB:

Follow instructions in section 1, but substitute the ATD Exposure Report for the SIIR.

Follow instructions in section 2 or section 3 as appropriate.

6. If the injury is fatal or serious (employee is sent to a hospital):

Complete the first page of the LHH Supervisor Serious Injury/Fatality Tool to determine whether Cal/OSHA notification is required. **This must be done immediately.** Also contact SFDPH OSH and LHH Senior Industrial Hygienist immediately.

If you answered yes to any questions on the first page of the tool:

Complete the second page.

Follow the instructions for contacting the Industrial Hygienist, AOD, or Nursing Supervisor and provide them with a copy of the completed tool **within 2 hours of the incident, regardless of the time of the incident.**

If you did not answer yes to any questions on the first page, no further action is required.

~~Appendix D: Supervisor's Forms to be completed~~

~~Supervisor's Incident Investigation Form (SIIR)~~

~~Employer's Report of Occupational Injury or Illness (Form 5020)~~

~~Employee's Claim for Worker's Compensation Benefits form (Form DWC-1).~~

~~Supervisor's Incident Investigation Form (SIIR)~~

San Francisco Department of Public Health

Supervisor's Incident Investigation Report

OSH Section, 101 Grove Street, Room 217, San Francisco California, 94102 • Phone # 415/554-2793 • Fax # 415/554-2562

Cal-OSHA Regulations require that employers investigate all occupational injuries, illnesses, and near misses. Use this form to document your investigation and corrective actions taken (use additional sheets if necessary). You can use information on the Employer's Report of Occupational Injury and Illness form (5020) to supplement your documentation. Please provide this form (along with forms 5020 and DWC-1) to the OSH Section on the same day and shift of the incident. OSH Section contact information is located at the top of this form.

1. Employee Information

Name: Last, First, MI	Social Security Number	Date of Incident / Injury (mm,dd,yy)

2. Event Type: ☐ Lost Time ☐ Restricted Duty ☐ Medical Treatment ☐ **Near Miss Documentation Only:** (Non-Injury or minor injury event & employee not treated by health care professional). ☐ Unknown

3. Treatment Location

Regular Hours: ☐ SFOHS ☐ St Francis at ATT& T Park ☐ Kaiser (Opera Plaza) ☐ CPMC Davies ☐ SFO Medical ☐ US Healthworks ☐ Valley Care OHS ☐ St Francis Treatment Room

After Hours: ☐ SFGH Emergency Department ☐ CPMC Davies ER ☐ Kaiser Urgent Care (Geary) ☐ Kaiser ER (O'Farrell) ☐ St Francis ER ☐ Other (Explain)

4. Briefly Describe Incident

5. Event Location: Please describe location where incident occurred (e.g. room #, floor, ward, bldg #).

6. Investigation: Causal factors are anything that may have contributed to the incident. Check as many boxes as applicable. Clearly list incident specifics in the space provided. Include additional sheets if needed.

☐ **Unsafe Working Conditions, specify:**
☐ **Unsafe Work Practices, specify:**
☐ **Training:**
☐ **Other, specify:**

7. Employee Input: What suggestions did the employee have for preventing similar incidents?

8. Witness Information: Please include the Name, Job Classification, Phone # of any witnesses to the incident.

9. Corrective Actions Taken: You must complete items A, B, & C. List corrective actions and completion dates below. "Be more careful" or "None" are not appropriate responses. Use additional sheets if necessary.	**Completion Date**
A. Supervisor discussed applicable points about the incident with affected staff.	
B. Supervisor solicited staff suggestions for prevention.	
C. What are you going to do to prevent similar events from occurring? Please list below.	
1.	
2.	
3.	

10. Immediate Supervisor

PRINT NAME	SIGNATURE	PHONE NO.	DATE COMPLETED

Note: If an employee is injured and being treated by a healthcare professional (HCP), you should be receiving written status reports from the HCP after each medical visit. Please fax all medical information and updates to the OSH Section at 554-2570.

DPH SIIR WHITE and YELLOW COPY: OSH SECTION, PINK COPY: FACILITY RECORDKEEPER 2009 REVISION

Useful Accident Investigation Questions

WHO

Who was Injured?
Who saw the accident?
Who was working with him/her?
Who else was involved?
Who else can help prevent recurrence?

WHERE

Where did accident occur?
Where was he/she at the time?
Where was the supervisor at the time?
Where were fellow workers at the time?
Where were other people who were involved at the time?
Where was witness when accident occurred?

WHEN

When did accident occur?
When did he/she start on the job?
When was he/she assigned on the job?
When were the hazards pointed out to him/her?
When did his/her supervisor last check on job progress?
When did he/she first sense something was wrong?

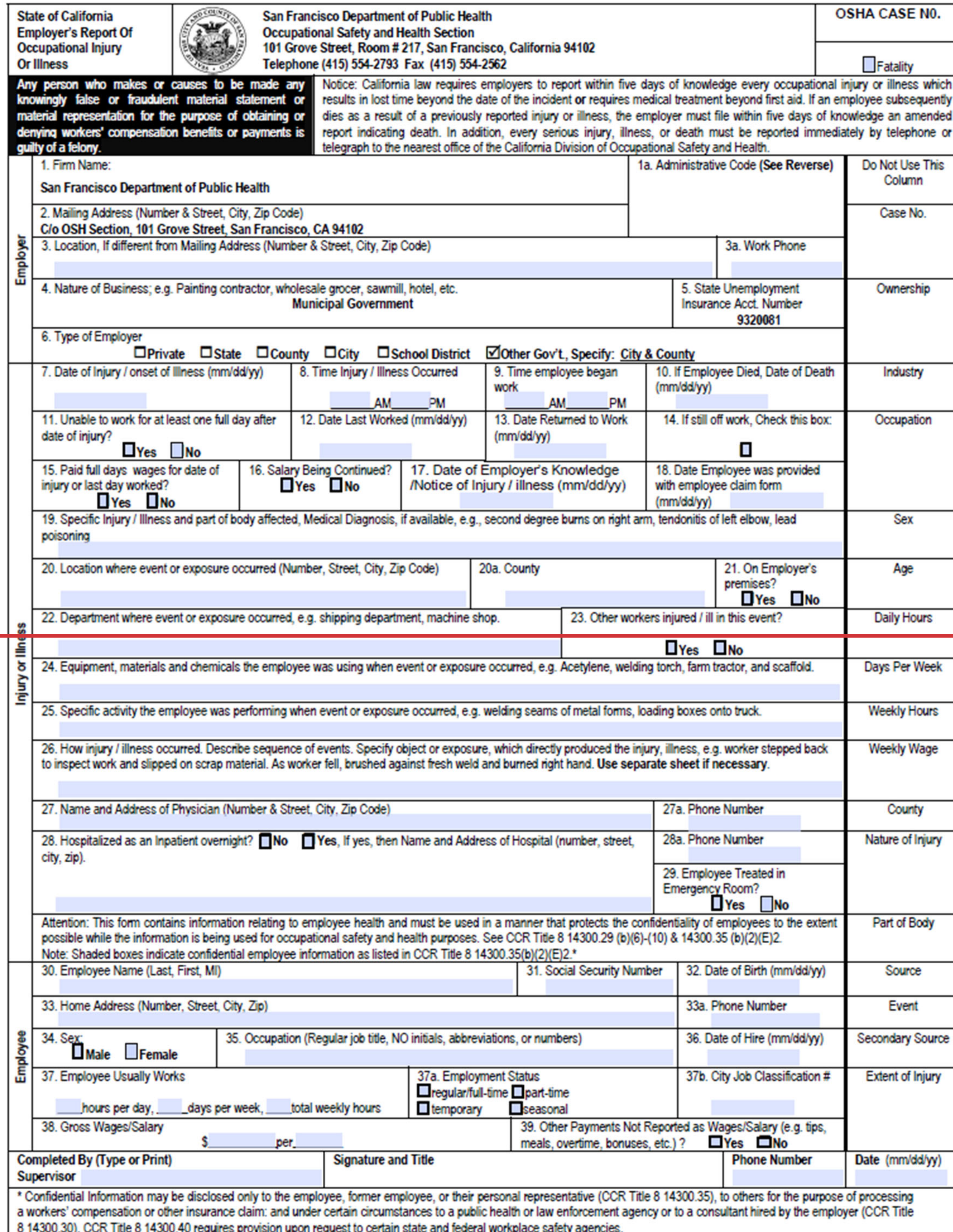
WHAT

What was the accident?
What was the injury?
What was he/she doing?
What had he/she been told to do?
What tools was he/she using?
What machine was involved?
What operation was he/she performing?
What instructions had he/she been given?
What specific precautions were necessary?
What specific precaution was he/she given?
What protective equipment should have been used?
What protective equipment was he/she using?
What had other persons done that contributed to the accident?
What problem or question did he/she encounter?
What did he/she or witness do when accident occurred?
What extenuating circumstances were involved?
What did he/she or witness see?
What will be done to prevent recurrence?
What safety rules were violated?
What new rules are needed?
What would have prevented the accident?

HOW

How did he/she get injured?
How could he/she have avoided it?
How could supervisor have prevented it?

Form 5020: Employer's Report of Occupational Injury or Illness



State of California
Employer's Report Of Occupational Injury Or Illness

San Francisco Department of Public Health
Occupational Safety and Health Section
101 Grove Street, Room # 217, San Francisco, California 94102
Telephone (415) 554-2793 Fax (415) 554-2562

OSHA CASE N0.

☐ Fatality

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Notice: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **or** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

Employer

1. Firm Name: **San Francisco Department of Public Health**
1a. Administrative Code **(See Reverse)**
2. Mailing Address (Number & Street, City, Zip Code) **C/o OSH Section, 101 Grove Street, San Francisco, CA 94102**
3. Location, If different from Mailing Address (Number & Street, City, Zip Code)
3a. Work Phone
4. Nature of Business; e.g. Painting contractor, wholesale grocer, sawmill, hotel, etc. **Municipal Government**
5. State Unemployment Insurance Acct. Number **9320081**
6. Type of Employer ☐ Private ☐ State ☐ County ☐ City ☐ School District ☑ Other Gov't, Specify: City & County

Injury or Illness

7. Date of Injury / onset of Illness (mm/dd/yy)
8. Time Injury / Illness Occurred ____AM ____PM
9. Time employee began work ____AM ____PM
10. If Employee Died, Date of Death (mm/dd/yy)
11. Unable to work for at least one full day after date of injury? ☐ Yes ☐ No
12. Date Last Worked (mm/dd/yy)
13. Date Returned to Work (mm/dd/yy)
14. If still off work, Check this box: ☐
15. Paid full days wages for date of injury or last day worked? ☐ Yes ☐ No
16. Salary Being Continued? ☐ Yes ☐ No
17. Date of Employer's Knowledge /Notice of Injury / illness (mm/dd/yy)
18. Date Employee was provided with employee claim form (mm/dd/yy)
19. Specific Injury / Illness and part of body affected, Medical Diagnosis, if available, e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning
20. Location where event or exposure occurred (Number, Street, City, Zip Code)
20a. County
21. On Employer's premises? ☐ Yes ☐ No
22. Department where event or exposure occurred, e.g. shipping department, machine shop.
23. Other workers injured / ill in this event? ☐ Yes ☐ No
24. Equipment, materials and chemicals the employee was using when event or exposure occurred, e.g. Acetylene, welding torch, farm tractor, and scaffold.
25. Specific activity the employee was performing when event or exposure occurred, e.g. welding seams of metal forms, loading boxes onto truck.
26. How injury / illness occurred. Describe sequence of events. Specify object or exposure, which directly produced the injury, illness, e.g. worker stepped back to inspect work and slipped on scrap material. As worker fell, brushed against fresh weld and burned right hand. **Use separate sheet if necessary.**
27. Name and Address of Physician (Number & Street, City, Zip Code)
27a. Phone Number
28. Hospitalized as an Inpatient overnight? ☐ No ☐ Yes, If yes, then Name and Address of Hospital (number, street, city, zip).
28a. Phone Number
29. Employee Treated in Emergency Room? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35 (b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.*

Employee

30. Employee Name (Last, First, MI)
31. Social Security Number
32. Date of Birth (mm/dd/yy)
33. Home Address (Number, Street, City, Zip)
33a. Phone Number
34. Sex ☐ Male ☐ Female
35. Occupation (Regular job title, NO initials, abbreviations, or numbers)
36. Date of Hire (mm/dd/yy)
37. Employee Usually Works ____hours per day, ____days per week, ____total weekly hours
37a. Employment Status ☐ regular/full-time ☐ part-time ☐ temporary ☐ seasonal
37b. City Job Classification #
38. Gross Wages/Salary $________ per____
39. Other Payments Not Reported as Wages/Salary (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Do Not Use This Column: Case No. / Ownership / Industry / Occupation / Sex / Age / Daily Hours / Days Per Week / Weekly Hours / Weekly Wage / County / Nature of Injury / Part of Body / Source / Event / Secondary Source / Extent of Injury

Completed By (Type or Print) Supervisor	Signature and Title	Phone Number	Date (mm/dd/yy)

* Confidential Information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim: and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

DPH OSH Form 5020 2006 REVISION

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

~~Workers' Compensation Form (DWC1)~~

San Francisco Department of Public Health
Occupational Safety and Health Section
101 Grove Street, Room 217. San Francisco, California 94102. P. 415-554-2793. F.415-554-2562

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* ____ Today's Date. *Fecha de Hoy.* ____
2. Home Address. *Dirección Residencial.* ____
3. City. *Ciudad* ____ State. *Estado* ____ Zip. *Código Postal* ____
4. Date of Injury. *Fecha de la lesión (accidente).* ____ Time of Injury. *Hora en que ocurrió.* ____ a.m. ____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* ____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* ____
7. Social Security Number. *Número de Seguro Social del Empleado.* ____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail ____ *Correo electrónico del empleado.* ____

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado* ____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* **San Francisco Department of Public Health**
11. Address. *Dirección.* **c/o OSH Section, 101 Grove Street, San Francisco, California 94102**
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* ____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* ____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* ____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* **Intercare Holdings Insurance Services Inc., P.O. Box 579, Roseville, California 95661**
16. Insurance Policy Number. *El número de la póliza de Seguro.* **Self-Insured**
17. Signature of employer representative. *Firma del representante del empleador* ____
18. Title. *Título.* ____ 19. Telephone. *Teléfono.* ____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*
EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notifación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally you employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer offers a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you return to work as soon as possible, you should actively communicate with your treating doctor, claims

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado." guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador, " le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones especificas, es posible que usted pueda ser tratado por su médico o grupo medico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas diferentes que si aplican cuando su empleador usa una Organización del Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a las presunta lesión ya será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesiones por un periodo limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

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administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for you employer: to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling (800) 736-7401. You may also go to DWC web site at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de menera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médio. Este trabajo modificado u otro trabajo podria ser temporal o podria extenderse dependiendo de la indole de su lesión o enfermedad.

Pagos por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de Lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesióno después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 dias dispués de que los pagos por incapcidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativio, es posible que usted reúne los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependian económicamente del trabajador difunto.

Es ilegal que su empleador: le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a). De ser probado, usted puede reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un limite establecido por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuniquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un official de información y asistencia, de la División estatal de Compensación de Trabajador (Division of Workers' Compensation – DWC) o puede escuchar información grabada, asi como una lista de oficinas locales llamando al (800) 736-7401. Ud. también puede consultar con la pagina Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado: La mayoria de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California (State bar) al (415) 538-2120, ó consulte con la pagina Web en www.californiaspecialist.org.

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MEDICAL WASTE MANAGEMENT PROGRAM

POLICY:

Laguna Honda Hospital (Laguna Honda) will comply with the California Medical Waste Management Act with regards to managing medical waste.

PURPOSE:

This program describes how Laguna Honda will collect, store, and dispose of medical waste in a manner that ensures employee safety and complies with applicable regulation.

DEFINITION:

"Medical waste" means any biohazardous, pathology, pharmaceutical, or trace chemotherapy waste not regulated by the federal Resource Conservation and Recovery Act of 1976 (Public Law 94-580), as amended; sharps and trace chemotherapy wastes generated in a health care setting in the diagnosis, treatment, immunization, or care of humans or animals; waste generated in autopsy or necropsy; waste generated during preparation of a body for final disposition such as cremation or interment; waste generated in research pertaining to the production or testing of microbiologicals; waste generated in research using human or animal pathogens; sharps and laboratory waste that poses a potential risk of infection to humans generated in the inoculation of animals in commercial farming operations; waste generated from the consolidation of home generated sharps; and waste generated in the cleanup of trauma scenes. Biohazardous, pathology, pharmaceutical, sharps, and trace chemotherapy wastes that meet the conditions of this section are not subject to any of the hazardous waste requirements

1. Medical Waste specific to Laguna Honda includes:

   a. Biohazardous waste (Regulated Medical Waste)

      i. Waste that at the point of disposal or thereafter contains recognizable blood, fluid blood products, containers or equipment containing blood that is fluid.

      ii. Waste containing discarded materials contaminated with excretion, exudate, or other secretions in which the resident was required to be isolated by the LHH infection control authorities.

   b. Sharps waste

      i. Syringes, hypodermic needles, blades, needles with attached tubing, or broken glass that has been in contact with biohazardous waste.

c. Contaminated Solid Waste

i. All moist waste including products that have been in contact with bodily fluids or waste that might attract vermin (i.e., tongue blade, diaper, urine cup, moist blood-stained dressing, non-sharp disposable instrument, or food waste that have been in contact with bodily fluids).

d. Pharmaceutical waste

2. Waste that is hazardous only because it is comprised of prescription or over-the-counter drug.

3. Chemo-contaminated waste

4. Any waste that previously contained, or has come into contact with, a chemotherapeutic agent. For the purpose of waste handling, “chemotherapeutic agent” means a cytotoxic drug, or an agent that kills or prevents the reproduction of malignant cells.

PROCEDURES:

1. General procedures are listed below and detailed procedures for each type of waste is given in Table 1.

a. Biohazardous Waste

i. Waste material must be segregated at the point of generation and placed in a labeled red biohazard bag. The bag should have sufficient strength and be impervious to moisture to preclude ripping, tearing, or bursting under normal waste handling conditions.

ii. Biohazardous waste containers shall be leak-resistant with tight fitting covers. When ¾ full, disposable biohazardous waste bags must be tied or taped securely to prevent expulsion of contents, and then placed into red bins in the waste storage room.

b. Body Fluids/Waste and Suctioned Fluids

i. Any volume of fluids that are not absorbed by other waste materials such as sponges and dressings must be contained in leak and break resistant containers.

ii. Liquid blood or semi-liquid waste can be poured down a public sewage system

c. Sharps Waste

i. All sharps must be placed in approved and labeled sharps containers.

ii. Sharps should not be disposed of directly in biohazard waste bags.

iii. Needles from syringes should not be removed or clipped.

iv. See the LHH Bloodborne Pathogen Occupational Exposure Control Plan for information on sharps injury prevention.

d. Pharmaceutical Waste

i. Pharmaceutical wastes should be segregated from other types of medical wastes. They should not be placed into red biohazardous bags but placed in pharmaceutical waste bags or disposable containers marked with the words “INCINERATION ONLY.”

e. Chemo-Contaminated Waste

2. Chemo-contaminated wastes should be segregated and collected in either the yellow waste containers or the black bin RCRA containers. This includes all waste generated while caring for a resident who has taken cytotoxic drugs within 48 hours.

Table 1. Alphabetical Listing of Waste Types and Disposal Guidelines

	Waste Type (Alphabetical)	Disposal Category	Collection Method
1.	**Biologicals** Serums, vaccines, antigens, antitoxins, and all preparations made from living organisms used in treatment, immunization, or diagnosis	Regulated Medical Waste	For non-sharps, discard into covered waste container lined with a red bag. For sharps, discard into plastic puncture-resistant “Sharps” container.
2.	**Blood, blood products and other body fluids considered potentially infectious** Suction containers, pleural evacuation containers, human lab specimens, cultures and stock of infectious agents or other receptacles containing: amniotic fluid, cerebrospinal fluid, pericardial fluid, pleural fluid, saliva during dental procedures semen, synovial fluid, vaginal secretions, and any other body fluid if visibly contaminated with blood and	Regulated Medical Waste	If free-flowing, and in a container which can be safely handled and closed, discard into red bag container. If soiled item is saturated or visibly dripping*, discard into container lined with a red bag (available in high-use areas, and all dirty utility rooms).

	items saturated or visibly dripping with those fluids.		
3.	Culture containers / mediums/ devices (used)	Regulated Medical Waste	Non-sharp items are placed into container lined with a red bag. Sharps are placed into designated plastic, puncture-resistant “Sharps” container
4.	**Chemo – contaminated waste.** This includes all waste generated in the care of residents receiving antineoplastic drug treatment for the duration of treatment plus 48 – 168 hours, depending on the drug.	Chemo-contaminated waste.	Dispose of waste in yellow or black pharmaceutical waste container.
5.	Diapers not saturated with blood	Standard Waste	Disposed into a container that is lined with a non-red plastic bag.
6.	Disposable gowns or dressings saturated / visibly dripping blood or other potentially infectious body fluid (see #2)	Regulated Medical Waste	Discard into container lined with a red plastic bag.
7.	Disposable gowns or dressings NOT saturated with blood	Standard Wasted	Disposed into a container that is lined with a non-red plastic bag.
8.	Feces	Standard Waste	Flush down hopper/toilet into the municipal sewer system. Note: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood.
9.	Gloves NOT saturated with blood	Standard Waste	Discard into waste container lined with a non-red plastic bag.
10.	Human Pathology Waste Includes tissue, body fluid specimens, body parts or organs (excluding urine and feces except as lab specimens)	Regulated Medical Waste	If solid specimen, place in covered container lined with a red bag. If free-flowing liquid, flush down hopper/ toilet into municipal sewer system.
11.	Isolation Room Waste – not considered Regulated Medical	Standard Waste	Dispose into waste container lined with a clear or white

	Waste except as items fit into specific categories (i.e. sharps, blood, dressings saturated with blood or other designated body fluid)		plastic bag, except as isolation waste fits into other categories.
12.	Isolation Room Wasted derived from highly dangerous communicable disease such as Class IV etiologic agents (Ebola, Marburg viruses, Lassa fever, etc.)	Regulated Medical Waste	Discard into covered waste container lined with a red bag which has been placed in the resident / clinic room.
13.	Instruments (Disposable) includes trocars, IV insertion guidewires, and other sharp disposable instruments	Regulated Medical Waste-Sharps	Discard into plastic, puncture-resistant “Sharps” container immediately after use.
14.	IV tubing and bags not visibly contaminated	Standard Waste	Dispose into waste container lined with a non-red bag.
15.	IV tubing and bags with visible blood	Regulated Medical Waste	Discard into container lined with a red bag (in the dirty utility room).
16.	Lab Waste – see Cultures, #3		
17.	Masks	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
18.	Menstrual / Peri Pads	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
19.	Pharmaceutical waste – includes unused pharmaceuticals or any pharmaceutical that has residual, free-flowing medication in it. This includes IV bags, tubing, and needles/syringes used for drug administration.	Pharmaceutical waste	Dispose in pharmaceutical waste container (~~white with blue~~ black bins with white top on unit for any pharmaceutical waste; within pharmacy space, may use white bin with blue top for non-hazardous medications))
20.	Sharps - includes hypodermic, intravenous, and other medical needles and attached syringes, scalpel blades, disposable sharp instruments, blood vials, and other glass in contact with infectious agents (slides & cover slips) used in medical care, and also discarded	Regulated Medical Waste _Sharps	Discard immediately after use into plastic, puncture-resistant designated "Sharps" container.

	unused sharps		
21.	Shoe covers not saturated (rarely indicated at LHH except for Norovirus)	Standard Waste	Dispose into waste container lined with a non-red plastic bag.
22.	Urine - NOTE: considered Regulated Medical Waste only as a lab specimen or if visibly contaminated with blood or other potentially infectious fluid	Standard Waste	Flush liquid urine hopper/toilet into municipal sewer system. For items contaminated with urine, discard into waste container lined with a non-red plastic bag.

3. Storage

Containment and storage of medical waste shall be in accordance with Chapter 9 (commencing with Section 118275) of the Medical Waste Management Act.

a. Medical waste storage locations are present on each neighborhood.

b. All medical wastes to be stored on site will be held no more than seven days in labeled containers.

c. Medical waste that is to be transported offsite shall not be subjected to trash chutes, compaction or grinding.

d. Pharmaceutical wastes may be stored on site for up to 90 days before sending them offsite for destruction by incineration. Pharmaceutical wastes totaling 10 pounds or less can be stored for up to one year.

4. Disposal

No person shall treat medical waste unless the person is permitted by the enforcement agency as required by this part or unless the treatment is performed by a medical waste generator and is a treatment method approved pursuant to Chapter 8 (commencing with Section 118215) of the Medical Waste Management Act of 2017.

a. Waste Hauler Information:
Stericyle, Inc. - Alameda County
30542 San Antonio Street
Hayward, CA 94544
510-471-0920
866-978-3744
866-783-7422
Transfer Permit Station #: P-114, TS - 114
EPA Identification Number: #CAD 980890321

b. All required hazardous waste manifests will be completed per Department of Transportation regulations.

5. Spill Cleanup

a. In the event of a spill of medical wastes:

i. Use latex or vinyl gloves as barrier. Don additional PPE if the risk of exposure to splash/spray is high.

ii. Use tongs, shovel, or other mechanical means to pick up solid waste, especially for sharps.

iii. Re-bag any regulated medical waste into the appropriate waste container.

iv. Before it is ¾ full, tie or tape the bag securely to prevent expulsion of contents.

v. Apply household bleach disinfectant to the area affected by the spill or contact EVS for assistance.

b. Sharps Container Spill

i. Recover the sharps using tongs, forceps, pliers, or other mechanical means. Do not use your hands to pick up sharps- even if gloves are worn.

ii. Place the sharps into the designated sharps container. If the sharps container is 2/3 filled, place the sharps into another sharps container. Do not fill the container over 2/3 full.

iii. Secure the lid and tape if necessary.

iv. Apply disinfectant in affected area if necessary.

c. Blood Leak

i. Place cones or other warning devices around the area to prevent people from walking through the blood spill and tracking blood throughout the area.

ii. Apply absorbent towels. Blood spill kits with appropriate absorbent cloths are available in CSR. Do not use UltraSorbs.

iii. Allow 10–20 minutes for the blood to be absorbed.

iv. Vinyl or latex gloves shall be worn when mopping a spill. Wear additional PPE if splash/spray is expected.

v. Place the blood-soaked absorbent materials in the biohazard bag.

vi. Mop the area with disinfectant and water. The mop shall be soaked in disinfectant bleach for 10–20 minutes after use, and then rinsed with clean water before using it again.

ATTACHMENT:
None.

REFERENCE:
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
California Health and Safety Code Sections 117600 – 118360: Medical Waste Management Act of 2017.

Revised: 13/05/28, 15/01/13, 16/03/08, 23/09/12, 26/07/21 (Year/Month/Day)
Renumbered to 73-11 13/09/30
Original adoption: 05/12/20 as LHHPP 74-02

Revised Food and Nutrition Policies and Procedures

1.96 Contract Food and Supply Purchases

Established and Revised: 3 / 2 6 3/84, 4/84, 12/87, 1/89, 1/92, 5/97, 9/06, 7/09
Reviewed: 8/13, 8/14

Policy: The Food and Nutrition Services (FNS) Department shall use set contracts for the purchase of food and supplies through the City and County Purchasing Department.

Purpose: -To reduce costs and maintain high quality food products.

Procedure:

1. The City and County Purchasing Department will initiate and process all contracts to be used by this department. We will be notified of contract length, number and other relevant information.

2. The use of purchasing contracts will be limited to use by appropriate managers for the purpose of purchasing supplies and equipment for Laguna Honda Hospital (LHH) only.

3. No personal use of city purchasing authority will be allowed. Employees may not purchase supplies from the hospital for their personal use.

4. Any deviation from this policy must be approved by the Director of Food and Nutrition Services, Associate Administrator of Support Services, and the Executive Administrator.

5. The department purchases from vendors which meet all city standards and requirements.

5.6. Currently, Vizient Novation Purchasing Group Purchasing Organization (GPO) or University Healthsystems Consortium may be used in place of City Purchasing as long as the GPONovation Vendor meets standard city requirements for vendors.

1.97 Food Production Performance Expectations

~~Established and~~ Revised: 3/26 ~~08/90, 5/97, 9/06, 7/09~~
~~Reviewed: 8/13, 8/14~~

Policy: All production employees who use recipes, production orders, forecast order worksheets, advance preparation lists, etc. will be assessed on the use of those ~~computer-generated~~computer-generated forms.

Purpose: To establish appropriate standards of performance for all food production areas so that each production employee knows his/her role in producing high quality, consistent products.

Procedure:

1. All recipes will be followed ~~exactly~~exactly, and any excess ingredients will be returned to the appropriate storage areas. The forecasted amounts will be made unless notified by the Chef or S~~s~~upervisor of a change.

Note: If the cook knows or feels that the recipe is incorrect prior to production, he/she is responsible for notifying the Chef or S~~s~~upervisor. Recipes may be reprinted as needed to reflect any update.

2. All ingredients for each recipe will be weighed and measured exactly as specified on the recipe. The final product produced will also be measured and the number verified with the yield on the recipe. All cooks must taste and test temperature of their products before ~~it~~ it's~~is~~ sent to the tray service area.

3. All food items will be distributed exactly as specified on the d~~D~~istribution section of the recipe. Exceptions will be made only by instructions from the Chef or S~~s~~upervisor.

Note: If the cook knows or feels a number is incorrect, he/she will notify the Chef or S~~s~~upervisor.

4. Any food products taken from the ~~Cafeteria~~cafeteria will be subtracted from the c~~C~~afeteria count and added to the Tray line count. Conversely, items taken from Tray line and sent to Cafeteria will also be ~~duly noted~~noted.

5. All food produced will be accurately and clearly documented on the Service Line Worksheet and Post Cost Summary Sheet.

1.98 Minimum ~~Proper Cooking~~ Internal cooking temperatures of Ground Meats

Revised~~iewed~~: 3/26~~9/06, 7/09, 8/13, 8/14~~

Policy: The recommendations by the United States Department of Agriculture (USDA) ~~and others~~ conclude that ground meats should be cooked at the following temperatures: ~~patties held at this temperature for just~~
~~.19 minutes (11 seconds) will usually kill all E.Coli 0157:H7 in beef.~~

1. Gound Meats are cooked to an ~~We must cook all ground beef patties to~~ internal temperature of at least 160~~55~~ºF.

~~1.~~2. Ground Poultry internal temperature of at ~~Consistent with proper cooking all meats with sauces will rise above~~ least 165~~55~~ºF.

1.99 Unused Food Portions

~~Established and~~ Revised: 3/26 ~~3/81, 3/84, 1/89, 1/92, 5/97, 7/00, 9/06. 7/09. 6/11~~
~~Reviewed: 8/13, 8/14~~

Policy: Food and Nutrition Services (FNS)~~The Department~~ will use safe handling techniques for unused food portions after each meal service.

Purpose: To reduce the effect of contamination of unused food portions.

Procedure:

1. All unused prepared food portions leftover from either the Tray Service, Galley Service, or Cafeteria Service will be returned to the Production Area for the chef or designated cook to determine if the food item should be kept or disposed. After the dinner meal service, the PM Supervisor will make the ~~determination~~decision in the absence of a chef or cook.

2. All unopened prepackaged items will be returned to proper storage.

3. All unused prepared food portions will not be used for ~~resident~~residents ~~or cafeteria~~ meal services.

4. All unused prepared food portions will be refrigerated in shallow pans. They shall be properly cooled, covered, labeled and dated.

5. Any unused items that have been determined to be utilized through the donation ~~Food Runners~~ c~~C~~harity p~~P~~rogram will be returned to proper storage in a designated area in the walk~~-in-~~in refrigerator. The food will be properly labeled and dated. Donation charity program ~~Food Runners~~ will ~~to~~ pick up any usable foods ~~two times per week~~. If charity program ~~Food Runners~~ does not pick up in a timely manner, the food is to be discarded accordingly.

Revised Nursing
Policies and Procedures

NOTIFICATION AND DOCUMENTATION OF CHANGE IN RESIDENT CONDITION

POLICY:

1. The Licensed Nurse will notify the physician, using Situation Background Assessment Recommendation (SBAR) * method of communication, whenever there is an unanticipated change in resident's physical, mental, or psychosocial condition indicative of decline resulting from injury, acute medical illness or from progression of chronic medical conditions.

2. The Licensed Nurse communicates verbally ~~using Situation Background Assessment Recommendation (SBAR) * Method of Communication~~ when notifying the physician.

3. Non-urgent clinical issues will be communicated to the primary care physician during regular business Hours or via secured chat in the electronic health record (EHR).

4. When the physician arrives to evaluate the resident, the licensed nurse will be available to provide pertinent assessment information and assist as necessary.

~~5. Urine toxicology screening (UTOX), for resident symptoms indicating a change of condition requiring a possible UTOX screen (e.g., observable signs of intoxication for which a code must be called, altered level of consciousness, abnormal vital signs such as RR<12, somnolence), shall be requested, as indicated, from the Emergency Department (ED), by provider any time a resident is determined to require an ED visit.~~

~~6. Charge Nurse to complete an Incident Report and submit to Quality Management (QM) for any resident requiring administration of Narcan.~~

5. When there is a change in resident condition, the family or surrogate decision maker will be notified.

6. For resident symptoms indicating a change of condition requiring a possible Urine Toxicology (UTOX) screen, refer to Hospitalwide Policy and Procedure (HWPP) 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use by Residents or Visitors.

7. An unusual occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student. Incident Reports shall be completed and submitted timely by any LHH employee who witnesses or becomes aware of an unusual occurrence. (Refer to HWPP 60-04 Unusual Occurrence)
    a. Charge Nurse to complete an Incident Report and submit to Quality Management (QM) for any resident requiring administration of Narcan.

PURPOSE:

To provide a standardized format for nursing to inform the physician and other interested parties about various changes in resident's condition so that the resident receives timely and appropriate treatment interventions.

BACKGROUND:

A change in clinical condition differs from **"significant change"** as defined in the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) as a decline (or improvement) in a resident's condition that (a)

will not normally resolve itself or is not self-limiting; (b) impacts more than one area of the resident's health status; and (c) requires interdisciplinary review and/or revision of the resident care plan. A change in clinical condition can lead to a significant change.

Reportable MDS significant changes for decline or improvement are listed below but not limited to:

- Significant change in the resident's physical, mental or psychosocial condition.
- A significant change or alteration in the treatment or care plan.
- A decision to transfer or discharge the resident from the facility.
- Significant change of weight (5 pounds, or 5% within 30 days, or 10% within the last 180 days).
- An untoward reaction to medications or treatments.
- Any life-threatening error in medicine or treatment (any risk to the resident).
- Any time the facility is unable to timely obtain or administer drugs, equipment, supplies or services as prescribed, under conditions which present a risk to the health, safety or security of the resident.

PROCEDURE:

A. Notification:

1. Physician Notification [{Refer to Hospitalwide Policy and Procedure (HWPP) 24-24 Nurse-Physician Communication During Quiet Hours Between 10 PM and 6 AM]}

    a. For physician notification, collect information and provide report using SBAR.

2. Family/Significant Others Notification (Refer to HWPP 24-11 Notifications of Family/Surrogate Decision-Makers (SDMs) and/or Conservators of Change in Condition and/or Death)

    a. For family notifications regarding a serious incident or change in condition, the licensed nurse and physician will discuss the situation and make a decision regarding which of them should notify family/significant other, taking into account any prior relationship with the family /significant other and the risk management implications.

B. ~~Reporting and~~ Documentation

1. Nursing Note

    a. Document the date, time and name of the physician who was notified of the change in resident's/patient's condition and each subsequent attempt to notify the physician.

    b. Document notification of the Nurse Manager, Nurse Supervisor, or Program Director.

2. Comprehensive Minimum Data Set (MDS) Assessment (Refer to HWPP 23-02 Completion of the Resident Assessment/Minimum Data Set)

    a. A Significant Change of resident/patient condition requires that a comprehensive MDS Assessment is completed no later than fourteen (14) days after the determination by the Resident Care Team (RCT) members that a significant change has occurred. After completion of MDS assessment, a special Resident Care Team Conference (RCC) should be scheduled for RCT discussion.

3. Resident Change of Condition Requiring Possible Urine Toxicology Screen (Refer to HWPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use by Residents or Visitors)

   a. Resident symptoms indicating a change of condition requiring a possible urine toxicology screen (UTOX) would include an altered level of consciousness, abnormal vital signs (RR<12), somnolence. Observable signs of intoxication as well as sign of overdose (not breathing, unresponsive, lips and fingers turning blue/grey, gurgling sounds rigid limbs), for which a code must be called. (Refer to HWPP 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use by Residents or Visitors)

4. Unusual Occurrences (Refer to HWPP 60-04 Unusual Occurrences)

   a. An unusual occurrence is determined as an event or condition, which has had or may have an adverse effect on the health or safety of a resident, visitor, volunteer, staff or student.
   b. Incident Reports shall be completed and submitted timely by any LHH employee who witnesses or becomes aware of an unusual occurrence. The initial report shall be completed by the first staff member responding to the event and those who are most knowledgeable about the occurrence.

APPENDIX:

None

REFERENCES:

Centers for Medicare & Medicaid Services. (2025). *Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) User's Manual* (Version 1.20.1). Retrieved from https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual - electronic access May 7, 2026
RAI/MDS Manual
Institute for Healthcare Improvement. *SBAR Tool: Situation-Background-Assessment-Recommendation*. Available from: https://www.ihi.org/library/tools/sbar-tool-situation-background-assessment-recommendation - electronic access May 7, 2026
SBAR Tool was developed by Kaiser Permanente
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm

CROSS REFERENCE:

Laguna Honda Hospital-wide Policies & Procedures
- 23-01 Resident Care Plan, Resident Care Team & Resident Care Conference
- 23-02 Completion of the Resident Assessment/Minimum Data Set (MDS)
- 24-11 Notification of Family/Surrogate Decision-Makers/Conservators of Change in Condition
- 24-24 Nurse-Physician Communication during Quiet Hours 10 PM to 6 AM
- 60-04 Unusual Occurrences
- 75-05 Illicit or Diverted Drugs and/or Paraphernalia Possession/Use by Residents or Visitors

Revised: ~~2000/~~10/2000, ~~2006/~~01/2006, ~~2008/~~01/2008, ~~2009/~~12/2009, ~~2010/~~10/2010; ~~2015/~~05/12/2015; ~~2020/~~05/19/2020; ~~2024/~~09/19/2024; 05/07/2026

Reviewed: 2024/12/10

Approved: 2024/12/10

Appendix A: Process Map for Change in Condition Requiring UTOX

Created 05/17/2019
Revised 10/29/2019

Process Map for Change in Condition Requiring UTOX

RESIDENT has any of the following symptoms:
- Altered Level of Consciousness
- Somnolence
- Respiratory depression (less than 12 breaths per minute)
- Intoxication (Drugs or Alcohol)

Discovered through:
- Observation
- Assessment
- Resident reporting unusual signs & symptoms
- Relative/Visitor report

Clinical suspicion of drug ingestion.

Notify Physician for Evaluation

Charge Nurse/ designee and Physician Review

If Narcan used, send Resident to ED.

Send to ED for further evaluation.

Do not send Resident to ED.

Request u-tox screen from ED.

Physician order comprehensive u-tox screen.

U-Tox Results reviewed by Physician

(+) for non-Rx medications.

Physician will review and discuss with Nursing and Pharmacy.

QM will page Nursing Operations (415) 327-1902.

Call CDPH within 24 hours.

(+) for Rx medications.

Physician will review and discuss with Nursing and Pharmacy.

Pharmacy will inform QM within 48-72 hours.

(+) for illicit drugs.

QM will review.

If resident sent to ED, page Nursing Operations (415) 327-1902.

(-) for non-Rx medications.

STOP

TRANSCRIPTION AND PROCESSING OF ORDERS

POLICY:

1. Physician orders are entered via Computerized Provider Order Entry (CPOE).

2. Licensed nNurses are responsible for acknowledging orders prescribed on their shift. Cut off times for acknowledging orders are:
   AM shift - 7am
   DDAY shift - 3pm
   PM shift - 11pm

3. The AM shift will print a 24-hour new order report from the electronic health record (EHR) daily at 7AM and place orders in the applicable sections of the Daily Clinical Review (DCR) form for the nurse manager to review (Refer to Standard Work on Laguna Honda Daily Clinical Review Form Instructions)

4. Incomplete, questionable or confusing orders are clarified with the prescriber and if appropriate, pharmacy, prior to implementation for resident/patient safety. The Nurse Supervisor/Manager on duty should be called if the clarification has not remedied the licensed nurse's concern.

3. The AM shift will print a 24-hour new order report from the EHR daily at 7AM and place orders in the applicable sections of the Daily Clinical Review form for the nurse manager to review (Reference: Laguna Honda Daily Clinical Review (DCR) Form Instructions Standard Work)

Verbal orders are not indicated when the prescriber is present, except in an emergency, in which case a repeat-back is acceptable. (Ref: 25-03 LHPP)

5. See Hospital-wide Policy & Procedure (HWPP) 25-03 for Verbal/Telephone Orders and HWPP 25-02 Safe Medication Orders.

Licensed Nurses may accept telephone or verbal orders from an authorized prescriber (refer to LHHPP 25-03 Verbal/Telephone Orders) and will confirm resident's medication allergies with prescriber and read back the order entered into the Electronic Health Record (EHR) for accuracy with the physician. Verbal orders are limited to situations in which immediate electronic communication is not feasible.

3. Verbal orders are not permitted for chemotherapy.

PURPOSE:

To assure that orders are accurately and appropriately transcribed and processed.

PROCEDURE:

A. Physician Nursing tion Orders

1. When acknowledging phsysician orders in the EHR, the Licensed Nurse will:
   a. Review the order for clinical relevance, accuracy, and safety and notify physician as-needed if clarification is required
   b. Nursing orders shall be placed in theCreate a Work List for the appropriate nursing discipline if necessary

c. Perform a procedure if needed
d. Create/revise documentation in the Avatar, flowsheets, and/or care plan if necssary~~.~~
~~a.~~e. Notify relevant parties (e.g., family/responsible party, Resident Care Team members, other departments) if necessary

~~**B. Telephone or Verbal Orders**~~

~~1. See Hospital-wide Policy & Procedure (HWPP) 25-03 for Verbal/Telephone Orders and HWPP 25-02 Safe Medication Orders.~~

~~C.~~B. Processing Orders to Pharmacy

1. Computerized Provider Order Entry for medications are sent electronically by the Electronic Health Record (EHR) to ~~the Pharmacy~~Pharmacy.

~~D.~~C. "STAT" Orders & Pharmacy Response Time

1. For STAT labs, refer to Nursing Policy and Procedure (NPP) H 6.0 After Hours STAT Blood Draw

2. "~~Nursing service and pharmacy (when open) shall process stat orders immediately. Medications shall be ready for administration within one hour of the time ordered.~~ Drugs ordered "Stat" that are not available in the facility emergency drug supply shall be available and administered within one hour of the time ordered during normal pharmacy hours. For those hours ~~When~~during which the pharmacy is closed, drugs ordered ~~STAT~~ "Stat" ~~which are~~ shall be available ~~in the emergency drug supply shall be~~ and administered ~~immediately~~within two hours of the time ordered.. Drugs ordered "Stat" which are available in the emergency drug supply shall be administered immediately."~~.~~ (Refer to Cal. Code Regs. Tit. 22, § 72355). The nursing supervisor shall be notified when access to the supplemental medication room or the on-call pharmacist is needed as outlined in the Pharmacy Policy & Procedure #02.03.00 Emergency and Supplemental Medication Supplies.

3. "Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered." (Cal. Code Regs. Tit. 22, § 72355)

~~E.~~D. Discontinued Medication Orders

1. Refer to NPP J 1.1 for Obtaining, Handling, Storing of Medications and HWPP 25-02 Safe Medication Orders

~~**F. Discontinued Medication Orders**~~

~~Refer to NPP J1.1 for Obtaining, Handling, Storing of Medications and HWPP 25-02 Safe Medication Orders~~

REFERENCES:

California Code of Regulations. (2026). Cal. Code Regs. Title 22, § 72355

Standard Work on Laguna Honda Daily Clinical Review (DCR) Form Instructions

None

CROSS-REFERENCES:

Hospitalwide Policy and Procedure
25-02 Safe Medication Orders
25-03 Verbal/-Telephone Medication Orders
25-150 Medication Administration

Nursing Policy and Procedure
H 6.0 After Hours STAT Blood Draw
J 1.1 Obtaining, Handling and Storing of Medications

Pharmacy Policy and Procedure
02.03.00 Emergency and Supplemental Medication Supplies

ATTACHMENTS/APPENDICES:

None

Revised: 2001/08/2001, 2006/04/2006, 2006/12/2006, 2008/03/2008, 2008/08/2008, 2010/10/2010, 2014/02/2014, 2015/07/14/2015, 2019/03/12/2019; 2020/06/23/2020, 2022/12/13/2022; 2025/04/08/2025; 4/29/2026

Reviewed: 2025/06/09/2025

Approved: 2025/06/09/2025

RESIDENT MEALTIME SUPPORT

POLICY:

1. Nursing staff will assist residents during meals to ensure a safe, sanitary, and dignified dining experience.
   This includes:
   - Supporting hand hygiene before and after meals
   - Using clothing protectors as needed
   - Providing adaptive devices, dentures, eyeglasses, and hearing aids during meals
   - Verifying meal trays match menu ticket orders (name, preferences, content, consistency)

   Residents will be offered:
   - Table service at clinically appropriate, height-adjusted tables
   - Neighborhood dining options and meal preferences
   - Three nutritious, appetizing meals daily plus snacks, aligned with national food standards

2. If a resident declines any food item, nursing staff will offer suitable substitutions based on available options and therapeutic diet orders. Requests beyond galley availability will be communicated to the diet office {[Refer to Food and Nutrition Services (FNS) Policy & Procedure 1.83 Resident Meal Services]}.

3. During respiratory infectious outbreaks, nursing will implement social distancing and infection prevention measures in communal dining areas or provide in-room dining as needed.

PURPOSE:

To provide respectful, attentive, and dignified assistance to residents during mealtimes, ensuring their nutritional needs are met in a safe, comfortable, and socially engaging environment. This support promotes independence where possible, fosters a sense of community, and enhances the overall well-being and quality of life for each resident.

PROCEDURE:

A. Preparation

Pre-Meal Preparation
- ~~Wash~~ Assist with toileting before the meals if needed
- Assist residents'/patients' to wash their hands and if needed, their face.
- Offer clothing protectors and assist with hand hygiene.
- Assist with applying eyeglasses, hearing aids, dentures.
- Orient residents to mealtime and escort them to their preferred dining area.
-
- ~~Adjust tables and lighting for safety and comfort.~~

Table & Tray Setup
- Adjust tables and lighting for safety and comfort.
- Disinfect tabletops and let air dry.
-
- Food is served timely and together to residents sitting at same table

- When serving resident meals, remove dishes off the meal tray and place on table directly (do NOT remove dishes from the warming plate). If resident prefers to keep dishes on the meal tray, include this preference in the care plan.
- Ensure hot liquids are safely placed and inform residents of their location.
- Keep meal cart door closed between tray deliveries.

Serving & Assistance

- Follow diet orders and aspiration precautions for at-risk residents.
- Position food and utensils for visibility and ease of use.
- Respect preferences—ask before opening or cutting food.
- Set up adaptive equipment and encourage independence.

Support for Visually Impaired Residents

- Describe food placement using clock-face orientation.
  - Example: "Chicken at 12:00, potatoes at 3:00."
- Inform residents of hot and cold liquid locations.

Group Dining & Feeding

- Arrange group meals to promote social interaction.
- Feed residents in rotation, allowing time to chew.
- Perform hand hygiene between assisting each resident.

B. Positioning

~~Chair~~ Positioning in Chair for Communal Dining

- ~~Seat residents upright with good body alignment to reduce aspiration risk~~Resident to sit as upright as possible with all meals and for at least 20 minutes after eating, unless otherwise ordered~~.~~.
- Uses stable chairs with armrests to prevent sliding or falling.
- Residents unable to sit upright should use assistive chairs – consult therapy as needed.
- Staff assisting with feeding should sit directly across from the resident at eye level.

~~Bed~~ Positioning in Bed for ~~Communal~~ In-Room Dining

- Elevate the head of the bed to at least 45°, or to the highest comfortable level, to aid swallowing and reduce aspiration.
- Support the head with a pillow to maintain alignment – slightly forward, not tilted back or resting on the chest.
- Use pillows to support arms and maintain alignment, especially on weaker sides.

Positioning for Enteral Nutrition

- Elevate the head of the bed to a minimum of 30° during feeding and for at least 30 minutes after feeding unless otherwise ordered. (Refer to NPP E 5.0 Enteral Tube Feeding Management)
- If HOB needs to be lowered for procedure (e.g., incontinence care) feedings should only be stopped for the duration of the procedure and restarted with HOB re-elevated as soon as procedure is completed.

Aspiration Risk

- ~~For residents with aspiration precautions~~Refer to Hospitalwide Policy and Procedure 26-02 Management of Dysphagia and Aspiration Risk

- ~~or enteral feeding, keep the bed elevated 45° or more for at least 1 hour after meals.~~

C. Assisting the Resident to Eat

Food Preparation & Comfort

- Prepare food from the tray and check if the temperature is comfortable for the resident

- Only mix foods if the resident requests it
  Promoting Independence & Dignity
- Encourage self-feeding when possible (e.g., holding bread or crackers)
- Avoid overfilling drink containers; use sipping lids only if needed
- Prepare food from the tray and check if the temperature is comfortable for the resident
- Ask before opening or cutting food. Open containers if the resident cannot; wear gloves when handling
  Food ModificationAssistance with Feeding
  Cut food into bite-size pieces only if requested or required
  Use ordered thickeners strictly as directed for residents at risk of aspiration
  Feeding Technique
  Offer a sip of liquid first to moisten the mouth and aid swallowing
  Feed small amounts at a time, placing food where muscle control and taste are best
  Allow time for chewing; do not rush
  Ensure each bite or sip is swallowed before offering more
  Alternate between food and fluids based on resident preference
  Monitoring & Safety
- Watch for "pocketing" (food not swallowed); slow down and encourage chewing
- Notify nursing staff if swallowing issues arise for speech therapy referral. Refer to Hospitalwide Policy and Procedure 26-02 Management of Dysphagia and Aspiration Risk

Cleanliness & Substitutes

- Gently clean the face and any nasal secretions; perform hand hygiene away food or liquid from the face as needed. Clean nasal secretions away immediately using a tissue and perform hand hygiene
- If less resident refuses, is not eating a food (or foods) served on the meal tray, or consumes less than 50% of the meal, the nursing staff will offer resident suitable food replacement from available selections and as appropriate for the resident's therapeutic diet order. is consumed or refused, offer appropriate substitute

D. After the Meal

- Clean and label any adaptive equipment used and keep it at the bedsideAny adaptive equipment/utensils used are cleaned and stored securely.
- Place the water pitcher within reach (unless restricted) and encourage fluids between meals.

E. Documentation

Record in the resident's electronic health record:

- If the meal was attempted or refused
- How much help was needed
- How much food was eaten

REFERENCES:

California Advocates for Nursing Home Reform. (2025, June 24). Food and nutrition. In *Nursing home care standards*. Retrieved April 14, 2026, from https://canhr.org/nursing-home-care-standards/ [1](https://canhr.org/nursing-home-care-standards/)

Centers for Medicare & Medicaid Services. (2025). CMS-20093: Tube-Feeding Critical Element Pathway [Form]. https://cmscompliancegroup.com/wp-content/uploads/2025/03/CMS-20093-Tube-Feeding.pdf

Sorrentino, S., Remmert, L.N., (20~~12~~25). *Mosby's textbook for nursing assistants*, (11~~8~~th ed), St. Louis,
MO: Elsevier

~~CAHAN (California Advocates for Nursing Home Reform (2016). Nursing Home Care Standards. Food and Nutrition. http://www.canhr.org/factsheets/nh_fs/html/fs_CareStandards.html~~

CROSS REFERENCES:

Food and Nutrition Services Policies & Procedures
1.83 Resident Meal Service

Hospitalwide Policies & Procedures
26-02 Management of Dysphagia and Aspiration Risk
26-04 Resident Dining Services

~~Food and Nutrition Services Policies & Procedures~~
~~1.83 Resident Meal Service~~

Nursing Policies & Procedures
E 1.0~~:~~ Oral Management of Nutritional Needs
E 5.0 Enteral Tube Feeding Management

Original: 01/09/2018

Revised: 01/09/2018; 02/09/2021; 04/11/2023; 10/31/2024; 06/12/2025; 04/14/2026

Reviewed: 12/16/2025

Approved: 12/16/2025

INTAKE AND OUTPUT (I & O)

POLICY:

1. In addition to when ordered by the physician, intake and output (I&O) may be initiated by the Licensed Nurse (LN) when clinically indicated.

2. Intake and output are measured for residents receiving the following:
   a. ~~residents receiving i~~Intravenous (IV) ~~t~~Therapy~~ ~~ {Refer to Nursing Policy & Procedure (NPP) J 6.0 Intravenous Therapy Maintenance}
   ~~a.~~ Total Parenteral Nutrition (TPN) {Refer to~~Nursing Policy & Procedure (NPP) J 6.0 Intravenous Therapy Maintenance}, including total parenteral nutrition (TPN) { Refer to~~ Hospitalwide Policy & Procedure (HWPP) 25-08 Management of Parenteral Nutrition}~~.~~
   ~~b.~~
   b.
   c. ~~Intake is measured for residents receiving~~ ~~e~~Eenteral ~~n~~Nutrition (Refer to HWPP 26-03 Enteral Tube Nutrition and NPP E 5.0 Enteral Tube Feeding Management System)
~~and on fluid restrictions; output are measured based on clinical indication {Refer to Hospitalwide Policy & Procedure (HWPP) 26-03 Enteral Tube Nutrition~~
   ~~c.~~ Residents with a
   d. ~~Intake and output are measured every shift for all residents with a u~~ urinary catheter (Refer to NPP F 5.0 Nursing Management of Urinary Catheter)
   e. Residents with an ostomy (Refer to F 6.0 Ostomy Management)
   f. Residents with a suprapubic catheter (Refer to NPP F 7.0 Replacement and Care Management of a Urinary Catheter)
   ~~d.~~g. ~~/ostomy~~ Residents ~~and/or has been~~ diagnosed with a urinary tract infection (UTI)~~.~~

3. Intake measured for residents on fluid restriction; output measured based on clinical indication.

~~2.~~4. Licensed nurse and/or nursing assistant records intake and output every shift.

~~3.~~5. Licensed nurse must document output for nephrostomy.

PURPOSE:

To provide an accurate record of fluid intake and output as is necessary for the individual.

PROCEDURE:

~~A.~~ **DOCUMENTATION:**
~~B.~~A.
~~**Location:**~~

~~1.~~ Documentation for intake/output shall be completed in two sections of the electronic health record:
1.
   ~~a.~~ I/O Flowsheet Activity Tab for Licensed Nurses
   a.
   b. PCA Vitals, I/O section within the Flowsheet Activity Tab for Nursing Assistants

~~2. **Frequency:**~~**2.**
~~3.~~
2. Document~~ed~~ for **each occurrence separately**:
   a. Intake or ADL Intake: (Refer to E 1.0 Oral Management of Nutritional Needs)
      ~~Document percentage~~Document percentage for all residents if the resident eats or drinks meals, snacks, or supplements by mouth ~~.~~
      i.
      ii. If an alternative meal is offered, document under the comment section.
      iii. Document if resident refuses meals, snacks, or supplements.
      iv. Enteral nutrition or intravenous ~~therapy :~~therapy ~~Refer to _____ policiy~~
   b. Urine:
      ~~i.~~ Voided Urine (ml): Urine that is measurable such as from a urinal, urinal hat, or bedpan
      i.
      Unmeasured urine occurrence and Urine Amount: for residents who urinated in a protective undergarment or in the toilet
      ii.
      ~~ii.~~ Urine incontinence (if resident has a urinary catheter, leave section blank)
      iii.
      Urine~~,~~ Color, Appearance, Odor as needed
      iv.
      ~~iii.~~v. ~~Uirnary~~Urinary ~~c~~catheters~~:~~ ~~Refer to F 5.0 Policy~~
   ~~a.~~ Stool:
   ~~b. Percent meals eaten (%)~~
   c. ~~Urine incontinence/urine amount occurrence (for residents who urinated in a toilet)~~
      ~~i. If no urine, leave "Urinary Incontinence" section blank~~
      ~~ii. Unmeasured urine occurrence (for residents who urinated in a protective undergarment)~~
      ~~iii. Voided urine~~
      ~~iv.~~ Bowel incontinence/unmeasured stool occurrence (~~-~~if resident has colostomy or ileostomy, leave section blank)
      i.
      ~~v.~~ If no stool during the shift, put "0" in unmeasured stool occurrence and leave "Bowel Incontinence" section blank
      ii.
      ~~vi.~~ Colostomy/~~I~~ileostomy bag ~~: r~~(Refer to NPP F 6.0 ~~change (if present)~~
      iii. Ostomy Management)
   ~~Colostomy/ileostomy urine occurrence (if present)~~

~~4.~~3. The following can be documented **at the end of each shift**:
      i. Urethral/Urostomy sections if present (total output, securement method, bag change, treatment) – If bag changed more than once, may indicate multiple changes in the comment section of "Treatment" (Refer to NPP F 6.0 Ostomy Management)

~~**I/O Flowsheet Activity Tab:**~~

~~Use the I/O Flowsheet section to document resident's measured intake and output~~

~~**Percent Meals Eaten (%):** Document for all residents, if there is oral intake of food.~~
- ~~If an alternative meal is offered, document under the comment section~~

~~**Voided Urine (mL):** Measured from a urinal or a urinary hat or bedpan~~

~~**Unmeasured Urine Occurrence:** For residents who urinated in a toilet, protective undergarment or urinal/bedpan/urinal hat but do not require strict I/OIf no stool, put "0".~~

~~**Urine Incontinence/Urine Amount:** For residents who urinated in a toilet. Do not answer for residents with catheter~~

~~**Bowel Incontinence/Unmeasured Stool Occurrence/Stool Amount/Stool Appearance:** For residents who had a bowel movement in a toilet and/or a protective undergarment~~

- ~~If no stool, put "0" in Unmeasured Stool Occurrence and leave "Bowel Incontinence" section blank~~
- ~~Bowel Incontinence: Do not answer for patients with ostomy~~

~~**Colostomy/Ileostomy:** PCA/CNA can only change the bag for a two-piece colostomy or ileostomy (Refer to NPP F6.0 Ostomy Management)~~

- ~~Document the following sections:~~
  - ~~Treatment section for bag change~~
  - ~~Unmeasured stool occurrence~~

~~5. PCA Vitals, I/O section within the Flowsheet Activity Tab:~~
~~6.~~
~~7. Intake~~
~~8. This section is for Pavilion Acute Unit only~~
~~9.~~
~~10. Output (mL):~~
~~11. Voided Urine (mL): Measured from a urinal, urinary hat, or bedpan~~
~~12. Urethral/Urostomy sections if present (If resident has a urethral catheter or urostomy present but there is no section to document on the electronic health record, inform Licensed Nurse).~~
~~13. Urethral Catheter:~~
~~14. Collection Container~~
~~15. Catheter Bag Changed~~
~~16. Securement Method: Select "Securing Device" if a stat lock is used.~~
~~17. Urine Output (mL)~~
~~18. Urostomy:~~
~~19. Treatment~~
~~20. Output (mL)~~
~~21.~~
~~22.~~ Care Planning
~~23.~~ :
~~24.~~4. For residents whom intake may not always be able to be accurately measured and/or reported (e.g., residents on outings, consuming beverages outside neighborhood), individual needs will be documented in the individualized resident care plan.

B. NOTIFICATION

1. Notify physician for ~~input and output~~I&O monitoring initiated by nursing.

2. Notify physician for any clinical suspicion of inadequate I & O.

3. Notify dietitian when resident is placed or removed from fluid restriction.

REFERENCES:

Elkin, M. K., Perry, A. G., & Potter, P. A., (20~~1~~2.). *Nursing interventions & clinical skills*, (~~5~~7th ed), St. Louis, MO: Elsevier

Nettina, S., (20~~10~~24). *Lippincott manual of nursing practice*, (~~9~~12th ed), Philadephia, PA: Lippincott Williams & Wilkins

CROSS REFERENCES:

Hospitalwide Policy and Procedure
File #25-08 ~~25-08~~ Management of Parenteral Nutrition
File #26-03 Enteral Tube Nutrition

Nursing Policy and Procedure
E 1.0 Oral Management of Nutritional Needs
E 5.0 Enteral Tube Feeding Management
F 6.0 Ostomy Management
J 6.0 Intravenous (I.V.) Therapy Maintenance

Revised: ~~2008/~~03/2008; ~~2009/~~09/2009; ~~2011/~~04/14/2011; ~~2012/~~09/25/2012; ~~2013/~~09/24/2013; ~~2014/~~07/22/2014; ~~2015/~~03/10/2015; ~~2019/~~03/12/2019; ~~2020/~~06/23/2020; ~~2025/~~01/08/2025; 4/14/2026

Reviewed: ~~2025/~~03/10/2025

Approved: ~~2025/~~03/10/2025

MEASURING THE RESIDENT'S HEIGHT

POLICY:

1. Licensed Nurses ~~, Patient Care Assistants,~~ and ~~Certified~~ Nursing Assistants may measure resident's height.

2. Residents' height is measured upon admission, annually, and as indicated.

PURPOSE:

To obtain accurate height measurements for care planning.

PROCEDURES:

1. Measuring the resident's height for resident's who can stand unassisted, are bedridden, unable to stand, or have a major spine deformity: **(**Refer to Skills (elsevierperformancemanager.com) for procedures on Assessment: Height Measurement)

2. Reporting and Documenting:
   a. Report to licensed nurse and document on the resident's electronic health record:
      i. Device and method used to measure height
      ii. Height measurement
      iii. Unexpected outcomes and related interventions (e.g., refusals)

REFERENCES:

Elsevier (20245) Assessment: Height Measurement (Ambulatory) https://point-of-care.elsevierperformancemanager.com/skills/19570/extended-text?skillId=AM_149&virtualname=lhh#scrollToTop – electronic access on April ~~9~~28, 2026~~5~~

~~National Institute for Health Research (NIHR) Southampton Biomedical Research Centre. (2014). Procedure for measuring adult height.~~ NIHR Southampton Biomedical Research Centre. (2014, June). Procedure for measuring adult height (Version 4) [PDF]. University Hospital Southampton NHS Foundation Trust. https://www.uhs.nhs.uk/Media/Southampton-Clinical-Research/Procedures/BRCProcedures/Procedure-for-adult-height.pdf - ~~R~~retrieved April 28~~9~~, 2026~~5~~ ~~, from https://www.uhs.nhs.uk/Media/Southampton-Clinical-Research/Procedures/BRCProcedures/Procedure-for-adult-height.pdf~~

CROSS-REFERENCES:

None

ATTACHMENTS/APPENDICES:

None

Revised: ~~20018/~~01/2018, ~~2010/~~03/2010, ~~2012/~~01/31/2012; ~~2019/~~03/12/2019; ~~2023/~~09/12/2023; ~~2025/~~04/09/2025; 04/29/2026

Reviewed: ~~2025/~~06/09/2025

Approved: ~~2025/~~06/09/2025

WOUND ASSESSMENT AND MANAGEMENT

POLICY:

1. The Registered Nurse (RN) is responsible for assessing each resident for presence of wound(s) on admission navigator and/or flowsheet section in the Electronic Health Record (EHR), performing wound assessment, dressing application, and notifying the physician for presence of wound infection, wound deterioration, and non-healing wound.

1.

2. The Licensed Vocational Nurse (LVN), under the supervision of the RN, may collect and document wound assessment data and perform dressing application as ordered by the physician.

3. Upon resident's intra-facility (within Laguna Honda) relocation, including Pavilion Acute, the sending and receiving registered nurses are responsible for reviewing resident's/patient's skin condition together and documenting for any presence of wound.

4. The RNs, Licensed Vocational Nurses (LVN), and Certified Nursing Assistants (CNA), within his/her/their scope of practice are responsible for observing and reporting changes in the resident's skin status.

5. To ensure wounds and other skin issues are not missed, Licensed Nurses are to perform and document weekly skin checks, and update EHR Avatar as needed.

PURPOSE:

To provide a guideline in wound assessment and appropriate wound management.

BACKGROUND:

Definitions:

Arterial - wounds caused by ischemia, which is related to the presence of arterial occlusive disease.

Diabetic or Neuropathic - Neuropathy is often associated with diabetes. Wounds results from damage to the autonomic, sensory, or motor nerves and have an arterial perfusion deficit.

Pressure – wounds due to the damage to the skin or underlying structures as a result of tissue compression and inadequate perfusion.

Venous – wounds caused by failure of the venous valve function to return blood from the lower extremities to the heart. This causes venous congestion and leads to venous hypertension.

PROCEDURE: (Refer to Skills: (elsevierperformancemanager.com) for procedures on Assessment: Pressure Injury and Wound)

A. Wound Assessment by Licensed Nurse

1. Cleanse wound prior to assessment {Refer to Nursing Policy and Procedure (NPP) 3.0 Wound Irrigation and Cleansing}

~~A~~Assess~~-~~ the following: wound location, type of wound (e.g., pressure injury, vascular, etc), wound ~~bed (~~bed (e.g., granulation tissue, necrotic tissue, etc.), measurements (length, width, depth), presence and measurement of any tunneling or ~~undermining, drainage~~undermining, drainage, wound edges/margins, and peri-wound.

2.

~~Use "Wound LDA" for all wounds/skin injuries including pressure injuries, erythema, ecchymosis~~

~~If resident has a Wound Vac, must have an additional LDA → "Negative Pressure Wound Therapy"~~

~~Document initial application of treatment ordered~~

~~Document pain assessment with wound care~~

3. Perform wound care per order and reassess wounds at least weekly, and/or when there is a decline in the condition of the wound, until healed

4. Compare assessment with the previous wound assessments to monitor wound healing.

5. Report to the physician and document any undue bleeding and/or untoward reactions. (Refer to NPP C 4.0 Notification and Documentation of Change in Resident Status)

6. Document progress towards healing, and resident's reaction to dressing change and response to pain, if necessary.

B. Wound Documentation by Licensed Nurse

1. Use "Wound LDA" when documenting wounds/skin injuries including pressure injuries, erythema, ecchymosis in the EHR.

2. If resident has a Wound Vac, must have an additional LDA → "Negative Pressure Wound Therapy"

3. Document initial application of treatment ordered

4. Document pain assessment with wound care

5. **Initial and Weekly Wound Assessment**: Create worklist tasks to notify staff of the weekly wound assessment and dressing changes as ordered. Include the following in the assessment documentation:
    a. **Site Assessment**
        i. Location
        ii. Wound Bed (include wound edges, drainage, bleeding)
        iii. Measurements (length/width/depth in centimeters, tunnelling, undermining)
    b. **Peri-Wound Assessment**
    c. Progress towards healing or deterioration
    d. Treatment & Dressing performed
    e. **Pain Assessment**

6. **Weekly Summary** for residents with wounds should include:
    a. Assessment of any new risk factors for developing a pressure injury
    b. Evaluation of the effectiveness of implemented wound/skin/treatment/interventions

c. Revision of wound/skin care plan as needed

7. **Every shift** documentation for residents with wounds
    a. IF the dressing change is not due
        ii. Document **Dressing Status**
        iii. Document **Site Assessment** as "UTA" for "unable to assess" and specify in comment section the reason
        iv. Document **Peri-Wound Assessment** to the extent the area can be observed without removing the dressing
    b. IF the dressing change is due (e.g., scheduled changes or soiled dressing)
        i. Document **Site Assessment** and **Peri-Wound Assessment**
        ii. Document **Dressing Change** and **Dressing Status**
        iii. Document resident/patient refusal to wound dressing change
    c. IF no dressing is ordered
        i. Document **Site Assessment** and **Peri-Wound Assessment**
        ii. The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection; whether pain, if present, is being adequately controlled

C. Wound Management

1. For management of pressure injuries, refer to Nursing Policy and Procedure K 1.0 Assessment, Prevention, and Management of Pressure Injury.

2. For management of skin tears, refer to NPP K 10.0 Prevention and Treatment of Skin Tears

3. Management of Skin Substitutes and Extracellular Matrix (ECM)
    a. Skin substitutes and ECM, which are used to promote healing for chronic wounds that have not responded to optimal care, are applied in the Outpatient Clinic.
    b. To prevent damage of the newly applied product, the primary dressing is left in place for up to 7 days, or per physician orders.
    c. Secondary dressing is changed when soiled or dislodged, or per physician orders.

4. Management of arterial, diabetic/neuropathic, or venous wounds - refer to the following table. For wounds that require compression dressing, refer to CoFlex TLC: Two-Layer Compression Kit - Instructions for Use

	Types of Wound	Types of Wounds		
		Arterial	**Diabetic/Neuropathic**	**Venous**
Characteristics	**Location**	The distal aspect of arterial circulation can be anywhere on the leg, including the toes and feet	Can be anywhere on the lower extremity, usually located on the foot	Located in the gaiter area (ankle to mid-calf), it is often medial malleolus and maybe circumferential
	Wound Margin	"Punched out," well-defined borders	Usually with a calloused edge	Irregular shaped
	Wound Size	Can be small, but often increases due to lack of arterial perfusion	Often small	Usually large

	Wound Bed	Pale wound bed, little or no granulation, necrotic tissue is common	Similar to arterial wounds, usually with a calloused edge	Usually shallow, can have viable or necrotic tissue
	Exudate	Minimal to no exudate	Minimal to no exudate	Can vary from none to heavy to generalized weeping
	Edema	If present, localized	If present, localized	Generalized edema to lower extremity
	Pain	Occurs at rest, at night, or when the extremity is elevated	Due to neuropathy, the pain maybe absent or severe	Often occurs in a dependent position along with edema
	Best Practice	• If perfusion is not adequate, consider vascular consult • If perfusion is adequate, follow protocol based on wound assessment and characteristics • If dry and stable, leave eschar intact	• Maintain optimal moisture • Control diabetes, if appropriate • Repetitive removal of callous • Bioburden control and prevention of systemic infection • Remove pressure with appropriate off-loading shoe or other appliance	• Compression • Remove necrotic tissue • Maintain optimal moisture • Protect periwound skin • Control bioburden • Ensure lower extremity moisturization
	~~Types of Wound~~	~~Arterial~~	~~Diabetic/Neuropathic~~	~~Pressure~~

~~A.~~

~~**PROCEDURE:**~~

~~B.~~

1. ~~**Management of Pressure Ulcer – refer to LHHPP 24-15 Management of Pressure Ulcers.**Management of Pressure Ulcer – refer to LHHPP 24-15 Management of Pressure Ulcers.~~
2.
3. ~~For management of arterial, diabetic/neuropathic, or venous wounds, refer to table under Background section.~~
4.
5. ~~Note: For wounds that would require compression dressing, refer to~~
6.
7. ~~Use of Advanced Wound Products Specific to Skin Substitutes and Extracellular Matrix (ECM)~~
8.
9. ~~Special dressing specifically the skin substitutes and ECM are only applied in the Outpatient clinic. Refer to Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM.~~
10. ~~To prevent damage of the newly applied product, the primary dressing is left in place up to 7 days.~~
11. ~~Secondary dressing is changed when soiled or dislodged.~~
12.
13. ~~Documentation and Reporting on the Electronic Health Record (EHR)~~
14.
15. ~~Document initial application of treatment ordered~~
16. ~~Document a complete wound assessment (e.g. location, description of wound, including size, quantity and quality of drainage if present, including wound edges and wound bed, condition of~~

surrounding tissues, progress towards healing and when deterioration of the wound is observed or suspected,) weekly.

17. Report any undue bleeding, untoward reactions to the physician; and document.
18. Document progress towards healing, resident's reaction to dressing change and response to pain, if necessary.
19. RCT will conduct a meeting for new onset or worsening of wound.

ATTACHMENTS:

Attachment 1: Two Layer Compression Bandage System
Attachment 2: to Skin Substitutes and ECM ProductsNONE

REFERENCES:

Coflex TLC Two-Layer Compression Kit Instructions for Use (2024) - https://ovikhealth.com/wp-content/uploads/2024/11/WEB_CoFlex-TLC-Lite-IFU_5000017841_TLCLITEIFU_r3-2024-05.pdf - electronic access on April 7, 2026

Elsevier (2025) Assessment: Pressure Injury and Wound - https://point-of-care.elsevierperformancemanager.com/skills/1242/extended-text?virtualname=sanfrangeneralhospital-casanfrancisco – electronic access on April 6, 2026

The Wound Care Handbook from Medline Industries (20017) - https://www.medline.com/wp-content/uploads/2017/02/CAT_Advanced-Wound-Care.pdf - electronic access on April 6, 2026

Bryant, R. A.., & Nix, D. P. (2012). Acute and Chronic Wounds: Current Management Concepts (4th Ed.). St. Louis Missouri, Elsevier, Mosby

CROSS-REFERENCES:

Laguna Honda Hospital-wide Policyies and Procedures
24-15 Management of Pressure Ulcers

Nursing Policiesy and Procedures
C 4.0 Notification and Documentation of Change in Resident Status
K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury
K 3.0 Wound Irrigation and Cleansing
K 10.0 Prevention and Management of Skin TearsK 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury

Revised: 08/2000, 03/2008; 05/12/2015; 03/12/2019; 02/13/2024; 04/09/2026

Reviewed: 02/13/202402/08/2026

Approved: 02/13/2024

EMERGENCY INTERVENTION FOR CHOKING

POLICY:

1. The Code Blue process shall be utilized for choking events, unless specific directive has been expressed in the resident's/patient's Advanced Directive, stating otherwise. (Refer to HWPP 24-16 Code Blue)

2. Nursing staff must follow current American Heart Association (AHA) guidelines for choking response.

~~1.~~3. Nursing staff must follow facility's procedures ~~(e.g., urgent speech referrals)~~ to safely manage residents/patients who are identified to be at risk of aspiration. {Refer to Hospitalwide Policy and Procedure (HWPP) 26-02 Management of Dysphagia and Aspiration Risk}

~~2. The Code Blue process shall be utilized for choking events, unless specific directive has been expressed in the resident's/patient's Advanced Directive, stating otherwise.~~

~~3.~~4. All nursing staff shall be trained in ~~conscious emergency~~ identification and intervention for conscious and unconscious choking during orientation, annually, and as needed.

~~4. All licensed nurses and patient care assistants (PCA) shall be trained and remain current in Basic Life Support (BLS).~~ All nursing staff shall maintain current Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) certification as required by job description.

5.

PURPOSE:

To ensure that residents/patients who are choking receive prompt, effective interventions.

~~DEFINITION~~BACKGROUND:

~~Choking is obstruction or constriction of the airway passage due to a foreign body such as inadequately chewed food which can result into respiratory blockage or even death.~~ Choking occurs when the airway becomes either partially or completely blocked by a foreign object, such as a piece of food or a small toy; by swelling in the mouth or throat, or by fluids, such as vomit or blood.

A person who is choking can quickly become unresponsive and die, so it is important to act quickly.

~~Abdominal thrust maneuver is a technique intended to remove foreign body from the airway passage to relieve resident from conscious choking. This maneuver consists of repeated abdominal thrusts by wrapping your arms around the resident's waist from behind and making a fist with one hand and placing it against the resident's abdomen. If a resident becomes unconscious from choking, perform cardiopulmonary resuscitation (CPR) with chest compressions and rescue breaths , checking the airway for blockage each time before giving breaths.~~

SIGNS AND SYMPTOMS OF CHOKING:

If a resident exhibits the following signs of choking, **IMMEDIATELY CALL FOR HELP and CALL A CODE BLUE:**

- Panicked, confused, or surprised facial expression
- Holding throat with hand or pointing to their neck
- High-pitched squeaking noises as the person tries to breathe, or nothing at all
- Coughing (either forcefully or weakly) or not unable to cough at all
- If the airway is totally blocked, the person will not be able to speak, cry or cough.
- The person's skin may initially appear flushed (red) but will become pale or bluish in color as the body is deprived of oxygen.

~~The universal sign of choking is clutching of the neck with hands; other choking signs include ineffective cough or no cough at all, inability to speak, possible cyanosis, high-pitched noise while inhaling or no noise at all, or poor or weak air exchange. Choking is considered a medical emergency and prompt intervention is needed.~~

~~While anyone can experience an episode of choking, specific residents who are at risk for aspiration and choking are identified with a pink sticker in the following locations:~~

- ~~Bed card (above bed)~~
- ~~Hallway~~
- ~~Mobility devices (wheelchairs, geri-chairs, canes, front wheel walkers, etc.)~~

~~The nurse manager, charge nurse or nursing team leader will designate the use of color coding and safety alert interventions based on a thorough assessment of individual resident needs and risks.~~

PROCEDURE:

~~A. Refer to: https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco Refer to: https://point-of-care.elsevierperformancemanager.com/skills?virtualname=sanfrangeneralhospital-casanfrancisco Skills: (elsevierperformancemanager.com)~~

A. Response

- Stay calm, call for help, and activate "Code Blue"
  - If the resident is in their room, press "Code Blue" button on nurse call panel, AND
  - Call 4-2999
- Stay with the person until assistance arrives
- If resident/patient is alert and responsive but shows signs of choking:
  - Encourage resident/patient to cough it up if they can
  - If BLS certified, follow AHA guidelines for choking response
- If resident/patient is able to expel, or nursing staff is able to retrieve the object that caused the blockage, the licensed nurse will retain the object until further instructions from the physician and nursing supervisor.

- After a choking incident, the registered nurse will perform a thorough assessment, inform the physician of assessment data and request for additional interventions ~~(e.g., urgent speech referral, update in advanced directive, or downgrading diet).~~ . (Refer to HWPP 26-02: Management of Dysphagia and Aspiration Risk)

B. Documentation

Licensed Nurse is to document the procedures and the condition of the resident, pre and post choking incident, in the electronic health record (EHR) and update resident care plan. (Refer to NPP C 4.0 Notification and Documentation of Change in Resident Status)

REFERENCES:

American Heart Association, BLS for Healthcare Providers 2020

American Heart Association(2025) 2025 AHA CPR Guideline Highlights | American Heart Association International | American Heart Association International - https://international.heart.org/en/news-and-events/2025/oct-cpr-guidelines-top-highlights - electronic access on April 10, 2026

American Red Cross (2026) Adult & Child Choking: Symptoms and First Aid - https://www.redcross.org/take-a-class/resources/learn-first-aid/adult-child-choking?srsltid=AfmBOorXehAiRAx6cju0mfi1YY64wHaKOCpZ9h4SCNZs1LPzSPZ7DWUf – electronic access on April 10, 2026

Elsevier (December 2025) Patient Education: Choking in Adults: What it Means https://point-of-care.elsevierperformancemanager.com/patienteducation/content?searchType=di&searchContext=peconditions&language=english&languageId=92888112-0e52-4516-b8db-f9aa2a31eb61&searchTerm=&virtualname=lhh – electronic access on April 22, 2026

CROSS REFERENCES:

Hospitalwide Policy and Procedure
- 24-16 Code Blue
- 26-02 Management of Dysphagia and Aspiration Risk

Nursing Policy and Procedure
- B 5.0 Resident Identification and Color Codes
- C 4.0 Notification and Documentation of Change in Resident Condition

APPENDIX/APPENDICES:

NONE

Revised: ~~2000/~~08/2000;~~,~~ ~~2005/~~01/2005~~,~~; ~~2010/~~03/2010;~~,~~ ~~2013/~~11/01/2013;~~,~~ ~~2014/~~03/25;2014;~~,~~ ~~2019/~~03/12/2019; ~~2024/~~01/02/2024; 04/10/2026

Reviewed: ~~2019/~~03/12/2019; ~~2024/~~09/16/2024

Approved: ~~2024/~~08/13

/2024

~~**ATTACHMENT:**~~

Deletion Nursing

Policies and Procedures

INSULIN SUBCUTANEOUS INFUSION THERAPY FOR PATIENT MANAGED INSULIN PUMP

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) will allow residents with diabetes who have an insulin infusion pump to self-manage their insulin needs under the supervision of LHH clinical staff.

2. Residents who have an insulin infusion pump and wish to continue to self-manage their diabetes will sign written consent by completing the "Contract for the use of continuous subcutaneous infusion (Insulin Pump) in the hospital" consent form.

3. Residents on a subcutaneous insulin infusion pump are responsible for their own subcutaneous puncture and the supplies needed.

4. Residents with an insulin infusion pump who are not able to demonstrate safe use of pump will be disconnected from the device by clinical staff. Staff will immediately notify provider for standard insulin orders and treatment guidance.

5. Insulin used in insulin pump will be provided by LHH pharmacy per physician order and will be stored in the medication cart, labeled, and maintained per hospital policy.

6. Any resident with insulin pump will have endocrinology service involved in their care and pump settings will be determined by endocrinologist.

7. Licensed nurses (LN) who care for residents with an insulin infusion pump will not manipulate the device and will only be responsible for monitoring and observing the residents' use of device.

8. LN will perform Point of Care Testing (POCT) per orders.

PURPOSE:

1. To provide safe care for residents with an insulin infusion pump that is used for self-management of diabetes.
2. Establish guidelines to staff for monitoring and documenting of resident's use of insulin infusion pump.

CONTRAINDICATIONS:

1. Subcutaneous Insulin Pump therapy should not continue if any of these reasons exist:
   a. Resident Care team deems the resident is not competent to manage their pump/insulin therapy safely.
   b. Resident develops altered cognition or level of consciousness.
   c. Pump is out of insulin and pharmacy cannot supply specific insulin type.
   d. Pump is malfunctioning.
   e. Infusion set is malfunctioning, and the patient has no replacement infusion sets to replace it.
   f. Patient does not want to wear the pump during hospitalization.

DEFINITIONS:

Insulin Infusion Pump – Small, computerized device that delivers doses of short or rapid acting insulin via subcutaneous infusion. Device can deliver insulin at a basal rate and/or as bolus infusions. Pump has a reservoir which stores the insulin to be delivered to resident. Reservoir is filled and replaced every 48-72 hours or per provider instructions.

Infusion Set – Infusion device which combines an infusion set (catheter) with an aid for infusion (inserter). It is used for inserting subcutaneous needle and is for single use only. Once inserted, the catheter is held in place by a transdermal patch. This site is connected to the insulin infusion pump with pump tubing. Infusion set is changed every 48-27 hours per provider instructions.

PROCEDURE:

1. Residents identified with insulin infusion pump, who wish to start or continue its' use, will need authorization from endocrinology and LHH provider who will provide instructions for pump setting orders which resident is to use.
2. Confirm the resident has signed consent and it is scanned to EHR.
3. LHH provider will enter orders in EHR.
4. Confirm with the resident the insulin infusion pump supplies are setup to be delivered to LHH or there is a plan for family/surrogate to bring supplies to LHH.
5. Responsibilities of LN caring for resident:
    a. Check infusion site for redness or dislodgement of infusion catheter each shift. If the appearance of the infusion site indicates inflammation or there is pain/tenderness at infusion site, notify provider as insertion set may need to be replaced.
    b. Review with resident the pump's basal rate and the remaining insulin reservoir amount every shift with site assessment.
    c. Report repeated high blood glucose readings to provider based on provider parameter order.
        i. New onset hyperglycemia despite insulin infusion may indicate the infusion set is not functioning properly and infusion set should be changed.
    d. Treat hypoglycemia per hypoglycemia protocol.
    e. Document observation of resident programming pump for all insulin boluses given by the patient through the insulin infusion pump in the MAR.
    f. Report to the physician if the patient is unable to operate the pump for any reason.
    g. Disconnect pump at catheter infusion site for the following reasons. Do not remove the subcutaneous application patch.
        i. If the pump malfunctions, infusion set dislodges, catheter kinks, or if reservoir becomes empty and the patient is not able to correct these problems by changing the infusion set and/or reservoir. This may be performed by resident.
        ii. If resident becomes unconscious due to suspected hypoglycemia.
        iii. If the resident care team determines that the resident is unable to operate the pump safely for any reason.
        iv. When resident is showering. This may be performed by resident.
        v. Per provider order to discontinue.
    h. Resident will be educated on the following:
        i. He/she should not change the pump profile settings without medical team's direction.
        ii. It is against hospital policy and state regulation to keep insulin vials at the bedside and to use insulin from home.
        iii. Insulin will be supplied by the hospital pharmacy.

iv. If resident cannot provide supplies for the pump, including extra infusion sets, reservoirs, and batteries, the infusion will be discontinued.
v. Resident will change the infusion set every 3 days if system remains uncompromised or if they experience unexplained hyperglycemia or if there are signs of infection at the insertion site.
vi. He/she shall show the LN or physician the pump settings whenever he/she requests.
vii. The pump should be disconnected for mammogram, bone density measurement, radiation treatment, CT scan, MRI, X-rays. The infusion set can stay in place unless it is made of metal.
viii. He/she should not change the pump settings without the medical team's direction.
ix. He/she will not inject insulin boluses without the LN's supervision and will show the LN the bolus amount before delivering via pump.

DOCUMENTATION:

1. LN will add an LDA in the EHR Avatar to reflect the insulin infusion pump titled "Pump Device".
   a. Complete assessment Q Shift
   b. Update LDA documentation with insertion site changes.
   c. When resident fills/refills reservoir with insulin provided by pharmacy, document in the MAR.

2. Document in MAR when resident self-administers bolus and/or correction insulin doses.

3. Care plan for self-administration.

CROSS REFERENCES:

Nursing Policies & Procedures:
G 5.0 Blood Glucose Monitoring

ZSFG & LHH Contract for the Use of Continuous Subcutaneous Insulin Infusion (Insulin Pump) In the Hospital

New: 05/10/2022

Revised: 05/10/2022; 05/16/2025

Reviewed: 08/19/2025

Approved: 08/19/2025

Attachment 1: Two Layer Compression Bandage System

Definition:

Coflex® TLC two layer compression bandage system delivers a light therapeutic compression to manage edema up to 7 days.

Features:

1. Compression bandage system is ideal for venous-type ulcers.
2. Advanced two-layer compression system provides support and compression to feet and legs
3. Sizes varies from S to XL.
4. Layer 1 is a soft foam with an absorbent coating (blue contact layer) that wicks away moisture and helps control odor.
5. Layer 2 is a soft foam with an absorbent coating (blue contact layer) that wicks away moisture and helps control odor.
6. Both layers are not made with natural rubber latex free and bond together when applied which keeps the system in place.
7. A nylon stocking is included to apply over the completed dressing for patient comfort and ease of movement under clothes and on bed sheets.
8. Comfortable and lightweight for increased patient compliance.

Application of Spiral Wrapping Technique:

Layer 1:

1. Flex the foot to 90 degrees and apply Layer 1 (Blue coating facing the leg) in two turns starting at the base of the toes.
2. Proceed up and around ankle, covering the Achilles tendon.
3. Return over the top of the ankle and down to secure the heel. Cover all exposed skin of the heel.
4. Wrap in a spiral up to the leg. While wrapping, overlap the bandage by half of the width of the bandage.
5. Finish below the heel and discard any unused bandage. Secure layer 1 (padding) with tape.

Layer 2:

1. Follow same the above procedure (from 1 to 5) using Layer 2 (cohesive bandage). Cohesive bandage must be at or near full stretch. The cohesive bandage will adhere itself.

New: 2023/02/20

Revised: 2023/2/20

Reviewed: 03/10/2023; 2024/02/13

Approved: 2024/02/13

Attachment 2: Skin Substitutes and Extracellular Matrix (ECM) Products

Indication:

Use with chronic wound that has not responded to optimal care (including both systemic and local wound management) and after all necrotic tissue, fibrinous slough, and surrounding callus has been debrided, to promote wound healing. Applied in Laguna Honda Outpatient Clinic only.

Background: Skin substitutes and Extracellular Matrix (ECM) can be classified as cellular (i.e., containing living cells) or acellular.

Cellular products are frequently referred to as skin substitutes and acellular products as extracellular matrix (ECM) scaffolds.

These products may be:

1. autologous (derived from the patient's body)
2. allogenic (derived from other humans, also called homograft)
3. xenographic (derived from non-human sources, e.g., porcine, bovine, equine, avian (also called heterograft)
4. biosynthetic (biological and manmade materials)
5. synthetic (man-made materials)

Cellular Products	Acellular Products
Contains living cells consists of autologous or allogeneic keratinocytes and /or fibroblasts and the ECM proteins and growth factors produced by these cells.	Nonliving produced from allogeneic, xenographic, biosynthetic materials.
Epidermal skin substitute are cultured keratinocytes taken as a biopsy either from the patient (autograft) or from another human (allograft).	Most commonly referred to as ECM scaffolds.
Dermal skin substitute contain fibroblasts seeded and cultured on a bioabsorbable matrix along with the ECM proteins and growth factors that they produced.	Xenographic porcine (Oasis Wound Matrix)
Bi-layered skin substitute is a living allogeneic bi-layered skin substitute consisting of keratinocytes and fibroblast.	Apligraf

New: 2015/05/12

Revised: 2023/2/20

Reviewed: 03/10/2023; 2024/02/13

Approved: 2024/02/13